

**Minutes of the Surgical Specialties Training Board meeting held at 10.30 am on
Wednesday 20 April 2016 in Room 6, Westport, Edinburgh**

Present: Dominique Byrne (DB) Chair, John Anderson (JA), Kerry Haddow (KH), Lorna Marson (LM), William Reid (WR), Hamish Simpson (HS), Ken Stewart (KS), Satheesh Yalamarthy (SY).

By Videoconference: *Aberdeen (1)* – Justine Royle; *Aberdeen (2)* - Kapil Kumar (KK), *Glasgow* – Helen Biggins (HB), John Butler (JB), Amanda McCabe (AMcC), Craig Wales (CW).

Apologies: Joanna Cuthbert (JC), Geraldine Brennan (GB), Jonathan Dearing (JD), Tracey Gillies (TG), Alison Graham (AG), Gareth Griffiths (GG), Adam Hill (AH), Brian Howieson (BH), Ewan Kemp (EK), Alan Kirk (AK), Mike Lavelle-Jones (MLJ), Graham Mackay (GM), Calan Mathieson (CM), Craig McIlhenny (CM), Douglas Orr (DO), Rowan Parks (RP), Andrew Renwick (ARe), Jackie Sutherland (JS), Rachel Thomas (RT). Ken Walker (KW).

In attendance: Helen McIntosh (HM).

Lead

1. **Welcome and apologies**

The Chair welcomed all to the meeting and in particular Mr John Butler, representing Cardiothoracic Surgery, Ms Justine Royle, representing Urology and Ms Kerry Haddow, ENT representative. Apologies were noted.

2. **Minutes of meeting held on 15 January 2016**

The following amendments were noted:

Page 5, Item 5.3, first paragraph, penultimate sentence to read 'For some specific types of OOP (OOPT), individuals ...'

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

3. **Matters arising**

3.1 **General Surgery of Childhood**

AMcC noted information received from Mr Atul Sabharwal, Chair of the short life working group (sponsored by the Royal College of Surgeons of Edinburgh and supported by the Royal College of Physicians and Surgeons of Glasgow) addressing the concerns about the future provision of Surgical Services for Children in Scotland in both elective and emergency settings. The group has held 4 meetings and has recently presented its initial draft paper to the Council of the Royal College of Surgeons Edinburgh.

The draft highlighted Paediatric Surgery's awareness of the possible impending crisis in service provision. There are significant concerns in several areas: there are fewer General Surgeons and Urologists in non-specialist centres carrying out paediatric surgical procedures, concerns around anaesthesia in non-specialist centres, changes to the training of General Surgery and Urology trainees, increased referrals to specialist centres and the potential for these centres to become overwhelmed without appropriate resources, inappropriate transfer of patients, and variation in regional practice leading to conflict and delay in care delivery with possible adverse outcome.

Discussions to date:

1 ISD Data: Elective and emergency procedures in specialist and non-specialist centres (2000-2013) up to age 16 years. Elective – orchidopexy, circumcision, inguinal herniotomy, PPV ligation. Emergency – scrotal exploration and appendicectomy. Site of management of children admitted with abdominal pain.

In summary, in the period 2000-2013 there has been a 3-fold increase in the number of circumcisions; for all elective procedures, a higher proportion of cases was undertaken under paediatric surgeons in 2013 than in 2000; elective groin cases showed the most consistent upward trend in % carried out by paediatric surgeons (71%-92%). The number and rate of admissions for abdominal pain is highest in the older group (10-15yrs), the majority of these admissions (90%) do not require surgery.

2 Assessment and operative management: Consider initial assessment and actual surgical procedure in non-specialist centre or referral to specialist centre. There would appear to be an increasing reluctance to assess and manage the abdominal pain and acute scrotum groups by adult General Surgeons and Urologists. This is despite relevant curricular requirements. A role has been proposed for local Medical Paediatric teams to assist initially.

3 Impending Retirements and Recommendations for type of appointments: Data on this are still being gathered, but there would seem to be no plans in non-specialist centres to replace impending retirements with job specifications requiring the provision of GSC. Recently-appointed Consultants have generally not been willing to provide the service, the reasons given being lack of experience, and inadequate/no exposure during training - despite clear requirements in the General Surgery and Urology curricula.

4 Discrepancies between CCT requirements and actual practice: Specific CCT stipulations are becoming less reflective of actual practice in non-specialist centres. Of the trainees surveyed 44% felt that rotation through Paediatric Surgery during their training would be valuable.

