Evidence submitted to The Royal College of Surgeons of England ‘Improving Surgical Training’ Consultation

A statement from

ASiT The Association of Surgeons in Training
www.asit.org

and

British Orthopaedic Trainees Association

12th November 2015
Authors:
Miss Rhiannon L Harries (ASiT President)
Mr Vimal J Gokani (ASiT Immediate Past President)
Mr Andrew J Beamish (ASiT Past President)
Mr Frank McDermott (ASiT Vice President)
Mrs Piriyah Sinclair (ASiT Vice President)
Mr Henry Ferguson (ASiT Past Vice President)
Ms Helen Mohan (ASiT Yearbook Editor)
Mr Adam Peckham-Cooper (ASiT Deputy Treasurer)
Ms Ciara McGoldrick (ASiT Northern Ireland Representative)
Mr David Bosanquet (ASiT Rouleaux Club Representative)
Mr Daniel Cocker (ASiT Past Mammary Fold Representative)
Ms Isabella Dash (ASiT Mammary Fold Representative)
Mr Chris Hoo (ASiT PLASTA Representative)
Mr Andy Cockbain (ASiT AUGISt Chair)
Major Anna Sharrock (ASiT Military Representative)
Dr James Glasbey (ASiT Foundation Programme Representative)
Mr John O’Callaghan (ASiT Thames Valley Representative)
Ms Sabina Rashid (ASiT North West Thames Representative)
Mr Chris Blick (SURG Past Chair)
Mr Richard Robinson (SURG Chair)
Mr Benjamin Lamb (SURG Academic Representative)

British Orthopaedic Trainees Association

Authors:
Mr Mustafa Rashid (BOTA President)
Mr Simon Fleming (BOTA Vice President)
Mr Steve Kahane (BOTA Treasurer)
Miss Sara Dorman (BOTA Secretary)
Mr Daniel Ryan (BOTA Education Representative)
This document is also supported by:

**THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH**

Trainees’ Committee

Nicholson Street, Edinburgh, EH8 9DW  
**Telephone:** 0131 527 1600  
**Email:** traineescommittee@rcsed.ac.uk  
**Web:** [http://www.rcsed.ac.uk](http://www.rcsed.ac.uk)

Mr Richard J McGregor (RCSEd Trainees Committee Chair)  
Mr Stephen O’Neill (RCSEd Trainees Committee Member)  
Mr George Markides (RCSEd Trainees Committee Member)  
Mr Peter Coyne (RCSEd Trainees Committee Member)

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**ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW**

Trainees’ Committee

232-242 St Vincent Street, Glasgow, G2 5RJ  
**Telephone:** 0141 221 6072  
**Email:** alexvesey@gmail.com  
**Web:** [http://rcpsg.ac.uk](http://rcpsg.ac.uk)

Mr Alex Vesey (RCPSG Trainees Committee Chair)  
Miss Mahua Chakrabarti (RCPSG Trainee Committee Member and Scottish AoMRC Trainee Doctors Group Representative)
About ASiT

The Association of Surgeons in Training (ASiT) is a professional body and registered charity working to promote excellence in surgical training for the benefit of junior doctors and patients alike. With a membership of over 2700 surgical trainees from all 10 surgical specialities, the Association provides support at both regional and national levels throughout the United Kingdom and Republic of Ireland. Originally founded in 1976, ASiT is independent of the National Health Service (NHS), Surgical Royal Colleges, and specialty associations. Governed by an elected Executive and Council, the Association is run by trainees for trainees.

