General Medical Council

Regulating doctors
Ensuring good medical practice

Small Specialties Thematic Review

Quality Assurance Report for paediatric cardiology

2011/12

Contents

Executive Summary

1. The review of paediatric cardiology looked at medical education and training within the speciality and how the stakeholders work together to assure the quality of the training. These stakeholders include the Joint Royal Colleges of Physicians Training Board (JRCPTB) and the deaneries responsible for delivering training. As part of this review we met with representatives of the JRCPTB. We also met with representatives from two deaneries (Wessex Deanery and the East Midlands Deanery) as well as the Lead Dean for the specialty, and a cross-section of trainees and newly qualified consultants. More detailed information on the review process can be found in annex B of this report.

2. All those that we spoke to during the course of this review acknowledged the challenges of quality managing a small specialty like paediatric cardiology, which has a low number of trainees across a number of different sites. We found examples within the deaneries of efforts to adapt their established and embedded quality management (QM) processes to provide more relevant and meaningful quality data on the specialty.

3. We also found acknowledgment from all those that we spoke to of the challenges that the specialty faces or may face as a result of the *'Safe and Sustainable'* review (a national review of children's congenital heart services), and the likely need to adapt how training is delivered at the sites affected by the outcome of this review.

4. At the deaneries we found that the Training Programme Director was pivotal in supporting QM processes, and that the success and failure of these processes was largely dependent on this role.

5. We spoke to a cross-section of trainees, and the majority had a very positive view of their training. However, we repeatedly heard from trainees that although they were aware of processes for raising concerns they might have about their training they would be unlikely to use such processes for fear of the possible impact on their future career. We found this a concern.

6. This review is part of a pilot investigating the quality of training in small specialities. It differs from other GMC quality assurance reviews as the focus is on a single specialty rather than on a region, a deanery or medical school. This report cannot be read as a review of QM processes at either the deaneries or the College visited – rather those that we visited are to be treated as exemplars and findings related to these deaneries may be of interest to other deaneries, Royal Colleges and faculties.

Key Findings

7. Requirements are made where change must be achieved in order for the stakeholder(s) to meet the standards. Recommendations are made where standards are being met, but improvements could be made to develop the quality of provision. Good practice is innovative practice that can be shared.

Requirements

Paragraph number	Requirement number		Standards Reference
Para. 42-45	01.	Postgraduate deaneries must ensure that paediatric cardiology training posts and programmes continue to cover the approved curriculum, where the pattern of service changes as a result of the Safe and Sustainable review. This may involve adding new locations to an approved programme or resubmitting for approval reviewed training programmes.	TD 5.1
Para. 79-83	02.	Postgraduate deaneries must provide trainees with comprehensive information about allocation to special interest areas. Selection into the special interest areas must be more open and explicit so that all trainees have an equal chance in competing for a particular area.	TD 4.5

Recommendations

Paragraph number	Recommendation number		Standards Reference
Para. 46, 49, 71, 92	01.	Postgraduate deans should continue to monitor compliance with WTR and take steps to ensure WTR compliance without compromising the quality of training	TD 2.1

Para. 53, 79	02.	The JRCPTB, the SAC and the deaneries should work together to reconcile and ensure their data on the number of trainees within paediatric cardiology training programmes is accurate. This should include information on which special interest areas being followed by trainees to benefit workforce planning.	TD 2.2 TD 5.4
Para. 57	03.	Postgraduate deaneries should consider routine and scheduled visits to quality manage training in paediatric cardiology.	TD 2.2
Para. 61	04.	The JRCPTB should establish and develop formal links with the Royal College of Paediatrics and Child Health to ensure continuity of training between core and specialty training and to promote interaction between paediatric cardiology trainees and paediatric trainees with an interest in cardiology.	None
Para. 68	05.	National training days should be scheduled sufficiently in advance to enable trainees to arrange their attendance.	TD 5.4
Para. 68	06.	The curriculum should be taught within the local training areas, and national training days should not be used for basic training but for amplification of knowledge already provided and the introduction of new approaches and methods.	TD 5.4
Para. 71	07.	Postgraduate deaneries should satisfy themselves that their deanery processes are sufficient to ensure that WPBA assessors are trained and there is protected time to complete assessments.	TD 6.35
Para. 75-76, 77	08.	Externality in the ARCP process should be formalised to ensure that the process is as transparent and fair as practical.	TD 6.7

Para. 100	09.	Postgraduate deaneries should ensure that TPDs receive training, support and appraisal for their role and that the uptake of this is monitored.	TD 6.36

Good Practice

Paragraph number	Good Practice number		Standards Reference
Para. 56	01.	Wessex Deanery grades all training posts in all specialties and all LEPs and this allows the Deanery to identify posts where training may be less than adequate and take the appropriate action.	TD 2.2
Para. 78	02.	All Wessex trainees are invited to attend ARCPs to give face-to-face feedback. This means that a richer, more representative selection of feedback is received, not just from borderline trainees.	None

Were any Patient Safety concerns identified during the visit?	
Yes ☐ *(include paragraph reference/s)*	No ☒
Were any significant educational concerns identified?	
Yes ☐ *(include paragraph reference/s)*	No ☒
Has further regulatory action been requested via the responses to concerns element of the QIF?	
Yes ☐	No ☒

Background to the review

8. The quality assurance of small specialties – that is, specialties with fewer than 250 trainees across the UK - is a theme that has been identified as a UK-wide area for investigation. This is largely due to difficulties in identifying issues and good practice in the GMC evidence base - a result of the small headcount and wide geographical spread of trainees within each specialty.

9. The aim of this project is to develop a process that will support the quality assurance of small specialties. For this purpose we have carried out three separate quality reviews of the following specialties: occupational medicine, medical psychotherapy, and paediatric cardiology.

