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Joint Royal College of Physicians Training Board (JRCPTB)
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To whomever it may concern,

Re: Trainee involvement in the development of a new cardiology curriculum

This letter confirms that Cardiology Specialist Advisory Committee (SAC) trainee representatives have been actively involved in the development of the new curriculum for Cardiology. The SAC chair and Training Programme Directors have recognised the importance of trainee representation at each stage of development. Three trainee representatives have regularly attended meetings, with wider input from trainee representatives of the sub-specialist cardiology societies, providing critical input and feedback to ensure the trainee voice remains heard. Trainee representatives have also sought to provide feedback across the four nations, ensuring updates and written information is openly shared with the wider trainee cohort.

Cardiology trainees recognise some potential value in the transition to a new curriculum. In particular, we are very supportive of a move to require only level 2 competence in diagnostic coronary angiography for those not intending to undertake sub-specialty training in coronary intervention. This reflects a move away from Consultant Cardiologists who are not specialised coronary interventionalists undertaking diagnostic angiography activity.

However, there are a number of issues of significant concern.

Firstly, it is clear the majority of trainees do not support the new Cardiology curriculum. In a recent JRCPTB survey, only 31% of trainees felt that the new curriculum would provide

sufficient skills to meet the future care needs of the UK population. Additionally, 74% of trainees felt that there would be challenges in delivering the new curriculum. A number of significant concerns have been raised and highlighted both during curriculum development as well as in trainee survey responses:

1. **Requirement for dual certification in General Internal Medicine (GIM)**

The cardiology trainee body is united in its opposition to a forced requirement for dual certification in GIM. The BJCA's annual survey data consistently demonstrates that an overwhelming majority feel this will reduce the quality of cardiology training, the skillset of future cardiologists and future patient care. Most cardiologists nationally have highly specialist job plans with very few undertaking regular general medical activity. Furthermore, cardiology training is already difficult to achieve in the available timeframe.

This is a particular issue due to the craft nature of the specialty with substantial procedural skill development required. For example, data from the BJCA annual trainee survey has repeatedly shown that the majority of trainees fall far short of the indicative required number of transthoracic echocardiograms. To insist on dual certification in GIM risks further limiting cardiology trainees' ability to obtain sufficient competence in cardiology. This has substantial patient safety implications and risks prolongation of training beyond the proposed timeframe in order to meet core competencies. This aspect of the change in training related to the new curriculum is specifically opposed by cardiology trainees. It should also be recognised that cardiology trainees have always contributed to general medicine within the existing training framework, with arrangements agreed at local level. This will most often occur during the early years of specialist training and involve management of the acute unselected take, and contribution to general medical cover overnight. *We strongly reject the requirement for dual GIM training as part of cardiology training.*

In concert with a requirement to undertake GIM, it has also become clear that there is a recent, additional proposal for higher specialty trainees to spend six months in another medical specialty. We share the grave concerns expressed by trainee representatives across the physician trainee body that this inflexible approach will put further strain on an already overworked trainee workforce, who will find it difficult to achieve the required competencies within the proposed timeframe. We completely oppose this proposal. We note that in a recent JRCPTB document ("Internal medicine training during higher specialty training", August 2021) it is understood that this proposal 'may cause difficulties of implementation in certain regions and for certain specialties and provided that the parent specialist wards provide enough exposure to a range of generalist medical patients then it is accepted that appropriate capability may be acquired in that context". *We cannot support this new curriculum unless it is agreed that, by default, all cardiology wards are*

said to provide sufficient exposure to a range of general medical patients, and cardiology trainees will not be expected to spend any training time embedded within another medical specialty.

