

**Response to The Shape of Training Steering  
Group Recommendations  
of 17<sup>th</sup> February 2015**

*A statement from the Council of*



released 19<sup>th</sup> February 2015



35-43 Lincoln's Inn Fields, London, WC2A 3PE, UK

**Telephone:** 0207 973 0301

**Fax:** 0207 430 9235

**Web:** [www.asit.org](http://www.asit.org)

**Twitter:** @ASiTofficial

**Email:** [president@asit.org](mailto:president@asit.org)

**Authors:**

Mr Henry Ferguson (Past Vice-President)

Mr Andrew Beamish (Past President)

Mr Vimal J Gokani (President)

*Written On behalf of the ASiT Executive and Council*

## Foreword

*‘Securing the future of excellent patient care’, the final report of the independent review led by Professor David Greenaway (The Shape of Training Review)<sup>1</sup>, has set recommendations regarding the structure and delivery of medical and surgical postgraduate training for the next 30 years. The changes proposed in its 19 recommendations are far-reaching and have significant implications, both for current and future patients and trainees in the UK. Since its initial report, a steering group was rapidly established, and six consultation events were undertaken to gauge opinion on the recommendations. ASiT was not formally invited to these consultations, but did gain access through other bodies. Following these consultation events, the Shape of Training Steering Group (STSG) has reported its recommendations to Health Ministers from the four UK nations for further consideration. On 17<sup>th</sup> February 2015, these recommendations were made public, and this document represents the opinion of ASiT on these proposals.*

## 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 2,300 surgical trainees from all 10 surgical specialties, 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.*

## Introduction

Following the six consultation events held by the Shape of Training Steering Group (STSG), Health Ministers representing the four UK nations have received a final report. The STSG released a summary of their recommendations to Ministers on 17th February 2015. Ministers are broadly supportive of the recommendations of the STSG, and have now approved development activity, which will explore how medical training might be adapted to meet future patient and service needs under the umbrella of the Shape of Training initiative. This development will be overseen by the STSG to ‘maintain consistency and ensure appropriate stakeholder engagement.’

## Response to Recommendations

ASiT is pleased to note that there is a commitment to avoid change to curricula for the sake of change, and to ensure that those curricula that are already fit for purpose are allowed to remain. There are also positive statements regarding the inclusion of trainee organisations such as ASiT within the ongoing process of proposal development, and that the pace of any change must be slow and staged, rather than rushed as was the case with the Modernising Medical Careers debacle. ASiT would raise concern over the definition of ‘aspects of the current training system that are... fit for purpose’. One could argue that medical training has evolved with the requirements of service, and on the basis of the available evidence. For example, despite the proposed move towards a ‘generic’ doctor, evidence suggests that in many surgical specialties those surgeons who are ‘fit for purpose’ are those with a sub-specialist interest, with better patient outcomes<sup>2,3</sup>.

However, as with much of the documentation regarding the Shape of Training Review, this statement is rather high-level and lacks the detail that could address our previously well-documented concerns<sup>4</sup>. Thankfully, it omits any reference to reducing the length of training – proposals which have created so much bad publicity of late. Of course, this also cannot be taken as a commitment to maintain length of training.

The STSG has made four recommendations. They are listed below, with ASiT’s response to each:

*1) Further work will be undertaken to describe how doctors' training can be more generic to better meet the current and future needs of patients. This will include a mapping exercise, led by the Academy of Medical Royal Colleges and supported by the GMC, to look at the extent to which Colleges have or can develop the generic components of their curricula.*

As alluded to above, this is difficult to relate to areas of surgical practice that have been shown to demonstrate improved patient outcomes with more specialism and centralization of care. We accept that a mapping exercise of current curricula is necessary to ascertain if any changes are indeed required within surgical curricula, but one would have hoped that a process of the type recommended by the STSG might have been conducted in advance of the conclusion being drawn that doctors are not trained broadly enough. The Academy of Medical Royal Colleges seems well placed to consider this task, but again, the document lacks clarity as to whether this will be performed 'in-house' by each specialty, or more generally by the whole Academy with GMC assistance.

