Summary of Plastic Surgery Specialty Advisory Committee Meeting 19/09/2018 & Joint SAC/Training Programme Director (TPD) Meeting 20/09/2018

The final triannual SAC meeting of the year was held at the Royal College of Surgeons of England on the 19th of September followed by the Joint SAC and Plastic Surgery Training Programme Directors meeting on the 20th of September. The meetings discussed a wide range of issue of relevance to plastic surgical trainees present and future.

1. SAC Membership
    a. Mr. Simon Wood (London) stepped down as the Plastic Surgery SAC chair as of the 20th of September 2018.
    b. He was replaced by Mr. Maniram Ragbir (Newcastle) as the new chair of the SAC and as a consequence he would be giving up his roles as National Selection Lead and Deputy Chair of the SAC. These roles will be appointed to after internal committee consultation.
    c. Professor Ian Whittaker (Swansea) was proposed as the Academic Representative to the SAC.
2. Curriculum Update
    a. Mr. Simon Wood updated the SAC on the current state of the Plastic Surgery curriculum development. The SAC has been charged by the JCST to in essence update the Plastic Surgery Curriculum in line with GMC document "Excellence by design" (pdf attached). The curricula must be shown to be meeting the themes of the "Shape of training report" (pdf attached). This would signify a move from assessment-based to a competency-based curriculum.
    b. The curriculum is currently in Stage 1 of development with the initial proposals to be submitted to the GMC by October 2018.
    c. As per the original timeline all medical specialties were to update their curricula by 2020 but the SAC was informed that this date has already been pushed to 2021 and possibly may be subject to further delays.
    d. From a trainee perspective things are likely to remain unchanged in the near future and once further updates are available they will be circulated to the membership
3. CCT research requirements
    a. The GMC and JCST are moving to standardise research requirements for the purposes of achieving CCT across all surgical specialties. This means finding the lowest common denominator across the specialities that would be acceptable to all.
    b. Current proposals (pdf attached) have 3 section requirements of which sections 1 and 2 apply to all plastic surgery trainees and section 3 applies to academic trainees.
    c. The committee agreed with contents of sections 1 and 3 but generated considerable discussion around section 2.
    d. The committee acknowledged that section 2 requirements are not robust and would signify a retrograde step compared to current CCT research requirements for plastic surgical trainees.

e. The committee will respond to the JCST/GMC requesting that each subsection of section 2 should relate to a separate piece of work i.e. publications, presentations and higher degree research work arising from a single project can only be counted once as either publications, presentations or higher degree and not separately under each subsection

4. Elogbook update
    a. Mr. Rob Winterton updated the SAC on issues relating to elogbook. Clarification was provided on the following issue of relevance to trainees:
        i. Indicative numbers
            1. Lymphnode surgery remains an area for the most inquiry regarding indicative logbook numbers. It only includes bloc dissection numbers (Axilla, groin, neck) and does not include SNB. The committee recognises that number of bloc dissections being performed nationally is reducing due to change in clinical practice and opportunities for trainees to undertake these procedures is reducing. Going forward the committee is considering the following 3 options:
                a. Keep the total lymphnode surgery number unchanged at 15 and accept that trainees might not be able to achieve these
                b. Keep the total lymphnode surgery number unchanged and include assisting and observed procedures in addition to P, SU, SS
                c. Reduce the total number for lymphnode surgery (say hypothetically to 10)
                d. Include SNBs as well as blocs and raise the overall number for lymphnode surgery (say for example to 30).
        ii. Unbundling & Coding of supervision
            1. Unbundling and supervision coding information is attached (pdf attached).
5. Less than full time training (LTFT) update
    a. Miss Tania Cubison updated the committee on issues relating to LTFT.
    b. Of particular note the SAC has provided strict guidance to local TPDs that WBA requirements for ARCP cycles should take into account LTFT i.e. a trainee working at 80% LTFT should be required to produce 80% of annual WBA requirements.
    c. Miss Cubison also informed the committee that she is arranging a local Yorshire/Humber LTFT meeting to bring together trainees and discuss their concerns and issues.
6. Simulation in Plastic Surgery
    a. Ms Mohanna updated the committee on developments in making simulation more accessible to trainees at a local level.

b. She informed the committee that there is funding available through PLASTA for setting up microsurgical surgical simulation at local unit level to the tune of up to £3000 which can be used towards the cost of equipment e.g. microscope.
c. There is currently a simulation model for cleft surgery training, which is in the final stages of development.

