

# CHALLENGES FOR THE FUTURE OF SURGICAL TRAINING

A discussion document

## THE SURGICAL FORUM



ROYAL COLLEGE OF  
PHYSICIANS AND  
SURGEONS OF GLASGOW



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**Author:**

John MacFie  
Chairman, Surgical Forum of Great Britain and Ireland

**In association with:**

Royal College of Physicians and Surgeons of Glasgow

Royal College of Surgeons of Edinburgh

Royal College of Surgeons of England

Royal College of Surgeons in Ireland

Federation of Surgical Speciality Associations:

Association of Surgeons of Great Britain and Ireland

British Association of Urological Surgeons

British Association of Oral and Maxillofacial Surgeons

British Orthopaedic Association

British Association of Paediatric Surgeons

British Association of Plastic, Reconstructive and Aesthetic Surgeons

ENT UK

Society of British Neurological Surgeons

Society for Cardiothoracic Surgery in Great Britain and Ireland

Vascular Society of Great Britain and Ireland

## FOREWORD

The paper has been written on behalf of the Surgical Forum of Great Britain and Ireland. It is based on the responses of the four Surgical Royal Colleges and the ten SAC-defined Surgical Specialty Associations to a previous discussion document issued by the Forum entitled “*Training Surgeons for Future Service Requirements*”, and, in particular, to the written commentary on a meeting of the Surgical Forum held at the Royal College of Surgeons of Edinburgh in April 2012, to discuss the future of surgical practice and training in Great Britain and Ireland.

Much of the specific language and terminology in the document relates to UK hospital and healthcare systems, but the generic thrust of the paper is equally applicable to surgical training in Ireland.

This document aims to be a commentary at a point in time, to be used to inform planning for those agencies responsible for surgical training at both general and specialist (and subspecialty) level, to assist in the quality management and quality assurance of elective and particularly emergency surgical care, and to reflect the opinion of those with expertise across the widely differing ranges of surgical care offered to patients in the United Kingdom and Ireland. It is also hoped that these views will be taken into account when reconfiguration of surgical services is being considered.

We are aware of current action being taken by other agencies, in particular the Shape of Training (SHoT) sponsoring board and (Health Education England’s (HEE) ‘Better Training Better Care’ project in giving expert advice on postgraduate medical education and training within the UK. Surgical training has, however, specific challenges that are itemised in this discussion paper, and it is considered entirely appropriate to attempt to find surgical solutions to surgical challenges.

With the prospect of a 30 year medical career, surgical training today needs to meet the demands of society and the surgical landscape of the future. Surgery provides a stimulating, satisfying and rewarding career, but we believe this can only be maintained through reversing the growing fragmentation within the surgical profession and confronting some of the difficult issues which must be addressed.

## THE NEED FOR CHANGE ("THE CHALLENGES")

These can be summarised as follows:

- *Emergency Surgery:* An increasing realisation that outcomes for emergency surgery (particularly, but not exclusively, emergency general surgery) are sometimes poor. In addition, it is now recognised that surgical emergencies are the most common reason for surgical admission in the UK, and this will increase with an ageing population. Elderly patients with peritonitis are amongst the most seriously ill patients the NHS has to deal with. A major challenge for surgical training is to ensure that there are adequate numbers of surgeons able to deal with the emergency take.
- *EWTR and the New Deal:* There is no doubt that the rigid legislation which surrounds working hours has had a negative impact on learning and has led to disruption to work patterns and a lack of familiarity within surgical teams as a consequence of rota working. As a profession we need to lobby for changes in the legislation whilst recognising the importance of alternative learning strategies such as simulation.
- *Specialisation:* This is usually associated with centralisation. In recent years, specialisation has often been at the expense of generalism which is required to deal with the breadth of emergency surgery. If the DGH model, and its equivalent in Ireland, is to survive, there needs to be recognition of the training needs for such institutions.
- *Manpower:* There is now a significant mismatch between consultant job opportunities and CCT (Certificate of Completion of Training) training numbers in some specialties. If trained surgeons (i.e. those with a CCT) fail to obtain a consultant appointment, then they may emigrate (which is a colossal waste of resource), accept a non-consultant post or seek an additional training opportunity such as a Fellowship.
- *Gender/lifestyle:* The variance between current undergraduate gender profile and gender proportionality amongst surgical consultants reflects badly on surgery as a profession and its ability to recruit women into surgery.
- *Curriculum:* The curricula for each of the 10 SAC-defined specialties are well developed and emphasise a need for trainees to be emergency-safe on attainment of CCT. The outcome of increasingly complex surgery may well be improved by further post-CCT training for both emergency and subspecialty practice. Mentoring at all levels of appointment should be encouraged.
- *Duration of training:* The UK and Ireland have some of the longest surgical training programmes in the world which can be shortened by more focussed training.

