Intercollegiate Board for Training in
INTENSIVE CARE MEDICINE

Curriculum for a CCT in
Intensive Care Medicine

Part I

The Handbook

Edition 2
August 2010

Preface

This, the 2nd edition of *The CCT in Intensive Care Medicine,* replaces *The CCT Intensive Care Medicine* Edition 1.   It has been revised to align with *Standards for Curricula and Assessment Systems*, GMC, London, 2010.

In 2007 the titles of trainees changed with the introduction of Modernising Medical Careers [MMC] and they changed again in 2008.   The term Specialty Registrar [StR] is used throughout this curriculum to encompass trainees who may still be in Fixed Term Specialty Training Appointments [FTSTA] and those with contracts as Core Trainees [CT] and Specialist Registrars [SpR].

      StR1 = CT1   = FTSTA1
      StR2 = CT2   = FTSTA 2
      StR3 = SpR1 = FTSTA 3
      StR4 = SpR2
      StR5 = SpR3
      StR6 = SpR4
      StR7 = SpR5

Abbreviations

A list of commonly used abbreviations is provided in Appendix 3.

Advice

The first point of contact for information concerning a trainee's training or career planning is this curriculum and the IBTICM website www.ibticm.org.

The next point of contact is the Board Tutor of the department in which the trainee is working. If the Board Tutor is unable to give the necessary guidance then the Regional Adviser should be asked for advice.

Only if the Board Tutor or Regional Adviser cannot help should a trainee contact the Board directly for advice because inevitably the Board will have no knowledge of the trainee's personal circumstances.

Contents

Overview of the CCT in Intensive Care Medicine

These documents are entitled *The CCT in Intensive Care Medicine*, but the principles described apply to all training undertaken for the purpose of programmes supervised by the Intercollegiate Board, whether Basic, Intermediate or Advanced Training, or training intended to lead to the award of the CCT in ICM with a CCT in a specialty of primary appointment.

This is a multidisciplinary training programme which has been developed by the Intercollegiate Board for Training in Intensive Care Medicine [IBTICM] in conjunction with the parent Royal Colleges, Regional Advisors and trainees in ICM, and many other contributors. It is a programme in evolution; revisions will be published when required.

The Intercollegiate Board will acknowledge satisfactory completion of all of the components of Intermediate or Advanced training formally by letter. Appointment to an approved programme in a post designated for CCT training, followed by satisfactory completion of the training programme and the assessments of competence to Advanced level will permit trainees to acquire a CCT in ICM awarded with the CCT in the specialty of primary appointment.

1.   Introduction

1.1   Aim

This document identifies the aims and objectives, content, experiences, outcomes and processes of postgraduate specialist training leading to a CCT in Intensive Care Medicine. It defines the structure and expected methods of learning, teaching, feedback and supervision.

It sets out what knowledge, skills, attitudes and behaviours the trainee will achieve. These are identified as learning outcomes that are specific enough to be a precise guide for trainers and trainees. A system of assessments is used to monitor the trainee's progress through the stages of training.

1.2   The scope of Intensive Care practice

Intensive Care Medicine has one of the broadest scopes of practice within the field of Medicine. Whilst practitioners may be based in Intensive Care and High Dependency Units their range of referral practice includes most of the modern acute hospital. Within a single day, Intensivists may find themselves involved in the care of patients ranging from the young to the very old; encompassing locations as diverse as the Emergency Department and the day case surgery unit.

The training requirements of ICM reflect both its historic origins and subsequent developments. Intensive Care grew out of two basic patient based needs. Firstly, it was recognised during the polio epidemics of the late 1950s and early 1960s that the management of large numbers of patients with acute respiratory failure was best managed in dedicated areas of the hospital. Secondly, the increasing complexity of surgical practice, again beginning in the 1960s, necessitated the creation of units which could offer more than limited recovery care. More recently the UK ICU Modernisation Agency programme recognised that severely ill patients were best cared for by multi-disciplinary, medical led teams that had expertise in ICM.

This need for a large breadth and depth of Medical, Anaesthetic and Surgical knowledge and skills distinguishes ICM from its parent disciplines. This also explains the need for multiple entry points to ICM training as defined in this curriculum. The close working relationship between ICM and its parent disciplines remains vital to successful practice. It has undoubtedly contributed to the recently documented success of ICM in improving both the process and outcome of care in severely ill patients in the UK [1]

1.3   Curriculum design and development

This curriculum represents a revision and rewrite of the previous curriculum documents taking into account guidance from the following two authorities:

a.   **The General Medical Council [GMC]** has developed and published a schedule of seventeen specific standards with which a postgraduate medical curriculum must comply. The IBTICM

---

[1] Hutchings A, Durand MA, Grieve R, Harrison D, Rowan K, Green J, et al. Evaluation of modernisation of adult critical care services in England: time series and cost effectiveness analysis. *BMJ* 2009;339:b4353.

fully accepts these as representing good practice in curriculum and assessment development and this document fully reflects these principles.

b.   **The NHS Litigation Authority [NHSLA]** is a Special Health Authority responsible for handling negligence claims made against NHS bodies in England[2].   The NHSLA has published standards expected of Trusts*.   **For training these emphasise the need for appropriate supervision and assessment, and the documentation of competencies.**   To assist employers, trainees and trainers to comply with this, the curriculum defines the competencies that have to be achieved and completed satisfactorily at each stage of training.   Importantly, this Edition includes reference to minimum clinical learning outcomes that all trainees must achieve before progression to the next stage of training.

1.3.1   The development process

The development of the syllabus for the CCT in ICM has drawn extensively on the CoBaTrICE syllabus created under the auspices of the European Society of Intensive Care Medicine.   The IBTICM acknowledges the vital role that the CoBaTrICE project group's work has played in designing this curriculum.

1.3.2.   Description of CoBaTrICE methodology[3]

Consensus techniques (modified Delphi and nominal group) were used to enable interested stakeholders (health care professionals, educators, patients and their relatives) to identify and prioritise core competencies.   Online and postal surveys were used to generate ideas.   A nominal group of 12 clinicians met in plenary session to rate the importance of the competence statements constructed from these suggestions.   All materials were presented online for a second round Delphi prior to iterative editorial review.   The initial surveys generated over 5,250 suggestions for competencies from 57 countries.

Preliminary editing allowed the original European working group to encapsulate these suggestions within 164 competence stems and 5 behavioural themes.   For each of these items the nominal group selected the minimum level of expertise required of a safe practitioner at the end of their specialist training, before rating them for importance.   Individuals and groups from 29 countries commented on the nominal group output; this informed the editorial review. These combined processes resulted in 102 competence statements, divided into 12 domains. Using consensus techniques core competencies were generated which are internationally applicable but still able to accommodate local requirements.   This provided the foundation upon which this competency based training programme for Intensive Care Medicine was built.

