

ACPGBI Education and Training Committee

Minutes of Teleconference, Thursday 6th October 2011 8.30pm

Participants

John Hartley – Chair (JH)

Austin Acheson (AA)

Dermot Burke (DB)

Justin Davies (JD)

Sharad Karandikar (SK)

Mike Lamparelli (ML)

Nuha Yassin (NY)

Jonathan Reynolds (JR)

Humphrey Scott (HS)

1. Apologies

Anne O'Mara (AOM)

Ruth McKee (RM)

Rupert Pullan (RP)

2. Minutes of meeting June 2011

These were accepted without alteration.

3. Matters Arising

MDT Training

AA and ML reported that the LOREC programme had been extended with funding to train another 28 MDT's. JH reported that he had spoken to Nigel Scott regarding the committee's suggestion that the didactic component of the LOREC training programme might usefully feature within the ACP's national meeting.

Endoscopic ultrasound training

JH informed the group that subsequent to the June meeting he had been in further dialogue with Andrew Williams. JH reported that a syllabus was ready to be posted in the CME section of the Education and Training webpage, and that additional introductory and course material was in an advanced stage of preparation. Andrew Williams had reported he was awaiting input regarding changes to the ACP website, since some of his course material might be impacted upon by any such changes. JH informed the group that he had spoken with AOM earlier in the week regarding the tendering process for revisions to the ACP website. Following meetings with the competing tenders in London in late September, the number of competing bodies had been cut from 3 to 2. A final decision was anticipated to be made within the fortnight, however it seemed unlikely that any significant revamp of the website as a whole would occur until well into 2012

Action: JH to feedback to Andrew Williams with regard to timing of any website changes.

Recognition of overseas fellowships

JH reminded the group that the title of the form produced by DB should be altered to reflect the fact that overseas experience could be undertaken as an OOPE or post CCT. JH and DB agreed to ensure Yorkshire trainees who had recently returned from overseas completed the form, and JH asked that other members of the group undertake to do the same in their own regions. In addition JH suggested to the group that a list of available overseas fellowships be compiled and posted on the website pending prospective collection of the above information. The group felt that this would be a worthwhile process. JH and JD agreed to produce a paragraph regarding their own experience overseas

Action: JH to produce a list of known overseas fellowship opportunities and post on the webpage. JH and JD to provide a short summary of the Cleveland and Toronto fellowships for the benefit of trainees interested in such opportunities and these to be posted on the webpage.

Survey of provision of training in coloproctology – regions vs deaneries

HS had led this survey and reported to the group. This survey consisted of 5 questions sent to ACP Chapter Representatives which aimed to map Deaneries against ACP Chapters, and survey provision of educational and training opportunities by the Chapters, as well as involvement of Chapter Representatives with regional SPR training in coloproctology. HS reported that responses had been received from 15 of 20 ACP Chapter Reps. There was general discussion around the preliminary results of this survey which HS had circulated prior to the meeting. The survey was acknowledged to be a work in progress. Emerging themes were that most Chapter Reps involvement in training was restricted to that within their Trusts. The Deaneries were noted to provide regional teaching. Concern was raised that this was generic and based on what was available rather than focussed on delivery of the curriculum. Chapter Reps who sat on regional training committees and worked closely with deaneries appeared to be more engaged in delivering colorectal training.

HS reported on plans to complete this work by contacting deanery programme directors in order to survey delivery of regional teaching and colorectal content. Longer term it was hoped that this work might inform discussion as to ways to promote delivery of the colorectal curriculum nationally.

Action: HS to chase up non-responders and commence survey of Deanery Programme Directors.

PBA's in Coloproctology

JH reported that Bill Allum had asked the committee to produce PBA's for abdominoperineal excision of the rectum and surgery for pilonidal disease. This request was the result of a number of enquiries from trainees. ML and JH had produced draft PBA's for APR and pilonidal disease respectively. JH had forwarded these to RM for comment, and would forward them to the SAC after appropriate revision.

Action: JH to revise PBA's as necessary and submit to the SAC on the committee's behalf.

Work for 2011/12

JH reported to the group that units around the UK would be contacted this month asking them to submit information for colorectal unit recognition, according to the 2009 criteria set by this committee. The autumn newsletter had contained preliminary notice to members that this work was about to get underway.

4. **Award for E Grand Rounds**

NY reported that this had been advertised through the Dukes' Club website and had stimulated interest. There was discussion regarding the most appropriate means of assessing the case reports submitted before September 2011 for the award of best E Grand Rounds presentation for 2011. JD and DB had taken the lead on review of submissions up to this point. JH suggested that he and one other member ought to join JD and DB in reviewing submissions and independently rank them before reaching a consensus. JR volunteered to assist in the process.

Action: JH to circulate submissions to JD,DB and JR for marking.

5. **Request for endorsement of educational website www.gastrotraining.com**

JH informed the group that a request had been made that ACP recognise this site and link to it, presumably through their E and T webpage. The group had received opportunity to review the site before teleconference. JD opened discussion and pointed out that although visually impressive the site's colorectal surgical content was some way below that which would be expected of a higher surgical trainee. There was unanimous agreement on this point. JH agreed to feedback to the submitting author that ACP did not feel it would be appropriate to support this portal in its current form.

