

STC Programme directors meeting

RCS England 5th Feb 2009

Attended by programme directors from all deaneries.

New lead dean identified - Nancy Redfern (Newcastle)

Chairman's report:

- MMC – one-off allocation of 10 ST3 posts in 2008 mentioned.
 - Uncertainty of status of those appointed to run-through in 2007 i.e. were they guaranteed run through in paed surgery or in surgery in general? Dealt with on a deanery level. Prevented involvement in national recruitment for 2009
 - Surgical training decoupled.
 - ⊞ Core 3 years then competitive entry into ST1-6.
 - ⊞ 'Sub-consultant grade' still being discussed i.e. not defined what happens when you finish ST6, will everyone get a CCT and become a consultant?
 - ⊞ Selection to ST3 level will not include a test of knowledge as MRCS is requirement
 - ⊞ CT selection may involve test of knowledge.
- Training consortia – few trainers have PAs in job plan for training
- National recruitment – not 2009, ?2010
- 'Eraut' report discussed – problem is training is undervalued and not a priority for trusts, need to formalise role of trainers.
- Workforce survey presented (as above)

National Recruitment Steve Buggle (Chief operating officer MMC board)

- Many specialties planning to use national recruitment by 2010
- Advantages include
 - 'fill-rate' – can identify candidate as appointable in more than one specialty and avoid multiple applications, if 1st choice candidate does not take post it can be offered to 2nd choice etc. (prevents having to re-advertise jobs)
 - Greater clarity
 - Standardised recruitment process
 - Maximise applicant pool
 - Economic for consultants/applicant/deanery
 - Applicant can identify own preferences, not dependent on when jobs advertised
 - Workforce planning (ensure right no of trainees for consultant posts)
- Different IT systems being used (not MTAS) – 4 systems being used by different specialties
- Model of recruitment preferred is college working with deanery/lead deanery. Interviewing can occur locally or in regional clusters.
- National recruitment will be supported by lead dean, DH MMC team, central funding for additional costs and to support development (not indefinitely, but for 2010).

- Timetable clearly set out for interested specialties –
 - Jan – express interest
 - Apr – submit project plan
 - May – review proposals
 - Jun – final proposals
 - Jul – review by peer review panel
 - Sep – submission to programme board

Disadvantage highlighted by DT – when a trainee leaves to take up consultant post, there will be empty training post not filled until next round of national training. SB stated that national recruitment would not preclude individual recruitment for posts that come up in between. Concern raised by me that this might detract from national selection.

Selection methodology – Rowena Hitchcock

- Toolkit produced by JCST
- Faculty of selectors to train local selectors
- Aim to gather data on selection tools to see how good they are (long term, e.g. who makes it as a consultant)
- Person spec is cornerstone of effective selection
- Short-listing has little validity ($r=0$)
- Aim – long-listing then shortlist (by machine marked test / CV assessment), then interview, then selection centre
- If interview is the only valid technique may need to interview more people (selection centre)
- Situational judgement test may be used – good evidence that this has validity (outside medicine). E.g on a night shift you find the consultant has prescribed a weekly drug daily. Do you a) ask the nurses if he makes lots of mistakes b) call him to discuss it c) change the prescription and leave it to day staff to discuss d) leave it till the morning. Rank in order of suitability.
- Selection centre – using several different tools incl. interviews. May include simulations, predetermined, trained assessors
- Q: does it add anything to interview? GH found that in Scotland it did not. Selectors will have to be robustly trained – takes time out of clinical work.

PMETB update – Sallie Nicholas Head of JCST

- Reminded role and makeup of PMETB (see website)
- Independent of royal colleges but commissions services from them
- JCST has to tell PMETB about any changes to curriculum
- JCST makes CCT recommendations and article 14 recommendations
- NB Definitions
 - OOPT (training) involves PMETB
 - OOPR (research) may involve PMETB if counting towards training
 - OOPE (experience) does not involve PMETB (deanery must approve)
 - OOPC (career break) does not involve PMETB
- For OOPT/R deanery seeks prospective approval, SAC has to give support, and check afterwards that objectives were met.
- PMETB news
 - PMETB will merge with GMC in 2010
 - New chairman is a surgeon

- PMETB now requires annual specialty reports from each specialty – “state of nation”
- Will be pilot process for approval of ‘well-trodden paths’ of OOPT (e.g. Melbourne, Cape town)
- Generic standards for training – supplemented by JCST standards for surgical training
- Standards for deaneries etc.
- Future doctors review – bluesky project
- www.pmetb.org.uk

Intercollegiate Exam – Graham Lamont

- Part 1 -
 - 110 single best answer questions + 135 extended matching questions
 - Pass rate set by modified Angoff procedure
- Part 2 – 3 attempts, if fail 3rd attempt have to resit part 1
 - Clinicals – 1 day, structured clinical assessments and communication scenario
 - Vivas – 3 sections, 2x20min vivas in each section
 - ☞ Urology / neonatal urology
 - ☞ Neonatal surgery / GI surgery
 - ☞ Endocrine + oncology / emergency
- There are more assessment points than before, and no ‘trap-door’ (instant fail) stations. Performance of examiners is reviewed and the performance of the exam reviewed.
- Future plans:
 - Quality assurance
 - Marking schema
 - Examiner training
 - Exam performance assessment
 - ???wholesale change to OSCE / remote access for written part
- Eligibility – no strict criteria but must be supported by trainers. Not recommended to take too early.

Liaison members role & Grievance procedure – Graham Haddock

- The role of SAC Liaison members is described in the Pink Guide
 - They liaise with postgraduate dean, training programme directors, chair of STC, trainers and trainees
 - Should attend RITA/ARCPs
 - Help to resolve local problems with trainees
 - Support STC
 - Help with deanery led quality management systems
 - Report to SAC from visits and RITA/ARCPs
- Current list of liaison members reviewed.
- Grievance procedure document discussed and accepted (will be posted on trainees website).