Following the adoption of the CoBaTrICE competency approach a UK expert group, constituted by the IBTICM and including lay representation, further refined the competencies. This included their division into competencies best achieved during Basic, Intermediate and Advanced training in ICM.   In a few cases, the practice of Intensive Care has moved on since the CoBaTrICE document was written and this is reflected in this curriculum.

---

[2] The Welsh Risk Pool and the Scottish Clinical Negligence and Other Risks (Non-Clinical) Indemnity Scheme (CNORIS) fulfil similar roles to the NHSLA. In Northern Ireland each Trust has its own risk assessment and negligence scheme.

[3] Bion JF, Barrett H. Development of core competencies for an international training programme in Intensive Care Medicine. *Intensive Care Med* 2006;32(9):1371-83.

1.4   Ongoing curriculum review

The curriculum will be reviewed regularly with an implementation date for any changes being not less than six months after their publication date.   Minor changes will be inserted in the on-line manuals immediately and will be collectively submitted to the GMC for approval once a year.   Major changes, such as a new unit of training, will be submitted to the GMC for approval as and when necessary and will be inserted into the curriculum when approval has been granted.   Summaries of changes are listed on the training pages of the IBTICM website as they occur.

Occasionally the Board has to take decisions that may affect the immediate interpretation or application of specific items in this manual. These will be published on the website and circulated to Regional Advisors.

1.5   Structure of the curriculum manual

The document has three parts:

- **Part I**   is the Handbook, an overview of competency-based training in ICM. It includes background information, current criteria and standards for training and assessment methods.
- **Part II**   is the Educational Training Record
- **Part III**   is the Syllabus for the training programme. This is divided into Basic, Intermediate and Advanced training sections. Each section defines the training objectives and defines the competencies required to fulfil those training objectives. These are presented within themed domains with mapping to assessment tools and GMP requirements.

2.   Principles of the training programme

2.1   Underlying principles

The principles of the UK CCT in Intensive Care Medicine training programme are that it:

- Is outcome based
- Is planned and managed
- Does not jeopardize safe practice
- Is delivered by appropriately trained and appointed trainers
- Allows time for study
- Includes core professional aspects of medical practice, that are essential in the training of all doctors
- Meets the service needs of the NHS
- Is prepared with input from the representatives of patients
- Accommodates the specific career needs of the individual trainee
- Is evaluated
- Is subject to review and revision

2.2   Training concepts

2.2.1   "Spiral" learning

The training programme is based on this concept which ensures that the basic principles learnt and understood are repeated, expanded and further elucidated as time in training progresses; this also applies to the acquisition of skills, attitudes and behaviours.

To facilitate this, the programme is divided into Basic, Intermediate, and Advanced levels, each consisting of a core of essential units of training which the trainees return to at each level, as well as specialist areas of practice which are introduced from the Intermediate level onwards. The outcome is such that mastery of the specialty to the level required to commence independent practice in a specific post is achieved by the end of training as knowledge, skills, attitudes and behaviours metaphorically spiral upwards.

2.2.2   Common competencies of medical practice required by all doctors

The trainee must also develop general professional knowledge, skills, attitudes and behaviours required of all doctors. The common competencies in the core aspects of medical practice [identified from the AoMRC Common Competencies and Medical Leadership Curriculum Frameworks] are as important as the clinical competencies identified and they should be attained seamlessly during clinical training. The specific areas identified are as follows:

- Time management and decision making
- Decision making and clinical reasoning
- Therapeutics and safe prescribing
- Patient as a central focus of care
- Learning, teaching and training
- Medical Leadership

- Principles of quality and safety improvement
- Principles of medical ethics and confidentiality
- Relationships with patients and communication within a consultation
- Breaking bad news
- Complaints and medical error
- Legal framework for practice
- Audit

2.3   Training environments

The training of Intensivists will occur in UK posts and programmes approved by the GMC, or in other posts and programmes for which prospective approval has been given. Departments in which training occurs must comply with the regulations and recommendations of the relevant national Departments of Health, the GMC and the IBTICM.

2.4   Trainers

Doctors responsible for training have to comply with the GMC generic standards for training[4]. The IBTICM *Criteria for the Appointment of Trainers* can be found in Appendix 4.

2.5   Out of hours commitments

Most ICM work is unscheduled and at least 50% of admissions to Critical care Units occur "out of hours". In view of this it is essential for trainees to gain experience outside routine working hours. This provides:

- An opportunity to experience and develop clinical decision making, with the inevitable reduction in out-of-hours facilities, under distant supervision
- An opportunity to learn when to seek advice and appreciating that, when learning new aspects of emergency work as trainees, they require close clinical supervision
- A reflection of professional ICU practice, as in most hospitals patients are admitted 24 hours a day, seven days a week, so requiring dedicated out-of-hours emergency facilities; there is thus a service commitment
- In view of these training needs at least 12.5% of time should be spent on ICU outside of 08:30 to 18:30 daytime hours at Intermediate and Advanced levels. Cover of other areas may be allowed provided the trainee is rapidly available for ICU at all times. Immediate cover for emergencies outside ICU is acceptable but there should be arrangements in place to ensure that ICU cover is not compromised.

2.6   Less than full-time [LTFT] trainees

After appointment in open competition any trainee, with Deanery agreed eligibility, can request to train less than full time. The training programme will be delivered on a *pro rata* basis for those who are eligible and have Deanery support. Each region has a LTFT training adviser who

---

[4] *Generic Standards for Training*. General Medical Council, April 2010

works with the RA and the local Deanery to ensure that the needs of those trainees are met. General advice on LTFT training is contained in the "Gold Guide"[5].

Finally, the European Medical Directive states that:

> "Part-time training shall meet the same requirements as full-time training, which shall differ only in the possibility of limited participation in medical duties to a period of at least half that of full-time trainees, including on-call duties."

This is interpreted to mean that LTFT trainees should, *pro rata,* undertake the same out-of-hours work as full-time trainees, including weekend on-call duties.

2.7   Supervision

The critical nature of ICU work necessitates very close supervision of trainees. However, this must be balanced against the need for trainees to develop towards independent, expert practitioners. As always patient safety is the most important priority and must override any other apparent training needs.

2.7.1   Clinical supervision

Every trainee must, at all times, be responsible to a nominated consultant. The consultant must be available to advise and assist the trainee as appropriate. Sometimes this will require the consultant's immediate presence but on many occasions less direct involvement will be needed. Supervision is a professional function of consultants and they must be able to decide what is appropriate for each circumstance in consultation with the trainee. The safety of an individual hospital's supervision arrangements is the concern of the local department in conjunction with the hospital management; it is necessary for them to agree local standards and protocols that take account of their particular circumstances.

2.7.2   Educational supervision

Every trainee must have a nominated educational supervisor to oversee their individual learning.