10. The aim of each quality review is to assess the quality of training within the specialty to ensure that it meets the standards set out by the GMC in *The Trainee Doctor* and the *Standards for Curricula and Assessment Systems*. Each review has focused on the provision of postgraduate education within the specialty and considered the policies, processes and systems in place to support this provision.

11. Each review has resulted in a report, which contains good practice, requirements and recommendations. These may be targeted at one or more of the following stakeholders: the college/faculty responsible for the curriculum and assessment system of the specialty, one or more postgraduate deaneries, one or more local education providers.

12. Requirements are made where change must be achieved in order for the stakeholder(s) to meet the standards. Recommendations are made where standards are being met, but improvements could be made to develop the quality of provision, and good practice is innovative practice that can be shared.

13. There will also be an evaluation of the processes adopted for each review and a proposal for an over arching process that can be adopted for any future review of a small or sub specialty

The Report

Part One: Paediatric Cardiology

Background to the specialty

14. Paediatric cardiologists treat patients of all ages with congenital heart disease, in addition to rare cardiac conditions that develop during childhood, and inherited or genetic heart disease. They cover a wide age range, from the cardiac development of the foetus to adults, and although historically paediatric cardiologists have primarily treated children, as these children reach adulthood, adults are becoming an increasing part of the consultants' workload.

15. Although paediatric cardiology is a highly specialist area, there is great diversity within it, from highly technical work treating patients in the catheter laboratory to the ultrasound diagnosis and subsequent management of a foetus with a complex heart problem, and much in-between, including pre, peri and post operative care.

16. Being a diverse specialty dealing with patients of all ages, paediatric cardiology crosses a number of traditional medical boundaries. Entry into training in the specialty is possible for both paediatric and core medical trainees and the administration of training is through the Joint Royal Colleges of Physicians Training Board (JRCPTB), although there are some links with the Royal College of Paediatrics and Child Health (RCPCH).

17. The GMC 2012 National Training Survey (NTS) identified approximately 40 paediatric cardiology trainees across the UK, working across ten different deaneries in England and Scotland. According to this data, there are currently no trainees in higher specialty training programmes in paediatric cardiology in Wales or Northern Ireland.

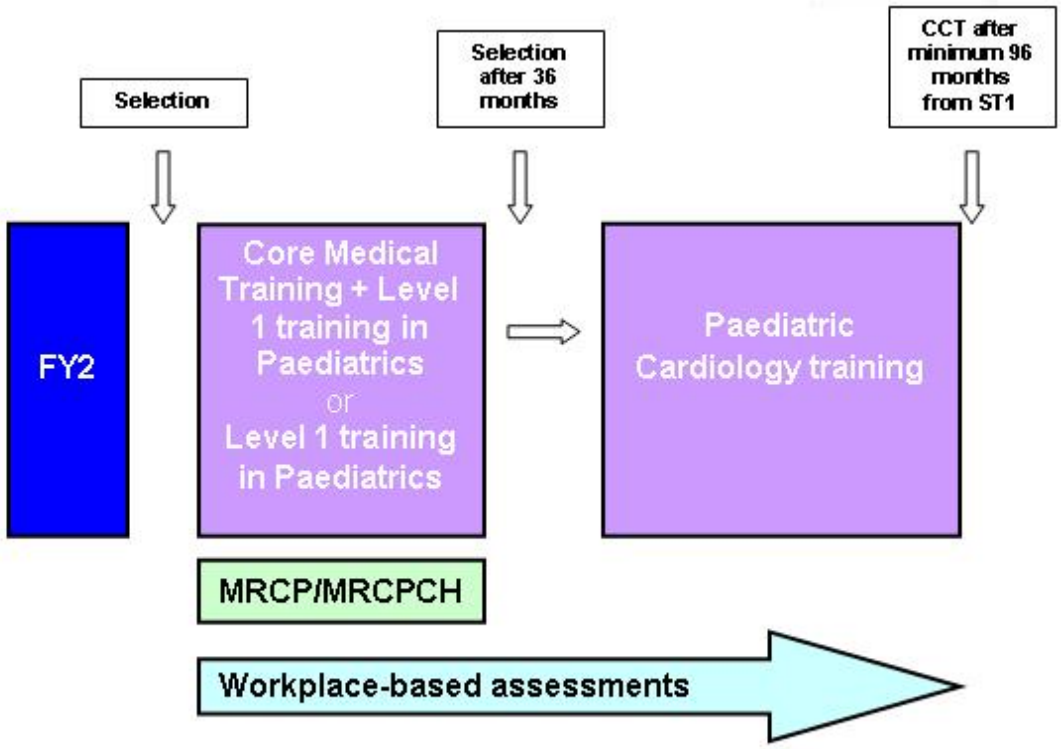
London Deanery	11
NHS West Midlands Workforce Deanery	7
Severn Deanery	7
Wessex Deanery	4
Yorkshire and the Humber Postgraduate Deanery	3
Mersey Deanery	2
NHS Education for Scotland (West Region)	2
Northern Deanery	2
East Midlands Healthcare Workforce Deanery	1
North Western Deanery	1
Total Number of Trainees	**40**

18. The 40 trainees are spread across 19 LEPs, which presents a challenge when analysing NTS data in any greater detail than deanery level as trainees may be identifiable by their responses.

19. Trainee feedback from 2012 NTS suggests that although paediatric cardiology trainees experience high work intensity this is coupled with a high overall level of satisfaction within their speciality.