## BACKGROUND INFORMATION

### Workforce

1. It is beyond the scope of this paper to analyse in detail workforce projections for all surgical specialties. *Appendix 1* provides a summary largely based on information received from Specialty Associations. In summary, there is evidence of an increasing mismatch between trainee numbers and potential consultant posts in many specialties.
2. Currently there are approximately 6,000 consultants in surgical specialties in England and Wales. There is unlikely to be a significant increase in these numbers over the next 10 years.
3. Currently much work in surgery is carried out by non-consultant surgeons, many of whom are international medical graduates. Restructuring of the surgical workforce may be an opportunity for increasing the number of job opportunities for UK graduates.
4. It is possible, in the future, that holders of a CCT, or those on the specialist register by other routes, may not all obtain traditional "consultant" posts.

### Numbers of trainees

5. The National Health Service, as a whole, is having increasing difficulty in providing services in the traditional way because of diminishing numbers of hours of work provided by doctors in training. This has been compensated for, to a degree, by an expansion in the Staff and Associate Specialist Grade and also by the development of a number of non-training grades variously known as Clinical Fellowships/Trust Fellowships/Clinical Officers, etc. The next few years are likely to see further significant reductions in trainee surgeons. There will also be a reduction in the numbers of trainee surgeons coming from outside the EU and from traditional areas of recruitment such as the Indian subcontinent.
6. Whilst, by definition, trainees have not *completed* training, it is noteworthy that trainees are all qualified doctors or dentists and that they continue to make a valuable contribution to service delivery. The current emphasis is, however, very much upon progressive supervised training, leading to the gradual acquisition of competencies, knowledge and experience. It is appropriate for trainees who practice under consultant supervision to undertake delegated tasks, for which they have received training, been assessed and for which a consultant accepts responsibility for delegating. The concept that qualified doctors are untrained for eight years and suddenly become trained once they acquire a CCT is erroneous, and raises unrealistic public expectations that all aspects of their care will be delivered by *fully* trained specialists.

### Costs

7. Current postgraduate training programmes in surgery in the UK and Ireland are amongst the longest in the world. The output of these programmes has, until recently, usually been a highly specialised surgeon. It must be considered whether it is necessary, or desirable, for the service as a whole that all specialists be trained to the present level in order to attain a consultant post in the NHS.
8. Whilst a consultant-delivered service is relatively expensive, and costs are an important factor in deciding whether or not to justify consultant expansion, many Trusts have already opted to employ Trust grade doctors who are not CCT holders to carry out non-complex surgery. This circumvents the present training and employment regulations, and threatens the standards which have been set by the Surgical Royal Colleges. Many of these posts are on short-term, time-limited contracts and are unsatisfactory.

## **EWTR and the New Deal**

9. The consequence of EWTR and the New Deal are well known. It has been estimated that, since August 2009, when the working week was restricted to 48 hours, the average trainee now receives a total of only 6,000 hours during training (as compared with 30,000 hours previously). Trainees in the future, therefore, will be less experienced than they were in the past. The use of modular training, simulators, dedicated training lists and more dedicated trainers are all useful adjuncts to training, but of themselves may not compensate for the reduced hours of training. There should be a comprehensive review of how service and training needs are delivered. We anticipate that, in the future, CCT holders may require additional training in areas of subspecialist interest.

## **Specialisation**

10. Increasing specialisation creates a paradox for the provision of all surgical care. The recent targets for elective surgical care have led to a depletion of support for emergency care and concerns about the adequate provision for such cases in many hospitals. Whilst it is inevitable that specialisation will continue, there is increasing recognition of the need to produce "generalists" who can provide emergency cover.
11. If the DGH model of care is to survive in any form, then recognition must be given as to how these hospitals will attract and retain good quality surgical staff. A case can be made for specific recognition within their contract for the provision of emergency care.