2.8   Responsibility for training in the workplace

Competency based training relies on WPBA's made during clinical service. The responsibility for the organisation, monitoring and efficacy of this training and assessment is shared by a variety of authorities:

- **The GMC** is responsible for approving programmes of training and training capacity
- **The IBTICM** is responsible for:
  - Advising the GMC on the competencies/learning outcomes in training
  - Advising the Postgraduate Deans on the arrangements for organising and monitoring the in-service training provided by schools and hospitals

---

[5] *A Reference Guide for Postgraduate Specialty Training in the UK*. Modernising Medical Careers. Third edition June 2009.(sections 6.47-6.57)

- o Evaluating the training of individual trainees and recommending them to the GMC for the award of CCTs
- **The Postgraduate Dean** is responsible:
  - o To the GMC for the quality management of the training programme
  - o For the overall training arrangements in each Trust. The Clinical Tutor/Director of Medical Education acts as the Dean's officer within the trust and has overall responsibility for the educational environment
  - o For ensuring that the ARCP process is organised correctly
- **Schools of Anaesthesia, Medicine, Emergency Medicine and Surgery** in conjunction with **local Specialty Training Committee** are responsible for:
  - o The administrative organisation of trainee placements/rotations in the training programme
  - o Monitoring the training programme
  - o Providing Annual Reports to the Postgraduate Dean
  - o The administrative organisation of ARCPs
  - o Working with CDs to ensure satisfactory local arrangements are in place to ensure in-service training is delivered in accordance with the principles adopted by the DH [in regard to rota compliance], the GMC, the IBTICM and the Postgraduate Dean
- **TPDs** organise the rotations to ensure that all units of training are covered
- **RAs** are responsible for representing the policies and views of the IBTICM in all relevant matters within their region
- **Board Tutors** are responsible, ultimately, for the overall training and assessment arrangements in their hospitals, working in conjunction with the individual educational supervisors.
- **Educational Supervisors** are responsible for ensuring an individual trainee has an agreed educational plan, that this is delivered, that the appropriate assessments are carried out and that the trainee receives regular educational and workplace appraisals
- **Clinical Supervisors** are trainers who are selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement.
- **Consultant/SAS trainers:** All consultants/SAS Intensivists who have any contact with trainees [which includes providing senior support and cover for out of hours duties] have a responsibility for providing appropriate training, supervision and assessment. They must comply with the GMC regulations for trainers.

2.9 Accommodation for training and trainees

Any hospital with trainees must have appropriate accommodation to support training and education; this may be in the Department of Anaesthesia or elsewhere in the hospital e.g. the Postgraduate Teaching Centre. This accommodation should include:

- A focal point for the ICU staff to meet so that effective service and training can be co-ordinated and optimal opportunities provided for gaining experience and teaching
- Adequate accommodation for trainers and teachers in which to prepare their work
- A private area where confidential activities such as assessment, appraisal, counselling and mentoring can occur
- A secure storage facility for confidential training records
- A reference library where trainees have ready access to bench books [or an electronic equivalent] and where they can access information at any time

- Access for trainees to IT equipment such that they can carry out basic tasks on a computer, including the preparation of audio-visual presentations; access to the internet is recognised as an essential adjunct to learning
- A suitably equipped teaching area and a private study area
- An appropriate rest area whilst on shift

3. Objective, entry criteria and structure of the ICM CCT programme

3.1 Objective of the programme

The objective of the programme leading to the award of a CCT in Intensive Care Medicine is to produce high quality patient-centred doctors skilled in ICM as well as their specialty of primary appointment with appropriate knowledge, skills and attitudes to enable them to practise at consultant level in both ICM and their primary specialty.

3.2 Entry criteria for the programme

Entry to the ICM CCT programme is by competitive appointment to nationally advertised posts. Applicants must already have a National Training Number (NTN) in one of the following acute specialties.

- **Anaesthesia**
- **Medicine**
- **Emergency Medicine**
- **Surgery**

Trainees must enter the CCT programme by appointment in open competition as laid down by national regulations. Trainees may be appointed to advertised CCT training posts in Intensive Care Medicine early in Specialty Training, and normally no later than two years before the end of their primary specialty training programme.

It is permitted for trainees with an NTN in one Deanery to apply for training in ICM in a different Deanery. Trainees will retain their primary specialty NTN following appointment to the ICM training programme.

Before CCT entry, it is desirable, but not essential, that trainees have 3 months experience of Intensive Care Medicine (Basic training) in a pattern defined by the Intercollegiate Board obtained in whole or in part during the following postgraduate training stages: Acute Care Common Stem (ACCS) Programme at the start of Specialty Training, as part of a Specialty Training Programme in one of the above primary specialties or in any other post recognised for training in ICM at Basic level. Trainees who enter the ICM CCT programme without Basic ICM training will need to complete this block before undertaking Intermediate training.

3.3 Structure of training

The interaction between the primary specialty programme and the ICM programme is necessarily complex and requires close cooperation in planning by the Programme Directors and Regional Advisers in both specialties. The ICM programme will continue to deliver training in the generic aspects of the primary specialty and where appropriate will arrange joint assessments and ARCP processes. As trainees will usually leave their primary specialty training programme to acquire ICM training, it is essential that Regional Advisors plan the appointments process and the individual training programmes as far in advance as possible, and that they maintain close

communication with the relevant primary specialty training committees. A lead-in time of six months between appointment and taking up the appointment is desirable

During the blocks of Intensive Care Medicine training in both Intermediate and Advanced levels, the trainee's duties will be exclusively dedicated to the practice of Intensive Care Medicine throughout the hospital.

All training in ICM will take place within the United Kingdom, in GMC-approved units, with the exception of any proportion of Advanced training undertaken in suitable overseas centres with prior approval by the GMC, the Intercollegiate Board and the appropriate Postgraduate Medical Dean. Basic and Intermediate training must be acquired in the United Kingdom (UK).

Once training in all programmes is completed to the satisfaction of the Intercollegiate Board and the College of the primary specialty, and accepted by the GMC, the CCTs in the primary specialty and ICM will be awarded. Trainees who are unsuccessful at gaining entry to an ICM CCT programme but gain the relevant competencies in the required format may still have their ICM training recognised by the IBTICM at either Intermediate or Advanced level. Trainees are encouraged to discuss this with the Regional Advisor in ICM as early as possible.

3.4 Components of the ICM CCT programme

[*See Table 1, below*]

3.4.1 Basic Training in ICM

The indicative minimum basic requirement is 3 months training in ICM. To allow immersion in the specialty this training must be undertaken as a single block. All trainees in anaesthesia and some in acute medicine will obtain Basic training in ICM in years one or two of their primary specialty. All ACCS trainees will also obtain Basic ICM training during their rotations. Although the indicative requirement is for 3 months, those posts which offer longer periods of continuous training in ICM provide better opportunities for reinforcement of learning, improved continuity of clinical care, and more effective integration of the trainee in the ICU team and the activities of the unit.

