The Specialty Advisory Committee (SAC) in General Surgery is tasked with ensuring that UK and Ireland trainees complete their training with a CCT in General Surgery, which implies competence across the general surgery curriculum at least to the stage where the trainee has achieved competence in managing the general surgery take unsupervised. The SAC needs to ensure that trainees emerging from their training are fit to fulfil the needs and requirements of the Health Service.

Two major elements now force a re-examination of the way in which general surgery is certified. Firstly the EWTD, New Deal and MMC all act to shorten the time available for training, to the extent that it is no longer possible to train to a standard of competence across the whole spectrum of general surgery. Trainees moving to a full shift on call system for 48 hour compliance in August 2009 will lose approximately 25% of their current elective training time. Secondly, the requirements of the NHS are changing, partly though patient demand for more specialist expertise and partly through the need and desire to focus expertise in particular sub-specialty areas in order to improve outcomes (eg breast and GI cancers, aortic aneurysm surgery).

An analysis of consultant posts advertised in the BMJ online in May 2009 showed 16 vacancies, as follows:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgeon</td>
<td>0</td>
</tr>
<tr>
<td>General + UGI</td>
<td>2</td>
</tr>
<tr>
<td>General + colorectal</td>
<td>2</td>
</tr>
<tr>
<td>General + Breast surgeon</td>
<td>4</td>
</tr>
<tr>
<td>Colorectal surgeon (laparoscopic)</td>
<td>2</td>
</tr>
<tr>
<td>UGI surgeon (intestinal failure)</td>
<td>1</td>
</tr>
<tr>
<td>Vascular surgeon</td>
<td>2</td>
</tr>
<tr>
<td>General + oncology (sarcoma)</td>
<td>1</td>
</tr>
<tr>
<td>Renal transplant surgeon</td>
<td>2</td>
</tr>
</tbody>
</table>

All posts specified a sub-specialty interest and participation in emergency general surgery was not required/optional for all 4 breast posts. Neither of the 2 vascular surgeon or 2 renal transplant posts required participation in the general surgery emergency rota as they would take part in a separate vascular or transplant rota. Indeed a majority (around 80%) of the UK and Irish population now have access to a 24/7 vascular surgery emergency service separate from general (GI) surgery.
These data question whether it is any longer essential to train breast, transplant and vascular trainees to be able to cope independently with the general (GI) surgery take, unless they wished to train in it as an option, for example by spending a minimum of one year each in UGI and colorectal surgery during their training. Likewise, is there any need for GI trainees to spend time training in breast or vascular surgery beyond the ST4 level? Undoubtedly there are significant benefits to obtaining an understanding of different sub-specialty areas in the early years of higher surgical training, but in reality most SpRs today have already selected a sub-specialist area by the end of year 3 and focus on that area exclusively during their last 3 years of training. They must then sit an exit exam in the generality of surgery, where they are often questioned in areas they are not comfortable or familiar with and have no intention of practising in as a consultant.

It seems clear that the Health Service of the future will require more consultants with a defined sub-specialty interest, reflecting and building upon the current pattern. Should the training and expertise of these consultants be better defined by following a more sub-specialty defined curriculum in their later years of training and sitting a more sub-specialty focussed examination at the end, such that entry in the Specialist Register might read “CCT in General Surgery with a sub-specialist interest in……………..”?

This concept preserves the General Surgery label, allowing flexibility within the workforce against future non-surgical developments in any one sub-specialty area. It also implies a continuing examination in emergency care and critical care of the surgical patient, followed by a more sub-specialty specific exam. Patients will be reassured that the person they are seeing has had the necessary sub-speciality training to a high standard. Consultant advisory appointment committees would be reassured that their potential appointee truly has expertise in the required sub-specialty field and as such would be demonstrably fit for purpose given that there are few advertisements for a general surgeon without a sub-speciality interest nowadays.

It would still be possible to train in general surgery, but in effect in the modern era this means general GI surgery, offering a mixture of laparoscopic surgery, non-resectional UGI surgery, less complex colorectal surgery and emergency GI surgery. It is increasingly undesirable for general surgeons without the relevant sub-specialist interest to undertake breast, transplant or vascular surgery, particularly for those just starting out on their consultant career with far less “flying time” in training than their more senior consultant colleagues had.