About BOTA

The British Orthopaedic Trainees’ Association (BOTA) was set up in 1987 and it subsequently became affiliated to the British Orthopaedic Association. BOTA is a democratically elected professional committee. It represents Trauma and Orthopaedic trainees across England, Scotland, Wales and Northern Ireland. BOTA has a current membership of over 1000.
Background

Following the publication of the Shape of Training Steering Group (STSG) recommendations\(^1\)\(^-\)\(^2\), Health Education England (HEE) have commissioned the Royal College of Surgeons of England to identify and recommend improvements to the quality of surgical training and lead a feasibility study and cost/benefit analysis of these options. The College is focusing on areas of General Surgical, Urology, Trauma Surgery and Trauma and Orthopaedics for the consultation process. Following a series of meetings with stakeholders, the Royal College of Surgeons of England is required to produce a report to HEE in October 2015. At time of publication, proposals for a potential pilot have only been suggested for General Surgery, with further discussions in other specialties yet to take place. ASiT and BOTA have welcomed the invitation to take part in the engagement process; however, we have concerns regarding some of the proposals. This document outlines our position regarding recommendations for improving surgical training.

ASiT and BOTA Position on Recommendations for Improvements in Surgical Training

ASiT and BOTA promote excellence in surgical training. In order to provide the best quality care to patients in the UK and Republic of Ireland, it is critical that surgeons are trained to the highest standards. In addition, it is essential that surgery remains an attractive career choice, with opportunities for career progression and job
satisfaction to attract and retain the best candidates into surgical training. Attracting and retaining medical graduates into surgery is essential in providing high quality care to future patients. In order to safeguard high standards in surgery, ASiT and BOTA recommend the following:

- The final product of training in any proposed training reforms should not be inferior, in terms of competency, technical ability, professionalism and employability, to the current CCT (Certificate of Completion of Training) holder. At the end of training, an individual should be competent to practice independently as a Consultant Surgeon within their chosen specialty.

- ASiT and BOTA recognise the importance of delivering a service that is responsive to the changing needs of the population. However, we also realise that to provide a high quality service to future populations, surgeons must continue to be the product of a high-quality, respected training process, in order to keep the surgical specialities an attractive career option, and to provide the best possible care to patients.

- We are strongly opposed to a move away from specialisation and towards generalism, as we do not believe that this is in the best interest of patients. While patients need surgeons competent in emergency surgery, the evidence clearly shows that specialist surgeons in high volume centres achieve better outcomes. Moving away from this towards generalisation is a retrograde step. Rather than reducing the number of specialists, training should be augmented to ensure that specialists also have sufficient general and emergency skills. We resist the move for the same number of Consultant Surgeons providing care in a more broad range of generalist areas. We support the expansion of the Consultant Surgeon cohort, providing high
quality specialist care to meet the demands of an ever more complex, enlarging, and ageing patient population, with a greater number of co-morbidities.

• ASiT and BOTA would not support any decrease in the length of postgraduate training as it currently stands. If a reduction is to be considered in the future, such major change would require successfully piloted training programmes, including the shift of workload toward more dedicated training alongside a lesser commitment to service provision. Supernumerary training posts would also need to be considered.

• ASiT and BOTA strongly oppose a maximum time for completion of training suggested as 8 years (following completion of foundation training) in on-going discussions; we encourage an individualised approach to training. Trainees often require pastoral care and career breaks in times of difficulty. A maximum time limit would compound pressures during difficult times. Additionally, ASiT and BOTA fully support the use of Out of Programme placements (for training, experience, career breaks, and research) as these bring diversity and a broad range of skills to the NHS and patient care. We strongly support the concept of less than full-time training (LTFT) to allow trainees to match their work-life balance, allow flexibility to have a family or undertake academia. Both Out of Programme placements and LTFT should be removed from any imposed maximum time limit to training.