3.4.2 Complementary Specialty Training

Complementary specialty training comprises 6 months in anaesthesia and 6 months in medicine. The medicine module may include a maximum of 50% of Emergency Medicine (EM). Complementary specialty training may be acquired in the following circumstances:

- **Acute Care Common Stem Training**
- **Specialty Training years 1-3**
- **Fixed Term Specialty Training Appointments**

It can also be offered as part of ICM CCT training programmes. It is usual for a proportion to form part of primary specialty training in anaesthesia or general internal medicine – thus anaesthetic trainees will need medicine as the complementary specialty and physicians will need anaesthesia, while surgical trainees must acquire both.

Training in the care of the acutely ill patient, and the '*Initial assessment of competence in the management of the acutely ill patient*' will occur during the Foundation Programme. However,

for trainees appointed to specialty training programmes prior to 2007 this training and assessment may be conducted at any time during Basic training in ICM or GIM.

3.4.3 Intermediate Training in ICM

This consists of 6 months dedicated education and training in ICM at ST3 level or above following the acquisition of Basic ICM competencies. This may be taken as either one continuous block or two blocks of approximately equal duration.

Intermediate competencies can also be acquired outside the ICM CCT programme provided that training has been undertaken in accordance with the guidance issued by the IBTICM.

In order to obtain IBTICM recognition of completion of an Intermediate level of ICM training then the trainee must have undertaken 6 months Intermediate ICM training, 6 months complementary training as defined in section 3.4.2, completed the 10 case reports and gained the appropriate competencies and educational sign-off.

3.4.4 Advanced Training in ICM

This consists of a further continuous block of ICM, in addition to the prior acquisition of Intermediate competencies. Although the block of training should be continuous trainees may rotate to different units in order to increase their experience. The expected duration required to achieve the competencies is 12 months. For the purpose of the CCT programme, Advanced training can only be acquired following competitive entry to an approved CCT programme of training in ICM. Up to 6 months of Advanced training may be undertaken in approved units overseas, given prior approval by the Board and the GMC.

3.4.5 Summary of indicative duration of components of the ICM CCT

The total duration of the programme for any particular trainee will vary with the specialty of primary appointment, how much of the primary specialty programme is allowable for training in ICM and how much of the ICM programme is allowable for training in the primary specialty. The components that must be carried out to meet the requirements of the ICM CCT are summarised in the table below in months:

Component of Training	Normal duration (Months)
Basic ICM	3
Complementary Anaesthesia	6
Complementary Medicine	6
Intermediate ICM	6
Advanced ICM	12

Table 1

Summary of Requirements for Training in Intensive Care Medicine			
	Definitions and requirements	**Variances**	**Notes**
Basic ICM Training	3 months ICM training in educationally approved posts	Must be taken as a continuous block. Time may be extended if competencies are not acquired in 3 months.	It is desirable but not essential to undertake Basic training before appointment to an ICM CCT post. It may be undertaken as part of ST training in the primary specialty, during ACCS training or in an FTSTA prior to entry to the ICM CCT programme. Intermediate training cannot commence without successful completion of Basic training.
Complementary Specialty Training	6 months of Anaesthesia and 6 months of Acute Medicine (of which up to 50% may be Emergency Medicine).	The period may vary according to rate at which competencies are acquired.	Competencies may be acquired after ICM CCT appointment, but must be satisfactorily completed before starting Advanced training.
ST post in primary specialty	Essential prior requirement for ICM CCT training.	None.	Specialty Registrar training programme in Emergency Medicine, Anaesthesia, Medicine or Surgery.
Competitive entry to ICM CCT programme	Competitive application to 'open' ST post in ICM. The trainee must already have a National Training Number in a primary specialty.	None.	Training post must be open to applicants from Anaesthesia, Internal Medicine, Surgery and Emergency Medicine. Closed or specialty-specific posts cannot be used for ICM CCT training. It is desirable (but not essential) that trainees have gained Basic level competencies before appointment to an ICM CCT post.
Intermediate ICM Training	6 months of ICM, generally taken in the first 3 years of primary specialty training. Trainees must have completed Basic ICM training	Minimum blocks of one half of projected duration of module Intermediate level ICM training (outside the CCT ICM programme) can be counted towards the ICM CCT programme provided it is to the standard required by the IBTICM. If the trainee elects not	Trainees wishing to undertake Intermediate training within their primary specialty must discuss this with their own Regional Advisors and the RA in ICM. Trainees should be supervised by the IBTICM as well as the primary specialty. They must register with the IBTICM to receive recognition of Intermediate training, even if they do not intend to progress to Advanced level Training.

	All trainees must complete the Educational Training Record, including 10 expanded case summaries.	to continue to Advanced training, this period may be designated Intermediate Training, but if appointed to the ICM CCT, this may replace part or all of Intermediate training.	
Advanced Training	12 months ICM training in a single block, taken in the later stages of primary specialty training. Trainees must have satisfactorily completed Basic and Intermediate training in ICM and Complementary Specialty training.	Trainees who enter the ICM CCT programme without having done more than Basic ICM training may complete the requirements for the ICM CCT in a single continuous module.	Trainees who undertook Intermediate training outside the CCT ICM programme must undergo a competitive allocation process for entry to Advanced Training. Advanced level Training taken outside the CCT ICM programme will not count towards a CCT in ICM. Advanced level training must be undertaken in the final 2 indicative years of the ICM CCT programme. Maximum of 6 months prospectively approved and satisfactorily completed overseas ICM training may be counted.
ICM CCT plus CCT primary specialty	Awarded as dual CCTs to trainees who have satisfactorily completed training in both primary specialty and ICM.	None.	

All specialist training in ICM must be undertaken in units that have been approved by the GMC.

4. Assessment

4.1   Annual Review of Competence Progression [ARCP]

Award of the CCT depends on having completed a recognised programme of training and having demonstrated key knowledge and capabilities in the course of assessments. Trainee progress through the curriculum is monitored by a scheme of assessments.

This evidence is reviewed at an ARCP and this determines the learner's further progress.

It is primarily the responsibility of the trainee themselves both to understand what evidence will demonstrate appropriate progress and to accumulate and tabulate this evidence. Inability to collect and organise the evidence is itself taken to be a significant failing which is likely to be reflected in other aspects of professional life.

The ARCP is organised and operated by Postgraduate Deans. Its general principles are laid down by the GMC and are described in the 'Gold Guide'. The IBTICM is responsible for advising on the specific evidence that is required in its specialty training programme.

The Trainee will work with their educational supervisor to develop evidence of satisfactory progression through their agreed learning. A summary of this evidence will then be presented by the educational supervisor to the ARCP.