All trainees would be expected to continue their commitment to the emergency rota throughout their training and to have their knowledge of the management of the emergency surgical patient tested in the Intercollegiate examination. Trainees wishing to participate in the emergency general surgery rota as a consultant must have spent a minimum of one year each in UGI and colorectal surgery during their higher surgical training, on top of any other specialty interest they may have.

It is proposed that general surgery trainees spend two years in ST3 and ST4 across the generality of surgery, as today, followed by a four year period of sub-specialty training (for UGI this would involve at least one year in colorectal and for colorectal one year in UGI in order to obtain emergency general GI surgery competence). The exit exam would become more sub-specialty specific, towards a sub-specialty suffix on the General Surgery Specialist Register entry, although it would still be possible to have the General Surgery CCT without a suffix. No major changes to existing training patterns are
anticipated, as the almost universal comment to these proposals from the specialist associations has been that these proposals simply reflect and formalise what is already happening on the ground. Formal application to PMETB for sub-specialty status is proposed for breast, colorectal, endocrine, transplant and UGI surgery (vascular surgery is applying for separate specialty status as it is already recognised as a mono-specialty in Europe).

This proposal has been debated and unanimously approved by the Councils of all the relevant specialty associations, including: Association of Upper GI Surgeons, Association of Coloproctology, Association of Breast Surgeons at BASO, British Association of Endocrine and Thyroid Surgeons, British Transplantation Society, The Vascular Society, Association of Surgeons in Training and the Association of Surgeons of Great Britain and Ireland. It has also been approved by the Joint Committee on Surgical Training (JCST) and by the JCST Executive, which includes all 4 Presidents of the Royal Colleges of Surgeons in the UK and Ireland.
2.1 a) A proposed sub-specialty cannot be one which is already a recognised Schedule 3 CCT specialty:

This application relates to the creation of five new sub-specialties of general surgery, namely breast surgery, colorectal surgery, endocrine surgery, transplant surgery and upper gastro-intestinal surgery. None of these sub-specialties are currently recognised as schedule 3 CCT specialties.

2.1 b) As a general rule, it will not be possible for several core CCT specialties to have sub-specialties with the same name. However, this may be possible where one sub-specialty is “shared” by a number of CCT specialties:

These proposals have been seen and agreed by all 9 surgical SAC chairs, who sit on the Joint Committee on Surgical Training, namely cardiothoracic surgery, general surgery, neurosurgery, oral & maxillofacial surgery, otolaryngology, plastic surgery, paediatric surgery, trauma & orthopaedic surgery and urology. No other CCT defined specialties have sub-specialties with the same name as those proposed.

**Breast Surgery:** There is a common body of knowledge, skills and competencies within the CCT specialties of general surgery and plastic surgery relating to breast reconstructive surgery after breast cancer operations, known as oncoplastic surgery. Modern breast surgery has adopted and adapted techniques and aesthetic principles from plastic surgery and is likely to continue to do so. Areas of generic knowledge and training between breast and plastic surgery are addressed by a joint general surgery and plastic surgery SAC interface group, which oversees 10 one year, pre-CCT oncoplastic breast fellowships each year, to which either breast surgery or plastic surgery trainees may apply. There are no current proposals for a breast sub-specialty in plastic surgery.

**Colorectal surgery:** There are no other CCT specialties applying for colorectal surgery sub-specialty status, nor are any anticipated in the future.

**Endocrine Surgery:** There are no other CCT specialties applying for endocrine surgery sub-specialty status, nor are any anticipated in the future. Some maxillo-facial and ENT surgeons undertake thyroid surgery but would not encompass the full range of endocrine surgery proposed.

**Transplant Surgery:** There are no other CCT specialties applying for transplant surgery sub-specialty status, nor are any anticipated in the future. Some urological surgeons do train in renal transplant surgery, but their numbers are small and there are no current proposals from urology to apply for a transplant surgery sub-specialty.

**Upper gastro-intestinal surgery (UGI):** There are no other CCT specialties applying for UGI surgery sub-specialty status, nor are any anticipated in the future.
Some thoracic surgeons undertake oesophageal surgery and often work in collaboration with UGI surgeons in this area, but there are no proposals to develop a sub-specialty from the cardiothoracic SAC. Oesophageal surgery is only a small part of the proposed UGI sub-specialty, which also encompasses gastric, pancreatic and hepato-biliary surgery. Some liver transplant surgeons do undertake complex hepatic and pancreatic surgery, but this would be encompassed under the common parent general surgery CCT.