2. **Transition arrangements for the new curriculum**

There is widespread animosity to the suggestion that all current trainees would be required to transition and receive a certificate of completion of training based on the new curriculum. This is felt to go against the basic tenets of pedagogical theory around curricular development and significantly diminish any support from the trainee body to the new curriculum. Recent BJCA survey data highlights profoundly diminished training opportunities after redeployment amidst the pandemic response, alongside high rates of trainee burnout (35% reporting substantial risk). Within this context mandatory transition to the new curriculum and its additional requirements places an unfair burden on individual trainees, risking further prolongation of training. It is strongly felt by cardiology trainees that those that have already started on the current curriculum should have the option to complete their training on the 2016 curriculum or transition to the new curriculum. Mandatory transition is likely to disproportionately impact academic trainees and those with protected characteristics including women and those working less than full-time. *Any forced transition of current trainees to the new curriculum cannot be supported by cardiology trainees.*

3. **Safeguards to ensure sufficient cardiology training time**

Given the requirement for GIM dual certification, trainees are also concerned about the safeguards available to ensure that they receive sufficient cardiology training. Trainees are understandably concerned that, if safeguards are insufficient, local trusts may require trainees to miss specialist training and fill gaps in general medical rotas. This will lead to an unacceptable reduction in what is already limited cardiology training. It is not sufficient to have a retroactive feedback system to safeguard cardiology training (e.g. trainees raising issues to their training programme director). *There must be robust, proactive safeguards to protect cardiology training in real time. Without these, trainee support for the new curriculum cannot be given.*

The new curriculum requires an indicative 12-month GIM training time, leaving a requirement for 48 months of cardiology training time. Given the craft nature of cardiology as a specialty with a large number of procedural elements which must be sufficiently mastered by trainees, any reduction in cardiology training time is not acceptable. In particular, we were alarmed to read in a recent JRCPTB document ("Internal medicine training during higher specialty training", August 2021) that "*the frequency and intensity of involvement in the AUT [acute unselected take] will be predicated on service*

requirement" and that "*there may, of course be an employer and service delivery imperative for higher trainees to support AUT through the whole of HST [higher specialty training*". We completely reject the premise that an individual's training should, in any way, be predicated on the service requirements of a trust or department. These are separate issues. The fact that the JRCPTB has suggested that service requirements may lead to an increase in GIM commitments from trainees illustrates that they have completely obfuscated their responsibilities as a training institution. If there are insufficient individuals required to provide service provision then this requires further recruitment rather than overworking trainees. Such proposals will result in higher levels of trainee burnout.

Additionally, this will reduce cardiology training time, and risks substantial numbers of trainees failing to meet curricular requirements and prolonging their CCT date, further depleting the consultant workforce. We strongly believe the only factor that should determine the time spent on GIM rotation or the AUT are an individual's requirements for training. *We cannot support this curriculum change until there are concrete assurances that service requirements will never be a factor in increasing the amount of time that cardiology trainees spent on GIM rotations or on the AUT.*

Given a requirement for 12 months of GIM training, we would expect that specific safeguards are put in place to ensure that this is not exceeded unless required for an individual's training. A 12 month block would be 52 weeks. We would expect and require that annual leave, study leave, and public holidays accrued for GIM work is taken from GIM training time (rather than having to be taken from cardiology training time). In addition, any zero days/rest days are taken from whichever component in which they are generated (e.g. AUT/GIM or cardiology). As the vast majority of trainees entering cardiology training are expected to have completed the foundation programme and IMT Stage 1, they will have five years of NHS service. As such, they would have 6.5 weeks (32 days) of annual leave, 6 weeks (30 days) of study leave (as defined in the Terms and Conditions of Service for NHS Doctors and Dentists in Training 2016 Version 9 [April 2021]), and 1.5 weeks (8 days) of public holidays. This leaves 38 weeks of general medicine training.

As a result of the above, specific safeguards must be put in place to ensure that no more than 38 total weeks of GIM training (including all AUT commitments) are required during cardiology training. Given the JRCPTB expectation that GIM training would take place over a three year period (see ("Internal medicine training during higher specialty training", August 2021), this would equate to 12.6 weeks each year. Given that it is expected that cardiology trainees undertake a minimum of 20 non-cardiology GIM clinics during training (2 working weeks), this would leave 12 weeks per year for GIM/AUT training. As such, we would envisage one of two scenarios. The first is that cardiology trainees are on a rota