• With respect to run-through training, there are recognised advantages to this option, including a fixed location for the duration of surgical training for trainees (excluding out of programme options or fellowships), the financial benefit for selection bodies of holding only one national selection process,
and the formulation of more focused and integrated training pathways. However, the benefit of an uncoupled training pathway is in providing a second ‘gateway’, thus ensuring competitiveness and allowing trainees sufficient exposure to a broader range of medical and surgical specialties to enable them to make more informed career choices. It is likely that a ‘one-size-fits-all’ approach to selection and training progress will not be acceptable to all stakeholders. If run-through training were to be implemented, we would strongly favour a consistent, robust and rigorous Annual Review of Competence Progression (ARCP) process to ensure consistency in standards of trainee performance, which are comparable to peers from a different geographical location. This would also require trainers and the Royal Colleges to provide an improved career guidance service through the early stages of a trainee’s career, including during the latter years of medical school. ASiT and BOTA note that run-through training in Neurosurgery, Cardiothoracics and, with small numbers, in Trauma & Orthopaedics in Scotland has been implemented with some success. However, a pilot of run-through training in Trauma & Orthopaedic Surgery in England was abandoned in 2011 after 3 years, due to a higher than acceptable drop-out rate. Robust, transparent and detailed proposals of how run-through training in Trauma & Orthopaedics, Urology and General surgery will be performed, should be outlined prior to any pilot, with the opportunity for all stakeholders to have input.

• We would support run-through training programmes as an option for academic trainees, as this would allow longer-term research projects to be undertaken, without risk of non-completion due to relocation. Special
consideration should be made about the timing of ARCP progression for academic trainees, reflecting reduced weighting of clinical exposure.

• ASiT and BOTA would welcome the introduction of modular-based training experiences in accredited units. We would envisage modular-based training to encompass clinical activities related to sub-specialty themes. There may be scope for a dedicated block to accelerate learning in interventional procedures such as endoscopic or radiological skills, where traditionally time allocation to such activities has been limited and indicative numbers for competency may be difficult to achieve within certain surgical training programmes. However, we recognise the importance of complementary exposure of outpatient clinics, elective operating and peri-operative ward care in the management of elective patients; as such we would not support the introduction of separate placement blocks of these activities. We also acknowledge the value of the continual assessment and development of non-technical skills and would be concerned about the implementation of such a system in certain groups, for example, less than full-time or academic trainees.

• ASiT and BOTA recognise the benefits associated with competency-based training progression in Specialty Training. Patients can be confident that the independent practitioner treating them has achieved competence, rather than being assumed to have done so after ‘serving their time’. However, there may be potential difficulties in delivering true competency-based training programmes. Wholesale ‘buy-in’ would be required from trainers, in the context of a current wide spectrum of trainer skills and effectiveness. In this system, it would be essential for trainers to also be required to demonstrate
their pedagogic competency as a trainer, including the ability to accurately and consistently assess the ability of their trainees. Additional novel assessment methods may be required, with associated piloting and validation. Bespoke progression may introduce difficulties in rota filling and workforce planning; particularly in light of modules still being time-based. Whilst the notion of competence-based training versus time-based training is desirable to match the acquisition of knowledge / skills at varying rates, it is neither achievable nor realistic given that Specialist Trainees cannot change clinical placements prior to 6 months, regardless of whether they have met all the competencies of that particular module. If training programmes shift toward greater training activity and reduced service requirements to assist competency achievement, additional service provision staffing will need to be provided.

- ASiT and BOTA recognise that the Allied Healthcare Professionals (AHPs), including, but not limited to, Surgical Care Practitioners, Advanced Nurse Practitioners and Physicians Associates, are a valuable workforce in the NHS, may improve patient care and have potential to enhance training. However, concerns remain regarding their defined role, their regulation, and the use of the term ‘Physicians Associate’ that may be misleading or confusing for patients. Furthermore, there has been little work undertaken to evaluate the cost-benefit for their role within the setting of the NHS. Prior to any proposals for the widespread implementation of AHPs, a rigorous investigation into these concerns should be sought, alongside exploration of patient reported outcomes and safety. ASiT and BOTA are concerned that the potential role of AHPs in a clinical role may impede or dilute training
opportunities rather than facilitate them. It is imperative that AHPs complement but not replace junior doctors and do not negatively impact on Surgeons’ training. We would however, welcome the expansion of phlebotomists, pharmacy assistants and administrative staff in order to lessen the service provision demands on Foundation doctors and Core Trainees.