7. National recruitment in Plastic Surgery Training
    a. Mr Ragbir updated the committee with the results of the last round of National Recruitment to Plastic Surgery Higher Surgical Training.
    b. Salient points of the report included:
        i. 23 NTN specialty trainees were appointed immediately following the interviews whereas 8 more NTNs have been released and appointed since the conclusion of the interview process.
        ii. Of the appointees 35% were appointed directly from Core Training (CT) Programmes where as the remainder were from non-CT programmes.
        iii. Only 1 trainee with more than 7 years of post graduation experience was appointed.
        iv. 6 trainees already holding an NTN reapplied to national recruitment. Of these only 1 was appointed.
8. PLASTA report/issues
    a. I informed the committee on the changes in the structure of the PLASTA committee following elections in July 2018 and our efforts to engage trainees at a local level.
    b. Specific concerns highlighted to the committee and discussed are as follows:
        i. Study leave funding
            1. Since the centralisation of study leave funding by HEE there were concerns from plastic surgery trainees that there was only 1 course listed as "mandatory" curricular requirement i.e. ATLS. This was in contrast to other subspecialties in surgery, which had far more mandatory courses and hence more assured funding to complete these courses.
            2. The committee did agree with the trainees concerns and will work to include EMSB, cadaveric flap course, microsurgery course and fracture fixation course on the mandatory list.
            3. However trainees must understand that once these courses are marked as "mandatory" they will be an essential requirement for CCT.
            4. Furthermore if in future the funding situation changes and HEE is unable to fund "mandatory" courses this will not change the status of these courses being mandatory for CCT i.e. trainees may end up having to fund these courses themselves in order to gain CCT.

ii. Aesthetics
    1. Training
        a. The committee holds the view that study leave should not be used to attend aesthetics training i.e. clinics and operating lists. These opportunities are considered as training requirements and as such LETBs/deaneries should make arrangements for trainees to attend them without having to sacrifice study leave.
        b. The committee chair and membership would like more evidence to document the variations in current provisions of aesthetic training across the UK and would like to base future guidance based on such evidence.
    2. Independent injectable practice by trainees
        a. The SAC stand on this issue is as follows:
            i. Trainees must declare any independent work undertaken in the realm of aesthetic practice at the time of their ARCP. This should be declared clearly on the form R. Failure to disclose such practice would leave them open to being brought up on probity charges.
            ii. The ARCP process will not appraise the independent aesthetic practice of the trainee.
            iii. Trainees should not be penalised at the time of ARCP for undertaking independent injectable practice as long as this practice is declared and all training requirements are fulfilled i.e. if a trainee meets all the requirements for ARCP Outcome 1 this cannot be downgraded based on undertaking aesthetic practice alone.

iii. Leadership course
    1. Proposals for a 1-day leadership course specifically designed to meet the CCT leadership requirements were prepared by PLASTA committee member Karen Lindsay and were presented to the SAC.
    2. The SAC were enthusiastic about the course proposal made by the Healthcare Leadership Academy that would provide access to pre- and post-course development plan, a face-to-face delivery of the course as well as additional login access to online space.

3. Mr. Ragbir did however raise the point that many LETBs do offer leadership development courses locally and free of cost. It would be worthwhile to gain an idea as to the current status of local leadership training provisions across the LETBs.

iv. Fellowships

1. The committee understands that there is regional variation in whether trainees are allowed to go on pre-CCT fellowships or not. A even within regions that allow trainees to proceed on pre-CCT fellowships there is a two-tier system for TIG and non-TIG fellowships.
2. As a rule the committee recognised the value of pre-CCT fellowships and is supportive of trainees going on pre-CCT fellowships.
3. The SAC recognised a need for a level playing field nationally and data needs to be presented to them with respect to regional variations in fellowship opportunities for trainees.

9. GMC survey report 2018
    a. Generally good report across all domains of the survey from the Plastic Surgery trainees.
    b. Northern Ireland identified as a negative regional outlier and the committee will gain further information from regional contacts regarding any persistent concerns from trainees.
10. Training Interface Groups Update
    a. Breast Surgery
        i. No concerns identified
    b. Cleft Surgery
        i. No concerns identified
    c. Hand Surgery
        i. A move from the TIG to place Plastics trainees to Orthopaedic Hand Surgery heavy units and vice versa. This created a situation with recruitment in the last round that resulted in Leeds not being allocated a TIG Hand Fellow. This was a unique situation and should be rectified by the next round.
    d. Head and Neck Surgery
        i. Only 2 plastic surgery trainees applied to the H&N surgery TIG and both were appointed.
    e. Reconstructive and Aesthetic Surgery
        i. A moratorium has been placed on recruitment to the RAS TIG until a curriculum has been approved by the GMC. At earliest this approval is anticipated by March 2019 with a potential interview for RAS TIG Fellows in September 2019 for 6-month fellowships to commence in January 2020.
11. CESR and CESR(CP) Training routes for trainees who complete their core training outside the UK

a. The committee discussed the plight of trainees who've been appointed to NTNs after having undertaken core surgical training outside the UK, e.g. Republic of Ireland. In these cases the GMC may not retrospectively recognise the core surgical training even though they have been appointed to an NTN via national recruitment. As consequence these trainees can still complete their Higher Surgical Training but will not be awarded a CCT. They would instead be eligible to apply for Certificate of Eligibility for Specialist Registration Combined Programme [CESR(CP)]. Within the UK, there's no difference in the recognition of a CESR(CP) and a CCT. Both certificates allow specialist registration on exactly the same terms. However outside the UK there may be restrictions on practice. Trainees should be provided this information and support as early as possible preferably before they take up an NTN.