*2) Measures to be scoped out, based on evidence collected through pilots, how to further develop the careers of doctors who are outside formal postgraduate training and who are not consultants, such as SAS grade doctors.*

When considering the future roles of Staff and Associate Specialist (SAS) doctors within surgical specialties, it must be borne in mind that these practitioners represent an equally valuable but different role to qualified consultants and consultants in training. Access to a National Training Number to gain a consultant post in a surgical specialty is through multiple levels of rigorous and fair academic and professional selection. Although unclear, the implications seem to be that SAS doctors will have equity of access to any future credentialing, and will therefore be in direct competition in areas of practice with consultants. ASiT believes this would be deleterious. This would create a 'backdoor' entry to independent practice, undermining existing rigorous selection processes, which exist to ensure the consultant workforce is selected based upon merit and has received appropriate and complete training.

3) *Measures to better prepare doctors to work across the interface between primary, secondary care and the community with more flexibility in training between the sectors.*

Regarding the preparation of surgeons in training to cross the primary, secondary and community boundaries, ASiT recognises the benefits that delivery of care closer to home can afford patients. However, quality cannot be compromised. As ASiT has previously asserted<sup>5</sup>, surgical practice within the community is currently poorly monitored, and has a low level of professional regulation when performed by General Practitioners with a Specialist Interest in Surgery, when compared to the scrutiny from which hospital surgeons benefit. If care is to be delivered by consultant surgeons practicing within the community, then certain, albeit minimal, generic skills should be incorporated into surgical curricula. ASiT refutes any notion that surgical trainees should be formally trained in the skills of General Practice, and would oppose a broad introduction of General Practice placements into surgical training schemes. This could serve to devalue the level of training current General Practitioners undergo.

4) *The STSG will support the GMC as they develop and pilot credentialing working with all stakeholders with an interest in this aspect of Shape of Training.*

The concept of credentialing seems to be growing into a stand-alone item, with its implementation now being referred to as a *fait accompli*. ASiT recognises the benefits of professional recognition regarding areas of highly specialist and in training terms, currently unregulated, practice. We appreciate that in certain subspecialised areas such as cosmetic surgery, formal certification offers confidence to patients. However, it is unclear what benefit credentialing would offer at less specialist levels of practice, including special interest areas which are currently recognised by specialist components of the FRCS examination.

Credentialing appears to be a further level of training above the proposed Certificate of Specialty Training (CST)-holder, who would be required to undertake only the most routine levels of surgical consultant practice. Despite several rather unconvincing iterations to the contrary, this concept is irretrievably linked with the

introduction of two tiers of consultant grade, and therefore in all reality represents a sub-consultant grade. There are multiple levels of uncertainty surrounding this concept, including, but not limited to:

What areas of practice would be included in a credential?

What would be the entry criteria for accessing a credential?

Who would commission a credential?

Who would fund the training necessary to gain a credential?

What safeguards would there be to ensure that 'grade inflation' does not occur with regards to credentials, necessitating CST-holders to privately undertake credentials to gain a consultant post?

How would a credential be maintained?

How will currently practicing consultants be assessed and credentialed?

Will European doctors have equal access to credentialing and represent direct competition to UK trained doctors?

Will doctors who trained overseas be required to undertake UK credentialing?

Would there be an associated extra cost to the CST-holder for the process of gaining and maintaining a credential, or would it be bundled in with revalidation?

In this unqualified form, they represent a desire to create a lower tier of consultant practice, with the potential for untold costs to be foisted upon already overburdened surgeons in training.

ASiT remains keen to be involved in further dialogue and consultation with all other stakeholders in this ongoing process, and is fully committed to the sentiment that patient safety must be at the heart of any proposals. Patients in the UK do not deserve a potentially undertrained consultant workforce delivering their surgical care.

## References

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