- Suggestions to merge some tiers of out of hours surgical rotas and a minimum of 10 individuals per rota, in order to make rota frequency less onerous with consequential increases in daytime learning opportunities, are admirable, but in reality may be difficult to achieve. Unfilled rotas throughout the UK remain a problem. Many surgical specialties, such as Urology, have small numbers of trainees per region, and achieving a minimum of 10 staff per rota may be impossible. Furthermore, it is common for some surgical specialties, particularly in General Surgery, to operate a three tiered full-shift system out of hours (FY1, FY2-CT2, ST3+). To suggest that this workload could be managed by only two tiers instead, either with or without AHPs, may be underestimating the workload required of doctors out of hours. We would also not support ST3+ trainees cross covering other specialties outside of their training curricula, or ST3+ trainees sharing the SHO grade rota commitments.

- We strongly encourage supporting Educational Supervisors in both time and financial reward, and to ensure that their efforts to support trainees are well recognised. We support the notion that trainers should have a job-plan that values their role as a trainer and allows dedicated, protected time allocated for training purposes. Trainers should meet with their trainees on a regular
basis to specifically discuss their training progress and learning needs, at least once a fortnight.

• We would support the introduction of a robust, regular and centrally organised system to recognise appropriately trained and competent Educational Supervisors. We would encourage this process to be included in the demonstration of continuous professional development, and not as a one-off certification.

• ASiT and BOTA would not support an enforced dedicated service provision period for junior doctors. This will only prolong training time further and would exacerbate the issues with recruitment and retention in surgical specialties. It may discriminate against female trainees, who wish to raise children. We would also have concerns related to appropriate supervision in any such posts.

• ASiT and BOTA would support the use of Entrustable Professional Activities (EPAs)\textsuperscript{11-12}, to include the assessment of generic professional capabilities.

• We recognise that simulation can facilitate the acquisition of both technical and non-technical skills. Currently, there is a paucity of simulation training access in some regional training programmes\textsuperscript{13}; the Joint Committee on Surgical Training (JCST) has not demonstrated that access to simulation training meets the minimum required for national rollout and mandatory inclusion into pan-surgical curricula. ASiT and BOTA oppose the introduction of compulsory simulation training without evidence that it can be delivered nationally, in all surgical specialities, without regional deficits, and hence recommend that there should be standardisation across the UK in terms of availability and access to local facilities\textsuperscript{13-15}. Simulation should be incorporated
into regional teaching programmes, which themselves should be high quality and consistent between regions. We feel strongly that any provision of simulation-based training should be at no additional cost to the trainee. However, whilst we support simulation training to supplement aspects of technical and non-technical skills acquisition, we refute the notion that simulation training can substitute elements of surgical exposure.

• Post-CCT fellowships should remain as additional training experience for advanced techniques or areas of practice confined to a niche sub-specialist interest. We would not support post-CCT fellowships for curriculum areas or levels of competency that are currently achieved within a surgical training programme. We refute the notion that specialist interest training, for example as a Colorectal Surgeon, should happen after the award of a CCT.

• ASiT and BOTA are opposed to proposals that appointments to post-CCT fellowships could be based upon a national selection process, rather than simply competitive appointments based on merit. Post-CCT fellowships are individualised in both the potential skills to be gained and location. A national selection process would be detrimental to this. It may also negatively affect trainees' opportunities to engage with overseas fellowships. This would decrease the diversity and range of skills and knowledge available to post-CCT fellows, and may ultimately affect the quality of surgical standards in the UK. We see benefit to a nationally managed system but with locally conducted interviews and selection process, similar to the USA and Canada. This would be advantageous for workforce planning, but maintain the individualised approach required for recruitment to fellowship posts in order
to achieve the maximum educational benefit. We feel the Specialty Associations would be best placed to oversee this process.

- ASiT and BOTA’s viewed on credentialing has been discussed previously\textsuperscript{17}. In brief, we feel strongly that credentials should not overlap with any skill or competency accredited in the existing curricula for award of a CCT, and should only be made available for doctors on specialist register or GP register.

- We welcome the recommendation that the Foundation Programme Year 2 should be surgically themed, with the inclusion of Emergency Medicine and Critical Care. This will expose potential Surgeons to surgical specialties and help garner interest to pursue surgery as a career option.

