Improving Surgical Training

Ian Eardley
Improving Surgical Training

- Relevance to Shape of Training
- What is wrong with training?
- Proposals to Improve Surgical Training
Shape of Training

- An agreement between:
  - Medical Education England
  - Academy of Medical Royal Colleges
  - GMC
  - Council of Postgraduate Medical Deans
  - Medical Schools Council
  - NHS Education Scotland
  - NHS Education Northern Ireland
  - NHS Education Wales
- Potential reforms to the structure of postgraduate medical education and training across the UK
- Professor David Greenaway was the independent Chair
- Reported 28th Oct 2013
Themes of the Report

Changing population needs
- Older patients with more co-morbidities
- Doctors who can deal with these co-morbidities
- Broad based training

Balance between “generalists” and “specialists”
- Service needs generalists to man the “acute take”
- Generalists working across a range of settings
- Specialists still have a role in delivering high quality outcomes

Need to broaden medical training
- Registration at graduation
- Broad based training
- Development of generic competences

Tension between service and training
- System that depends upon trainees to deliver service
- Exacerbated by EWTR
- “Apprenticeship” style training

Need for more flexibility in training
- Transferable competencies
- Increasing female trainees
- Credentialling
Proposed Training Structure

Medical School
- Registration at graduation

Foundation
- Largely unchanged
- 2 years

Specialty Training
- Several broad based themes
- Last 4-6 years
- Lead to a CST

Credentialing
- For some
- Last 1-2 years

Flexible Academic Training

Generic “Professionalism” Training
Credentialling

CST

CST

CST
Shape of Training

- UK-wide implementation group, chaired by Professor Ian Finlay
  - Workshops in September 2014
  - Reported to Ministers Christmas 2014
  - HEE was mandated to take forward several areas of work, including:
    - Mapping of curricula via AoRMC
    - “Improving Surgical Training” with RCS England

General themes for CST
- Primary – secondary care interface
- Interaction with employers
- Issues relating to SAS doctors
- Academic pathway
- Credentialing
Improving Surgical Training

• Report commissioned by HEE
  • Initiated in March 2015
  • Report by October 2015

• Nature of the Report
  • Potential ways of improving surgical training
  • Description of potential models
  • Feasibility of a pilot
  • Financial modelling
  • Stakeholder feedback
  • Recommendations for further work
Timeline

- **Report commissioned**
  - March 2015

- **RCS England led group**
  - April – Sept 2015

- **Stakeholder consultation**
  - Aug – Sept 2015

- **Report submitted**
  - 12th October 2015
What are the biggest problem(s) with Surgical Training?
Problems with Training

- Imbalance of service and training
- Inadequate time for training
- Inflexible training process
Problems with Training

Imbalance of service and training

Inflexible training process

Inadequate time for training

Especially in the early years of training
Chance meeting a core surgical trainee (urology) in the interventional radiology suite during the last month of her 6 month attachment

Problem
- During the 6 months, she was part of a “2 in 16” acute surgical rota
- 5 CSTs, 6 Fellows, 5 gaps / locums
- Internal cover of gaps

Result
- 18 days elective urology training in 6 months
Evidence: Full Shift Rotas ......
Evidence: Logbook experience ......

- Appendicectomy
- E-logbook
- 2,032 core trainees

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Recommendations

- “Professional” Trainers
- Refined process of Training
- Reduced service commitment
- Changes to product of Training

Improving Surgical Training
Improving Surgical Training

Reduced service commitment

- Minimum of 10 in a rota cell to maximise daytime elective training
- Where possible, merge tiers of rotas
- Non medical workforce to support juniors, INCLUDING SHARING ON CALL RESPONSIBILITIES

“Professional” trainers

- Trainers should demonstrate aptitude and training
- Consistent relationship with trainer and mentor (apprenticeship)
- Adequate time in job plan to train
- “Long” training attachments with “Team” support
- (Only) high quality training units
Improving Surgical Training

**Refined process**
- Competence based progression with maximum and minimum duration of training
- Entrustable Professional Activities
- Run through structure
- Enhanced selection and ARCP
- Explicit targets in each stage of training
- Enhanced simulation including intensive induction (annual boot camp)

**Refined product**
- Competent to deal with the generality of the specialty
- Where appropriate, early years should be broad based
- Themed 2nd year Foundation
- Nationally funded, QA and selected Fellowship programme
Specialty Engagement

- General surgery
- Urology
- (Neurosurgery)
- (T&O)
General Surgery

• **Issues**
  - Emergency general surgery
  - Breast surgery
  - Specialist (usually oncological) surgery
  - (Trauma surgery)
  - Emergency Urology
  - Emergency general surgery of childhood
General Surgery

Early years
- Emergency general surgery
- Critical care
- Paediatric
- Vascular
- Urology
- Assessment by WPBA, EPA, MRCS

Middle years
- Upper GI
- Lower GI
- Emergency general
- Trauma
- Assessment by EPA, WPBA

Later years
- Upper GI
- Lower GI
- Emergency general
- “Elective”
- Assessment by EPA, WPBA, FRCS

Post CCT
- Fellowships

- CCT holders will have the competencies to take up a post in a DGH and will be able to receive an unselected surgical take and deal with 90% of the totality of general surgery, including elective abdominal surgery

Competence based progression

- 6-8 years

Flexible Academic Training

Generic “Professionalism” Training
Economic Analysis

• Supported by University Hospitals of Leicester NHS Trust
• Annual (total) cost of a surgical trainee £198,000
• Costs of the extra non medical workforce largely offset by savings in Locum costs
Timeline

- **Report submitted 12th October 2015**
- **Autumn spending review**
- **HEE will respond to NHS England January 2016**
- **New HEE mandate March 2016**
- **Pilot ?? August 2017**