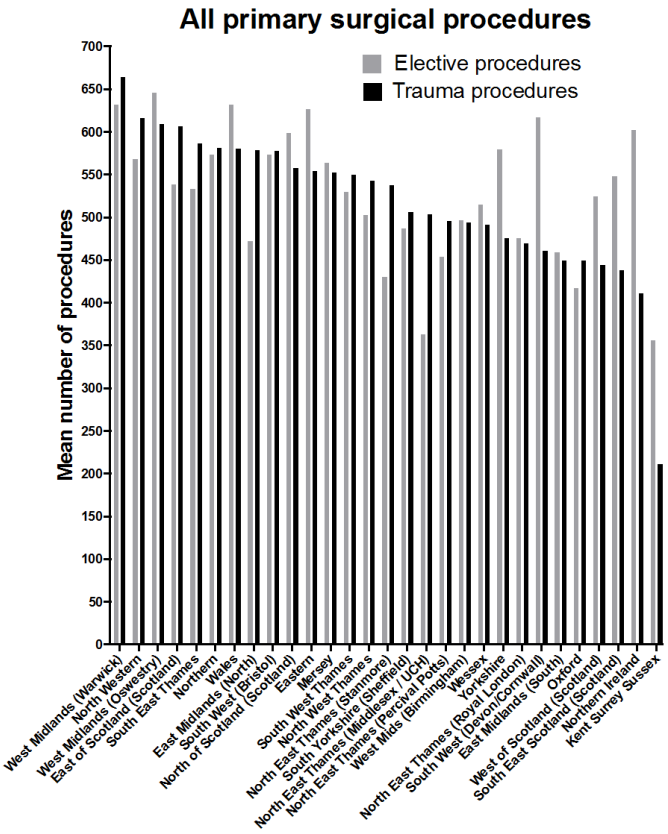
JCST

Joint Committee on Surgical Training

Specialty Advisory Committee
Trauma & Orthopaedics

Welcome to the 4th T&O SAC newsletter. As I had no adverse comments about the revised format of the last newsletter, I will continue using that format for the time being. The recent review of the structure and function of the SACs, which has been accepted by JCST and the college presidents, has placed a responsibility upon all SAC chairs to produce a newsletter following each SAC meeting. So far I have only managed 3 per year because of the time it takes to produce something which is, I hope, readable. A quarterly newsletter might have to be somewhat more brief.

The most recent SAC meeting included our annual review of the indicative numbers. The SAC are aware that this is an extremely sensitive issue and that any changes should only be made for very good reason. We reviewed data from the logbook, kindly supplied by Mr Mike Reed, clinical lead for T&O with the e-logbook, which showed that in terms of overall numbers, and for most indicative procedures that these were generally being met by training programmes. Even for 1st ray surgery, where the numbers are known difficult to achieve in some regions, the vast majority of programmes were achieving the target. From this point of view therefore the SAC agreed no changes to the current numbers.



The SAC also discussed the implications of a recent appeal court judgement in relation to a CESR application. The judgement effectively prevented the GMC from considering the paediatric experience of the CESR applicant on the basis that there was no indicative number that related to surgery in childhood. The SAC considered that this issue had to be addressed and therefore agreed that there should be one additional indicative number specifically related to paediatric orthopaedic experience. Discussions about what procedure this should be continue, but it is likely to be manipulation of a distal radial fracture in a child. While this should be readily achievable for all trainees, we are currently exploring how this can

best be recorded in the logbook. If it were to require the addition of a new procedure, it will take time before it can be reasonably counted. On the other hand if the indicative number can be calculated from age and the current procedure of manipulation of fracture of distal radius, then we should be able to implement the number fairly quickly.

The SAC are also aware that indicative numbers can induce target chasing behaviour such as unbundling of procedures. There is clearly a professional judgement that has to be exercised in deciding whether an operation should be recorded as one or more procedures. For example few people would disagree that one patient undergoing a femoral nailing and proximal humeral fixation under one anaesthetic should have that recorded as two procedures. On the other hand not everyone would agree that a metatarsal osteotomy combined with an Akin's osteotomy and a soft tissue correction should be counted as three procedures. I would hope that most people would count that as one procedure, but perhaps not all. A degree of consistency is important in this respect otherwise the numbers become meaningless. Validation of logbooks is the way of achieving this consistency.