## **Feminisation of the workforce**

12. A majority of graduates from medical schools in the UK now are female. If surgery wishes to continue to attract the brightest and the best, many of whom will be female, then training and employment within surgical specialities must, in future, be more flexible.
13. The surgical disciplines must continue to attract young doctors whether male or female. This will necessitate recognition of work/life balances, the need for individuals to have career breaks and the fact that facilities must be made to enable surgeons to evolve and "reinvent" themselves throughout a career.
14. There needs to be a recognition that some trainee surgeons (both male and female) may welcome the opportunity to spend part of their career in posts which are perceived as not being as intensive as some specialist stand-alone consultant posts, and which, in addition, allow flexibility, security of employment and the possibility of career development at a later date.
15. The perceived inflexibility of surgical training, with a single end point (consultant appointment), may no longer be fit for purpose.

## **ROUTINE SURGERY**

16. Much hospital work is routine and can be safely performed without the need for sub-specialised consultant staff. Routine surgery forms the bulk of surgical practice and would best be delivered by surgeons who have achieved a CCT. At present, much "routine" surgical work is performed by various grades of staff, sometimes in an inconsistent and variable fashion. This important part of surgical service delivery should be regulated, and unsupervised surgical procedures should only be performed by validated "trained" surgeons.

17. Therefore, a CCT should be awarded to surgeons at a stage when they are competent to deliver routine and emergency surgery. Service provision by such surgeons should eliminate variation, improve outcomes and address the safety agenda. This applies to much general and orthopaedic surgery and to many other conditions within surgical hospital practice.
18. The cancer reform agenda has led to the centralisation of major cancer surgery into high volume units where the outcomes are better. Whilst there is no doubt that the management of patients with malignant disease has benefitted, there is an emerging consensus that there needs to be more focus, in the near future, on non-cancer and, in particular, emergency care.

## **TRAINING VERSUS SERVICE REQUIREMENTS**

19. It is important for the surgical community to confer the appropriate status on surgeons in training, and to convey their value as practitioners (albeit in a journey of development) to the strategists, politicians, and management of the National Health Service. The Forum acknowledges the need for a graduated independence of practice as trainees' seniority progresses, with proportionate supervision available, without exception, on all occasions.
20. The tension between service and training is exacerbated by an early move into subspecialisation (all surgical specialties are quite different in this regard) and the potential for destabilising the generalist foundation to each surgical specialty. The Forum is emphatic that, whatever else, all trainees at CCT must be competent in stabilising, triaging and initiating management pathways for emergency surgical care. Additionally, the CCT holder, in the majority of instances, should be competent in operative management of such cases, but would also be able to recognise their limitations and refer onwards to appropriately specialist surgeons as required.
21. In the event of there being an inadequate concentration and intensity of work in district hospitals (or, indeed, in university units), then these units should not be allocated trainees.

## **REDEFINING THE CCT AND THE END POINT OF SURGICAL TRAINING**

22. At present, the CCT in each of the 10 SAC-defined specialties is achieved after a minimum of eight years of training, and passing the appropriate examination. Training is defined by carefully constructed curricula for each specialty. Possession of a CCT permits the holder entry onto the specialist register and entitles them to apply for a consultant post. Possession of a CCT indicates the level of knowledge and experience commensurate with the individual being competent to operate unsupervised in the generality of their chosen specialty and provide emergency on-call cover.
23. The provision of surgical services in the UK should be determined by the needs of the population. Most surgery carried out in the NHS is for a limited number of common conditions, and complex surgery is rarer and needs to be performed in highly specialised facilities, often by multidisciplinary teams. In surgical practice, the common operations are relatively easy to identify. It seems logical to ensure that surgeons in training are trained to competence in these procedures. It is, therefore, possible to conceive of a system which would allow the award of a CCT once competence is achieved in these common procedures. Thus, the definition of a "trained" surgeon relates to competence in performing the majority of the common surgical procedures in the specialty.
24. If a trained surgeon is defined in this way, then the length of training will change. One approach is to train people to a level of specialisation where they are highly competent but relatively undifferentiated in surgical skills and then to appoint them to do the majority of the surgical procedures that are required by the majority of patients. Subspecialisation can occur later, and should be determined by the needs of the service.

