Minutes of the Surgical Specialties Training Board meeting held at 10.30 am on Monday 10 October 2016 in Rooms 1 and 2, 2 Central Quay, 89 Hydepark Street, Glasgow (with videoconference links)

Present: Dominique Byrne (DB) Chair, Helen Biggins (HB), John Butler (JB), Gareth Griffiths (GG), Amanda McCabe (AMcC), Craig McIlhenny (CM), Hamish Simpson (HS), Craig Wales (CW), Satheesh Yalamarthi (SY).

By videoconference: Luke Boyle (LB) deputising for Rachel Thomas, Megan Lanigan (ML), Lorna Marson (LM), Rowan Parks (RP), William Reid (WR), Andrew Renwick (ARe).

Apologies: John Anderson (JA), Joanna Cuthbert (JC), Geraldine Brennan (GB), Jonathan Dearing (JD), Tracey Gillies (TG), Alison Graham (AG), Kerry Haddow (KH), Adam Hill (AH), Brian Howieson (BH), Alan Kirk (AK), Kapil Kumar (KK), Mike Lavelle-Jones (MLJ), Graham Mackay (GM), Calan Mathieson (CMa), Douglas Orr (DO), Alasdair Robertson (ARo), Justine Royle (JR), Ken Stewart (KS), Jackie Sutherland (JS), Rachel Thomas (RT), Ken Walker (KW).

In attendance: Helen McIntosh (HM).

1. **Welcome and apologies**
The Chair welcomed all to the meeting and apologies were noted.

2. **Minutes of meeting held on 1 July 2016**
One amendment was noted:
Page 7, Item 9.5, to delete second sentence.

With this amendment the minutes were accepted as a correct record of the meeting.

3. **Matters arising**

3.1 **Changes to Breast Surgery training**
JA will report to the STB after the next SAC meeting. **JA**

3.2 **Core Surgery progression to ST3**
The paper summarised CT2 output at July 2016. There were 36 respondents including those with extensions to training and the total equalled the number who were recruited at 2014 making a good comparison. The paper showed 16% of trainees do not pass MRCS as compared to 8-10% in rest of UK and 25% leave Surgery. 72% in Scotland complete core training (75% in rest of UK) – 33% progressed to Surgery (UK 34%) – 46% (43% UK) progressed to other specialties and 54% (53.9% UK) progressed from Core to ST3/Research. This showed Scotland did not have a particular issue and was not performing worse than elsewhere.

ARe noted he recently provided externality for ARCPs elsewhere in the UK and based on that experience he considered that the Scottish trainees he knew were performing at a higher level in terms of use of logbooks and abilities and received better experience and were more rounded trainees. SY noted they released some trainees in the first year due to MRCS failure and his view was that trainee quality was not as high. A quarter to a third of trainees progressed well while around a third did not engage and hence experienced issues. No trainees in Scotland sat both parts of the exam before starting programme – 50% have Part A. There were

no specific training courses to support trainees to sit exams but they did use the days provided by the College. ARe felt the biggest issue was trainees at the end of CT1 without Part A putting pressure on themselves to get both Parts at the same time. DB proposed requiring trainees to have Part A by the end of CT1 otherwise they could be given an Outcome 2. LM noted externals did not approve and LB felt it was unnecessarily harsh to award an Outcome 3 and reported Medicine specialties awarded Outcome 2s for exam failures. ARe felt it was easier to manage at the end of CT1 rather than at CT2 as this would require extra posts; DB noted trainees can have up to a year's extension to training in total so this would impact on HST. There were potential implications whatever they did. ARe felt it was better for trainees to leave Surgery at this stage and experience gained in was useful for those moving into other specialties.

The group discussed the reasons why the 12 respondents did not gain posts and instead went into locum posts – whether this was because they did not perform as well or there was a high competition rate in specialties to which they applied. It was acknowledged Plastic Surgery trainees generally needed an extra LAT year; T & O also often needed further experience not met by 2 years in core training. Overall it was felt that core training plus one year would be a better model.

