

# The Surgical Forum of Great Britain and Ireland

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## **The Shape of Training** ***“securing the future of patient care”***

*A response on behalf of the  
Surgical Forum of Great Britain and Ireland*

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Royal College of Surgeons of Edinburgh • Royal College of Surgeons of England  
Royal College of Physicians and Surgeons of Glasgow • Royal College of Surgeons in Ireland  
Federation of Surgical Specialty Associations comprising: Association of Surgeons of Great Britain and Ireland  
Association of Oral and Maxillofacial Surgeons • British Association of Otolaryngologists - Head and Neck Surgeons  
British Association of Paediatric Surgeons • British Association of Plastic, Reconstructive and Aesthetic Surgeons  
British Association of Urological Surgeons • British Orthopaedic Association • Society of British Neurological Surgeons  
Society for Cardiothoracic Surgery in Great Britain and Ireland • The Vascular Society of Great Britain & Ireland

## **Foreword**

The Shape of Training Review (ShOT) was launched following an agreement between the key organizations that are responsible for the delivery, commissioning and regulation of medical education. These include Medical Education England, the Academy of Royal Colleges, the Confederation of Postgraduate Deans and representative health organizations from Scotland, Wales and N Ireland. A fundamental review of medical training was deemed necessary because the needs of patients in the UK are changing rapidly. It is recognized that doctors have to care for patients with chronic illness and multiple co-morbidities, this is partly a consequence of an aging population.

The final report of this independent review led by Professor David Greenaway, sets recommendations regarding the structure and delivery of medical and surgical postgraduate training for the next 30 years. The changes proposed within its 19 recommendations are far-reaching and have implications for both current and future trainees in the UK.

## **Background**

The Surgical Forum of GB and Ireland, formerly known as the Senate of Surgery, is comprised of the Presidents and Vice Presidents of the 4 Royal Colleges and the Presidents of the 10 SAC defined surgical specialities. The Surgical Forum is therefore the only truly representative voice of surgery across the entirety of GB and Ireland.

In recognition of the importance of the ShOT review and the fact that its recommendations have far reaching implications for patient care, the Surgical Forum agreed it would be appropriate to hold a one day meeting devoted exclusively to this topic. This meeting was held at the Royal College of Surgeons of Edinburgh on March 20<sup>th</sup> 2014. The Presidents and Vice Presidents of each of the 4 Royal Colleges attended as did the President of the Federation of Surgical Speciality Associations (FSSA). Presidents or representatives of 9 of the 10 SAC specialities (the Vascular Society being the only absentee) were also present. In addition, written statements were received from patient liaison groups and ASIT. The Presidents of ASIT and BOTA were also present together with CEOs of the Royal Colleges of Physicians and Surgeons of Glasgow and the Association of Surgeons of GB and Ireland.

The speakers at this meeting were:

- Ms Clare Marx, Consultant Orthopaedic Surgeon, and Member of the Expert Advisory Group, Greenaway Report
- Professor Rowan Parks, Deputy Medical Director, NHS Education for Scotland
- Mr Andrew Beamish, President, ASIT
- Mr Jeya Palan, President, BOTA
- Professor Nicholas Gair, Chief Executive, Association of Surgeons of Great Britain & Ireland
- All participants were invited to give their views and those of their affiliated organisations

## Summary

There was broad agreement amongst the members of the Surgical Forum that:

- the broad goal of medical education must be to deliver trained doctors that match the needs of the local population with some organisational change to adapt to local requirements
- there needs to be greater emphasis on the need for generalist as opposed to specialist skills particularly in the care of the emergency acute patient
- a return to apprenticeship style training and an acceptance that training times will vary between individuals and disciplines is welcomed
- the role of the “consultant” requires revision to recognize the fact that consultant responsibilities change over career lifetime
- training in a defined subspecialty will require additional post CST training termed credentialing

## Introduction

For the sake of clarity, the comments, criticisms, areas of agreement or disagreement as discussed in the Forum meeting are listed here as they apply to each of the 19 recommendations of the ShOT report. This paper should, therefore, be read in conjunction with the report:

1. *“Appropriate organisations must make sure postgraduate medical education and training enhances its response to changing demographics and patient needs”*

**Agree: The Forum’s paper “Training Surgeons for future service requirements” was based upon this assumption.**

2. *“Appropriate organisations should identify more ways of involving patients in educating and training doctors”*