- Any trainee entering into a pilot scheme should be benchmarked against their peers at the National Selection process in order to ensure and maintain high standards of patient care.

**Core Surgical Training**

- The indicative minimum time for Core Surgical Training should remain at two years.

- We strongly support the notion of 6-month placements in Core Surgical Training.

- ASiT and BOTA would not support that Core Surgical Trainees should be formally trained in the skills of General Practice or Obstetrics and Gynaecology, and opposes any introduction of General Practice or Obstetrics and Gynaecology placements into core or higher surgical training.
• ASiT and BOTA recognise the potential benefit to Core Surgical Trainees of undertaking high-quality training experiences within Critical Care, Anaesthetics or Emergency Medicine, with defined learning outcomes relevant to surgical practice. However, time in non-surgical specialties during Core Surgical Training should not exceed more than 6 months in total, and should not result in those completing core training failing to meet minimum application criteria for ST3 level Specialty Training. If a trainee has undertaken these specialties during Foundation Training, the benefit may be less for that individual. Recruitment procedures into specialties that require minimum numbers of index procedures should be sensitive to the fact that some trainees may be less experienced in surgery.

**General Surgery**

• We oppose Emergency General Surgery (EGS) becoming the default end product of a general surgical training programme. For trainees that wish to subspecialise in EGS, they should be able to opt for this as a specialty choice. ASiT anticipate that the number of General Surgeons who wish to subspecialise in pure EGS will be low; only 15.4% (42/276) of higher General Surgical trainees stated they would accept a pure EGS consultant appointment if offered at interview. Changes to the FRCS exam would need to be considered to facilitate those wishing to specialise in EGS as they may undertake their exam in General and EGS Surgery in a similar manner to those who currently undertake their exam in general and colorectal.

• Proposals have been made to incorporate a specialist interest alongside EGS, in order to help with job satisfaction, prevent burn out, and offer flexibility
and transferability to employers. However ASiT has concerns regarding EGS consultants performing specialist interest surgery. This is of particular relevance to elective colorectal cancer resections, where ACPGBI have stated that surgeons must be a core member of the colorectal multi-disciplinary team (MDT) and have performed at least 20 resections with curative intent in the previous year of practice, which have been recorded by the MDT and been submitted to NBOCAP\textsuperscript{19}. Likewise, AUGIS have recommended a minimum of 15-20 oesphago-gastric resections, 12-16 pancreatic resections, and 15-25 liver resections per annum (based on a population of 1-2 million for oesphago-gastric and 2-4 million for hepaticopancreatobiliary)\textsuperscript{20}. We think it may be unrealistic that a consultant appointed in EGS will be able to maintain this minimum number per annum within their job-plan and therefore unlikely to be able to take up a specialist interest in resectional cancer surgery.

- To attract surgical trainees into General Surgery, it is essential that workforce-planning concerns do not erode trainees’ autonomy in selecting their subspecialty interest. Ultimately, attempts to force trainees down a training route may result in high attrition rates. This then makes workforce planning more difficult and is counter productive. A move towards making EGS the end point of training will likely make it difficult to attract trainees into General Surgery. Competition for surgical jobs has deteriorated over the past 5 years with a competition ratio of 2.1:1 in 2015, compared to 7:1 in 2010\textsuperscript{21-22}.

- ASiT supports the introduction of structured modular placements, incorporating EGS. It is essential that these modules deliver high-quality
training and operative experience. Preferably educational supervision within EGS modules would be by a Consultant with an interest in Emergency General Surgery, however delivery may be dependant on local infrastructure.

- Separation of elective and emergency workload in the early years of higher surgical training could be beneficial in allowing greater operative exposure where the local workload permits\textsuperscript{14}. However, skills gained in elective modules could be used to demonstrate or accelerate competence in emergency surgery.

- We support the notion of structured training exposure to General Surgery of Childhood\textsuperscript{22}. This is essential to support the safe and timely management of the acutely unwell child with surgical conditions. Paediatric day case operative lists and surgical clinics could be accommodated within the training programme.