5 Examples of good practice: T&O and Anaesthesia. All orthopaedic trainees are expected to assess and treat simple emergency conditions in children, and have to demonstrate experience of managing children in order to obtain CCT. All rotate through a Paediatric post (3-6 months), the FRCS (T&O) exam includes a compulsory viva on "Hands and Paediatrics". Paediatric Anaesthesia forms part of the final FRCA and it is expected that all trainees at CCT are able to manage healthy children aged 3 and older for simple procedures.

6 Role of the Royal Colleges, SAC and others: The group will recommend a cohesive approach by all relevant training and credentialing bodies to support the safe and effective locally-delivered GSC service.

7 Support of Medical Paediatrics to ensure sustainability: The vital role of paediatricians to support General Surgery of children in the non-specialist centres will be addressed

8 Transport issues: In the elective setting, if surgery is centralised, either the

surgeon or the child or both will need to travel for the initial clinic appointment. Consideration needs to be given to the remote areas of Scotland and to planning for such a situation. Overnight accommodation may be required for the visit as well as for the perioperative stay. The child may require preassessment; video links may help, and IT support would be needed for history, notes and investigations in the right setting. In the emergency setting - may require transfer for urgent surgery. Provision of adequate infrastructure to support increased numbers of transfers should be planned for.

9 Support from tertiary centres: There are current links via outreach by Paediatric Surgeons visiting District General Hospitals. There are also proposals to accommodate General Surgery trainees for 3-6month rotations in the main Paediatric centres (e.g. Units in Edinburgh and Glasgow could incorporate 1 and 2 trainees respectively), with a remit to be tailored to the work required for delivery of GSC (this type of rotation is already in force in Aberdeen for North of Scotland Region trainees). Refresher lists for General Surgeons should also be considered. Specialists could visit non-specialist centres in the initial stages of service development.

10 Recommendations for training of General Surgery trainees and Post-CCT fellowships for General Surgeons. 3 broad scenarios are postulated: The status quo is not sustainable, with the threat of sub-standard service provision.

1. Centralisation: this clearly disenfranchises local populations, can lead to deskilling of the local workforce, results in more emergency cases travelling, and brings with it resource implications.
2. Forward planning: to select individuals who would provide a sustainable 'elective' caseload. (seems most reasonable proposal)
3. Timing and integration of training: When? later stages of specialist training and be 1 year duration. Where? In the environment that most closely resembles that in which they are likely to find themselves, with release to specialist centre. Who should provide the training during this period? mainly those who have provided the care to date in the non-specialist centre. Content? Curriculum is in place. Recognition of training? Workforce and colleges are aware of the impending crisis, although it is less clear to what extent the government is aware of the current state or of the costs to rectify. Role of post-CCT fellowship? A significant undertaking, beyond remit of this paper.

The Chair of the working group will contact DB to discuss the draft paper and AMcC will report on the final paper when available.

WR noted opportunities for Paediatric Surgery under Shape of Training. The specialty must make its voice heard to influence any Scottish Government initiatives. DB said there was a desire provide trainees with some experience in Paediatric Surgery although there would be little motivation as it was not included in consultant job descriptions. There was discussion about current consultant appointments to General Surgery with a defined Childhood role, however this was separate from the provision of emergency cover for the General Surgery of Childhood and these skills were essential and required participation of a complete Consultant group. The plan under Shape of Training was for modular training to include both emergency-safe and extended elective commitment. The General Surgery SAC wanted to develop experience and training in Child emergency

procedures.

The Urology SAC already requires trainees to gain indicative numbers in Paediatric Urological procedures and was now looking at how to achieve time commitment. However, the emphasis remained on trying to provide emergency-safe training. HS confirmed that T&O trainees all must rotate in Paediatric Surgery.

3.2 **Surgery Curriculum Mapping post-ShOT**

The General Surgery SAC carried out a mapping exercise last year with the aim of improving patient care and compiled a report based on responses to specific questions. JCST then produced an overview for the Academy which then in turn responded. The mapping exercise had 4 main themes – ensuring doctors were emergency-safe, general training, linking primary and secondary care, and the commitment to lifelong learning. It found that by the time of CCT individuals were already emergency-safe, there was scope for collaboration with primary and secondary care, there was no desire to shorten craft specialty training, and there was interest in area of credentialing. RP and GG have produced a discussion document for JCST and it will be discussed at the next STB meeting.

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WR said the UK ShOT group met at the end of March and agreed to do further work with those who submitted responses, one of them being Surgery. Detailed discussions will take place soon at a UK level and Scotland has already begun discussions about implementation of the Report. Overall he felt that Scotland was in a good position to move forward and that the Surgical body saw this as an opportunity and not a threat.