25. The whole premise of this document requires an adjustment of the expectations of all involved in surgical training. It shifts the focus of training to the needs of patients and the service. All parties have to accept that this is what determines the pattern of training. It is important to emphasise that this is not “dumbing down” surgical training, but is merely changing the "end point". It keeps the award of a CCT to indicate that an individual is trained to a certain level of competence, which enables that person to independently manage the generality of the specialty, both elective and emergency. Individuals who wish to develop further subspecialty interests may require additional experience and training which, in some specialties, may be achieved pre-CCT and, in others, may require post-CCT training, entry to which would be on a competitive basis. This will ensure that high standards are achieved and maintained. This relies on a shift in the expectations of the service providers so that they will be involved in delivering and supporting the education of their trained workforce. This is not unusual in other professions, and should be introduced into surgical training.

## THE CONSULTANT GRADE

26. The lack of hierarchy/progression within the consultant grade is an outdated model, and needs to change. The journey through consultant life needs to be better defined with clear aims and goals for progression.
27. The profession must embrace the concept of modification of the consultant grade.
28. One proposal is that the consultant role evolves over time. This model presupposes three phases in a consultant career: **Phase 1** on first appointment, during which posts are "front loaded" with emergency commitments; **Phase 2**, when consultants would have evolved a subspecialty interest and reduce their on-call commitment; and **Phase 3**, the latter part of a surgeon's career when he/she might be expected to come off the on-call rota and place more emphasis on teaching, administration or research. Such a three-phase model of a consultant career may discourage early retirement, would certainly promote teamwork and recognises the importance of lifelong learning.
29. Such change and development does not necessarily imply titular or fiscal alterations to the grade, but does provide a more explicit recognition of professional strengths and responsibilities at different stages. Appointment to a grade in the early "thirty somethings" without a development plan, other than through the appraisal process, is a lost opportunity. A more robust portfolio should feature to include the development of interests in areas of management, leadership, education, research, etc., along with a clearer presentation of these duties in work plans.

There is an expectation that a consultant would be expected to have a front-loaded emphasis on emergency care during the earlier years of their consultant practice, which would reduce as they near retirement. It is also recognised, however, that the smaller specialties involve smaller numbers of consultants within the team, and the luxury of discontinuing emergency on-call is an opportunity equally accessible across all surgical specialties.

30. There should be no confusion around graduation within the single rank of consultancy being aligned with the notion of a sub-consultant rank. The Forum does not support the development of any surgical post functioning at independent level that does not require a CCT as a baseline credential and, therefore, the only post suitable for independent practice is that of the consultant.

Professional development within consultancy is currently an extremely opportunistic event and that lottery of opportunity should be removed through better utilisation of job planning and revalidation. This is a matter for future discussion.

## RECONFIGURATION OF SERVICES

31. It is important that agencies such as the Surgical Forum, who are delegated the responsibility for training of the next generation of surgeons, are able to do so with some confidence around anticipating the pattern of service for which that trainee output is intended. To that extent, the Forum, with its attendant responsibilities, does have a legitimate position in voicing its views on service configuration.
32. The current trend in configuration of services seems to be towards centralisation, but the emergence of Managed Clinical Networks and Managed Service Networks have allowed retention of appropriate levels of activity outwith centralised units, a particular requirement of more rural settings. Whilst local political imperatives often militate against centralisation, the Forum is aware of the need to retain sufficient clinical activity for the purposes of skill maintenance for preservation of high-quality district services. What is less clear, however, is the appetite for current and future generations of surgical trainees to work in a district hospital setting and there is a significant need for such a forecasting project. Consideration must be given as to how surgeons can be "incentivised" to work in district hospitals. Failure to do this will result in diminution of standards in some hospitals, which is unacceptable.
33. Replication of subspecialty activity across all districts is clearly untenable and, indeed, the increasing interdependency of surgery with other diagnostic and service infrastructures is another reason for the inexorable drift towards centralisation of some surgical subspecialties. If there is to be future investment in training for the staffing of district general hospitals at the secondary care level, there must be explicit commitment in policy terms to a long-term future for this model. Repeated changes to configuration of services, albeit on the premise of responsiveness to the healthcare needs of our population, make planning for future job descriptions an uncertain activity.
34. A centralised service does not preclude high-quality outreach or high-quality shared care arrangements. This would appear to be a preferred model for several surgical subspecialties, and many specialties have already identified that a proportion of trainees and young consultants would be satisfied with this form of job description, at least for a finite time in their career. There would need to be an exit strategy from this kind of post. This would appear to be the most dependable model for future planning of specialist services.
35. Clarity should be sought on how the population demand/service demand for surgical services is coordinated by bodies such as the National Commissioning Board and how this influences workforce decisions. Surgical Royal Colleges and Specialty Associations should become more influential with guiding workforce planning and implementation of changes to training requirements. This includes advising about the relevant number of specialty fellowships.