Entry into the specialty

20. Those wishing to enter specialty training must first complete both a foundation and a core-training programme. There are two core training programmes relevant to paediatric cardiology training: Core Medical Training (CMT) plus one year of Level 1 Paediatric training, or Core Paediatric Training (Level 1), administrated by the JRCPTB and the RCPCH respectively.



21. Training from ST4 onwards is specific to paediatric cardiology training and is solely managed by the JRCPTB. Training to the Certification of Completion of Training (CCT) requires the completion of both core and higher training in a GMC approved training post, normally over a period of five years in higher training.

Curriculum and Assessment

22. The specialist training curriculum for paediatric cardiology was most recently reviewed and approved in 2010. The JRCPTB required all trainees to transfer to the new curriculum.

23. The curriculum is an indicative eight year programme, with the first three years in core training, followed by five years of specific paediatric cardiology training - the final two years of which trainees follow two years of special interest area (SIA) training, which mirrors the adult cardiology curriculum.

24. The assessment system for paediatric cardiology is based on Workplace Based Assessments (WPBAs), and these are used to gather evidence and promote formative feedback on the trainee's progress. The following WPBAs are used within the specialty:

- multi-source feedback (MSF)
- mini- clinical evaluation exercise (mini- CEX)
- direct observation of procedural skills (DOPS)
- case-based discussion (CbD)
- patient survey (PS)
- audit assessment (AA)
- teaching observation (TO).

25. The small size of the specialty means that it is not feasible to run a full specialty certificate examination, however the JRCPTB is piloting a formative knowledge based assessment that if successful will be used in the future. Through the course of this review we spoke to trainees who had participated in this pilot

E-Portfolio

26. Paediatric cardiology trainees use the JRCPTB ePortfolio, a central web-based tool that allows trainees to log all evidence of their experience, competencies and courses for their entire medical training period. Trainees who enter from the paediatric route have a different format of ePortfolio, and although the two cannot be merged they can be linked.

Joint Royal Colleges of Physicians' Training Board (JRCPTB)

27. The JRCPTB is a Federation of the Royal Colleges of Physicians within the UK and is the body responsible for setting and maintaining standards for physician specialist training in the UK.

28. Paediatric cardiology is one of 33 specialties or sub-specialties that sit under the JRCPTB. A Specialty Advisory Committee (SAC) assists and supports deaneries to manage and improve the quality of education across each specialty.

29. Each SAC draws together experts from deaneries across the UK and is comprised of leading consultants, trainees and lay representatives. Training Programme Directors (TPDs) from each of the deaneries are often members of the SAC, and both the TPDs of the deaneries that were visited as part of this review are members. The Lead Dean for the specialty also sits on the committee.

30. The JRCPTB and the SAC are tasked with the following activities:

- annual review of the curriculum and assessment systems
- production of an annual specialty report (ASR) submitted to the GMC
- provision of deanery advice during deanery visits to Local Education Providers; of external advice on ARCP panels; and advice and support for new training posts and programmes
- recommendation of trainees eligible for CCT or CESR.

College support for trainers and trainees

31. Trainees attend five national training days a year for each of the first three years of their training (ST4-ST6), with each day being hosted by a different deanery. The training days are used to deliver much of the knowledge-based component of the curriculum and trainees are required to attend a minimum of four of these days in order to achieve a satisfactory ARCP outcome. TPDs also arrange additional educational sessions to supplement these training days within their LEPs.

Deaneries

32. There are paediatric cardiology trainees in ten deaneries across England and Scotland (see para.17). As part of this review the visit team visited both the Wessex and East Midlands deaneries to explore in greater detail the quality processes at work. Both deaneries are used as exemplars and we recommend that all deaneries consider the findings and judgements of this report.

Wessex Deanery

33. According to the 2012 GMC NTS, the Wessex Deanery has four paediatric cardiology trainees, all based at University Hospital Southampton.

34. Paediatric cardiology sits within the School of Medicine, which offers training in 27 different specialties - all of which fall under the JRCPTB (see para 28).

35. The Postgraduate Medical Dean for the Wessex Deanery is also the Lead Dean for paediatric cardiology, and sits on the JRCPTB SAC.

36. The Deanery was last reviewed by the regulator (PMETB) in 2009 and the report is available on the GMC website. Paediatric cardiology was not one of the specialties reviewed as part of the visit, though wider QM processes were assessed.

37. Further information on the Wessex Deanery Quality Framework can be found at:
http://www.wessexdeanery.nhs.uk/quality_management/quality_management.aspx

East Midlands Deanery

38. According to the 2012 GMC NTS, the East Midlands Healthcare Workforce Deanery has one paediatric cardiology trainee, based at Glenfield Hospital. As part of this visit we also met with another trainee from the West Midlands Deanery who was in a placement within this deanery and two paediatrics trainees with an interest in cardiology.

39. Paediatric cardiology sits within the School of Medicine (South).

40. The Deanery was last reviewed by the regulator (PMETB) in 2009 and the report is available on the GMC website. Paediatric cardiology was not one of the specialties reviewed as part of the visit, though wider QM processes were assessed.

41. Further information on the East Midlands Deanery Quality Framework can be found at: http://www.eastmidlandsdeanery.nhs.uk/page.php?area_id=12

Part Two: Summary of Findings

Findings by Key theme

National challenges:

42. We undertook this review during the consultation period for *'A new vision for children's congenital heart services in England',* often referred to as *'Safe and Sustainable'*. Although the outcome of the consultation was not known until after the evidence gathering phase of this review had been completed, we received much feedback on this during the course of the review. We made it clear to those that we spoke to that we could only consider the impact of any changes arising from this consultation on medical education and training.