3.3 **Urology – National Training Days**

JR reported they planned to increase the number of these meetings. The item was deferred to the next meeting for more detailed discussion.

Agenda

3.4 **Remote and Rural Surgery**

JA noted the report was submitted some time ago and has now been published. The report has stimulated media interest and he and others are to be interviewed by the Herald newspaper tomorrow (21 April 2016) on this subject.

DB noted recommendations 3 and 5 on page 1 of the report as those of most relevance to the STB and in particular noted recommendation 5e – consideration should be given to allocating two ST national training numbers within the General Surgery training programme in Scotland for trainees interested in Remote and Rural Surgery. JA acknowledged it would not be possible to ringfence this and individuals could not always commit long term as their aspirations may change as their training progressed. This would also probably involve the removal posts from elsewhere.

As there was a limited number of subspecialty areas, they were considering modular training to include Remote and Rural which should address its recruitment issues. JA noted the General Surgery curriculum specified Remote and Rural elements. The biggest issue was identifying trainees who wanted to take up such posts. KK added that NES was funding a Fellowship in Orkney; however, there remained issues around proleptic appointments, including whether they would be given the appropriate necessary supervision and training or were simply seen as surgeons who would provide service. He felt there should be a curriculum or a QA

mechanism to ensure standards.

WR confirmed that consideration of Remote and Rural practice was included in the Shape of Training Report and post-CST Fellowships or modules and credentialing could all be developed. The GMC was looking to Scotland to suggest ways of achieving this.

4. **Gold Guide 6th edition**

The .pdf version of the latest version of the Gold Guide was circulated with the papers for the meeting in addition to the URL to on-line access. There were several aspects which had been updated, mainly in terminology. Three specific areas were highlighted – updates on LATs, IDTs and LTFT. Section 7 updated the ARCP processes, review and appeals; WR noted increased legal involvement in this.

5. **Major Trauma Centres**

5.1 **Discussion of potential educational impact**

RP had sought the Board's view on the impact on education and training of establishing Major Trauma Centres (MTCs). The STB was not being asked at this stage to debate the number of centres which should be established.

At present 18 hospitals delivered major trauma care and this was neither sustainable nor the best way to provide care. Most programmes in England have an MTC within their region, but it was easy to see how this could be a source of significant concern for those without. In Scotland, it was felt that the treatment provided in some centres may be suboptimal by modern-day standards and that this would therefore not provide the best exposure for trainees; the establishment of MTCs would provide better training. The paper circulated for today's meeting defined 3 types of centres/hospitals – MTCs, Trauma Units and Local Emergency Hospitals. It was recognised that there would be some overlap in the areas of care covered by these centres as well as a tendency for some practice to drift – probably from Local Emergency Hospitals and Trauma Units into the Major Trauma Centres.

KK felt that while the development of MTCs was a positive step, there was a risk that 25% of Scotland's T&O trainees (those in the North of Scotland Region) would be excluded from access to MTCs if the MTCs were located in the central belt and that they would therefore require a secondment in order to train in that aspect of care. Those trainees would be disadvantaged (in financial and/or social terms) and this might in turn impact on recruitment. WR said they were already taking a pan-regional programme approach and could facilitate rotations in MTCs to suit the curriculum. His concern was the potential drift of staff from DGHs to MTCs and consultant opportunities, but in terms of training he felt the logistics would be worked out wherever MTCs were placed and however many there were. In National programmes, trainees already move to other areas for training experience; however, this involves expense and personal disturbance to trainees. CW noted the expense involved in OMFS rotations but noted that the creation of a fixed trauma slot within the programme had helped with trainees' acceptance of this. The board discussed whether backfill would be required and agreed that while it was for TPDs to identify the need for this, a statement of general principle was required. In summary, it was agreed that MTCs will impact on training and benefit trainees by providing exposure to major trauma. Some flexibility in rotations would be necessary in order to accommodate training in the MTCs for all trainees and there

would be potential disadvantages around backfill and its costs, destabilising training, removing experience in some centres and the personal impact on trainees if there was no centre in their area. JA said they would have to consider delivery of “special interest” training in MTCs as current consultant staff might not have experience at that level. There was resource outwith the NHS as military trainees received significant trauma training and collaboration with the Military should therefore be considered. NES enjoyed good relationships with the Military and improved links could be developed. SY felt that they should also consider exposure to Trauma Care in A&E for Core and Foundation trainees.

DB would prepare the Board’s response for submission to RP.