- ASiT feels that removal of elective vascular exposure for General Surgical trainees will not only be detrimental to surgical and haemostatic techniques learnt by the General Surgical trainee, but will also have a knock-on effect to the provision of Specialist Trainee cover within vascular teams, as current numbers of Vascular Specialist Trainees will not meet this need (and is unlikely to in future).

- We advocate the acquisition of basic trauma competencies for all General Surgical trainees, with advanced training opportunities available for those who are aiming to routinely deliver emergency care in major trauma centres.

- We recognise that future General Surgical trainees with an interest in Breast Surgery are unlikely to undertake General Surgical on-call commitments as a Consultant and should, therefore, not require as much exposure to
Emergency General Surgical training compared to those who will undertake General Surgical on-call commitments as a Consultant. This would maximise training opportunities for both parties. This is supported by results from a recent survey of 107 Breast trainees via Mammary Fold, which suggested that 87% were keen to be appointed as a Consultant without Emergency General Surgery cover. The majority felt that General Surgical Emergency cover as a trainee should continue until ST6 level; the loss of transferable skills was the main cited reason to continue emergency workload as a trainee.

- There should be increased provision of optional interface Specialty Training during surgical training i.e. General Surgical trainees with an interest in Breast Surgery may benefit from undertaking optional Plastic Surgery modules.

Overpage is a suggested model for delivery of General Surgery Specialist Training; we feel that this model is potentially generalisable across the nation.
Phase One (ST3-4)

- **Module EGS 1**
  - Daytime emergency cover only
  - 6 months

- **Module Lower GI**
  - Elective daytime work
  - Out of hours emergency cover only
  - 6 months

- **Module Upper GI**
  - Elective daytime work
  - Out of hours emergency cover only
  - 6 months

- **Module Vascular**
  - Elective daytime work
  - Out of hours emergency cover only
  - 6 months

Phase Two (ST5-6)

- **Module EGS 2**
  - Daytime emergency cover only
  - 6 months

- **Module Upper or Lower GI**
  - Elective daytime work
  - Out of hours emergency cover only
  - 6 months

- **Module General Surgery of Childhood**
  - Elective daytime work
  - Out of hours emergency cover only
  - 3 months

- **Module Special interest**
  - Elective daytime work
  - Out of hours emergency cover only
  - 6 months

- **Module Endoscopy**
  - Elective daytime work
  - Out of hours emergency cover only
  - 3 months

- **Module Specialist interest**
  - Elective daytime work
  - Out of hours emergency cover only
  - 9 months

Phase Three (ST7-8)

- **Module EGS 3**
  - Daytime emergency cover only
  - 6 months

- **Module Special interest**
  - Elective daytime work
  - Out of hours emergency cover only
  - 18 months

- **Module Interface specialty**
  - Elective daytime work
  - 6 months

- **Module Specialist interest**
  - Elective daytime work
  - Out of hours emergency cover only
  - 18 months

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Modules for all general surgery trainees

Modules for those with an interest in upper GI, lower GI, emergency general surgery (endocrine/ transplant)

Modules for those with an interest in breast, transplant, endocrine (dependant on desire to offer general emergency cover as Consultant)
Urology

- ST3-6 should continue to provide a varied experience of core/general Urology. ASiT would support a 4-year initial phase of Higher Surgical Training in core/general Urology, with a later 1-year phase of subspecialty modules. However, ASiT would not support a reduction to 4 years of Higher Surgical Training to create consultants in core Urology, with only a quota of trainees going on to complete a final subspecialty year.

- A CCT holder in Urology should be able to deal with the majority of urological emergencies, including, but not limited to:
  - Priapism
  - Fournier’s gangrene
  - Testicular torsion/ trauma
  - Ureteric and bladder injury
  - Urinary retention
  - Upper urinary tract obstruction
  - Renal trauma (nephrectomies are rarely performed and local arrangements should be made for interventional radiology support for embolisation, or for referral to a Urologist with an interest in renal surgery as required).