4.1.1   Evidence for the Annual Review of Competence Progression [ARCP]

A wide variety of information is available as evidence for the annual review. It is deemed to be the learner's responsibility to present their reviewers with evidence of satisfactory progress. This will be in the form of the learners 'Portfolio of Learning'. Sources of information are:

- Evidence of performance in professional examinations – if applicable
- A log of clinical work undertaken
- A reflective diary of learning experiences
- The results of WPBA's: DOPS, mini-CEX, CBD and ACAT's
- The Clinical Supervisors end of unit Assessment Form[s] [CSAF]
- A record of agreed targets and outcomes from interviews with their educational supervisor
- A multi-source feedback if appropriate
- Specific evidence of performance in areas such as research and education

It is accepted that there is no good evidence of the validity and reliability of any of these evidences. The process of reviewing them is not arithmetic. The educational supervisor must seek to use these evidences to answer four questions:

Table 2

Questions for ARCP Panels		
Criterion	**Domains in GMP**	**Evidence**
1. Has the learner undertaken a clinical workload appropriate in content and volume to the acquisition of the learning outcomes?	1,2,3	Logbook; CSAF; Appraisal
2. Has the learner met the general educational objectives of the curriculum and personal and specific objectives agreed with their educational supervisor or as a previous remedial programme?	1,2,3	Log-book; Educational supervision reports; Appraisal
3. Do the learners' supervisors believe that they have performed satisfactorily in their clinical work, as judged by their reports and the workplace-based assessments?	1,2,3,4	Log-book, WPBAs; educational supervision; CSAFs
4. Is there evidence that the learner performs satisfactorily as a member of a clinical team including teamwork and a focus on safe practice?	2,3,4	Multi-source feedback; CSAFs; Appraisal

Table 3

Domains of Good Medical Practice	
Domain	**Descriptor**
1	Knowledge, Skills and Performance
2	Safety and Quality
3	Communication, Partnership and Teamwork
4	Maintaining Trust

4.2 Workplace-Based Assessments [WPBA]

The IBTICM has developed an integrated set of workplace-based assessments [WPBA], which are to be used throughout the entire postgraduate training programme. They are blueprinted against, and support, the curriculum and every learning outcome that is identified in the curriculum is matched to at least one possible assessment. WPBAs must only be undertaken by those who are appropriately trained; if they are performed by others than consultants in Intensive Care, a consultant must take ultimate responsibility for the assessment outcome.

The assessment system is available for download from the IBTICM website. It is also available in paper format from the Board, for which a charge is made on application.

4.2.1 Choosing Appropriate Assessment Instruments

The curriculum was reviewed and the cognitive, psychomotor and behavioural learning outcomes have been allocated to appropriate instruments for WPBA. As an outcome-based

curriculum identifies very large numbers of items, a strategy of sampling assessments has been selected in order to make the assessment task manageable and to minimise the disruption of normal work and the possibility of increased risk to patients.

An assessment instrument has been identified for every competency in the curriculum. Where possible, more than one methodology is identified so that it is possible to triangulate performance. It is intended that a sample of these assessments will be undertaken by each learner.

The choice of which outcomes to assess is left to the learner and their educational and clinical supervisors. This will depend on the opportunities that the clinical work presents and the learner's needs.

4.2.2   The Available Assessment Methodologies

A pragmatic approach to the choice of assessment methods has been adopted. Many Consultants are familiar with Foundation Programme assessment methods, and are trained in their use. It was therefore decided to continue with these same systems throughout CT and ST training. These are the ICM mini-CEX [ICM-CEX], DOPS and CBD. In addition these methodologies have a practical utility attested to by experience in their use and at least some objective evidence that correctly applied they have validity and reliability. We have added the ACAT test that is used in some other specialties for the assessment of larger segments of clinical work.

4.2.3   How many workplace-based assessments?

The purpose of the ICM WPBAs is not to tick off each individual competence but to provide a series of snapshots of work, from the general features of which it can be inferred whether the trainee is making the necessary progress, not only in the specific work observed, but in related areas of the application of knowledge and skill. The number of observations of work required will not be fixed but will depend on the individual trainee's performance.

The IBTICM sets a minimum number of DOPS, ICM-CEX, ACAT's and CBD's for each training block (see below). Where a trainee performs unsatisfactorily more assessments will be needed. It is the responsibility of the trainee to provide sufficient evidence of satisfactory performance and satisfactory progress in their annual review. They will need evidence of performance in each block of training or section of the curriculum they have undertaken. This may increase the number of assessments they need. It is the educational supervisor's responsibility to help the trainee to understand what that evidence will be in their specific circumstances. The educational supervisor will then write a summary of the learner's performance for the ARCP.

Once again it must be stressed that there is no single, valid, reliable test of competence and the ARCP will review all the evidence, triangulating performance measured by different instruments, before drawing conclusions about a trainee's progress.

IBTICM Level	Minimum Number of WBPA
Basic ICM	MSF x 1 DOPS x 3 ICM-CEX x 2 CBD x 1
Intermediate ICM	MSF x 1 DOPS x 2 ICM-CEX x 2 CBD x 2 ACAT X1
Advanced ICM	MSF x 1 DOPS x 1 ICM-CEX x 2 CBD x 3 ACAT X 2

4.2.4 CBD, DOPS, ICM-CEX and ACAT

Example forms appear on the IBTICM website, www.ibticm.org.

Assessment by the direct observation of work is based on the belief that an expert is able to make a judgement about the quality of an expert process by watching its progress. This is the methodology of the motor vehicle driving test and there is a long history of the use of observational assessment in the accreditation of practice.

4.2.5 Scoring observational assessments

The primary question on the IBTICM assessment form is whether the observer considers the performance satisfactory or not. The threshold for this decision is part of the observer's judgement, as an expert in the field. This criterion has been adopted by the Board rather than marking against a scale, because of the difficulty in defining other grades of performance.

If the assessor believes the performance to be satisfactory they are asked to offer feedback; both positive and negative.

If the observer rates the performance unsatisfactory they must complete a grid, which tabulates the specific areas for concern.

The feedback given to learners who perform satisfactorily is less structured. This is not believed to be very significant in the context of our training practices. The advantage of presenting an assessment that is easy to complete when work is satisfactory is overwhelming in improving compliance, and engagement with the testing regime.

4.2.6 Case-based Discussion [CBD]

The IBTICM has defined topics for CBD that are appropriate to all the contexts of training. Assessments should not be made using other topics without checking that they are appropriate i.e. the issue is in the curriculum for the trainee's present state of training.

CBD can be used for a variety of training and assessment purposes as indicated in the curriculum section of this document. It will often focus on patient management. CBD is also used for assessing the more generic, and less clinical, knowledge and skills needed for effective practice. e.g. evidence based practice, maintaining safety, teamwork, clinical research methodologies etc.

4.3   Logbook and Portfolio

Trainees are required to keep a record of the cases that they undertake. The trainee must have had a significant input into the care and management of the patient and this input should be mapped onto the major domains of the curriculum. Brief diagnostic information should also be included preferably using the ICNARC diagnostic criteria which are used by the majority of units. There is also an opportunity to place reflective comments in the case record. The case logbook will be part of the portfolio of evidence that the trainee will collect to demonstrate their experience and competence. In the event that assessments indicate underperformance in an area of practice the first response is to check from the logbook that the learner has had sufficient exposure to it. Incompetence in the face of what is usually sufficient exposure is a cause for concern.

