

SAC MEETING 15TH MAY 2008

ROYAL COLLEGE OF SURGEONS OF ENGLAND

TRAINEE REP REPORT

1. Apologies accepted
2. New members – nominated by BAPS +/- training programme directors, aim not to have too many people on SAC. Will temporarily invite Shawqui Noor as he is only lead PD not currently represented – to be temporary pending possible restructuring of SAC
3. Minutes of last meeting accepted. Matters arising:
 - a. **Travel expenses** – unsatisfactory response. JCST not offering to pay at present. Most trusts currently paying. Creative response required.
 - b. **Jobs in Scotland** – lap training fellowship in Edinburgh approved, 1yr, pre CCT post, open to all UK trainees. Urology post not approved.
 - c. **Liaison members** will be required in some regions when people leave.
4. **JCST – meeting** held in Edinburgh. Minutes not yet available. Concerns that PMETB overturning decisions made by JCST as to whether people should get Article 14. Recently trainee accepted by PMETB who had been rejected by JCST. Note that new chairman of PMETB is surgeon. Also note that there are fewer Article 14 applications than previously. PMETB have never paid JCST for article 14 work
5. **MRCs** – seems to be sorted. Format of exam from 2009 has been agreed and will include OSCIs. ?will involve patients.
6. **Core surgical training** – government has rejected Tooke suggestion to split FY1 and FY2. Some specialties will have run through from ST1/2. Others, including paed surgery will have 3 years core surgical training. Others include General Surgery, Neurosurgery and Plastic surgery. These decisions made by SACs and JCST ?how formal – not very. Then 6 years of higher surgical training (extends training by 1 year). For 2009 onwards. Royal College of surgeons wants to take back control of core surgical training, not yet agreed.
7. **Workforce issues**
 - **Meeting at RCS Mar08** – DoH have no central data on consultant numbers! RCS wants to create database. T&O close to required numbers, ENT don't want expansion. DoH won't fund project.
 - **NHS Workforce review team meeting** – as part of general surgery. David Thomas presented paed surgery data. Expansion in numbers still required. Will work more closely with deans to help with expansion.
 - Currently 5% growth per annum in paediatric surgery. 141 consultants in England, 5 Wales, 21 Scotland, 7 N Ireland, including urology, academics and locums.
 - Aim 4 per million – agreed between BAPS and DoH ?when. Target no of consultants = 200 England. Scotland will achieve target by 2008/9, England by 2017, Wales >2020.
 - Transfer of GPS workload would result in 65% increase workload for paediatric surgery.
 - Will need about 15 new posts per year to accommodate all registrars.
 - CMR presentation re trainee numbers – discussion included realization that there are not enough consultant posts for the number of trainees completing training. Part of problem is that there is no capacity in theatres, anaesthetists, bed etc for hospitals to appoint lots of new consultants.
8. **General surgery of childhood** – Pye letter discussed.
 - **Meeting of Children's Surgical Forum (DD report)** - APA adamant that anaesthetists should never be the block to operating on children. Prediction that 15% paediatric units will

close soon, due to inability to staff medical paediatric rota. Conclusion – should be networks, SHAs should sort out their own networks.

- **Letter from Bernie Ribeiro** – wants to identify centres that can train surgeons in GPS. DT has contacted all centres that have general surgeons in paediatric surgical training posts – some working well, some not.
 - Noted that no imperative in general surgical training to do paediatric surgery, unlike ENT, Ortho. Only 2 trainees in 16 years have opted to do paediatric part of exam. George Youngson has written a report for govt of Scotland about GPS provision in Scotland.
 - Discussion as to who should deliver paediatric surgery of childhood. What about emergencies?
 - RCSEd has documented that surgery in children should be undertaken by Paediatric Surgeons where possible.
 - No conclusions
9. **Training programme in Hull** – approve post
10. **ST3 posts** - seem to have been appointed to good candidates. Will be huge problems next year when 48 hour working week comes in and there will be no locums available.
11. **ISCP update** – (EC) all major curriculum changes have to go through PMETB. Minor changes do not need to be updated. For our curriculum main problem at the moment is with assessment tools incl. PBAs. Progress is being made.
12. **E-logbook** – also progressing. Recommend Edinburgh logbook (not ISCP logbook).
13. **Intercollegiate exam** – Oxford exam very well organised (good feedback apart from one threatening email). 75% passed with NTN, much lower if no NTN, 0% if not training in UK.
14. **National selection** –
- MMC programme board distributed person spec for 2009. Scotland more detailed, more ‘desirables’ to allow selection between candidates. Scotland form very successful, used with scoring sheet (0-4 points for each aspect). MMC board will not accept upper limit of experience in paediatric surgery. How to define appropriate career progression? Agree terms with shortlisting committee in advance. Remove extra-curricular activities.
 - Positive feedback from specialties that have done national selection. JCST to host ½ day workshop to allow those specialties interested to learn from those who had done it.
 - Paediatric surgery keen to participate in 2009
 - All consortia should be represented
 - Could do 2 site interviews – not popular
 - Lead dean and denary would have to host this - our lead dean is in Aberdeen, would need English dean.
15. **Quality Assurance** – assessment completed by ST1s at the end of 4 month placement. Detail provided esp negative assessments. I raised concerns that the trainees will all be identifiable to their trainers on the SAC as only 5 trainees involved therefore not at all anonymous. Reassured that there are far more than 5 ST1 posts so individual trainees not identifiable. Comments that this data does not allow changes to be made to jobs when problems have been identified.
16. **Post CCT fellowships** – David Drake reported
- Aim to create NEW posts, that do not dilute training of current trainees, specialist surgery not part of curriculum
 - Post-holder will be: Post CCT, NTN in England, wish to develop extra skills
 - Fellowships determined by national and regional requirements, can be trans-specialty e.g. trauma/bariatric
 - 364 days, non-extendable, not in same training centre year after year
 - 2008 – 4 centres applied, 2 fellowships awarded:
 - Liverpool - Oncology
 - GOSH – minimally invasive
 - QA – JCST will monitor impact of fellowship on training of other trainees. 4 page flowchart – with lots of hurdles. ?written by whom. 2, 6 and 12 month reports will be required.
 - Diploma awarded at end if ok