

Paediatric Cardiology

Trainee Newsletter from June SAC Meeting

The meeting was attended by both outgoing (Gareth Morgan) and incoming (Dom Hares) trainee representatives, to allow smooth transition. As in the past when Gareth has updated people as much as possible, I'll try and stick to the areas of the meeting that had direct relevance to trainees. Suffice to say it was a long meeting, but I'll try and be fairly brief.

National Interviewing

There was a discussion as to whether in the future it would be worthwhile having a single interview panel assess candidates for jobs all over the country. Recent interviews were held in London (run by the London deanery) for jobs in both London and Southampton, although subsequently a job has become available in Newcastle which was interviewed and appointed locally.

Since the availability of jobs is likely to be sporadic and not to fit neatly within any prescribed timetable, it was felt that the best way to attempt to ensure quality across the board would be to have a nationally agreed personal specification, but that short-listing, interviewing and appointment would be at a local level. Some deaneries may link in the future if jobs become available at similar times, but this arrangement will not be fixed.

Workforce Planning

Despite the problems foreseen with a glut of trainees qualifying at a similar time and unknown numbers of consultant jobs being available, it was felt that the number of trainees should be maintained at the same level. There is still an aim to have 2 paediatric cardiologists per million of population across the UK, and this would not be possible if training numbers were reduced. It was mentioned that pressure is being applied to try and create more consultant posts. Those trainees who reach CCT and are in their grace periods are currently being allowed to extend them past the traditional 6 month limit, and this practice is set to continue for the foreseeable future.

Conversions (5 to 3 year)

There has been one trainee from Southampton who has successfully converted from the 5 year to the 3 year curriculum and received a CCT. This conversion was performed after a Penultimate Year Assessment at which the training record of the trainee was analysed. It was discussed that there were no formal arrangements in place to convert from one curriculum to another. It was felt that a trainee who had performed a number of DOPs and Mini-CEXs, along with 360 degree appraisal would be much easier to assess for conversion. It was suggested that for any further conversions, these evaluation tools should be used as a means of assessment, and as many as possible should be performed prior to a PYA.

There were thought to be one or two trainees in the country who were considering conversion at present.

Assessment Tools

Although DOPs and Mini-CEXs are already validated, there was discussion about how useful they are at discriminating between acceptable and below acceptable levels of practice. Case based discussions have not yet been validated, although this process is ongoing. It was felt that the most important form of assessment is the 360 degree, multi-source feedback kind, and that as trainees we should be regularly involved in this. This is thought to be the best discriminator of good practice.

Patient/Parent questionnaires are to be trialled in a number of deaneries throughout the country, to assess their usefulness.

Knowledge Based Assessments

Within the Royal College of Physicians we are currently the only speciality who are not doing KBAs. In some cases these are taking the shape of exit exams and in others multiple-choice questions taken along the course of training.

Unless we do KBA in some form, we may be forced into it in a much worse and less controllable format (eg. An exit exam). There is a provisional plan to introduce KBA as part of the national training days, possibly with an initial emailed set of questions completed prior to the day that is then repeated at the end of the day to confirm that learning has occurred. Watch this space.

There was a question as to whether trainees should participate in European exams, although PMETB would not consider this useful as the SAC would not have any specific say in topics covered and into the suitability of the exam.

National Training Days

The first training day at GOSH was hailed as a great success, with most units having most of their trainees present. The next training day will be in Bristol in late September (although the date has not yet been finalised - I will be hassling them so that we can start to book early travel).

There is a drive amongst the SAC to make attendance compulsory at these meetings, which will continue to be free to attend. A minimum level of 80% attendance was mentioned and is likely to be a requirement for passing RITAs, although special circumstances for not attending will be considered and there is an aim to have most of the sessions available for on-line catch-up learning. The compulsory attendance was thought to be a good way of putting pressure on all units to release all of their trainees for the day.

It was pointed out that the service commitment of a trainee is actually only to provide out of hours cover, and that if there are issues providing time off for training days then consultants within the unit should provide cover.

Clinics should be reduced as appropriate to account for the lack of trainees, and routine procedures should not be booked on these days. The training representative (consultant) from each unit is aware of this agreement and should be sorting this out - if there is difficulty getting time away from any unit then please let me know so that I can raise this as an issue.

Some trainees and some units were apparently unaware of the training day until a day or two prior to its occurrence, despite information regarding it being available on the paediatric cardiology forum for over three months. Although attempts will be made in the future to advertise days well in advance (particularly using the online forum on doctors.net.uk), it was felt that trainees do need to take some responsibility with keeping up to date with what training is available.

Since the training days are going to be compulsory, the current courses which are discussed in the curriculum (Fetal, MRI, Arrhythmia) will become less important, and there is a plan that they will no longer be compulsory. This change will take some significant amount of time (probably a year or so) and trainees should continue to complete the courses in the meantime.

Three year training and sub-specialty fellowships

There was a lot of discussion regarding the difficulties in recruiting to sub-specialty fellowships, not least funding issues which have been exacerbated by the transition to a three year curriculum. There are currently only a handful of these positions available, in fetal medicine (which has just changed from a one year to a two year program), severe pulmonary hypertension (but for some reason not mild or moderate) and interventional cardiology. Departments have been encouraged to submit fellowships for approval, and it is envisaged that each training centre will be able to train fellows in at least one sub-specialism.

Unfortunately, there is no extra funding available for any of these training posts at present. One option was to go back to a system of five year training, of which three years would be core paediatric cardiology and the last two would be a compulsory period of sub-specialty training (which would then be pre-CCT and hence funded fully by deaneries). There is a plan that the fellowships would be open for national application and competition, but also that trainees may be able to opt to remain in their base unit (if successful in open competition).

That's basically the major portion of what was discussed, if anyone has any specific queries then get in touch. Gareth is going to sort out passing on the Doctors.net forum to me so that will still be up and running and I'll try and keep in touch.

Dom Hares
Trainee Representative