Action: JH to feedback to the physician responsible for the site.

6. **GMC recognition of colorectal surgery as a subspecialty**

JH reported that he and Nigel Scott had appeared at the GMC in January on behalf of ACP in support of an application process for subspecialty

recognition for colorectal surgery. Although that meeting had been felt to be successful the process had stalled over the requirement that opportunities for subspecialty training and accreditation must be accessible to surgeons who are CCT holders. ACP Council in June had voted unanimously in favour of continued efforts to gain subspecialty recognition for colorectal surgery, and the Presidents had petitioned the SAC asking for their support in this process. As a result ACP represented by the President, Karen Nugent and JH had met with the ASGBI Executive, the Chairman of the SAC (Bill Allum) and President of AUGIS in London on the 20th of September. At this meeting it was agreed that the process for subspecialty recognition should be re-established. The significant concern at that meeting was that the CCT will be in general surgery with a subspecialty interest, and that future CCT holders must be capable of dealing with an unselected take in general surgery. The SAC Chairman asked that the specialty societies task their education and training committees to review their previous submissions to the GMC with the particular aim of ensuring that competencies required for the award of CCT were realistic, and that the submitted curriculum was realistic in terms of the requirement to deal with an unselected take.

7. Review of previous curriculum submission to GMC

The previous curriculum submission had been received from the SAC and circulated to the group 48 hours prior to the meeting. This is an extensive document which it was recognised that the group had not been able to review in detail. A letter from the SAC asked three things of the E and T committee; firstly that the subspecialty curriculum should be reviewed to ensure that the competencies were realistic in terms of achievement at the award of CCT, secondly to review the index procedures for colorectal and ensure that these were appropriate, and thirdly to review the elective and emergency general surgery component of the curriculum and ensure that these competencies were achievable within the context of 4 years (ST 5 to 8) focussed training in GI surgery of which 1 year would be upper and 3 years lower GI with exposure to an unselected take during each of those years. In

order to inform discussion the SAC had forwarded the results of a survey of consolidation sheets for the 20 trainees awarded a CCT in 2011, 8 of whom had expressed a colorectal interest. The numbers of index procedures in colorectal surgery were agreed to be worryingly low. In addition the number of emergency laparotomies which had been performed by the trainee prior to award of CCT was agreed to be particularly worrying. It was accepted that this was a small survey and that ongoing work was underway by the SAC, but there does appear to be a real issue as to whether the current CCT is fit for purpose.

JH informed the group that on first reading the specialty component of the curriculum appeared to be broadly realistic with the possible exception of less frequently performed procedures such as ileal pouch surgery (currently a requiring level 4 operative competency at CCT), surgery for pre-sacral tumours and TEMS excision. The group accepted that it was probably unrealistic for trainees to be proficient in these less frequently performed procedures at the award of CCT. It was agreed that the committee would work in pairs to review the sub-sections of the specialty curriculum over the next fortnight in order to allow JH to submit comments to the SAC by the end of October.

There was broad discussion regarding the index procedures which were felt to be largely acceptable. It was suggested that APR should be added as the term anterior resection were open to interpretation and a number of anterior resections might not give an insight to the trainees exposure to a significant rectal cancer practice.

The curriculum for emergency surgery had been briefly reviewed by JH and JR both of whom felt that the trauma curriculum was aspirational and beyond the scope of current general surgical training. It was recognised that this curriculum may have been developed for a possible subspecialty of trauma and/or vascular surgery which may in time, therefore, with the development of trauma centres become relevant. However, at present given that trainees are being awarded CCT with only a handful of trauma laparotomies having been performed (as evidenced by the survey of consolidation sheets for

recently awarded CCT holders) it was deemed unrealistic. JR agreed to review this section in detail and come back with comment for the SAC.

Action: JH to circulate individual components of colorectal subspecialty curriculum to the group for comment. JH and JR to review the emergency surgery and trauma curriculum. Comments to be returned to SAC and presented to Council and Executive.

8. **Endoscopy training document from AUGIS**

JH had circulated a document on endoscopy training for surgical trainees which had been received from Bill Allum. This document was the result of prior collaboration between AUGIS and ACP, had undergone alterations by AUGIS in recent weeks and was being passed back to ACP for final comment. Key recommendations were that there should be equal access to GI endoscopy training for surgical and medical trainees, and that there should be a single process for the training and assessment of GI endoscopy. There was general discussion regarding difficulties experienced by the group in both the delivery of, and access to (NY), endoscopy training. This document was agreed to be of great importance and was passed without further amendment.

Action: JH to return document to Bill Allum.

9. **Any other business**

DB presented his Tutor's Report. There had been a very successful Specialty Skills In Coloproctology Part I course held at the RCS in September. This practical course was full with 15 delegates, informal feedback at the time from delegates and faculty had been good. Formal feedback analysis was awaited. The Part I and Part II courses will be run again in early 2012. DB reported on plans to develop a course in pelvic floor disorders to add to the colorectal portfolio at the RCS.

10. **Date and time of next meeting**

Early December – date and time TBC.

John Hartley

Hull, October 2011