for general medicine commitments for a total of 12 weeks per year (for a maximum of three years) with no GIM or AUT commitments (including no GIM on call commitments) outside of these weeks. Alternatively, if cardiology trainees are expected to provide year round cover for the AUT, then no more than 12 weeks can be lost from cardiology training in any given 12 month rotation (with two years of cardiology training completely exempted from GIM/AUT commitments). This would equate to a maximum one week of AUT days and one week of AUT nights every 13 weeks with appropriate zero hours/rest days accrued during GIM/AUT training time taken from GIM/AUT training. If trainees are required to undertake any periods of higher intensity of GIM/AUT commitment then this must be compensated by additional periods where trainees are have no GIM/AUT involvement to ensure that cardiology training is safeguarded.

As set out in the recent JRCPTB document ("Internal medicine training during higher specialty training", August 2021), where trainees are contributing to a specialty on-call rota as part of their curricular requirements, it is expected their involvement in the AUT will be limited to the indicative three year period.

We expect and require that a commitment is made by the JRCPTB that no cardiology trainee will be asked to undertake any GIM/AUT training or GIM/AUT service commitments above this level. If further time on GIM rotations is required, this must be taken from AUT time.

4. Reduction in time spent in advanced cardiology training

The new curriculum will reduce the proportion of time in the final two years of training that are devoted to sub-specialty training. This is due to be made up by sub-specialist training time in the third year of training. However, it is unclear how this training will be delivered across regions where provision for training in advanced themes for service areas in earlier training years may not be possible. This is a particular concern when combined with the requirement for dual certification in GIM, and may lead to an unacceptable reduction in advanced training time.

Ultimately, we should strive for the future curriculum to produce Consultants who are the same if not better equipped to deal with complex cardiology patients in the future. If the new curriculum fails to deliver adequate training experience, future trainees may be mandated to undertake additional post CCT fellowships which will have a disproportionate impact on women in cardiology, those that are less than full time, as well as academic trainees. Ultimately if a post CCT trainee does not meet the current standards accepted at Consultant level this may pose a significant risk to patient safety. *We would request that the new curriculum is modified to ensure that the proportion of time in ST7 and ST8*

allocated to sub-specialty training is not reduced from that outlined 2016 curriculum (at ST6 and ST7 levels).

5. **Advanced training choices**

Cardiology trainees are disappointed by the advanced themes of service options outlined in the new curriculum. A number of current sub-specialties have not been recognised in the new curriculum. Furthermore, the removal of the modular aspect of the current 2016 curriculum limits trainee choice. This limits the versatility and variety of consultant cardiologists that will result from this curriculum. This has the potential to lead to consultants who cannot appropriately serve their local populations.

There are concerns with proposed the use of credentialing to provide training in additional areas. We believe that this process has the potential to provide training in important areas not covered in the advanced themes of service; for example, inherited cardiac conditions, structural intervention (including TAVI), and heart disease in pregnancy. However, at present these there is little detail on how these credentials would work in practice. Without these being completed we have strong reservations about the implementation of the curriculum. *We require the appropriate credentialing areas to be finalised prior to us supporting implementation of the curriculum.*

We have additional concerns about the use of credentialing. Given the additional burdens to trainees introduced by the new curriculum, it is expected that credentialing training will have to be undertaken at the post-CCT stage. This will add further time to an already very long training period. What, if any, assessment of this impact on trainees with protected characteristics or those working less-than-full-time has been undertaken? *Without assurances that these trainees are not disadvantaged by this new process, we cannot support this new curriculum.*

It is clear that there are a number of substantial issues that trainees feel will worsen both cardiology training and patient care. Whilst we appreciate the requirement for additional GIM training originates from the Shape of Training report, we cannot accept curriculum proposals that risk reducing the quality of training in cardiology as this will be of detriment to those who follow the curriculum, as well as the senior Consultant workforce who may increasingly be required to support new appointments.

As a result of the above outlined issues, we cannot provide trainee support for the new curriculum in its current form. If the curriculum is implemented without substantial modifications to address the above issues, this would be over the strong objections of trainees.

We strongly request that all stakeholders in the new curriculum revisit these issues and that appropriate changes are made prior to introduction of any new curriculum.

Yours,

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