**Agree: Patient liaison groups are now an integral part of Colleges and Associations.**

3. *“Appropriate organisations must provide clear advice to potential and current medical students about what they should expect from a medical career”*

- There was detailed discussion about aspirations and perceptions of surgical trainees. At present a substantial majority of surgical trainees aspire to what they term a specialist post. Specialization is associated with enhanced status. This needs to be addressed if trainees are to be encouraged to develop generalist skills. As such we agree with comments in paragraph 43 which explicitly state that employers must make broader roles more attractive.
- There is an urgent need to educate and inform surgical trainees about manpower issues throughout the speciality spectrum.
- Notwithstanding the putative benefits to society of ensuring a medical workforce with generalist skills, the Forum agreed that there is now no doubt that volume-outcome data strongly support specialisation of many conditions. Such specialisation will inevitably result in further reconfiguration of hospitals with only the larger centres being equipped to perform uncommon procedures. Such reconfiguration is not without dangers as have been experienced in Ireland where concentration of cancer services has resulted in difficulties in recruiting surgical staff to non cancer hospital.
- Reconfiguration should be of services rather than of hospitals. The development of regional networks would provide a model allowing local care for general or high volume conditions, with low volume conditions being treated within the network at the most appropriate place. This does not rely on the development of supercentres, which will, potentially remove the local delivery of care.
- The regional approach means that the uncommon procedures are done where the most appropriate team is, which may be still in a small unit.

4. *“Medical schools along with other relevant organisations must make sure medical graduates at the point of registration are capable of working safely in a clinical role suitable to their competence level and have experience of and insight into patient needs”*

See comments under paragraph (5).

5. *“Full Registration should move to the point of graduation from medical school, subject to the necessary legislation being approved by Parliament and educational, legal and regulatory measures are in place to assure patients and employers that they are fit to practise”*

The Forum recognized the potential benefits of this proposal:

- Moving the point of registration would be a catalyst to medical schools to ensure their graduates were fit for purpose in a clinical environment.
- Such a move, particularly if combined with an appropriate competency test, would ensure harmonization with Europe.
- The mismatch between the pastoral responsibilities of medical schools between graduation and registration would cease (at present many F1 doctors complete their preregistration year at geographic sites distant to their medical school and as such pastoral care transfers to deaneries which are ignorant of undergraduate career).
- At present Foundation years are a mish mash of posts which serve trainees poorly. Often used to plug rota gaps little attention is made to career progression or acquisition of generic learning skills. Moving the point of registration is welcomed but not if this is at the cost of moving F2 into core training.
- Moving the point of registration would absolve medical schools of the need to guarantee full employment in Foundation posts for all their graduates.

However, the Forum could not provide unanimous support for this proposal. Some of the reasons for this were as follows:

- It would result in some graduates of not getting a post because of competition from the EU. Currently there are around 170 extra graduates in the UK for FY posts and we feel that additional posts should be created to ensure that all graduates are placed. This would be preferable to them applying overseas at FY1 level to systems that they have not previously experienced.
- Some form of inter deanery support should be provided to F1 doctors allocated to posts distant to their alma mater.
- This proposal is somewhat tangential to Greenaway and would be better dealt with separately. It will require significant changes in Undergraduate medical education and associated legislative changes. Greenaway is already a major challenge without this specific proposal.

6. *“Appropriate organisations must introduce a generic capabilities framework for curricula for postgraduate training based on Good Medical Practice that covers, for example, communication, leadership, quality improvement and safety”*

**Agree: See response to recommendation (10)**

7. *“Appropriate organisations must introduce processes including assessments that allow doctors to progress at an appropriate pace through training within the overall timeframe of the training programme”*

**Agree: See response to recommendation (8)**

8. *“Appropriate organisations including employers must introduce longer placements for doctors in training to work in teams and with supervisors including putting in place apprenticeship based arrangements”*

- A return to apprenticeship style training is universally welcomed.
- There was general agreement that indicative years of training are inappropriate in a craft speciality like surgery. Progression should be determined by acquisition of competencies.
- Achieving competence indicates an appreciation of safety but does not indicate experience.
- An interpretation of the schematic diagrams outlined in the ShOT suggests that completion of specialist training may be achieved within six years. This would be difficult to achieve for a craft speciality such as surgery. Acquisition of CCT takes eight years at present and there are already concerns about adequate exposure to surgical procedures to ensure trainees are emergency safe. This concern might be accentuated by a two year reduction in indicative training particularly if one of the Foundation years was incorporated into specialist training.
- Problems with training times have been accentuated by EWTR.
- Accelerated training programmes would necessitate a careful reappraisal of curriculae, a more widespread adoption of simulation and consideration of alternative training strategies (e.g. modular training in high volume units).
- A shortened training programme mandates a review of the curriculum with emphasis on the generality of care. In most surgical specialties this will focus on the management of the emergency patient. A consequence of this will be an increased need for individuals to pursue post CST training if they are to develop “sub specialty” skills. The Forum supports this in principle.