The portfolio of learning is more than a logbook. It will include reflections on learning and a record of other teaching and of discussions with the educational supervisor.

4.4   Expanded case summaries

At Intermediate training level the trainee is required to submit 10 expanded case summaries at local level. More information on the case summaries can be found in on the IBTICM website, www.ibticm.org. These are designed to assess the trainee's depth of knowledge in a particular area of practice and will also assess their ability to practice evidence based medicine and communicate written information in a succinct manner. They may also be used as the basis for CBDs.

4.5   Evidence of participation and attendance at training events

Until recently evidence of attendance at a learning session was taken to be the standard for accumulation of credits in continuing medical education. Attendance does not assure that learning has occurred but it does signify compliance with an appropriate learning plan. There are a number of aspects of training that lie on the periphery of practice such as Research Methods, Management, Teaching and Assessment. At present there is little focussed assessment in these areas and significant practical difficulties lie in the way of introducing summative assessment.

The IBTICM has at present adopted the middle ground in these areas and requires that evidence of participation in learning is presented to the ARCP. These include attendance at specific courses, evidence of presentation at local audit and research meetings and records, and feedback from teaching the trainee has delivered.

4.6   Examinations

Currently the ICM CCT programme has no compulsory written or oral examination as part of its assessment. The IBTICM believes that external examinations do have an important role in a balanced portfolio of assessment tools. It therefore strongly encourages ICM trainees to take the UK Diploma in ICM. The European Diploma in ICM and the Irish DIBICM are alternative examinations. However, possession of such qualifications is not currently necessary for the award of the ICM CCT.

More information on the UK Diploma in ICM can be found at www.ibticm.org.

4.7   Independent Appraisal

Evidence to inform the ARCP must include an appraisal. The organisation of this process will depend on local arrangements and the primary specialty of the trainee.

4.8   Trainees in difficulty

Doctors in training can encounter either personal or professional problems which may affect their performance. With the introduction of personal development plans, appraisal, annual assessment, learning agreements and clinical governance, trainees who struggle to achieve their goals within the expected timescale can be more easily identified and may require support during their career. *Whatever the reason for difficulty it should be identified as early as possible.*

Deaneries will have a clear strategy for dealing with such situations encompassing the spectrum of performance difficulties. Depending on the level of risk the educational supervisor will require a variable degree of support. It is highly recommended that all those involved in the education and clinical supervision of trainees are aware of their local strategy to ensure appropriate support can be provided to the trainee and that patient safety is maintained. In situations where trainees appeal against assessment or other decisions, and informal resolution is not possible then the process described in the Gold Guide will be followed[6].

4.9   The Educational Training Record: establishing a framework for individual learning

The Educational Training Record [ETR] forms Part II of this curriculum. All trainees must maintain an Educational Training Record as part of their Portfolio. When they start a training module in ICM they should:

- complete an educational agreement or equivalent method for assessing training needs within the first two weeks
- attend to self-directed learning
- arrange dates for regular review of their progress at least every three months
- recognise that assessment will involve the professional judgement of the assessor

---

[6] The Gold Guide Third Edition June 2009

- recognise that assessment is a continuous process especially that of behaviour and attitudes
- arrange for appropriate and relevant documentation to be available for the ARCP process to demonstrate satisfactory progress
- maintain a portfolio of educational activities within their ETR.

Tutors must communicate closely with the primary specialty College Tutor. There should be an initial assessment at the start of training (within the first few days), and an outline educational agreement must be established between trainer and trainee within the first two weeks. This should be reviewed regularly. Progress should be assessed at least every three months, and should be based on the educational contract.

4.10 Assessors

The IBTICM, in collaboration with the Deaneries recruits, appoints and trains both Board Tutors and Regional Advisors. Their roles include assessment of trainees and an assurance that trainee assessments are being undertaken to a uniform standard. Assessments within the ICM programme are conducted by consultants, specialty doctors and trainees. All assessors are required to have completed training in the use of the workplace based assessment tools. Training in using the assessment tools is provided by deaneries, locally within Trusts and when necessary from the Colleges as part of their Educator programmes.

5.   Out of Programme

For the award of a CCT, trainees must complete the GMC approved Intensive Care Medicine programme in its entirety[7]. There are opportunities for trainees to undertake approved periods of time outside of the approved programme as experience, research or training.   When contemplating undertaking a period out of programme, trainees should discuss the options and consequences of taking time out of programme with their Educational Supervisor, College Tutor and TPD.

5.1   Out of Programme Clinical Experience [OOPE]

OOPE is defined by the GMC as:

"'Out of programme clinical experience' that does not count towards the award of a CCT."

OOPE may be obtained in clinical or research posts in the United Kingdom or overseas that have not received *prospective* approval from the GMC.

Although IBTICM approval is not required for this out of programme experience, it is essential that trainees inform the Board and the Training Department of their respective parent college of the dates of all OOPE so that prospective completion dates can be revised.

5.2   Out of Programme Experience for Training [OOPT]

OOPT is clinical training, taken out of programme that will count towards the CCT provided certain conditions and requirements are met. They are:

- On commencing OOPT the trainee must be in a GMC approved training programme having completed the Basic and Intermediate levels of training *in their entirety.*   This does not preclude setting up and planning OOPT during Intermediate level training
- Only 6 months in total during Advanced training can be taken as OOPT – OOPT **cannot** be counted toward Basic or Intermediate level ICM
- The OOPT programme must map to Advanced level competencies identified in the ICM CCT programme
- The OOPT post must be prospectively approved by the GMC with support from the Postgraduate Dean and respective parent college *[At least six months should be allowed for the approvals process]*
- OOPT may be in appropriate Advanced level clinical posts in the UK or overseas
- The last 6 months of the overall CCT training programme normally should be in the UK
- The trainee on his/her return must complete a report on the time spent on OOPT and submit it, together with an assessment report from the local supervisor, to the Deanery, the Board, and their respective parent college

---

[7]   Article 6[1] of The General and Specialist Medical Practice [Education, Training and Qualifications] Order 2003.

5.3   Out of Programme Experience for Research [OOPR]

OOPR is a research post or experience taken out of programme. Due to the time constraints of the ICM CCT programme, the Board cannot allow this time to count toward the ICM CCT. However, trainees can apply to the GMC for OOPR to count toward their parent specialty training programme; trainees should consult the relevant parent specialty CCT curriculum for details on how much research can be counted toward it.

5.4   Applying for OOPT

It should be made clear to trainees that any proposed period of OOPT must be arranged at the earliest opportunity.   Gaps created within the rotation will need to be filled and if the OOPT is to be spent overseas, the acquisition of visas and the necessary licensing documentation for clinical work may be lengthy and difficult.