43. The local faculty representatives that we spoke to held the view that any changes in the number of paediatric cardiac surgery centres would inevitably impact on the nature of paediatric cardiology training posts at those centres. The JRCPTB felt that there were significant areas of the paediatric cardiology curriculum where training could only be provided in LEPs where there was a surgical presence. The absence of a surgical presence would restrict the range of paediatric cardiology procedures that could be undertaken in that LEP.

44. Trainers and trainees in the two deaneries that we visited commented that training posts (and consultant posts) without paediatric cardiac surgery on site would become less attractive and more difficult to fill. They also held the view that there would be a knock-on impact on other specialties that were dependent on this surgical function. Both of the deaneries were potentially affected by the review as both University Hospital Southampton and Glenfield were under consideration for closure as surgical centres (*the Safe and Sustainable* review announced on 4 July that the former would be retained and the latter would cease to be a surgical centre from 2014 onwards).

45. Following the outcome of the consultation deaneries will need to review training posts in the light of changes to the pattern of children's services arising from *Safe and Sustainable,* and satisfy themselves that all training posts continue to offer opportunities for trainees to gain the experience required by the curriculum, either at an existing or new location. Where these opportunities cannot be found at other locations then the training programme would need to be amended and submitted to the GMC for approval.

The Trainee Doctor

Domain 1: Patient safety

46. Work intensity is a universally acknowledged issue across the specialty, and this was recognised by all of those that we spoke to. The Royal College of Physicians' own survey of paediatric cardiology trainees indicates both a high level of intensity and Working Time Regulation (WTR) non-compliance, and the 2012 National Training Survey reinforces this finding.

47. The 2012 NTS also gave an above average score for clinical supervision, induction and handover, which suggests that although trainees are working long hours they are doing so with adequate preparation and support. Feedback from the trainees that we spoke to supported these findings.

48. All the trainees that we spoke to were positive about the supervision they received, and as is common within other small specialties, there was good contact between the trainee and the trainer. In many cases the educational supervisor and clinical supervisor were the same person. There were no concerns about being able to access support as and when required because many of the trainees work in close proximity with their supervisor as part of a multi-disciplinary team, and usually in a hospital environment.

49. We noted that a high level of work intensity could lead to trainee errors, although we found no evidence of this happening. We found that work intensity impacted on the availability of time for the trainer to train and the ability of trainees to access local teaching, although this was not the only reason (see para. 71).

50. We found that there were robust processes for identifying, supporting and managing trainees whose progress or performance, health, or conduct is giving rise to concern. However these were largely lead by the local faculty and self-referrals were uncommon, because of a reluctance among trainees to report any concerns they might have (see para. 88). Both deaneries had respected and well-resourced professional support units that could offer support to trainees.

Domain 2: Quality management, review and evaluation

51. Both the JRCPTB and the representatives of the deaneries that we visited acknowledged the challenges when quality managing a small speciality. We noted the efforts made by the deaneries to include small specialties in their quality systems and processes and where necessary make changes so that they are more effective. We also noted the commitment of all the stakeholders to contribute to and learn from this review.

52. We noted efforts to raise the profile of paediatric cardiology by each of the stakeholders we visited. The JRCPTB is undergoing a transformation process, and as part of the new process all SAC chairs will sit on a separate stakeholder board. This is intended to help raise the profile of each specialty and ensure that all specialties,

including small specialties such as paediatric cardiology, have representation at the highest level of information sharing and decision-making. This should strengthen the role that the SAC plays in supporting deaneries.

53. We also noted efforts to improve the quality of the data collected. The JRCPTB is actively seeking to improve the quality of their data sets, and we acknowledge that this is a work in progress. For example, the list of trainees is inaccurate and out of date. We also found inconsistencies in the number of trainees recorded by the deaneries, the JRCPTB and the GMC.

54. We noted that the Annual Specialty Report from the JRCPTB was now a combined report and covered all of the specialties that they are responsible for. With the focus on exception reporting, this means that not all specialties now feature in the report. Paediatric cardiology did not specifically feature in the most recent version submitted to the GMC but there were comments which covered all the specialities including paediatric cardiology.

55. We noted the attempt by each of the deaneries to gather their own quality data and to fill the gaps in their evidence base. For example, both deaneries that we visited used trainee questionnaires and surveys to gather feedback on the quality of education and training delivery. We are concerned that such feedback may be attributable, which was acknowledged by both the deaneries. Wessex Deanery is also considering using longitudinal analysis of trainee feedback, which may provide a solution to the difficulty of gathering meaningful trainee feedback.

56. An initiative to gather quality data has been undertaken by Wessex Deanery, with each training post graded (A-D) using information from the NTS, 360 feedback, and ARCP feedback. A 'Confirm and Challenge panel' verifies the final grading of each post. This annual process helps to identify posts of concern, and the TPD is responsible for producing an action plan in response. Wessex has conducted this grading for more than 600 posts across the Deanery. All paediatric cardiology posts were satisfactory. We would highlight this as an area of good practice for ensuring that posts continue to deliver satisfactory training.

57. We found in both deaneries that the role of the Training Programme Director (TPD) was key to the successful implementation of QM processes and the delivery of curriculum and assessment. Paediatric cardiology is a small specialty and the TPD is likely to have multiple roles. These might include being an educational supervisor, a clinical supervisor, working in the same LEP as the trainees, being a close working colleague of other consultants, and being involved in consultant appointments.

58. In both Wessex and the East Midlands Deaneries we found strong links within the local faculty but it was unclear whether it was the people or processes that supported these links. For example, both deaneries commented that not all TPDs contributed to School reports, and there appeared to be only informal remedial processes in place for those who did not. In Wessex, reports were received from 19 of the 27 TPDs. The JRCPTB also reported difficulties in receiving reports from Heads of School and training programme directors. We also found that the TPD had no

involvement in formal deanery visits to LEPs, although they did carry out quality check posts if a concern was raised or in response to a trigger.