9. *“training should be limited to places that provide high quality training and supervision, approved and quality assured by the GMC”*

The Forum recognised that not all units should be designated training units. Those that are should be subject to review, and those that are not should be able to apply through a defined process.

10. *“Postgraduate training must be structured within broad specialty areas based on patient care themes and defined by common clinical objectives”*

- The Forum has no objection in principle to this recommendation.

However, many Specialty Presidents commented upon the practical and logistical difficulties in achieving amalgamation of areas of specialist practice. For example, neurosurgery, having initiated broad-based early years training including neurology, neurointensive care, related neuroscience disciplines, emergency medicine, neurointensive care and other related surgical disciplines, has struggled to deliver that programme due to the inflexibilities and workforce limitations of current postgraduate training. Similarly, paediatric surgery would welcome closer liaison with medical paediatrics.

- The Forum also commented upon the desirable objective of common core training between for example, general surgery, urology and paediatric surgery. Such common core training would facilitate cross cover arrangements in hospitals, often permit treatment closer to home, and be more efficient of available resource.
- The Forum recognizes that the aim of encouraging more interdependent training between different speciality areas offers great benefit but poses significant challenges. We would recommend a working party should be established to investigate these possibilities for the surgical specialities.
- The Forum is in general agreement with the suggestion that there are three “broad levels of competence” (paragraph 90). These equate to a trainee, an individual competent to perform independently and a doctor with specialist skills. This issue was debated at length by the Forum and the following observations made:
  - a) Competence is essential to define safety but is distinct from experience. Competence should be assessed nationally by representative organisations, not locally by employers to ensure uniformity of standards.
  - b) 2 tiers of competence as envisaged for the consultant role would infer that early years having an emphasis of emergency care. Movement between these tiers would be by competitive selection. Trusts might opt for proleptic appointments in anticipation of a particular clinical need. This would permit targeted post CST training.
  - c) Such a scheme recognizes that a consultant career may span over 30 years, and as such, flexibility and change are essential. The suggestion that there is a 2 or (3) tier consultant model amounts to “stretching” of the career ladder.
  - d) Adoption of 2 or more tiers of consultant appointment mandates formal adoption of mentoring for all new consultant appointments and a recognition of the importance of team work. Additionally, adoption of such a process would mandate clarity as to means of career progression.
  - e) The Forum recognizes the concerns of BOTA and ASIT who have expressed the view that a 2 or more tier consultant system might result in another lost tribe of doctors. Further they have stated “there is a significant risk that these proposals will produce a clinician who is not sufficiently trained to practice independently at

the level of a consultant surgeon, a fact that will inevitably lead to a subconsultant grade in all but name unless this is specifically addressed from the outset of any change in the delivery of surgical training“.

- f) A 2 or 3 tier of consultant appointment already exists in a majority of modern healthcare systems worldwide and accord with current practice in most other professions. There are suggestions that this policy is already tacitly accepted in Government.
- g) A tiered consultant career progression is not a sub consultant post.

11. *“Appropriate organisations working with employers must review the content of postgraduate curricula, how doctors are assessed and how they progress through training to make sure the postgraduate training structure is fit to deliver broader specialty training that includes generic capabilities, transferable competencies and more patient and employer involvement”*

- The Forum agrees that curriculae will have to be tailored to employer requirements and involve patients (paragraph 95).
- Workforce planning should be at a national level. Employers should be involved as should patients, but it should not be governed by local demand. For smaller specialities, such as neurosurgery, this could result in gross imbalances with a culture of ‘he who shouts loudest gets most’.