## SUMMARY

- **There is a need to train surgeons to meet the demands of society. Therefore, not all surgeons will be able to enter the specialty of their choice, and the expectations of trainees should be managed accordingly.**
- **More emphasis needs to be placed on the provision of emergency services. This may require dedicated consultant appointments and financial rewards for on-call delivery.**
- **Appointment to consultant posts is likely to remain intensely competitive. The numbers and nature of posts available will be determined by market forces and reconfiguration. It is probable that not all CCT holders will necessarily take up consultant posts immediately.**
- **Some subspecialty training maybe carried out after the award of a CCT, although in some specialties it is recognised that this can, to some extent, be accomplished in the later years of pre-CCT training.**
- **It is likely, in the future, that first appointments after CCT will have a significant initial emphasis on emergency work and/or the development of a general practice within the specialty; this balance will vary according to speciality, but there should be contractual agreement that opportunities for career development would be available.**
- **Strategic phased career development within the consultant grade should become standard.**
- **There is an urgent need for employers, HEE and LETB's to utilise the professional expertise of Colleges, SACs and Specialty Associations in workforce planning.**
- **There is an urgent need to ascertain policy commitment to the continuation of the district general hospital as a model for service provision. Thus, there is a need to align the surgical curriculum for practice in this setting, and to avoid unnecessary emphasis on subspecialty training, so that surgical education is fit for a variety of purposes.**

**John MacFie  
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## APPENDIX 1

### General Surgery

There are 2,087 consultant "general" surgeons in the UK, making it the largest surgical specialty. The majority of "general" surgeons declare a subspecialty interest (upper GI, coloproctology, vascular, transplant, endocrine or breast). The Colleges and relevant surgical associations recommend a consultant workforce ratio of 1:25,000 population, and an overall maintenance of consultant surgeon numbers. The Centre for Workforce Intelligence (CfWI) suggests that the supply of general surgery consultants over the next 10 years is forecast to increase to 2,560 FTE in 2018, an average increase of 4% annually assuming that retirement is at 62 years, 30% of trainees are delayed in completing their training by at least a year, and that there are 60 international recruits per annum and only five conversions from staff grade or associate specialist grade to consultant. Assuming these data to be correct, then there will be in of the order of only 47 new consultant posts per year on average. Recent data suggest that there are approximately 148 consultant "general" surgical posts advertised annually. The best case scenario is, therefore, approximately 200 vacancies per year. This needs to be weighed up against numbers of individuals obtaining a Certificate of Completion of Training (CCT) each year, the numbers of successful Article 14 and CESR applications, and competition from Europe. The evidence suggests that "General Surgery" has a surfeit of trainees who expect a traditional consultant post with a subspecialty interest.

### Orthopaedics and Trauma

There are 2,056 consultants in this specialty. The British Orthopaedic Association recommends a consultant workforce ration of 1:15,000 population, and recommends an expansion of consultant numbers. There is considerable discrepancy between presumed numbers of consultants in this specialty quoted in RCSE document and that in CfWI. This latter recommends a decrease in trainee numbers against a background of a small increase in consultant numbers in the next 10 years.