It is the responsibility of the trainee to provide all necessary information in their applications to the Deanery.   An application form and checklist can be downloaded from the training pages of the Board's website, www.ibticm.org.

5.5   Secondment between Schools and Deaneries

Secondment of a trainee to an approved training or research post in another School or Deanery [e.g. to obtain training not available in the "home" School or Deanery, such as Complementary Specialty training] is not regarded as OOPT; the secondment is an integral part of that individual's training programme.[8]

5.6   Maternity leave and sick leave

The Board allows maternity and/or sick leave to count toward the ICM CCT, on a pro rata basis in conjunction with the trainee's parent specialty.   For example, a trainee is permitted to have up to 3 months of maternity and/or sick leave counted toward the CCT programme in anaesthesia, which runs for an indicative timeframe of approximately 60 months, ie 5% of the programme. The Board will permit trainees to count the same time toward their ICM training programme on a pro rata basis – this would equate to approximately 3 weeks for Advanced level training.

Anything up to and including this time frame can be taken as maternity leave and/or sick leave without necessarily delaying the expected CCT date. This will require the trainee concerned to make efforts within the remaining training period to make up the specific elements of training which were missed in order to acquire the necessary competencies. The expected CCT date should be deferred if the period of maternity and/or sick leave results in a trainee missing a key component of the training programme which cannot be compensated for in the remaining period of the programme.

---

[8]   Gold Guide, section 6.98

6.   Equality and diversity

Equality of opportunity is fundamental to the selection, training and assessment of intensivists. It seeks to recruit trainees regardless of race, religion, ethnic origin, disability, age, gender or sexual orientation.   Patients, trainees and trainers and all others amongst whom interactions occur in the practice of ICM have a right to be treated with fairness and transparency in all circumstances and at all times.   Equality characterises a society in which everyone has the opportunity to fulfil his or her potential.   Diversity addresses the recognition and valuation of the differences between and amongst individuals.   Promoting equality and valuing diversity are central to the anaesthesia curriculum.   Discrimination, harassment or victimisation of any of these groups of people may be related to: ability, age, bodily appearance and decoration, class, creed, caste, culture, gender, health status, relationship status, mental health, offending background, place of origin, political beliefs, race, and responsibility for dependants, religion and sexual orientation.

The importance of Equality and Diversity in the NHS has been addressed by the Department of Health in England in 'The Vital Connection'[9], in Scotland in 'Our National Health: A Plan for Action, A Plan for Change'[10] and in Wales by the establishment of the NHS Wales Equality Unit. These themes must therefore be considered an integral part of the NHS commitment to patients and employees alike.   The theme was developed in the particular instance of the medical workforce in 'Sharing the Challenge, Sharing the Benefits – Equality and Diversity in the Medical Workforce'[11].   Furthermore, Equality and Diversity are enshrined in legislation enacted in both the United Kingdom and the European Union.   Prominent among the relevant items of legislation are:

- Disability Discrimination Act 1995
- Disability Discrimination Act 2005
- Disability Discrimination (Public Authorities)(Statutory Duties)(Amendment) Regulations 2008
- Employment Act 2002
- Employment Equality (Age) Regulations 2006
- Employment Equality (Age) (Consequential Amendments) Regulations 2007
- Employment Equality (Age) Regulations 2006 (Amendment) Regulations 2008
- Employment Equality (Sexual Orientation) Regulations 2003
- Employment Equality (Religion or Belief) Regulations 2003
- Employment Equality (Religion or Belief) (Amendment) Regulations 2004
- Employment Relations Act 1999
- Employment Rights Act 1996
- Equality Act 2006
- Equal Pay Act 1970
- Equal Pay Act 1970 (Amendment) Regulations 2003

---

[9] The Vital Connection: An Equalities Framework for the NHS: DH, April 2000
[10] Our National Health: A Plan for Action, A Plan for Change: Scottish Executive, undated
[11] Sharing the Challenge, Sharing the Benefits – Equality and Diversity in the Medical Workforce: DH Workforce Directorate, June 2004.

Appendix 1: Summary of the training process and Assessments of competence

Basic level ICM

Training requirements
- Undertake Basic training, following the Basic ICM curriculum, in approved posts for ICM

Assessments to be completed
- Be supervised jointly by the primary specialty tutor and the ICM Tutor
- Initial assessment of competence in the management of the acutely ill patient (if not completed in the Foundation programme)
- CPR skills (if not already assessed in anaesthetic or internal medicine modules, or no ALS course in preceding 12 months)
- WPBA's covering the Basic curriculum

Documentation to be available at ARCP
- ETR
- Workplace based assessments

Conditions to be met to move on to next training level
- Successful ARCP
- Completed Basic training documentation

Complementary Anaesthesia and Medicine

Training requirements
- undertake Complementary Anaesthetic or Medicine Training (if required), following the ACCS, Anaesthesia, GIM or EM curriculum, in approved posts

Assessments to be completed
- As documented in the ACCS, Anaesthesia, GIM or EM training programme

Documentation to be available at ARCP
- ETR
- Workplace based assessments

Intermediate level ICM

Training requirements
- Be in an approved numbered ST post in a primary-specialty
- Have undergone competitive entry to specialty training in ICM if following the ICM CCT programme
- Have completed the Basic level competencies and requirements
- To undertake Intermediate ICM training following the Intermediate ICM curriculum

Assessments to be completed
- Be supervised by the ICM Tutor and RA-ICM in conjunction with the primary specialty
- WPBAs covering the Intermediate curriculum
- For complementary specialties see above

Documentation to be available at ARCP
- ETR
- Workplace based assessments
- 10 expanded case summaries
- Case logbook

Conditions to be met to move on to next training level
- Successful ARCP
- Completed Intermediate training documentation
- Completed complementary training

Advanced level ICM

Training requirements
- Have completed Basic and Intermediate level assessments of competence and requirements
- Have undergone competitive entry to a specialty training post in ICM if Intermediate training was completed outside an ICM CCT training post
- To undertake Advanced ICM training following the Advanced ICM curriculum

Assessments to be completed
- Be supervised by the Board Tutor and RA-ICM
- Complete the Intermediate ICM competency assessments
- WPBAs covering the above areas

Documentation to be available at ARCP
- ETR
- Workplace based assessments
- Case log book

Conditions to be met to complete the CCT
- Successful ARCP
- Complete the Advanced assessments of competence and requirements

All the assessment forms, clinical log book, ETR and records of meeting documentation are available for download on the IBTICM website at www.ibticm.org.

