



Royal College of Paediatrics and Child Health
Specialist Advisory Committee for Neonatal Medicine

Sub-Specialty Training in Neonatal Medicine

The National Grid: the first two years

Scope of this report

Work on the Grid began in 2000/2001, and the first set of trainees in neonatal medicine to have been selected by national UK competition began work in September 2002. The second cohort was appointed in March 2003. This report has been prepared in part to provide information to the trainees themselves – to whom many congratulations are in order – but mainly as feedback to the Royal College of Paediatrics and Child Health, Deans, future trainees and trainers about how the process is shaping up. The first draft was written by Dr Janet Rennie, who has served on the CSAC (College Specialist Advisory Committee) since its inception in December 1997, and who is now Chair. Comments and suggestions have been added from other members of the CSAC, and from the past Chairman, Professor Neil Marlow.

The concept of the Grid

The idea of a national training system for paediatric trainees who want to acquire subspecialty experience is not entirely new, but once serious discussions began in 2000/1 the implementation process moved very fast. It is now time to reflect.

The points in favour of a national neonatal training system are:

- Guaranteed training;
- Quality training;
- Ability to match trainees against suitable training programmes and posts;
- Manpower planning;
- CV enhancement for the selected trainees, who succeeded in open competition;
- Accountability;
- Two centre recommendation helps prevent parochialism.

The points against the system are:

- Inflexibility;
- Loss of control and ownership for trainers - this does not need to be a disadvantage but it does need to be managed;
- Difficulties in planning job allocations for programme directors;
- The requirement to move around the country is disruptive of family life and against the ideas behind Calman training;
- It is possible to train in neonatology outside the grid, which consequently needs to “add value” to remain attractive to trainees;
- The requirement to be in possession of a NTN number excludes some potentially excellent applicants such as people who can’t move; those from outside the EEC; those in neonatal research posts without a number;
- Some have expressed concern that a national “CCST date” will lead to a glut of newly emerging qualified neonatologists at one point in the year and a dearth of applicants for consultant posts at other times. This is probably theoretical because CCST dates will never be exactly the same.

The training posts and programmes

Hospitals which had a track record in neonatal training and were willing to continue in this role were invited to put in a prospectus, and to band together to prepare two year programmes. A great deal of work went into this, and the neonatal CSAC received a number of excellent programmes. At least one contributing centre in all these programmes (with the exception of Scotland) have now been visited, at least in part, and the process of inspection and accreditation continues, with much of London still to go. New centres are already applying and others are expressing interest in becoming accredited tertiary level neonatal training centres.

Points which have emerged from the training programmes and their inspections are:

- A requirement was set for clinical experience to be gained in two separate, different, approved, training centres for two of the three years of higher specialist training has led to much discussion and controversy. The advantages are that the trainee is exposed to different trainers, and different approaches. The disadvantages are that it is disruptive, and in some areas of the UK requires long-distance travel or a move, and a year is too short to carry out a research project. Some have pointed out that it is possible to be exposed to different trainers, and different philosophies of neonatal care, within one centre.
- There is still a lack of clarity on what constitutes a minimum period of UK training; the advice from the RCPCH HST committee is that “the majority” of training should be in the UK. But what constitutes the scheme (is the whole of higher professional training), what constitutes the UK, and what is a majority? Belfast and Dublin have suggested pairing up to provide a 2 year programme, which seems eminently sensible and will provide good training. But Dublin is in the EEC but not the UK and further advice is that this will not be acceptable. A trainee who spent one year in Belfast, one in Dublin and the third “elective year” in Paris or Melbourne would not qualify for CCST in neonatal paediatrics under the current rules.
- There is a need to define the process whereby hospitals apply to become part of an existing programme, in other words how the programme is expanded. There have been major difficulties with the London/Oxbridge programme which are still not resolved (see below), although this scheme has been by far the largest contributor of posts to the Grid. Some posts have not been filled in the current scheme.
- The London Deanery has problems rotating year 4 trainees out of London, and has experienced financial problems with removal expenses, etc, for trainees moving into London.
- There are still problems with inter Deanery movements, not just into and out of London but also in other areas of the country.
- Some programmes which have been inspected, accredited, and approved by CSAC and the RCPCH HST Committee have yet to put any posts at all into the Grid. Others have been accredited and have put in their post but have yet to receive a Grid trainee.
- Scotland has remained problematic – partly due to the same financial difficulties with inter-Deanery transfers which London have experienced, the fact that not all Deaneries have neonatal numbers, and the large distances involved.