### Urology

The previous recommendation of one WTE urologist to a population of 80,000 will need to be revised in the light of an ageing population and the extension of complex care to the very elderly and those previously deemed untreatable due to co-morbidities. A ratio of 1:65,000 balances increased staffing costs with the savings generated by better outcomes and less expensive community care. As such, a significant increase in consultant numbers is recommended. In contrast, CfWI data suggests that training numbers are appropriate to consultant vacancies and that no significant expansion is required. Currently there are 800 Consultant Urologists in the UK with an average annual rate of expansion of 4.5% for the last 13 years, and 329 recognised trainees as of December 2010. These figures include all those appointed through National Selection in May 2010. The total also includes those in ACF and ACL posts. It has also been assumed that trainees will take 50% of their six-month "Grace" period (*BAUS Annual Workforce Survey 2010*). In urology, there is an anticipated surplus of trainees over anticipated consultant appointments of seven in 2011 rising to 15 in 2013.

### ENT

ENT UK believes that trainee numbers should be managed to avoid many CCT holders being unable to obtain substantive consultant appointments in the UK. In English National Selection for the years 2011 to 2013, 32 NTN's each year will have been appointed in England. Over the past five years, around 30 consultant posts per year have been advertised in England. There is evidence that some trainees have resorted to leaving the UK, some through choice, others through concern about finding a post in England. However, the situation does appear now to be stabilising and, to avoid an undersupply of suitably qualified consultants in the future, ENT UK and the ENT SAC have suggested a slight increase in the annual English recruitment figure to 35 per year from 2013.

### **Oral and Maxillofacial Surgery**

Workforce planning for this specialty has been stable over several years and has seen approximately 4% average yearly consultant expansion. There is a high volume of simple routine surgery performed, largely by non-consultant grades. The training of these individuals has been variable but most are singly dentally qualified. There now exists a specialist training programme in dentistry for the new specialty of oral surgery. A service configured with the proper balance of consultants in OMFS with subspecialist interests, set alongside properly trained dental specialists able to deliver high quality routine oral surgery, is an ideal model of service delivery and is an economical training model. There are already subspecialty interface training fellowships in oncology, cleft lip and palate, craniofacial and cosmetic surgery, where numbers are broadly aligned to anticipated workforce requirements. So, OMFS has gone a considerable way in the direction of travel advocated within this paper. Further managed networks are required in some areas, and a greater number of specialists trained in oral surgery to function as non-consultants are required.

### **Plastic and Reconstructive Surgery**

The British Association of Plastic and Reconstructive Surgeons' view is that this document largely is designed for General and, to a lesser extent, Trauma and Orthopaedics. We agree that there is a need to train surgeons to meet the demands of society, that not all surgeons will be able to enter the specialty of their choice and the expectations of trainees should be managed accordingly.

The management of emergency care differs within different subspecialties of plastic and reconstructive surgery, and dedicated subspecialty consultant appointments allow for this. We support increased financial rewards for provision of on-call surgical care.

We agree that the appointment to consultant posts is likely to remain intensely competitive. The numbers and nature of posts available will be determined by market forces and reconfiguration. It is probable that not all CCT holders will necessarily take up consultant posts immediately.

We strongly believe that much subspecialty training is carried out after the award of a CCT. It needs a differentiation between continued consultant professional development and training *per se*. Our curriculum recognises, and allows for, the fact that subspecialisation occurs in the later years of pre-CCT training. The SAC in Plastic Surgery feels strongly that the CCT is fit for purpose. Their view is that if a trainee is not fully trained, the curriculum and the specialty's training needs to be addressed in that particular specialty rather than to continue training post-CCT possibly unsupervised. This needs to be separated from continued professional development.

Unlike General Surgery, future first appointments after CCT may have a significant initial emphasis on emergency work, depending on the subspecialty.

We agree that strategic phased career development within the consultant grade should become standard, but may not relate to any emergency provision (e.g. cleft surgery).

We agree that there is an urgent need for employers, HEE and LETB's to utilise the professional expertise of Colleges, SACs and Specialty Associations in workforce planning.

There is an urgent need to ascertain policy commitment to the continuation of the district general hospital as a model for service provision. This applies particularly to General Surgery, and we would support this specialty in the alteration of their consultant provision. We recognise that there may be a need to align the general surgical curriculum for practice in this setting and to avoid unnecessary emphasis on subspecialty training, so that surgical education is fit for a variety of purposes.

As the document stands, BAPRAS would support its application to some specialties, particularly General Surgery, but have reservations about its applicability to Plastic and Reconstructive Surgery.