DB

6. Scotland Deanery

6.1 Quality management process

The latest report from the Surgery sQMG was awaited. DB noted Jill Murray has temporarily replaced Harry Peat as Surgery QIM. WR reported Training Management was working on changes to the ARCP process to clarify, standardise and streamline it and deal with the increased number of legal challenges.

SY reported on externality discussion at a Core Surgery meeting in London. It was proposed to split the country into 3 sectors – London and the South/ Midlands/ NE England, Scotland and Ireland and externality would be rotated. WR confirmed that externality was compulsory; it was good practice to have an external at each panel and this was required for non-standard outcomes. Videoconference could be used to facilitate panellist attendance. Trainees achieving an Outcome 1 do not require to be seen on the day and could be seen outwith the ARCP process at a different time of the year. All trainees should meet their Educational Supervisor before ARCP and Supervisors were required to provide a report for the panel. All evidence must be provided 2 weeks in advance and trainees should be informed in advance of non-standard Outcomes. LM reported that Urology reviewed research at the same time. JR said they held 2 days of informal meetings in November where all trainees were seen to discuss training planning, research and pastoral care if required. If issues were flagged up at that meeting, a letter was included in the Deanery file only and not recorded in ISCP. This was also a good opportunity for trainers to network and plan training for the year. The June meeting was a formal ARCP and trainees with non-standard Outcomes were given due notice of the date and required to attend. Trainees on standard outcomes were not required to attend at that time.

WR confirmed College liaison representatives were welcome at ARCPs. Lay involvement was more complex and they were working to produce a model for this. Lay input was helpful especially on non-standard ARCPs.

There will be no change to the ARCP process this year. The STB agreed that while it is not necessary to review all trainees in face-to-face meetings at ARCP, it was best practice to see everyone once a year in an informal setting to review progress and to record the meeting in ISCP.

7. Recruitment

7.1 2016 updates from specialties

- *Trauma and Orthopaedics* – ST1 recruitment in Glasgow was completed and all 18 posts filled. Six ST3 posts remained for recruitment.

- *General Surgery* – recruitment will take place this week and next. Competition ratio was down at less than 2:1. An appointment has been made to run the process for the next 2 years.
- *ENT* – recruitment will begin in May. Applicant numbers were down at roughly a 2:1 ratio.
- *Plastic Surgery* – national recruitment will be held 5-6 May in London. Scotland had 8/9 vacancies and they were likely to fill however concerns remained about the recruitment process.
- *Core Surgery* – UK nationally there were 1300 applicants for 591 posts and a 100% fill rate with 245 reserves. As yet there was no data on how many of Scotland's F2s had been successful. JA considered Scotland was disadvantaged due to Foundation themed programmes in England and candidates scored higher in the current Core recruitment process if they came from England. DB agreed to seek information from the Core Surgery National Recruitment Office regarding this. DB
- *Urology* - recruitment will take place next week. They were oversubscribed but as present there were no further details.
- *OMFS* – recruitment was held in February in Bristol. There were 17 posts nationally and 11 candidates were appointed. Two posts were advertised in Scotland and one candidate appointed. The specialty was reviewing marking and other aspects of recruitment and will seek information on those who were not appointed and on their subsequent performance.
- *Paediatric Surgery* - national recruitment will take place next week for 2 posts. There was no detail on numbers who have applied. Last year there were 60 applicants for 17 posts and all slots in Scotland filled.
- *Cardiothoracic Surgery* – there were no vacancies in Scotland this year however there should be one post in 2017. The ST1 pilot was working well.

8. Sustaining Medical Workforce

8.1 IMTF applications from Urology (Lothian)

All applications were positively received by the STB and passed to NES. Two further late applications have been received for Urology and the STB membership had been asked to consider these. The responses received (n=12) were unanimously supportive. KS asked if it was appropriate to recommend IMTF posts in hospitals under enhanced monitoring; DB felt the posts involved could contribute to improve training. WR said that enhanced monitoring status and placement of trainees were 2 separate issues and it was for the local team and Deanery to make a decision. He also confirmed that they kept a watching brief and were able to pick up concerns for trainees and Fellows. This required close co-operation with the relevant TPD. A further application for an IMTF in Colorectal Surgery in Lanarkshire had been received by the STB and was therefore considered at the meeting. The Board was supportive of this application also but with a recommendation that the post should be filled in consultation with the TPD to facilitate the advance planning required to ensure that there were no clashes of training priority and/or training grade which might otherwise jeopardise the training of local trainees.

The STB approved the applications.

9. Updates

9.1 Service

No update was received.

9.2 Specialties

- *General Surgery*

The SAC meets next week and one item for discussion was the future of training with an interest in Breast Surgery. At ST7 and 8 there would be no requirement to provide General Surgery. He will report to the STB after the meeting.