The process of appointing trainees to the programmes in England and Wales

In neonatal medicine, as in other subspecialties, it was decided that we would interview applicants who were applying from year 3 posts in neonatal units. The idea behind this was that the trainees would already have some experience of neonatology, and they would already have been assessed and considered suitable for further training in this subspecialty by their local RITA panels. The application date has been January with interviews in March and a start date the following September.

This system has led to some problems:

- The local “click” dates for CCST were not the same all round the UK, and there was much confusion about who was, and who was not, eligible to apply. For example, could you apply in January if you would be in year 3 by March? This will never completely be resolved; even if a national “click” date is set (as in the US) there will always be individuals who have different dates because they were ill, came from abroad, or have been on maternity leave.
- Applicants who failed to be appointed the first time have wished to apply again the following year. By then they are in year 4, and have only one year of training left. Should they be denied the opportunity to apply again because they are “too trained” or because if they are successful they will occupy a training slot, and use more money than was originally allocated for their training? If it is decided that trainees can only apply once then the Grid system will be a very harsh process. We have in fact allowed several individuals to apply twice but this needs further discussion and a resolution.
- If a candidate is rejected by the Grid interview system twice, but obtains experience, fulfils the curriculum, and has satisfactory local RITA (Regional In-training assessment) assessments then he or she will be eligible for a neonatal CCST in any case. There will be no requirement for this individual to declare on their CV that they were not considered suitable for further neonatal training at a national level.
- The requirement to rank individuals in order for the posts to be allocated is particularly difficult. The quality of the field will vary from year to year and no interview system can be that robust. It is one thing to assess candidates as suitable for training in neonatal medicine, it is another matter entirely to rank 10 or 12 candidates accurately after a panel interview lasting about 30-40 minutes.
- The original concept of the 3 year HST was that there would be 2 clinical years in 2 separate centres (so that a variety of exposure would be gained), and one elective year. The trainees so far have universally been appointed from clinical posts in year 3, and have gone on to be offered two further years of clinical training. Whilst this may well be fine, the need to service clinical posts in neonatal units seems to be driving the choice of posts, and so far no trainee has been offered a year in a fetal medicine unit, or a year in research.

Review of the Neonatal CSAC's specific experiences

The 2002 Round

In 2002 12 trainees were selected from 14 applicants. There were 15 posts on offer. The selection process was by competitive interview, and the interviewing team were impressed by the high quality of the applicants. We developed a structured and scorable approach to the interview which has been used twice now, and seemed reasonably robust. We accept the difficulties that interviewing will always bring and re-iterate the problems created by the need to rank applicants (v.s.).

One appointed trainee chose a career pathway in academic neonatology, rejecting the proffered scheme, and one took deferred entry. This left 10 to commence their two years of higher specialist training in neonatal medicine in September 2003. One trainee has since withdrawn from the Grid altogether to take up a Clinical Lecturer's post, and nine continue.

From the 2002 round, we learnt the following:

- In future, deferred entry should not be possible: candidates will have to withdraw and reapply. The reason for this is that it will be impossible for programme directors to plan placements otherwise, particularly as the numbers involved roll up.
- For the foreseeable future, candidates will have to attend the interview in person, although consideration may be given to attempting teleconferencing when suitable facilities are available. The reason for this is that it was simply not possible to rank candidates fairly without treating all of them the same. If the need for ranking is abolished for any reason, distance assessment would be easier.
- Communication, communication and communication. There were complaints at all levels. The programme directors complained that the Northern Deanery, who were handling the applications, did not let them know who was coming. The trainees complained they did not know where they were going. CSAC members complained because they were not in the loop between the Northern Deanery and the Programme Directors, and were fielding telephone calls and e mails at all hours. In short, at the end of the 2002 round, nobody was happy.