2.1c) There should be a current or predicted future demand for such specialists in the health service. This should be supported by information on how many doctors are expected to apply for the sub-specialty training:

In England there are nearly 6000 consultant surgeons of whom nearly 1800 are general surgeons - breast, HBP, Upper GI, Lower GI, endocrine etc. Approximately 430 SAS surgeons are also registered as general surgeons. Apart from trauma & orthopaedic surgery, general surgery is significantly larger than all the other CCT defined surgical specialties. Although over 1800 SpRs in training are recorded on the table below, these figures need to be interpreted with caution following recent changes in the training system.

Surgery workforce census September 2007 England

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Consultants</th>
<th>Associate specialists</th>
<th>Staff grades</th>
<th>SpRs</th>
<th>SHOs</th>
<th>F2s</th>
<th>F1s/PRHO</th>
<th>Total</th>
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<tbody>
<tr>
<td>Total:</td>
<td>5,769</td>
<td>661</td>
<td>1,007</td>
<td>5,911</td>
<td>1,720</td>
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<td>77</td>
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<tr>
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<td>262</td>
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<td>4</td>
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<td>37</td>
<td>21</td>
<td>3</td>
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<td>Oral &amp; maxillofacial surgery</td>
<td>308</td>
<td>61</td>
<td>152</td>
<td>160</td>
<td>335</td>
<td>5</td>
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<tr>
<td>Plastic Surgery</td>
<td>261</td>
<td>23</td>
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<td>396</td>
<td>67</td>
<td>16</td>
<td>7</td>
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<td>Trauma &amp; orthopaedic surgery</td>
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<td>475</td>
<td>360</td>
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<td>426</td>
<td>103</td>
<td>60</td>
<td>151</td>
<td>1,458</td>
</tr>
</tbody>
</table>

Breast: Over the last 20 years breast surgery has evolved to a point where it is now viewed as a major sub-specialty of general surgery. The knowledge and skills
required to practice modern breast surgery have resulted in increasing sub-
specialization in both training and service delivery such that new consultants are
now appointed as pure breast surgeons with minimal or no general surgical
commitment. The main driver for breast sub-specialization was the introduction of
the national breast screening programme in the late 1980’s. It is likely sub-
specialization will be further driven by revalidation. Specialist breast care has been
shown to improve patient experience and outcomes. In the recent NHS cancer
patient survey of 2002, ‘Breast’ scored highly (in comparison with other tumour
groups) regarding patient experience and this is in the main due to a focused
speciality identity and a well organized and mature multidiscipline structure – all
driven by the specialty. The breast service model is seen as the beacon for cancer
services in general and other tumour groups emulate it. Over the last 10 years the
specialty, through rigorous national audits -NHSBSP (screening) and BCOMM
(symptomatic) – has driven up the quality of care by encouraging the translation of
specialist standards to a national service. UK breast specialty development leads
most other countries where care is fragmented and mainly delivered by non-
specialist surgeons.

The association of breast surgery (ABS) has a total membership of over 635 of
whom surgeons comprise nearly 500. Consequently ABS membership represents
approximately 27% of the general surgical workforce. This is likely to be an under-
representation of the true numbers of surgeons offering breast as not all UK breast
surgeons are registered with ABS. Revalidation is likely to increase specialist
society membership so that it more accurately represents specialty workforce
numbers. Mammary Fold, the breast trainee forum, has 236 members of whom 144
are specialist trainees; 70 in the final 3 years of training. Mammary fold
membership therefore represents approximately 15% of the general surgical
trainees in higher specialist training. Once again this may under represent the true
numbers of surgeons interested in training/practicing in breast surgery but none the
less this suggests a future consultant shortfall, especially as over 180 (36%) of the
ABS members are due to retire in the next 10 years (retirement at 65yrs; if taken at
60 years the figure is 50%). Women make up 8% of the current consultant general
surgery workforce but 26% of general surgery SpR’s are female. Anecdotal
evidence suggests this gender-shift is more pronounced in breast surgery than
general surgery as a whole. Domestic responsibilities and commitments mean they
will not want or be in a position to offer full-time work especially in their early years
of consultancy. These factors suggest a potential need for increased numbers of
trainees entering breast surgery in the future.