Domain 3: Equality, diversity and opportunity

59. We note that work intensity within the specialty can make less than full time training (LTFT) a difficult option for trainees. However, we found opportunities for LTFT training and spoke to trainees who are training LTFT, the majority of whom reported a positive experience.

Domain 4: Recruitment, selection and appointment

60. There are dual entry routes into the specialty and trainees can spend their core training under either RCP or the RCPCH. However, the majority of trainees come into the specialty via the paediatrics route (in 2012 this figure is 100%).

61. We were keen to explore links between the RCP and RCPCH and how consistency of curriculum and continuity of training is ensured, especially as both routes use different core paediatric training (see para 20). The team found some formal links between the two royal colleges. For example, a member of the paediatric cardiology SAC also sits on the RCPH committee, and many of the members hold dual membership of both colleges. However these links could be strengthened to benefit both Colleges.

62. We also found that within both deaneries, core training was delivered by one school, and specialty training was delivered by another. In Wessex, the School of Paediatrics delivers core training whereas the School of Medicine delivers specialty training. We found informal links between the different schools.

63. We are satisfied that only trainees who had successfully completed core training would move into higher specialty training, although we recognise that this is not a guarantee that all trainees have the same competencies when starting specialist training. The SAC reported that many of the trainees that come via the core medicine-training route would have spent some time in locum posts in paediatrics to gain experience.

64. Recruitment into paediatric cardiology is now held nationally by Wessex Deanery, and the first cycle was completed shortly before we visited the Deanery. We found universal support for national recruitment as an opportunity to calibrate the process and make it more transparent, as well as benefiting workforce planning.

65. We also explored recruitment of trainees into Special Interest Areas as part of this review (see para.79)

Domain 5: Delivery of approved curriculum, including assessment

66. The 2012 NTS indicated significantly below average responses from paediatric cardiology trainees in the areas of local and regional teaching, and the responses to

feedback were average. This is likely to be the result of work intensity (see para 46) although scheduling did play a role in difficulties accessing regional teaching. Trainees did however give an above average response to adequate experience of training, and this is largely due to the close relationship between trainees and consultants, particular in teaching and learning practical skills. When this works, which is most of the time, this is highly valued by both the trainee and the trainer.

Curriculum

67. The paediatric cardiology curriculum is reviewed by the SAC every three years, and was last reviewed in 2010. The SAC was very proactive in transferring all trainees onto the new curriculum from the previous version.

68. Trainees attend five national training days per year for each of the first three years of their training (see para.31). We found that due to a combination of work intensity within the specialty and scheduling, trainees had difficulty in arranging time to attend these training days. We heard that they are often organised at relatively short notice, with a typical notice period of six weeks. We recommend that further notice is provided for trainees and if possible dates for all five of the days are agreed in advance at the start of each year to ensure trainees are able to attend.

69. We found that the responsibility for ensuring the curriculum was covered lies with the trainee, and that they are expected to map their evidence against the curriculum in their ePortfolio. Although we heard that efforts had been made at mapping the curriculum by TPDs, in each of the deaneries that we visited these were both incomplete. We were however confident that ARCPs from ST4 onwards, and the Penultimate Year Assessment would identify any areas that the trainee would need to develop in order to achieve CCT. We would encourage both deaneries to complete the curriculum mapping exercise.

Assessments

70. The field of workplace-based assessments (WPBAs) is a rapidly moving one, and although changes to the assessment systems were made when the curriculum was last reviewed in 2010, this is a constant area for review by the JRCPTB. There is a working group looking at standardising WPBAs across the specialties, and there will be a pilot across ten specialities (but not paediatric cardiology). We look forward to seeing this initiative develop.

71. We acknowledge the impact of high work intensity on the delivery of WPBAs. Many trainees reported difficulties getting their assessments signed off, and it was suggested that the ePortfolio made completion time consuming. We encourage the deaneries to consider the training and guidance given to WPBA assessors as a possible means of mitigating this issue.

72. We received feedback from both trainers and trainees that some WPBAs were less relevant to the specialty than others, including mini-CEX and DOPs. However, in a speciality where there is no final exit exam, where knowledge-based assessment

(KBA) is only just being introduced (see para73) we need to be assured that trainees are competent to progress.

73. The JRCPTB is rolling out KBAs, to be used as an annual test from ST4 onwards. This has been piloted with 20 paediatric cardiology trainees and the JRCPTB are in the process of gathering feedback. These KBAs contribute to the ARCP process, but have no pass mark, as the trainee is meant to demonstrate progression from year to year and is a formative assessment. We support the introduction of KBAs for all trainees, and the continued efforts by the JRCPTB to improve WPBAs.

EPortfolio

74. Both the RCP and the RCPCH use different versions of the e-portfolio, although we were assured by the JRCPTB that incompatible ePortfolios (see para 26) would not be an issue as assessors would look at all portfolios at CCT, and there is no common portfolio from medical school through to foundation and then core.

75. We found that TPDs carried out random checks of ePortfolios. However the process to quality check ePortfolios could be formalised to ensure consistency in the approach taken across LEPs.

76. Arrangements for external involvement at ARCP have not been formalised within the specialty but we are confident that the minimum requirements as set out in the Gold Guide are being met and often exceeded. We also note the external input into Penultimate Year Assessment (PYA), which at the time of our meeting with the SAC was close to 90%, although we have now been assured by the JRCPTB that this now applies to all trainees. We also found that the ARCP decision aid has helped consistency across the specialty.