## Neurosurgery

Neurosurgical practice in the United Kingdom is fully consultant-led and substantially consultant-provided. The 2012 SBNS workforce survey confirms that less than 3% of the total 310 WTE non-training workforce in the UK and Ireland is made up of non-consultant posts. There is a high level of subspecialisation within neurosurgery. Consultants typically have a portfolio of two or three complimentary subspecialist interests. Approximately 50% of all neurosurgical inpatient activity is undertaken on an emergency or urgent basis.

In order to meet these service demands, the neurosurgical training programme provides for a full range of emergency competencies together with a foundation for subspecialist practice. National selection into this very successful, eight-year run-through programme remains highly competitive with a competition ratio of 11:1. The acquisition of subspecialist skill is supported by specialist fellowships undertaken immediately before or after CCT.

The neurosurgical CCT is set at a level that requires the newly appointed consultant to be competent to manage and supervise the emergency activity in a neurosurgical unit without direct assistance. Although there has been some reduction in the experience of new CCT holders reflecting changes in neurosurgical practice, in particular the provision of intervention or radiological procedures for vascular disorders, the essential standard of the CCT has not been reduced.

Neurosurgery faces the substantial challenge of balancing the demands of delivering complex elective care with the provision of emergency services. The maintenance of training standards and subsequently a broad range of consultant competencies will require changes in consultant working practices and career development, together with the restructuring of neurosurgical services.

## Vascular Surgery

The Vascular Society would agree with BAPRAS that this document only applies to General Surgery and is not of particular relevance to the new specialty of Vascular Surgery. We are no longer a subspecialty of General Surgery and have mapped our training numbers to anticipated future requirement for consultant vacancies (20 per year). Vascular Surgery will be consultant delivered and there is no requirement for a sub-consultant grade.

The Society has recently published documents on Training and Provision of Service and these can be accessed at [www.vascularsociety.org.uk](http://www.vascularsociety.org.uk). These describe in detail our requirements for training and service provision to ensure the maintenance of high quality, safe practice to all patients with vascular disease.

Emergency surgery will be covered 24/7 in a number (~ 50) of major arterial centres and service reconfiguration is in process throughout the country. From 2013, vascular services will be nationally commissioned and this will further drive specialisation to large volume vascular hospitals.

We have ensured that future vascular posts are EWTD compliant; both at consultant and training levels and that they will deliver first class, high quality care to all patients with vascular disease in the UK and Northern Ireland. There will be equality of access to vascular surgical, interventional radiology and critical care based on reconfigured services providing high quality, low mortality related 24/7 care.

All arterial operations will be carried out in these major vascular centres which will be the hubs of the modern vascular networks. Further specialisation will be delivered in a smaller number of recognised arterial hospitals with expertise in complex open aortic/endovascular techniques; protocols are being developed by the vascular CRG and will be subject to national commissioning from 2013.

With recent work to map workforce to requirement, we do not envisage the mismatches described in this document and with the reorganisation into larger teams of consultants all providing service from major arterial sites we have future proofed against gender/lifestyle variance.

Vascular Surgery has a new curriculum, and we have achieved the agreement from all modern vascular networks for joint training of the new batch of vascular trainees in both open and endovascular techniques; this has the agreement of the RCR and BSIR.

For these reasons, the Vascular Society is unable to support the current document, but is aware of its relevance to General Surgery.

### **Paediatric Surgery**

There are around 150 consultant Paediatric Surgeons in the UK, largely working in specialised centres, the majority of which provide both a secondary and tertiary service, and as such does not have the same service provision issues experienced by General Surgery as outlined in this paper. However, the British Association of Paediatric Surgeons (BAPS) supports the paper, as many of the training and manpower issues are similar.

Paediatric Surgeons maintain a high level presence out of hours, directly delivering emergency care, and, at present, BAPS and the SAC consider the training programme and CCT as fit for purpose in providing newly appointed consultants who are “emergency safe”.

In regard to the low volume / high complexity tertiary procedures performed by Paediatric Surgeons, BAPS supports the development of regulated post-CCT Fellowships which are already well established in the subspecialty of Paediatric Urology.

BAPS and the Children’s Surgical Forum actively advocate the development of regionally based clinical networks to support the provision of both an elective and emergency secondary level service for older children outside of, but supported by, the specialised centres. This would include robust transfer services and the training of General Surgeons to provide this service where applicable.