Colorectal: Colorectal surgery is an important part of general surgery, since a
large part of the emergency general surgical take is for colorectal problems.
Colorectal surgery is a popular choice amongst trainees. A recent survey of over
70 SpRs in the South West general surgery training programme showed that
almost 50% of them were interested in a colorectal sub-specialty interest. There
are a number of issues that are pushing colorectal surgery into a subspecialty role.
The most important of these is colorectal cancer. The DH is fully committed to a
specialist agenda in the management of cancer and through the peer review
process has set about recognising units and in particular individual surgeons as
being recognised as a specialist with the skill and back up necessary to treat
colorectal cancer. Future appointments will require that the appointee can
demonstrate appropriate training in colorectal surgery and the management of colorectal cancer. For this reason it is inevitable that there will be continuing demand to surgeons trained in the subspecialty of colorectal surgery.

**Endocrine Surgery:** It is anticipated that there will continue to be a demand for endocrine surgical specialists in the health service as evidenced by the recognition of the specialist association by the DH, ASGBI, Intercollegiate exam board and the Cancer Peer Review process. Two to three endocrine surgery consultant appointments a year in England are expected and enough trainees entering the system to match this need. In the case of endocrine cancers, a critical mass of expertise and large MDTs are required so the work tends to flow to cancer centres rather than cancer units. Typically there is one big cancer centre for each health region but significant numbers of non-malignant cases are also done in the DGH setting by endocrine/general surgeons who have also trained in other surgical subspecialty areas.

**Transplant:** There are currently 24 renal transplant units (of which 8 also do pancreas transplants) and 7 liver transplant units. The recommendations of the Organ Donation Taskforce which reported in January 2008 plan for a 50% increase in donors over 5 years which translates into 1700 extra transplants per year. It is therefore likely that there will need to be some growth in consultant numbers to meet this need. In order to fill the likely number of consultant jobs it is predicted that there should be 5 kidney transplant trainees and 1-2 liver transplant trainees entering training each year.

**Upper GI:** Upper gastro-intestinal surgery embraces oesophago-gastric (OG), hepato-biliary-pancreatic (HPB) and bariatric surgery (surgery for morbid obesity), including surgery of the spleen. It involves both benign and malignant conditions, resectional and reconstructive surgery including laparoscopic and other minimally invasive procedures. AUGIS represents this subspeciality under the umbrella of the Association of Surgeons of GB&I and includes the British Obesity and Metabolic Surgical Society (BOMSS). All surgeons are fully trained ‘general surgeons’ and normally participate fully in a ‘general surgery’ on call rota. Most larger units in big hospitals have further sub-specialised their elective activity into HPB, OG or bariatric surgery and in some very large centres emergency activity has also been split into upper and lower GI surgery.

There is now no longer any doubt that all the major oesophago-gastric and hepatobiliary-pancreatic resectional surgery should be (and in the main is) carried out by surgeons with a subspecialist interest, within larger units with high volume throughput. This is heavily supported in the literature and more recent guidelines regarding high volume centres/surgeons and the improvement in outcome (SIGN guideline No. 87 for oesophago-gastric cancer 2006 [www.sign.ac.uk](http://www.sign.ac.uk)) and the Department of Health Guidance Document on ‘Improving Outcomes in Upper gastro-intestinal cancers’ 2001. There are however further data now becoming available to suggest that there is also a volume/outcome relationship with less major surgery (anti-reflux, bariatric and cholecystectomy) all of which would further support the recognition of upper GI surgery as a distinct ‘sub-specialty’ within general surgery.
In highly specialised units there is a regular demand for surgeons with sub-specialist training in upper GI surgery and this is unlikely to change in the foreseeable future. In other hospitals without specialist upper GI cancer surgery there is a perceived need for a broadly trained upper GI surgeon to provide general upper GI services. These surgeons will have training in both oesophagogastric surgery and HPB surgery, including laparoscopic surgery. Bariatric (obesity) surgery is becoming much more prevalent as a result of the obesity epidemic, and surgery is currently the only successful treatment for severe obesity which decreases morbidity and mortality. Bariatric surgery is performed by oesophagogastric surgeons in the main. This surgery is performed in larger and medium sized hospitals. Upper GI surgery is popular with trainees second only to colorectal surgery and accounting for around 20% to 25% of trainees declaring a specialist interest. It is known to be a competitive sub-specialty as the number of posts which involve performing major cancer surgery at major centres is relatively small.