77. We understand that a proposal for routine externality was recently put forward to COPMeD by the JRCPTB. We view the SAC as providing an opportunity to introduce a more formalised arrangement for externality at ARCP, and that this would also provide the trainee with an opportunity to provide feedback about their training (see para. 88). The issue of externality generally is currently being explored in our comprehensive review of quality assurance.

78. All Wessex trainees are invited to attend their ARCPs in person to give face to face feedback to the lay member and this is always after the ARCP panel is completed. We commend this system as it provides a more holistic and detailed view of the trainee experience, and not just from borderline trainees. We do accept that this level of involvement may not be possible in all specialties due to the number of trainees concerned. Wessex also puts equal emphasis on the ePortfolio at ARCP to deter trainees from cramming WPBAs into the last few months prior to the panel.

Special interest areas

79. The final two years of specialist training - ST7 and ST8 – are spent training in special interest areas (SIAs). CCT cannot be awarded without this. Trainees do not select their SIAs until ST7 and ST8, although they might have an idea of the area they wish to specialise in upon entry at ST4 and may therefore favour selecting centres that can offer their desired interest area.

80. The SIAs that are available are:

- Adult congenital heart disease
- Foetal cardiology
- Advanced imaging (CT/MRI)
- Diagnostic and therapeutic catheterisation
- Invasive electrophysiology and pacing in children and adults with congenital heart disease
- Pulmonary hypertension
- Heart failure and cardiac transplantation
- Advanced echocardiography

81. SIAs are not subspecialties – there is no separate curriculum, and not all centres can offer all SIAs. We did find that the term SIA and subspecialties were interchangeable by those that we spoke to and that this could cause confusion.

82. We found that the JRCPTB has difficulty in obtaining information on which trainees are studying which SIA, as this information is not recorded on the trainees' ARCPs. This makes workforce planning and meeting demand for each special area a challenge.

83. We also found that unlike recruitment into the specialty at ST4, which is nationally managed, SIAs are managed locally and the recruitment process is not clear or consistent, and is potentially open to challenge. We heard from trainees that there was no equity of opportunity among trainees because recruitment and selection is very much a matter of the trainee being in the right centre at the right time when a SIA post becomes available. There was clear support from those that we spoke to that this area of specialty training should be made more transparent, for example providing trainees on entry into the specialty at ST4 with information on SIAs available at each centre, or by holding national recruitment at ST6.

Domain 6: Support and development of trainees, trainers and local faculty

Support for trainees

84. Throughout the review we observed that trainees were supported in their learning through adequate departmental induction, variety of workload, daily supervision and learning opportunities (although work intensity had an impact on both local and regional teaching). This was supported by evidence from the 2012 NTS.

85. At Wessex Deanery we found that deanery induction is an expectation rather than a requirement, and although there is a half-day deanery induction this has yet to be rolled out to small specialties. The deanery is keen not to duplicate the induction that trainees receive at their LEPs and the induction policy is currently under review. Patient safety is not currently covered in deanery induction, but they expect that the governance structures and processes are part of LEP induction.

86. We found that although trainees tend to work in isolation from other paediatric cardiology trainees, peer support is available. We found this support comes from paediatric trainees with an interest in paediatric cardiology, and the multi disciplinary team at each centre. There was also informal support among the trainees, for example email communication and attendance at training days. Some of the trainees also worked across more than one centre (e.g. Leicester and Birmingham, Oxford and Southampton) and this was an additional source of support. Trainees also spoke highly of the East Midlands Higher Specialty Forum, which is another source of peer support.

87. The 2012 National Training Survey also highlighted higher incidences of undermining within paediatric cardiology, and we were keen to explore this area. We raised this with the SAC, and the SAC highlighted that the NTS often conflates paediatrics with paediatric cardiology and that this can skew results for the specialty. The SAC also said that there no formal mechanism for survey results coming back to the SAC, although each SAC member would be aware of any local outliers and feedback from ARCP.

88. We explored this with trainees, and we were concerned at their perceived reluctance to raise any concerns they might have for fear of jeopardising their future careers. We acknowledge that this is a challenge in small specialties, and although there are clear benefits to this closeness (good communication and working relationships), this aspect remains a significant concern. This also means that the doctors in difficulty processes (see para 50), while robust, are entirely local faculty led and self-referral is minimal. We encourage deaneries to develop opportunities for trainees to feedback in confidence, for example at ARCP.

89. The reluctance to self-disclose was acknowledged by those that we spoke to, and there was a view that informal processes (relationships between trainers and trainees) would help reduce the need for formal intervention. There was also an acknowledgement that some of the interventions may not be appropriate or effective, for example inter-deanery transfer, due to the close knit nature of the specialty.

90. Both of the deaneries and the JRCPTB stressed the involvement of trainee representation in the SAC, and how this ensured that there was representation at all levels. We encourage the continued support for the role to ensure that it is an effective vehicle for trainee feedback.

91. In the East Midlands Deanery we learned that there had been tension between paediatric cardiology trainees and paediatric trainees, who were in

competition for access to training. This was resolved through school intervention and the clarification of roles.

Support for trainers

92. We acknowledge the impact of work intensity on job plans, particularly as the same consultant may also act as trainer to both paediatric cardiology trainees and paediatric (with an interest) trainees.

93. In both deaneries we found evidence of formal processes for the training of trainers.

94. In Wessex Deanery, educational supervisors must attend a deanery-approved training course, which is refreshed every three years. This is recent innovation and as a result some previous supervisors have refused to attend, which puts pressure on those who are willing. The course covers all aspects of the role and was found to be useful by the trainers that we spoke to. Appraisal for educational supervisors takes place as part of their normal substantive role, and is a matter for the LEP. The Deanery currently has no means of feeding into and monitoring appraisal of educational activities. We are confident that trainee feedback would identify a trainer that was not of the required standard and action would be taken as a result.