Fifteen posts were put into the pool in 2002:

Region	Location of post
London/Oxbridge	Hammersmith Homerton UCL St George's King's College John Radcliffe, Oxford Addenbrooke's, Cambridge
Trent	Sheffield Sheffield Leicester Royal Infirmary
South West	Southmead, Bristol
Yorkshire	Leeds
North West	Liverpool Women's St Mary's Manchester
Wales	Royal Gwent/UHW Cardiff

The trainees were placed as follows:

Region	Location of post/rotating to	Trainee
London/Oxbridge	Hammersmith/HH UCL/Hammersmith St George's/King's King's College/St George's John Radcliffe, Oxford/Hammersmith London Addenbrooke's, Cambridge/left the scheme	1 flexible 1 1 1 1 1
Trent	Sheffield/Notts	1
Yorkshire	Leeds LGI/Leeds St James'	1
North West	Liverpool Women's/ St Mary's Manchester	1

Most trainees achieved their first or second choice allocation.

What are the experiences of the 2002 trainees?

The trainees met together at the National Trainees Day held at the RCOG on the 25th June. The trainees were canvassed about their experiences, both in person and using a confidential questionnaire.

The Grid trainees who have taken part in the CSAC appraisal visits were in general very positive about their clinical training. One was experiencing difficulty accessing

exposure to fetal medicine and neonatal surgical post-op management experience due to the very busy nature of his clinical post.

Those who have trained outwith the Grid are usually equally positive about their experiences. Trainees have been interviewed at every assessment Visit.

Several study days for the Grid trainees have been held around the UK. A course specifically targetted at management training has been run, and another one (“Peak performance”) has been fixed for October 2003.

What are the experiences of the programme directors?

All the neonatal programme directors attended the June meeting. A separate session was held for them to air their views, which was hugely valuable.

The current UK neonatal programme directors are as follows:

Dr Andrew Currie	Trent
Dr Paul Duffy	Scotland
Dr Geoff Durbin	W Midlands
Dr David Evans	South West
Dr Dorothy Garvie	South Thames
Dr Mike Hall	Wessex
Dr Jane Hawdon	North Thames/Oxford/Cambridge
Dr Lawrence Miall	Yorkshire
Dr David Milligan	Northern
Dr Nim Subhedhar	North West & Mersey
Dr Carol Sullivan	Wales
Dr Richard Tubman	N Ireland

- At present there is inadequate resource for the neonatal CSAC to assist programme directors as much as it would like in delivering the curriculum. There are no plans for a web based national web-board, or an exit exam, and all these need discussion.
- The view of the programme directors was that the neonatal training programme was high quality, accredited, syllabus and competency driven but was not flexible
- More communication was needed at the time of the Grid appointments regarding who was suitable for training and who was going where; the Northern Deanery perhaps lacked support for the large amount of administration that this took
- Serious consideration was given to changing the “two centre” rule to a recommendation not a requirement, providing that a single centre could fulfil all the training requirements and enable the trainee to cover the syllabus and acquire the competency. We felt that it was this that was important, not geography.
- The difficulties of proleptic appointments to the Grid, and gap years in the grid were discussed

What are the experiences of the Deans and the College?

So far we have not had feedback from the Deaneries. Within London, there has been support for the Grid although the point has been made that removal expenses, etc, can

be considerable if a trainee is appointed from another Deanery and moves into London to take up a post. From the College perspective, a meeting has been convened at the RCPCH with the President (Professor Craft) and Patricia Hamilton, Training Officer, for the 25th September.

How will the current trainees be assessed?

- Appraisal is a big topic nationally, and this is our main task over the next year or so. The problem is increasing because local regions are abandoning face to face RITA assessments so the opportunity for CSAC to “sit in” on this exercise will be lost. Further, the RITA process is not meant to act as a formal appraisal system in any case.

Ideas so far include – acting up as a consultant with outside supervision, like “teacher training”; an exit exam; a national appraisal; local RITA appraisals with CSAC input (the current system); a sequence of observed practice scenarios with local mentor assessment.