12. *“All doctors must be able to manage acutely ill patients with multiple co-morbidities within their broad specialty training and most doctors will continue to maintain these skills in their future careers”*

- The Forum concurs with the view that all trained doctors should be competent in emergency care and that specialist doctors should continue delivering some general care (paragraph 104).
- The Forum shares concerns expressed in the report about a crisis in emergency care (paragraph 102).
- The Forum recommends that consideration be given to dual accreditation e.g. there is good evidence of benefit from “orthogeriatricians”.
- There was agreement that it is very difficult to solve the paradox posed by the management of the ill emergency patient. On the one hand these patients numerically are the largest group needing admission to UK hospitals mandating a need to train doctors to be emergency safe. However, in reality, management of these patients demands experience. Some specialities have expressed the view that the concept that you train someone to be emergency safe and then train them more thereafter is the wrong way round as many sick emergency patients require specialised care.

13. *“Appropriate organisations including employers must consider how training arrangements will be coordinated to meet local needs while maintaining UK-wide standards”*

- We acknowledge the concern expressed by ASIT concerning this recommendation: the proposal is one of a dictated career structure where CST-holders could be asked to retrain to fulfill local service needs, regardless of their own career intentions. This will be

unpalatable for the majority of current surgical trainees given the time and personal funds invested in training to-date.

14. *“Appropriate organisations including postgraduate research and funding bodies must support a flexible approach to clinical academic training”*

**There was general agreement.**

15. *“Appropriate organisations including employers must structure CPD within a professional framework to meet patient and service needs, including mechanisms for all doctors to have access, opportunity and time to carry out the CPD agreed through job planning and appraisal”*

**Again, there was broad agreement.**

16. *“Relevant organisations including employers should develop credentialed programmes for some specialty and all subspecialty training, which will be approved, regulated and quality assured by the GMC”*

- The Forum supports the principle of post CST training termed credentialing. However, it was unanimous in stating that there needs to be careful QA of such training and this would be best achieved through the Colleges or Specialist Associations (not the regulator).

17. *“Appropriate organisations should review barriers faced by doctors outside of training who want to enter a formal training programme or access credentialed programmes”*

- The Forum has no disagreement with the suggestion that Staff Grade and Associate Specialist Grade doctors could avail themselves of additional training (paragraph 128). However, there was a consensus that this should be by competitive entry.

18. *“Appropriate organisations should put in place broad based specialty training (described in the model)”*

- The section in the report on post graduate training (paragraph 134) is comprehensive. It recommends broad based speciality training of 4 to 6 years after Foundation. The Forum agrees that the duration of training may vary between specialities and that this will need to be determined by the UK delivery group. The Forum believes that a working party should be established to examine these issues for the surgical specialities.

- We note the recommendation that the award of CCT be changed to CST and this marks the point at which doctors are able to practice within their identified scope with no clinical supervision. As the numbers of indicative cases being performed by surgical trainees is already falling for a number of well known reasons and is likely to fall further with these proposals the Forum agreed that training within the surgical specialities will need to be more focussed on generic topics particularly emergency care. Further, this proposal can only be safe if adopted at the same time as mentoring and an acceptance that newly appointed consultants will invariably work in teams.

19. *“There should be immediate consideration to set up a UK-wide Delivery Group to take forward the recommendations in this report and to identify which organisations should lead on specific actions”*

The Forum welcomes this and hopes the surgical specialities will be involved.

## Other Issues

In the course of discussions throughout the day and during feedback, a number of other issues pertinent to the Shape of Training report but not specifically referred to within it, became apparent. These can be summarized as follows:

- a) That failure to accept the principles outlined in ShOT would inevitably result in massive reconfiguration of hospitals and the demise of the District General Hospital model of care.
- b) Emergency medicine is a major problem. Failures of provision here impacts on all other specialities.
- c) Feminisation of workforce.
- d) Concerns over academic training.
- e) Adoption of fixed term consultant contracts.
- f) Middle grade non consultant posts. There was general agreement that substantial numbers of elective surgical procedures are already performed by Staff, Associate Specialist and Specialty surgeons.
- g) It is important to emphasise that within surgery in general there is a spectrum of views. The smaller specialties, such as neurosurgery, are already handling the tension between emergency competence, generalism and specialism. Understandably, therefore, they view many aspects of ShOT with considerable concern.
- h) The general feeling is that whilst training may change, a one size fits all type policy would be detrimental. Implementation of The Shape of Training must allow variance amongst differing disciplines.

## Conclusions and recommendations:

- ❖ **The broad principles outlined in ShOT report were accepted**
- ❖ **Consultant career should be tiered**
- ❖ **The Forum suggests that a working party is established to investigate common themes between different surgical sub specialities to enhance training and facilitate subsequent cross cover. This working party should be part of the UK delivery group.**