2.1 d) The application must clearly state which Royal College / Faculty or other relevant body is responsible for developing and administering the sub-specialty training, and which CCT specialty it will form part of:

All five sub-specialties proposed will form part of the general surgery CCT specialty. Trainees will continue to have a broad early training in general surgery and will be expected to complete intermediate general surgery training in ST3 and ST4 and also to complete final stages training in emergency and general surgery as specified in the ISCP curriculum (http://www.iscp.ac.uk/Syllabus) for years ST5 to ST8. They will be expected to be on call for general surgical emergencies for at least 4 years of their STR training. Responsibility for training lies with the Royal Colleges of Surgeons, developed and administered through the Joint Committee on Surgical Training (JCST) and the Specialist Advisory Committee (SAC) in general surgery.

2.1 e) If the sub-specialty is shared by two or more CCT specialties, these should be listed. If these are run by different Royal Colleges / Faculties or other bodies, the leading organisation for sub-specialty should be specified, with evidence of clear support of all of the proposals from the others:

No other Royal Colleges/Faculties or other bodies share the proposed five sub-specialties. Some training in breast reconstruction surgery after cancer is undertaken jointly with the Plastic Surgery SAC, there is also an interface between oesophagogastric surgery and cardiothoracic surgery for training in oesophageal cancer surgery for thoracic surgeons. Some transplant surgeons enter the specialty through Urology. Some otolaryngeal surgeons and maxillo-facial surgeons undertake endocrine surgery, but mainly confined to the thyroid. None of the relevant SACs outside general surgery have proposed sub-specialty development in the proposed areas of general surgery.
2.1 f) A proposed sub-specialty should reflect a discrete body of knowledge, skills and competencies sufficiently distinct to justify its creation. A statement must be provided as to why the demand for the sub-specialists cannot be met through existing specialty and sub-specialty arrangement:

Two major elements now force a re-examination of the way in which general surgery is certified. Firstly the EWTD, New Deal and MMC all act to shorten the time available for training, to the extent that it is no longer possible to train to a standard of competence across the whole spectrum of general surgery as there simply isn’t enough time available. Trainees moving to a full shift on call system for 48 hour compliance in August 2009 will lose approximately 25% of their current elective training time and so need to focus on one or at most two sub-specialty areas of general surgery in order to achieve competence to CCT level in them. Secondly, the requirements of the NHS are changing, partly though patient demand for more specialist expertise and partly through the need and desire to focus expertise in particular sub-specialty areas in order to improve outcomes (eg breast and GI cancers, aortic aneurysm surgery).

**Breast:** Breast surgery, mainly but not exclusively, serves the needs of breast cancer. It is a high volume specialty and needs to attract and retain a large percentage of surgical trainees. Existing specialty and subspecialty training is rapidly adapting to offer the full range of specialist skills required by a modern breast surgeon. It is now widely acknowledged that a specialist breast surgeon requires a minimum of 3 years training which cannot be obtained in a 4-5 year SpR training programme without sub-specialty training in specialist units. As other branches of general surgery also become more specialized it is increasingly difficult to offer specialist training outside of a specialist breast unit. EWTD and new deal have considerably restricted training time which now has to be specialty focused if not specialty specific in order to achieve competency to consultant standard in the time available.

The depth of knowledge and range of skills and competencies required to practice modern breast surgery now require extensive subspecialty training as reflected in the breast education and training portfolio developed and delivered by the specialty through the RCSEngland and leading specialist Units - it is one of the most heavily subscribed surgical programmes with over 500 participants in the last 10 years. NEW START, the UK sentinel node training programme is another specialty initiative, which is unique in surgical training in that the whole team as well as the surgeons training was validated so ensuring patient safety during the learning curve.

The national mastectomy and breast reconstruction audit has identified gaps in access to reconstructive surgery – this already being addressed through other training initiatives developed in conjunction with the Breast/plastic interface group and the highly successful nine national Oncoplastic fellowships which are now in their 6th year having successfully trained nearly 50 Oncoplastic consultants.