- ASiT would not support junior Urology registrars providing General Surgical on-call cover, and vice versa. The proposal may be advantageous in the DGH setting where the Consultant Urologist on call currently takes on the majority of the Urology workload above FY/CT level out of hours, with only minimal or no Urology middle grade support. There are several concerns raised to this proposal:
o General Surgical Consultants will most likely have to be present to supervise Urology trainees in theatre out of hours to a greater degree than their own trainees and may not view training Urology ST's as a priority in this ‘out of hours’ situation and therefore does not provide good training.

o In some departments where Urology trainees currently undertake 24 hour on calls (with elective activity cancelled during the on call day and for all or part of the following day) moving to cross cover with General Surgery may reduce the loss of elective activity that currently takes place. This clearly has implications for both training and to the Urology department in question regarding lost elective activity.

o As a result, rotating to a DGH where such a work pattern is in place would be less attractive to Urology trainees and may create a two tier split within training rotations.

o Indicative numbers are already proving difficult for some trainees to achieve. Further loss of elective training opportunities due to these proposals would only worsen this situation.

o The vast majority of work currently undertaken by General Surgical middle grades involves clerking of patients and reviewing surgical admissions, rather than gaining operative experience. This would again be of limited education value to a Urology trainee, and would require the setting of targeted, relevant learning goals, with buy-in from general surgical trainers, to make any such placement beneficial. There is also the issue that in some larger surgical departments there are two surgical middle grades on call, with the more senior trainee in
theatre while the more junior is clerking patients, reviewing ward patients etc. It seems likely that it would be the more junior and surgically inexperienced Urology trainee that would find themselves undertaking the latter.

Trauma and Orthopaedic Surgery

• At present, the Trauma & Orthopaedic surgery SAC and British Orthopaedic Association (BOA) have not seen or discussed proposed changes to Trauma & Orthopaedic Specialist Training. BOTA fully supports the inclusion and leadership of the T&O SAC and BOA in shaping any and all changes to Trauma & Orthopaedic surgical training, with the inclusion of trainee representation.

• Whilst AHPs are used within Trauma & Orthopaedic surgery in ward-based and theatre practitioner roles, it is unrealistic and implausible to expect that they wish to, or will be able to, be trained to participate as ‘first on call’ for the specialty.

• As mentioned previously, widespread change to run-through training in Trauma & Orthopaedic Surgery in England and Wales must be carefully considered, as a previous pilot including four regions was not deemed successful and was abandoned in 2011. BOTA would be in favour of further discussions about how to ensure a national run-through programme could be delivered successfully, to ensure trainees have flexibility to change career paths, maintenance of career progression, and ample career support prior to start of the programme.
• BOTA supports the concept of nationally funded and advertised fellowships. However, recruitment should be performed locally. BOTA supports the BOA and associated specialist societies to quality assure, assess, and advertise these fellowships.

• Whilst generally, BOTA supports six-month placements in a clinical attachment, and one-year placements in an institution, this must remain flexible. Spending 1 year in a tertiary-referral specialist centre may impact on the ability to acquire general and specialist Trauma & Orthopaedic skills.

Trauma Surgery

• Trauma surgery and emergency surgery are distinct, and the definition of competence in these contexts requires further work. Although many technical emergency surgical skills can be taught in the elective setting, this is not the case for trauma surgery proficiencies. Focused trauma surgical training curricula, to be delivered in highly selected units, should be developed.

• We recognise the importance of appropriate trauma training to provide two levels of trauma capability. The first is the initial assessing surgeon (usually General Surgery but could be another surgical specialty) who can competently manage the trauma patient in the immediate term, with the second being a specialist in trauma who delivers care within a trauma centre.

• All trainees declaring a specialist interest in Trauma Surgery should be able to provide lifesaving surgical care at the point of CCT. This skill-set should include insertion of a surgical airway, resuscitative thoracotomy, trauma laparotomy, and surgical manoeuvres to control haemorrhage and
contamination. The knowledge required could be attained through taught modules (such as Definitive Surgical Trauma Skills Course or live porcine training) and assessed through existing or novel Workplace Based Assessments to assure competency.