RP felt it would be helpful to track the group of 12 to check where they were in 12 months' time and in future for this work to done annually for each cohort. DB will ask JA to take this forward. **JA**

3.3 **Changes to Urology procedures for CCT**

CM noted this was discussed at the SAC meeting last week which he was unable to attend. He has written to the SAC Chair registering his disagreement but as yet has received no response. He will update the group at the next meeting after receiving the minutes of the SAC meeting. **CM**

3.4 **ARCP process – NES guidance**

DB's tabled paper listed ARCP evidence requirements for SOAR/ISCP and what must be updated. As required evidence varied from year to year the paper will cross-reference websites e.g. College. He stressed the need for each trainee to have a Learning Agreement signed off in advance of the ARCP online review (likely to be set at 2 weeks). All evidence must be recorded including that from previous training years as well as evidence from outwith training programme as long as this was dated and not too long ago or time limited. Trainees must be informed of their outcome 4 weeks' before the face-to-face meeting if one is required. ARCP dates can be set at the beginning of the training year and trainees informed which will give them time to gather required evidence. Guidance will be issued at the same time and this will act as a reminder for trainees and TPDs to ensure trainees were aware of the requirements. The group agreed the guidance should specifically state that trainees failing to submit evidence 2 weeks before ARCP should be sent a written letter; DB will check whether it was planned to include this in the generic introductory guidance. **DB**

WR stressed the need for consistent ARCPs across Scotland. Engagement with the process throughout training was crucial as this was part of the professionalism standard and trainees and trainers were expected to fully participate. Educational Supervisors must sign off SOAR declarations and trainees must collate required evidence. Standard operating procedures were essential and must be adhered to

and an Outcome 5 must mean the same wherever it was awarded and also when converted to an Outcome 1 or 2. The same applies to seeing trainees for non-standard outcomes – all correct procedures must be followed. He noted England was interested in the pilot which Scotland will run in November/December.

3.5 **T&O early years' curriculum**

Representatives will meet immediately after the STB meeting to discuss how to move forward. A paper will be produced for the next STB meeting. **Agenda**

4. **Scotland Deanery**

4.1 **Deanery Newsletter**

The March 2016 newsletter was circulated for information.

4.2 **Quality management report**

ML reported QRPs were completed and the team was now working on building a calendar for next year and will circulate information to TPDs. WR thanked all for their input to the process which has produced good data. The general view was there were no real surprises and red flags from last year have changed to pink/black/green showing they were making inroads into improving programmes and there was better engagement from employers. DB also noted the very helpful preparatory work by the Quality team and especially Adam Hill on data analysis and presentation.

37 visits were scheduled for next year however where possible they will aim to do one visit where Core and HST were to be visited and some may also be 'good practice visits' so the number should reduce.

4.3 **SAC representatives' expenses – NES**

DB reported that Surgery SAC representatives have historically claimed expenses from their Health Boards however there was now a willingness from NES to consider the arrangement. Some STB members were also SAC representatives and therefore do not need such an arrangement. SAC representation was not geographical but was based on experience and information. The group agreed it was not necessary to formalise arrangements as long as information from SAC members was communicated to specialty representatives. Specialty representatives will ask SAC representatives to summarise information/provide minutes of meetings as required. **Specialty reps**

5. **Recruitment**

5.1 **2016 updates from specialties**

- *CST*

Forty-eight posts were advertised last year and all West posts filled and were likely to fill this year. The East programme had some gaps in difficult to fill posts.

- *Urology*

CM reported they were able to fill late LAT posts via national selection and although 2 people appointed to post subsequently withdrew they were able to appoint other candidates in their places. He flagged their withdrawal as a professionalism issue. WR said there was a divergence of opinion however felt those who withdrew should be sent a formal letter noting that this was unacceptable. GG agreed this was unprofessional but there was little they could do before the contract of employment was signed. CM felt it would be appropriate for

a letter from the Head of national selection to be sent to those who withdrew after appointment.

The group agreed the principle of late appointment worked well.

- *Paediatric Surgery*

All posts filled; they will advertise one post in August 2017 and potentially a second.

WR noted NES was unable confirm whether backfill arrangements for NTN holders OOPR for 1-2 years would be funded this year as information was not yet available from Scottish Government/Health Boards. He also noted NES would be sympathetic to backfilling NTN posts in the event of long term sickness absence however this was a regional decision.

- *Cardiothoracics*

JB reported a national desire to extend ST1 recruitment and so they will recruit to one ST1 level post in August and one LAT to backfill an OOP.

- *T & O*

Recruitment went well and it was hoped this would repeat next year – applicant ratio was 10:1. Interview dates have been set for the beginning of February in Glasgow.

- *OMFS*

There were 2 vacant slots – one for recruitment in August 2017 and one identified for an IDT.

5.2 **Remote & Rural Surgery**

5.2.1 **Attitudes of General Surgery trainees**

5.2.2 **Core Surgical Training placement**

The group considered a summary paper of a survey by 2 trainees on attitudes of General Surgery trainees to Remote & Rural Surgery. Main barriers were skills and specialisation which fitted well with the Shape of Training development although the survey's response rate was only 50%. Remote & Rural experience was already provided for CST trainees in the East and SY reported that trainees were generally happy with the exposure. There have been some issues in Stornoway where locums covered vacant consultant posts and this has affected the quality of training however the posts in Fort William, Stornoway and Elgin were all very popular.