**Colorectal:** Colorectal surgery reflects a discrete body of knowledge. The basis of this is firstly anatomical; the specialty being defined as pertaining to diseases of the colon, rectum and anus. Secondly, colorectal surgeons deal with a variety of conditions affecting these organs and are not just defined by treating one disease
process. Thus a colorectal surgeon will have expertise in treating cancer, inflammatory bowel diseases, functional disorders and anorectal diseases. The older distinction of a surgical oncologist as some one who treats cancer surgically has given way to a more specific role dealing with a variety of conditions affecting the colon and rectum. The specialty of colorectal surgery is defined by the comprehensive ACPGBI curriculum, currently undergoing revision for the ISCP. This curriculum has been adopted by the European Society as the basis of colorectal surgery throughout Europe.

**Endocrine:** Endocrine surgery represents a discrete body of knowledge, skills and competencies and this is evidenced by our curriculum and proposals for a separate option to be examined on endocrine surgery in the intercollegiate exit examination in general surgery. Surgery of the thyroid, parathyroid and adrenal glands is highly specialised and technically complex and requires detailed knowledge of endocrinology well beyond that expected in other areas of general surgery. The physiological disturbances which may occur during and after endocrine surgery are potentially lethal if not managed by an expert familiar with these problems.

**Transplant:** Transplantation Surgery is already considered as a sub-specialty within General Surgery, although not formally recognized as such, hence this application. There is a distinct curriculum within ISCP for transplantation and a discrete body of knowledge, skills and competencies which is different from general surgery and its sub-specialties. Trainees can also elect transplantation as their sub-specialty interest in the Intercollegiate Exam. Furthermore there are two main types of consultant jobs in transplantation: those that have another specialty interest e.g. general surgery and transplantation or HPB surgery and transplantation; or those that have a pure transplantation job. All trainees will have a CCT in General Surgery, but there is logic to having the sub-specialty of transplantation surgery recognized to reflect both their training and subsequent consultant job. There will also be a likely benefit for health care providers and patients who will see that future consultants will be officially recognized as having been trained in general surgery and the sub-specialty of transplantation, whereas a the moment they are only recognized officially as having been trained in general surgery.

**Upper GI:** Upper GI surgery reflects a discrete body of knowledge which is anatomically defined by the organs of the upper gastrointestinal tract, specifically the oesophagus, stomach, duodenum, pancreas, spleen, liver and biliary tree. It is not common for surgeons being trained now to have a detailed experience in these anatomical sites other than if they are specifically training in this sub-specialty. However as most surgical emergencies relate to the GI tract all GI surgeons training now will have at least a year’s training in upper GI surgery, just as all upper GI trainees with undertake a year of coloproctology in order to achieve competence in dealing with general surgery emergencies. In Europe there is a specialist qualification in HPB surgery and it is a sub-specialty option within the Intercollegiate exit examination.
2.1 g) Impact on main CCT specialties, approved sub-specialties and other health professionals must be assessed and prove to be positive. Any changes to their training, numbers and working practices must be deliverable without adverse overall effect on service:

These proposals are an attempt to formalise and regulate a situation which has already developed in most NHS hospitals. A few small rural hospitals still require general GI surgeons capable of undertaking straightforward upper and lower GI surgery and there is nothing in these proposals which will prevent continuing to train in this field. The impact on the service will be minimal as the changes have already taken place informally.

Breast: Breast subspecialty approval will not have a detrimental impact on any other CCT specialty or subspecialty. Breast education and training is already delivered as a subspecialty within the general surgery CCT specialty framework and no conflicts have been noted. Increasingly breast surgeons demit from the emergency surgery rota after a few years’ consultant appointment- time and workload pressure making it difficult to remain competent in both spheres. Revalidation will drive this change further. A recent ASGBI consensus statement noted it was no longer appropriate for a breast surgeon who did not offer elective general surgery to remain on the emergency rota. In the future it is likely that more breast surgeons will demit from the on-call rota and general surgery services but this is likely to happen in any case and consultant expansion, particularly in GI surgery, is currently filling the gaps.