• In General Surgery, Gastrointestinal Surgical Trainees who intend to staff trauma units would require at least a six-month rotation through a high volume vascular or trauma unit, and similarly Vascular trainees through gastrointestinal units.

• It is advocated that these trainees are supported through nationally or internationally gained out of programme trauma fellowships to attain the necessary breadth of knowledge and familiarity with Trauma Surgery.

• For those trainees who wish to pursue a career in Pre-Hospital Emergency Medicine, modules in Anaesthesia, Critical Care and Emergency Medicine should be accommodated within a bespoke surgical training programme incorporating out of programme experiences, and mechanisms to achieve this alongside achieving surgical competencies in a timely manner by CCT should be developed. We fully support the suggested model overpage, from the Pre-Hospital Emergency Medicine Curriculum Committee, which could be integrated into a range of surgical specialties:
Conclusions

Whilst some of the proposals made by the Royal College of Surgeons of England ‘Improving Surgical Training’ Consultation process are admirable in an attempt to improve surgical training throughout the UK, ASiT and BOTA feel strongly that the concerns raised in this document require addressing prior to any implementation.
Reflection on the Consultation Process

The below observations are based on the experiences of Miss Rhiannon Harries (ASiT President) and Mr Mustafa Rashid (BOTA President), as members of the RCSEng ‘Improving Surgical Training’ Steering Group only, and do not reflect the views of others authored in this document.

The RCSEng ‘Improving Surgical Training’ Steering Group and Stakeholder Group Meetings were chaired by Mr Ian Eardley (RCSEng Vice-President and former JCST Chair). The series of meetings and trainee attendance is recorded below:

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<th>Meeting Date</th>
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<td>11th May 2015</td>
<td>Miss Rhiannon Harries</td>
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<td>Steering Group</td>
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<td>9th June 2015</td>
<td>Mr Mustafa Rashid</td>
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<td>Stakeholders Group</td>
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<td>10th July 2015</td>
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<td>Mr Benjamin Lamb (SURG Academic Representative)</td>
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<td>Dr Kitty Mohan (BMA Junior Doctors Committee Co-Chair)</td>
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<tr>
<td>8th September 2015</td>
<td>Miss Rhiannon Harries</td>
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<td></td>
<td>Stakeholders Group</td>
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<td></td>
<td>Mr Mustafa Rashid</td>
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<td>Mr Benjamin Lamb</td>
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<td>9th September 2015</td>
<td>Cancelled on the day</td>
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<td>Steering Group</td>
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There were other meetings and communications held by the chair of the IST group that ASiT and BOTA were not party to.

We have concerns surrounding the lack of minutes for the five consultation process meetings. Mr Rashid and Miss Harries raised the issue as a discussion point on the meeting of 10th July 2015 and an agreement was made that meeting notes would be circulated to those who had either attended or had been invited to attend. Meeting notes were only circulated for the meeting dated 10th July 2015, and no further meeting notes were circulated.

We also have concerns that final document submitted to Health Education England by RCSEng occurred on 12th October 2015, and there was a significant delay before Trainee Steering Group stakeholders were forwarded a final version of the report. Miss Harries received a paper version on 4th November 2015. Mr Rashid has not received a copy at time of the publication of this document.

We note that during the consultation process, the British Orthopaedic Association (BOA) and Trauma and Orthopaedic Specialty Advisory Committee (T&O SAC) have elected not to pursue plans for a pilot within Trauma and Orthopaedics. In their discussions with BOTA, it is clear that the issues have been discussed in detail and they feel that the current T&O curriculum and CCT-holder provides appropriate and high quality care for NHS patients in the generality of Trauma & Orthopaedic surgery.
References


   http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_Training___UK_Steering_Group_statement___Approved_version_16_2_15.pdf


ASiT and BOTA have published a number of statements that are available at:  http://www.asit.org/resources/articles

http://www.bota.org.uk/home/position-statements/