95. The Deanery receives information from the LEP via the DME report on the number of trainers who have been trained and dates of any outstanding training. The deanery also holds database records of those trainers who are fit to train. There are plans to expand this to clinical supervisors for whom there is currently no formal training.

96. Wessex has also encouraged the development of a departmental education lead (DEL) responsible for the training environment in each specialty within the trust. We would be interested to examine feedback on this initiative as it develops. We note the potential for overload if the same consultant takes on the role of educational supervisor, clinical supervisor and TPD.

97. In the East Midlands Deanery, leadership training is being expanded to include Heads of School, and then to TPDs and educational supervisors. There are also new courses for educational and clinical supervisors although these are not mandatory.

98. The Deanery is also introducing appraisals for TPDs, which is separate to appraisals in their substantive role.

99. The Deanery is auditing the training that trainers receive and developing a database to store these records. This is a work in progress because the information is not readily accessible due to the number of different bodies carrying out the training. The deanery has requested this information from Trust DMEs.

Support for local faculty

100. The role of Training Programme Director within a small specialty like paediatric cardiology is critical as many processes go through this role. We found little evidence of specific training for this role, although TPDs attended generic courses for trainers. TPDs also sit on the JRCPTB Specialty Advisory Committee to share issues and good practice.

101. It is also likely that the TPD acting as educational supervisor for trainees, will be a clinical supervisor and a consultant whom trainees work with on a day-to-day basis. In this type of situation, deaneries should ensure that there is sufficient support and guidance for each role, and that there is close enough oversight of the training programme to ensure that if there were to be any issues or concerns then they can be identified and responded to.

Annex A

The GMC's role in medical education

102. The GMC is responsible for setting and maintained standards and outcomes for medical education and training in the UK. The Quality Improvement Framework (QIF) sets out how the GMC will carry out this duty in 2011-2012, and how we will work with other organisations working in this area such as colleges/faculties and postgraduate deaneries.

103. The GMC's Quality Assurance (QA) activity will be targeted towards areas of risk identified through the GMC's evidence base. This will include, but is not restricted to, information gathered through National Training Surveys, Annual Specialty Reports (ASRs), Deanery Reports (ADRs) and Annual Review of Competence Progression data (ARCP). Additional evidence could also be gathered from visits to deaneries and responses to concerns.

104. In order to ensure a coordinated approach, the GMC will identify common risks across all stages of medical education and training, and ensure that risks are explored across both the small specialty review process and the regional visits process.

105. You can find out more about the GMC's responsibility and quality assurance activity here: http://www.gmc-uk.org/education/postgraduate/information_for_trainee_doctors.asp

Annex B

Visit overview

Visit Team Leader	Graham Saunders
Visit Team members	Jennifer Adgey Rick Turnock Rosalind Blackwood
Education Quality Analyst	Robin Benstead

Date	Activity	Comment
16 March 2012	Meeting with Specialty Advisory Committee (SAC)	Attendance at SAC meeting and a questions session with committee members to cover QM processes links with the deaneries.
Various dates in April 2012	Telephone interviews with trainees and newly qualified consultants	Individual telephone interviews with six paediatric trainees and newly qualified consultants from a range of deaneries to explore their educational experience within the specialty
19 April 2012	Attendance at national training day	Opportunity to meet and interview trainees from all of the deaneries – this was attended by approximately 25 trainees. Areas for exploration included trainee support.
26 April 2012	Meeting with representatives of the JRCPTB	A meeting to explore some of the themes identified so far including QM processes and links with the deaneries, and an opportunity to interview senior representatives of the JRCPTB including the Medical Director.
27 April 2012	Meeting with Lead Dean for paediatric cardiology	An interview with the Lead Dean to explore themes identified thus far.
17 May 2012	Visit to Wessex Deanery	To explore at a local level some of the issues established in previous visits; to explore how the specialty is quality managed at deanery level; to

		meet with Lead Dean for the specialty.
31 May 2012	Visit to East Midlands Deanery	To explore at a local level some of the issues established in previous visits; to explore how the specialty is quality managed at deanery level.

Annex C

Action Plan for Paediatric Cardiology small speciality review

Requirements

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
Req.1		Postgraduate deaneries must ensure that paediatric cardiology training posts and programmes continue to cover the approved curriculum, where the pattern of service changes as a result of the Safe and Sustainable review. This may involve adding new locations to an approved programme or resubmitting for	The safe and sustainable review is the subject of a number of legal challenges: The IRP has been asked to review the proposals, and there is a Judicial review, both due in February 2013. It is therefore not certain what the impact will be on approved programmes.	SAC to monitor situation as it becomes clearer, and seek external input if required. Approved programmes may need to be re-configured and if training cannot be provided at a new location then a new location needs to be approved ; this will need to be done with the support of SAC, who will then need to check that the programme can deliver the curriculum. SAC then support the recommendation to GMC. Discussion over the development of 'form C' for SAC use to approve, which	Ongoing – dependent n outcome of review.	SAC

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		approval reviewed training programmes.		will supplement GMC form A & B. Lead Dean to amend the offer letter/preference letter for trainees starting ST4 to make it clear that an alternative post will be offered if the withdrawal of training affects ability to deliver the core curriculum/ that the programme may need to be reviewed to ensure it can deliver the curriculum (wording to be agreed). To be taken to COPMeD. To consider rotations for the future (e.g. vascular/cardiothoracic surgery). GMC approvals to send out letter to deaneries with approved programmes,	Immediate – to capture 2013 intake.	Lead Dean GMC Approvals