Oncoplastic surgery is now embedded and synonymous with breast surgery – especially with the younger generation of surgeons attracted by the challenges and skills required to practice this complex surgery. Generic training between breast surgeons and plastic surgeons who wish to subspecialist in breast reconstructive/oncoplastic surgery has been very successful and helped to break down professional boundaries – interdisciplinary partnerships and collaboration are now delivering a more patient focused service. Enhancing opportunities for specialist Oncoplastic training in breast surgery will improve the overall quality of care and outcomes as well as allow equity of access to reconstructive and breast aesthetic services in England. Plastic surgery is a small specialty and it is unlikely there will be the investment and expansion required to meet the oncoplastic needs of the large numbers of breast patients. The National mastectomy and reconstruction audit highlights the ‘postcode’ lottery of reconstructive services. Sub-specialty training will allow greater provision of oncoplastic skills across the UK. Such surgery is time consuming and manpower intensive often requiring 2 surgeons working simultaneously. Surgical time will need to be gained from other aspects of the breast service such as breast diagnostics and assessment. This is likely to increase the need for breast clinicians/physicians.

Colorectal: Colorectal surgeons are already working as a subspecialty, concentrating on diseases of the colon, rectum and anus. The impact of recognition of colorectal surgery as a sub-specialty of general surgery would be fairly minimal, as changes in practice have already occurred.
**Endocrine:** Minimal or no impact on existing services is anticipated as the sub-specialty is currently in existence.

**Transplant:** It is not envisaged that there will be any significant impact on the CCT specialties of general surgery and urology or of other health professionals. Sub-specialty training in transplantation surgery is already provided within the ISCP curriculum and this application is made to formalize and recognize what is already occurring in practice.

**Upper GI:** Upper GI surgeons are already working as a subspecialty and this is especially obvious in the large cancer centres. The impact of recognition of Upper GI Surgery as a sub-specialty of general surgery would be fairly minimal, as changes in practice have already occurred.

2.1 h) **PMETB will not approve a sub-specialty with the same name as one listed in the European Medical Directives as a specialty in which a specialist certificate is awarded in other EEA member states even though it is not a UK CCT specialty:**

None of the proposed sub-specialties is listed in Directive 2005/36/EC as a specialty. There is a specialty of Gastroenterological Surgery in many EU countries, but this is not the same name as colorectal surgery or upper gastro-intestinal surgery.

2.1 i) **Evidence of clear willingness from the health service providers to support and develop the sub-specialty should be submitted:**

To be attached.

2.1 j) **Application should elaborate on where within the postgraduate training it is considered appropriate to introduce the sub-specialty training and specifically whether it will be undertaken before or after CCT is awarded. Outline of the criteria for entry, assessment and successful completion of sub-specialty training should be presented:**

The general surgery higher surgical training programme currently takes 6 years to complete, of which 3 years are spent rotating around different elective sub-specialties within general surgery and gaining experience in emergency surgery. The latter 3 years then focus on sub-specialty training, following the relevant sub-specialty syllabus for higher training currently on the ISCP website and approved by PMETB. In all five proposed sub-specialties it is envisaged that the current system will continue and that sub-specialty training and training in emergency general surgery will be completed before CCT. In order to enter sub-specialty training, trainees must successfully complete the competencies specified in the ISCP curriculum for ST3 to ST5 training, as certified by a satisfactory RITA or ARCP assessment by the Deanery. Assessment will continue on a yearly basis through ST6 to ST8, as now and the trainee will be expected to pass the Intercollegiate Specialty Examination in general surgery containing sections on
emergency surgery, critical care and the relevant sub-specialty modules. Successful completion will be marked by satisfactory progress in the RITA/ARCP Deanery process with appropriate certification as well as success in the Intercollegiate examination.

2.1 k) If the sub-specialty is agreed and then later becomes a CCT Schedule 3 listed specialty, the two will have to be differentiated by different names and different training programmes:

This is understood and agreed by all 5 proposed sub-specialties.

Application completed by:

SAC in General Surgery
Association of Breast Surgery at BASO
Association of Coloproctology GB&I
British Association of Endocrine and Thyroid Surgeons
British Transplantation Society
Association of Upper Gastrointestinal Surgeons

Application approved by:

Association of Surgeons GB&I
SAC in General Surgery
Association of Surgeons in Training
Joint Committee on Surgical Training (JCST)
JCST Executive on behalf of RCSeng, RCSEd, RCPSG and RCSI