The 2003 round

The posts which were offered for September 2003 are listed in the following table:

Training Programme	Post
London/Oxford/Cambridge	Chelsea & Westminster Homerton
4 posts – “choose from 6 centres”	Northwick Park Royal London St Mary’s UCH Addenbrooke’s (to UCH or Homerton)
South Thames (sub-London scheme)	King’s St George’s
Trent	Queen’s Nottingham Leicester Royal Infirmary
Wales Wessex	Royal Gwent Hospital Princess Anne, Southampton to St Mary’s Portsmouth St Mary’s Portsmouth to Princess Anne, Southampton.
South West	St Michael’s, Bristol Southmead, Bristol
West Midlands	North Staffordshire Birmingham Women’s Birmingham Heartlands
North West Yorkshire	St Mary’s Manchester Leeds General Infirmary

Concerns were:

- Many of the 24 posts were offered as individual posts. They were not offered as a fixed 2 year “scheme”.
- Some of the proposed slots (Northwick Park, St Mary’s, Chelsea & Westminster, Royal London) were not on the original “approved” list which was put out in the training document by CSAC prior to the visits process being completed. These hospitals were represented in the London appraisal visit, but have not been formally accredited and will be visited in 2003/4. If the Grid continues in its current form London/Oxbridge need to put forward coherent training programmes ahead of time, and we need to facilitate them in this by inspecting all the proposed centres as soon as possible. Discussions have been held with the London Deanery, who remain very supportive of the Grid system in spite of the problems it creates for them.
- Newcastle, the only centre to have been approved for a full 4 years, have not managed to put in any posts so far; the same is true for Scotland.

The 2003 applicants and interviews:

In 2003 there were 19 applicants; 18 of whom were short listed.

There was a problem with one applicant whose forms did not arrive in time because he had paid insufficient postage, and his experiences should be used to warn future applicants to send material by recorded delivery. Another candidate received an acknowledgement of her application but her details were inadvertently removed from the pack. Fortunately this came to light, albeit late and to the distress of the candidate and the interview committee.

16 were interviewed (2 did not turn up)

15 were appointed. 13 of the applicants were appointed to the posts of their first choice, 1 the second. A final applicant, who was not allocated to their first choice centre, decided not to move deanery and remained outside the Grid.

The allocation of trainees for September 2003 is listed in the following Table:

Training Programme	Post	Trainees
London/Oxford/Cambridge 4 posts – “choose from 6 centres”	Chelsea & Wesminster	
	Homerton	1
	Northwick Park	1
	Royal London	1
	St Mary’s	1
	UCH	1
	Addenbrooke’s (to UCH or Homerton)	
South Thames (sub-London scheme)	King’s St George’s	
Trent	Queen’s Nottingham	1
	Leicester Royal Infirmary	1
Wales	Royal Gwent Hospital	
Wessex	Princess Anne, Southampton to St Mary’s Portsmouth - 1	
	St Mary’s Portsmouth to Princess Anne, Southampton. – 1	
South West	St Michael’s, Bristol	1
	Southmead, Bristol	1
West Midlands	North Staffordshire	1
	Birmingham Women’s	
	Birmingham Heartlands	
North West	St Mary’s Manchester	1
Yorkshire	Leeds General Infirmary	1

Conclusions

There has been much support for the Grid, but there is no doubt that a careful review is essential if we are to continue to operate this system. This document has already served as a starting point for discussion and debate, and this discussion needs to continue and broaden.

The following points emerge:

Should the Grid be abandoned and the work of the CSAC be concentrated on devising the syllabus, working out appraisal criteria and approving centres as being suitable for higher training in neonatology?

The trainees like the Grid – they like guaranteed training and the “stamp of approval” of competing nationally for training

There is much support from the programme directors

The “two centre” rule needs to be thoroughly examined yet again.

The feeling at the Programme Directors meeting was that this could be a recommendation not a requirement, providing that the syllabus and competencies could be met. Further discussion will be held at CSAC over the next few months.

If the grid continues the advertisements must be for schemes not posts; the posts in a scheme must be worked out and agreed in advance no matter how difficult this will be at local level. Programme Directors, Deans, etc all need to be kept in the loop and this takes administration time and money.

An elective year must be made a realistic option.