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month / year)	Lead
				reminding them of the implications of safe and sustainable and process for approving locations once impact of safe and sustainable is clearer.		
Req.2		Postgraduate deaneries must provide trainees with comprehensive information about allocation to special interest areas. Selection into the special interest areas must be more open and explicit so that all trainees have an equal chance in competing for a particular area.	Discussion over practicalities of having national recruitment to SIAs (entry into specialty is carried out nationally by Wessex deanery). Suggestion to seek guidance from cardiology (advanced specialist area modules) on how they manage their SIAs. JRCPTB mentioned they would like to be able to identify which posts offer SIAs and to track trainees through the posts. An agreement would need to	SIA options to be made explicit at recruitment (through use of Form A and B). Deaneries to hold open competition among trainees in their deanery for SIA posts. Only open to trainees from other deaneries in exceptional circumstances. SAC to map SIAs and feed into workforce planning. Guidance to be sought from cardiology SAC on their approach to SIAs.		Deaneries, with support from SAC Deaneries SAC SAC

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			be reached with deaneries how to capture and share this information.			

Recommendations

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
Rec.1		Postgraduate deans should continue to monitor compliance with WTR and take steps to ensure WTR compliance without compromising the quality of training.	Discussion over the merits of this, what action is needed in practice in addition to what is currently done. Have trainees opted out?	Deaneries to **continue** to monitor	Ongoing	Lead Dean

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
Rec.2		The JRCPTB, the SAC and the deaneries should work together to reconcile and ensure their data on the number of trainees within paediatric cardiology training programmes is accurate. This should include information on which special interest areas being followed by trainees to benefit workforce planning.	The JRCPTB briefed us on improvements since the visit, and how there is now an agreement with the deaneries to provide quarterly data sets of trainees in post, those who have resigned, ARCP data etc. The ePortfolio can also be used to flag up trainees not known to the JRCPTB. The JRCPTB confirm that their data has improved significantly over the past 6 months and there will be further improvement over the next 3-6 months time.	JRCPTB to continue data exercise.	Ongoing	JRCPTB
Rec.3		Postgraduate deaneries should consider routine and scheduled visits to quality manage training in	There was discussion over how ARCP or SAC training days might enable SAC members to talk to trainees face to face to gain quality feedback on training/	SAC to look at suggested methods of gathering feedback.		SAC

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		paediatric cardiology.	It was also suggested that SAC trainees reps attending training days might be used to collect information on the quality of programmes in other deaneries. It was suggested that trainee rep be used to gather feedback from trainees on these days and report back.			SAC/Trainee rep
Rec.4		The JRCPTB should establish and develop formal links with the Royal College of Paediatrics and Child Health to ensure continuity of training between core and specialty training and to promote interaction	The RCPCH has produced a special curriculum for paediatricians with an interest in cardiology. Need to check progress with GMC.	We do not have a record of this curriculum.		

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		between paediatric cardiology trainees and paediatric trainees with an interest in cardiology.				
Rec.5		National training days should be scheduled sufficiently in advance to enable trainees to arrange their attendance.	Trainee rep has timetable dates for 2013.	To be actioned by trainee rep who is responsible for organising this.	Immediate	Trainee rep/SAC
Re.6		The curriculum should be taught within the local training areas, and national training days should not be used for basic training but for amplification of knowledge already provided and the		The SAC to ensure that prior to the approval of future programmes they ask what is the structure for delivering teaching, rather than in service teaching. This could be added to form C (see req.1)	Immediate	SAC

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		introduction of new approaches and methods.				
Rec.7		Postgraduate deaneries should satisfy themselves that their deanery processes are sufficient to ensure that WPBA assessors are trained and there is protected time to complete assessments.		LD to take to COPMeD	Next COPMeD meeting	Lead Dean
Rec.8		Externality in the ARCP process should be formalised to ensure that the process is as transparent and	Attendees acknowledged the challenges of securing externality for ARCP processes within a small specialty. The PYA, which has formalised externality, fulfils a similar function and	JRCPTB to explore a formal rotation or regional approach (for ARCP in all specialties) once future focus of externality & the role of the college has been agreed.		JRCPTB and SAC

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		fair as practical.	covers all trainees in their final year. JRCPTB keen to do this with all specialties but propose waiting until the future of externality has been determined following the GMC quality review.	SAC – to consider viewing the ePortfolio and checking education supervisor's report.		SAC
Rec.9		Postgraduate deaneries should ensure that TPDs receive training, support and appraisal for their role and that the uptake of this is monitored.		LD to take to COPMeD	Next COPMeD meeting	Lead Dean
n/a			Discussion over recognising the difference between post specialty and programme specialty: that paediatrics with an interest work alongside paediatric cardiology trainees but	Lead Dean happy to be involved in extending this review to paediatrics. GMC also to consider this in future small specialty reviews.	To be included in GMC small speciality evaluation	GMC GMC

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			were not included in this review. Although this was a review of the speciality, we could have looked at other trainees as part of it.			

Good practice

Report Ref	Due Date	Description	Details of dissemination	Any further developments planned to enhance the area of good practice	Timeline for action (month/ year)	Lead
GP 1		Wessex Deanery grades all training posts in all specialties and all LEPs and this allows the Deanery to identify posts where training may be less than adequate and take		Lead Dean to raise at COPMeD meeting.		Lead Dean

Report Ref	Due Date	Description	Details of dissemination	Any further developments planned to enhance the area of good practice	Timeline for action (month/ year)	Lead
		the appropriate action.				
GP 2		All Wessex trainees are invited to attend ARCPs to give face-to-face feedback. This means that a richer, more representative selection of feedback is received, not just from borderline trainees.		Lead Dean to raise at COPMeD meeting.		Lead Dean