JA

- *Plastic Surgery*

KS noted the proposal for centralising Cleft Surgery provision. If accepted all trainees would have to rotate to Glasgow. This will be discussed at the next STB meeting. He also noted discussion on Aesthetic Surgery at the Plastic Surgery SAC meeting.

Agenda

- *Core Surgery*

SY reported that 50% of CT2 trainees progressed into ST3 or LAT posts – 25% of trainees do not finish programme within 2 years, 10% due to exam failures leading to a number of extensions to training time. This was not budgeted for and could cause financial pressure although the numbers were small. He had held back some posts from national recruitment to allow for extensions. There were some gaps this year and he will discuss this with ARE. HM will circulate the papers prepared by SY to the STB.

HM

- *Urology*

Noted introduction of robotic surgery.

- *OMFS*

CW reported enthusiasm at the SAC meeting for the simulation programme and also discussion on the need for more rigour in the national ARCP process.

- *Paediatric Surgery*

AM reported SAC concern around trainee access to sufficient numbers of TOF (trachea-oesophageal fistula) repairs. Numbers were small and so opportunities were being lost.

- *Cardiothoracic Surgery*

JB reported the plan in England to split Cardiac Surgery and Thoracic Surgery with no mixed practice from 2020. DB noted a letter received from Mr Sean Barnard, SAC Chair, seeking Deanery support for the proposal that trainees choose between Cardiac and Thoracic Surgery training after ST4, and so the curriculum for ST5-ST8 will have to change. DB and JB both felt this was an inevitable development. It would affect ST1 Cardiothoracic Surgery recruitment and it was likely that trainees would receive 4 years of mixed Cardiothoracic training followed by 4 years of HST in the designated area (Cardiac or Thoracic). Trainees already in programme would be allowed to continue without change. A new exam will not be introduced although its structure might have to be modified and the development would not create a new specialty. DB will respond to the letter from the SAC Chair noting the change to the curriculum.

DB

9.3 SAC update

9.4 Academic

9.5 MDET

9.6 Colleges

No updates were received.

9.7 Simulation

The meeting held in February to discuss setting out a way forward was well attended. A draft summary statement has been produced and will be issued.

- 9.8 **Trainees**
No update was received.
- 9.9 **JCST**
The JCST January newsletter was received for information. One priority recorded was to ensure all were supported and participating in RoT. ISCP 10 was awaited and more information will follow.
- 9.10 **CoPSS**
Noted: the group will meet in 4 weeks' time.
- 9.11 **SCCCSS**
No update was received.
10. **AOCB**
- 10.1 **CT2 trainees and Outcome 3**
JA asked if it would be possible to obtain additional funding from NES in the event that there were more Outcome 3s than could be covered by available salaries. WR said they were considering scope for flexibility but that Scotland was not an outlier in the UK.
- 10.2 **Silver Scalpel Award**
Mr Gareth Griffiths has received this award; the STB recorded its congratulations.
- 10.3 **sQMG**
In future the sQMG will be held on the same day and follow the Surgery STB meeting. Some sQMG dates will be rescheduled. The format of the meeting was up for discussion and input was welcomed. WR noted some STBs were already doing this.
11. **Dates of next meetings**
- 10.30 am on Friday 1 July 2016 in Room 6, 2 Central Quay, 89 Hydepark Street, Glasgow
 - 10.30 am on Monday 10 October 2016 in 2 Central Quay, 89 Hydepark Street, Glasgow.

Actions arising from the meeting

Item no	Name	Action	Who
3. 3.1	Matters arising General Surgery of Childhood	To report on the final paper when available.	AMcC
3.2	Surgery Curriculum Mapping post-ShOT	To discuss discussion paper at next meeting.	Agenda
3.3	Urology – National Training Days	To discuss at next meeting.	Agenda
5. 5.1	Major Trauma Centres Discussion of potential educational impact	To draft response for RP.	DB
7. 7.1	Recruitment 2016 updates from specialties • <i>Core Surgery</i>	To seek information at the core	DB

		recruitment meeting in May.	
9. 9.2	<p>Updates Specialties</p> <ul style="list-style-type: none"> • <i>General Surgery</i> • <i>Plastic Surgery</i> • <i>Core Surgery</i> • <i>Cardiothoracic Surgery</i> 	<p>To report to the STB after the SAC meeting. To discuss Cleft Surgery provision at next meeting. To circulate SY's papers to the STB. To respond to SAC Chair.</p>	<p>JA Agenda HM DB</p>