ARe said he would be happy to consider providing experience in Oban for the West if they could move a salary or use a vacant GPST slot on an ad hoc basis. WR said funding models and approvals would have to be considered and discussed with Scottish Government e.g. short term exposure for 2 weeks as a 'taster'. A major review of unfilled GP posts/programmes was ongoing and there will be a major reconfiguration of existing posts so the model may be challenging. Any proposal would have to be taken to the Transitions Group with clear information on benefits. The group agreed DB will ask JA to provide a paper for discussion. DB will also organise a virtual meeting with ARe and SY to consider Remote & Rural CST exposure in the West. **JA, DB**

6. **Updates**

6.1 **Service**

No update was received.

6.2 **Specialties**

- *CST East*

SY reported a trainee was working on assessing the quality of training by comparing logbooks. The results will be available next year.

- *Paediatric Surgery*

AMcC noted she and the General Surgery TPD were currently looking for ways to backfill General Surgery commitments to enable a trainee to have experience in General Surgery of Childhood. She will keep the STB informed. DB said a precedent has already been set in Glasgow but this was dependent d on available finance/salaries moving a salary could affect the future of the vacancy. RP further noted a precedent in the South East regarding an OOP at ST6/7 level. The trainee should be encouraged to get experience in outreach as well as the operating list to maximise the value of the placement.

- *Cardiothoracic*s

Noted: Deanery visit at the end of November.

- *T & O*

HS reported a pan Scotland training day was held on 1 September; this was very well received and will run again next year. The group noted T & O in Scotland scored very highly in the BOTA survey – 4 of the top 7 were Scottish programmes.

6.3 **SAC update**

GG noted work on the General Surgery curriculum by HEE and the English college. There will be a single curriculum for all UK for pilot and non pilot trainees.

6.4 **Academic**

No academic update was received.

6.5 **MDET**

WR noted the Triennial Review took place on Friday 7 October. No firm information from the GMC on its review will be received before January 2017.
RP reported the Transitions Group approval for 2 posts to re-allocate from General to Vascular Surgery. Formal approval would have to be sought for any future re-allocations.

6.6 **Colleges**

RP reported the College Council met on Friday 7 October when it focused on Shape of Training and the General Surgical pilot and agreed general support for single curriculum.

GG confirmed the pilot will focus on 3-4 main areas – environment/process of training and contribution of non-medically qualified staff. The programme was likely to be runthrough via the Core selection process provided there was a robust and benchmarking process at ST3 standard. The curriculum will be based on high level outcomes so will include entrustable areas and assessment via workplace based assessments etc – the pilot will use more enhanced assessment (EPAs).

6.7 **Simulation**
No update was received.

6.8 **Trainees**
The BMA has produced a position paper on the General Surgical pilot; LB will send it to HM to circulate to the STB **HM**

6.9 **JCST**
The JCST Newsletter was circulated for information; noted the award of Silver Scalpel to GG. JCST will next meet on 11 October.

6.10 **CoPSS**
6.11 **SCCCSS**
No updates were received.

7. **AOCB**
7.1 **Chair of Surgery STB**
WR informed the STB that DB will demit office and thanked him for his effective chairing of the STB. During this time, he has consolidated the business of the STB and applied clear and logical thinking to issues and discussion. On behalf of the STB he wished DB well for the future.

Interviews for his replacement will be held on 11 October.

8. **Dates of next and future meetings**
DB confirmed his successor as STB Chair will set future meeting dates.

Actions arising from the meeting

Item no	Item name	Action	Who
3. 3.1	Matters arising Changes to Breast Surgery training	 To report after SAC meeting.	 JA
3.2	Core Surgery progression to ST3	To take forward cohort tracking.	JA
3.3	Changes to Urology procedures for CCT	To update the STB at the next meeting.	CM
3.4	ARCP process – NES guidance	To check content of introductory section.	DB
3.5	T&O early years' curriculum	Agenda item for next meeting.	Agenda
4. 4.3	Scotland Deanery SAC representatives' expenses – NES	 To ask SAC reps for info as required.	 Spec reps
5. 5.2 5.2.1 5.2.2	Recruitment Remote & Rural Surgery Attitudes of General Surgery trainees Core Surgical Training placement	 To provide a paper for discussion. To arrange virtual meeting to discuss placement in West.	 JA DB
6. 6.8	Updates Trainees	 To circulate BMA position paper to STB.	 HM