Appendix 2:   Indicative durations of ICM CCT programmes

CCT	Expected Duration
ICM + Anaesthesia	Time required by specialty of primary appointment less recognised ICM time plus 21 months ICM plus 6 months acute medical specialty
ICM + Medical Specialties	Time required by specialty of primary appointment less recognised ICM time plus 21 months ICM plus 6 months anaesthesia
ICM + Surgical Specialties	Time required by specialty of primary appointment less recognised ICM time plus 21 months ICM plus 6 months anaesthesia plus 6 months acute medical specialty
ICM + Emergency Medicine	Time required by specialty of primary appointment less recognised ICM time plus 21 months ICM plus 6 months anaesthesia plus 3 months acute medical specialty

* In all cases time required is time required to obtain competencies

Appendix 3: Abbreviations

Abbreviation	Term
ICM	Intensive Care Medicine
IBTICM	Intercollegiate Board for Training In Intensive Care Medicine
ICU	Intensive Care Unit
StR	Specialty Registrar
HDU	High Dependency Unit
CCT	Certificate of completion of training
WPBA	Workplace based assessment
GMC	General Medical Council

Appendix 4: Criteria for the appointment of trainers

This document sets out criteria for the appointment of trainers, including extending recognition as trainers to those who have been appointed *other* than by standard NHS Advisory Appointments Committees [AAC]. It also takes into account that some postgraduate training may have to be delivered in hospitals outside the NHS.

Training in the NHS

The GMC is responsible for approving post and programmes for training. Clinical training is ordinarily delivered in NHS hospitals by consultants, approved staff and associate specialist [SAS] grades, [12] and by senior trainees. Senior educators/clinicians with responsibility for education and training are joint appointments by the IBTICM and Deanery. Trainers are supported by RAs and Board Tutors appointed with input from the Deanery and hospital management by the IBTICM and by educational supervisors appointed locally.

The example of trainers and teachers has a powerful influence upon the standards of conduct and practice of trainees. [13] It follows that all those involved in training and teaching should recognise and meet their responsibilities. [14] In particular:

- Consultant and SASG doctors involved in the training or education of trainees should be aware of the objectives of the training programme and participate in its optimal construction and delivery
- Consultants, SAS grades and others involved in teaching must fulfil the CPD requirements for the clinical appraisal process
- Trainers and teachers should take steps to acquire the skills of a competent teacher [15]
- All should fulfil the essential and fulfil or at least aspire to the desirable criteria [see below]

Consultant trainers

- The AAC committee at which the Colleges are represented is a check on the suitability of a consultant as a trainer
- Consultant trainers in the NHS must be listed in the Specialist Register and have been appointed to a substantive NHS consultant, University, or Defence Medical Services post by a properly constituted AAC. Subject to the local College Tutor's agreement, expressed by matching trainees to the consultant's training capacity, recognition of such appointees as trainers is automatic
- Consultant trainers should comply with the GMC Standards for Trainers that come into effect in February 2010

SAS trainers

The IBTICM encourages Board Tutors to identify SAS doctors with aptitude and to nominate them as teachers, specifying their areas of expertise. Those who undertake teaching must have opportunity to acquire the skills of a competent trainer.

---

[12] *Non consultant career grade doctors*. RCoA College Bulletin 2001: 9;407
[13] Good medical practice, *Teaching and training, appraising and assessing*, GMC 2006, paragraph 15
[14] *Ibid*, paragraph 16
[15] *ibid*

Trainees as trainers

By the time they complete their CCT programme trainees must have learnt to assume responsibility for the supervision of more junior trainees. As part of their preparation for becoming a consultant, senior trainees should have the opportunity to contribute to the organisation and delivery of formal training under the supervision of the Board Tutor or other designated trainers as identified in this curriculum.

Trainers in NHS Foundation Hospitals and the Independent Sector

NHS consultants and SAS doctors who have been recognised as trainers, as described above, carry their personal recognition when working outside their NHS base.

Consultants and SAS doctors appointed to posts in Foundation Trusts that do not use College representation for AACs, to Independent Sector Treatment Centres or to Independent Hospitals do *not* have automatic recognition as trainers. In such instances the Board will offer recognition in a personal capacity:

- *Foundation Trusts:* In the case of Foundation Trusts when no College representation has been used during selection, the Board delegates its authority to the local Board Tutor.
- *ISTCs:* In ISTCs, private hospitals or any other institution without a Board Tutor, the Board delegates this authority to the local RA or Deputy.

In both instances the following criteria[16] should be used as guidance for recognition, which should follow a meeting between the Board Tutor or RA and the consultant.

Criteria for appointment as a trainer

Essential criteria

- The trainer's employing institution *must* be integrated into the local Schools of Anaesthesia, Medicine, Emergency Medicine and Surgery
- Willingness to teach and commitment to deliver 'hands on' teaching and training including preoperative and postoperative care
- Regular clinical commitment [e.g. in operating theatres, clinics, critical care units]
- Listing in the GMC Specialist Register
- Compliance with current GMC revalidation requirements
- Successful completion of annual assessment or appraisal by a consultant anaesthetist
- Robust evidence of recent continued CPD normally based on the previous two years
- Being up-to-date and supported in a post with protected time for further CPD
- Familiarity with the assessment procedures and documentation of the knowledge, skills, attitudes and behaviour components of competency based training
- Willingness to assess continuously the trainee throughout the appointment, and to complete trainees' assessment forms on a regular basis as necessary
- Participation in audit
- Safeguarding trainees' attendance at core curriculum teaching meetings
- Ability to detect the failing trainee

---

[16] The criteria are common to all trainers; those who have already gained recognition should use them as a guideline for maintaining their skills as trainers.

Desirable criteria

- Successful completion of a '*Training the Trainers*' course or equivalent
- Ability to use educational technology
- Familiarity with teaching evidence-based medicine
- Ability to provide remedial support to the trainee in difficulty
- Willingness to guide and stimulate trainees to carry out audit and if appropriate clinical research
- Willingness to ensure that the volume and content of training lists and other sessions reflect the additional time required for training
- Willingness to mentor individual trainees

Appendix 5: Curriculum development working group

The IBTICM wishes to acknowledge the helpful input of the Anaesthesia curriculum writing group in producing the *Part I* document. In particular *Part I* draws heavily on that group's Educational expertise and understanding of the Education process. The group also drew on the expert assistance of James Goodwin, the IBTICM Senior Administrator.

Dr Dilshan Arawwawala	Consultant ICM
Dr Anna Batchelor	Chair and curriculum lead
Dr Simon Baudouin	Chairman, IBTICM
Dr Charles Gillbe	Past Chairman, IBTICM
Mr James Goodwin	Senior Training Administrator, IBTICM
Dr David Greaves	Assessment lead, RCoA
Dr Peter MacNaughton	Consultant ICM
Dr Ramani Moonesinghe	Consultant ICM
Dr Peter Nightingale	Past Chairman, IBTICM
Dr Graham Nimmo	IBTICM member, Consultant ICM
Dr Alison Pittard	RA representative, Consultant ICM
Dr Louie Plenderleith	Consultant ICM
Dr Laura Price	Trainee ICM
Dr Hannah Reay	Senior Research Nurse ICM
Dr Andy Tomlinson	Chair and curriculum lead, RCoA
Mr Barry Williams	Lay member, IBTICM
Mr Craig Williamson	Training Manager, RCoA