Validation on paper, by signing the front cover of a report printed out many months after a procedure and just prior to ARCP, is not effective and merely says that the person signing the report believes, but does not know for certain, that the contents are true. Contemporaneous electronic validation, while clunky in its present form, gets round this issue. Therefore, the SAC want trainees to have all of their logbook cases validated electronically. Instructions on the current methods of validating operations electronically will soon be available on the logbook website, and as work takes place over the next year to improve the integration of ISCP and the logbook the process should become easier. Trainers should note that in validating a procedure in a trainee's logbook they are at the same time building their own logbook which should be useful when it comes to revalidation.

The SAC also discussed one further topic in relation to the CCT guidelines. That related to the evidence that should be present in a trainees portfolio in relation to competence in the reception and assessment and initial management of major trauma cases. In the current CCT guidelines the only thing relating to this is a critical condition CBD on the physiological response to trauma. The next revision of the curriculum, due in 2017, is likely to include some significant revisions in relation to trauma experience, and as a preliminary to this the BOA training standards committee, which is responsible for the curriculum, asked the SAC if they would consider as an interim measure introducing what would in effect be a critical CEX in this area. The SAC agreed that it would add this to the current CCT guidelines and start looking for CEX on the reception and assessment of major trauma in portfolios presented for CCT.

National selection. This year's national selection process was carried out in Elland Road stadium in Leeds between the 23rd and 26th of March. There was a 20% reduction in the number of applicants this year which was not entirely unexpected following the large number of appointments last year. This, combined with a determined effort to get enough interviewers so that 6 streams could be run on each day, meant that we were able to complete the process in just under 4 days. My thanks to all those who took part.

This year there are likely to be more than 200 jobs available, and with approximately 350 people interviewed the competition ratio is lower than it ever has been. This raises significant concerns as to whether or not all posts will be filled, and that some potentially weak applicants, scoring close to the cut-off point, might be appointed.

The method and timing of the determination of the cut off score last year caused a significant degree of disquiet. The methodology employed had resulted in some otherwise reasonably high-scoring candidates not getting posts. The degree of unhappiness in relation to this was such that one unsuccessful applicant took HEYH to the High Court challenging many aspects of last year's process. The legal challenge was successfully defended on all counts. In particular the judge said: the use of the Angoff methodology was legal; the use of a "killer" station was legal; and the post-hoc decision as to what methodology to employ was also legal. In particular the judge made it clear that in his view, on the grounds of patient safety, it was better to fail to appoint the odd good candidate than to risk appointing a weak and potentially unsafe candidate.

Given the very low competition ratio this year the method for determining appointability will have to be considered very carefully once scores are available. At the time of writing, no scores are yet available for review.

ISB | INTERCOLLEGIATE SPECIALTY BOARDS
and Joint Committee on Intercollegiate Examinations

FRCS (T&O). One of the many meetings that the SAC chair has to attend is the intercollegiate board meeting in relation to the specialty exam. The intercollegiate board is always on the lookout for new examiners. To see whether or not you are eligible please visit the exam board website, http://www.jcie.org.uk/content/content.aspx?iD=23 but in general you must have been a consultant for at least 5 years, working more than 5 PAs, have previous examining experience e.g. MRCS, and be in good standing with both the college and the GMC. There is also the opportunity, which you can arrange through the board offices in Edinburgh, to observe diets of the exam.

One final thing in relation to the exam. The SAC are of the view that it is inappropriate for people who have already sat the exam to be applying through national selection for appointment into ST3. We will continue to try and get this put into the person specification, but a critical step in this is to have the wording of the exam regulations changed which is anticipated in due course.

Membership of the BOA. The SAC discussed a letter from the BOA president concerning whether or not programme directors should be fellows of the BOA. While generally supportive of the view that programme directors should be fellows of the BOA, the SAC felt that it was in no position to mandate that. It should be noted, however, that the BOA owns the curriculum, and that there is a lot of useful information in relation to curriculum delivery on the BOA website. This is currently accessible to all, but may become password protected in future.

QIs for research. As many of you will be aware, JCST publishes a number of quality indicators for surgical training posts. A number of minor changes introduced a few months ago produced a flurry of discussion on Twitter. As part of that discussion it was pointed out that the Pink Book, which is now distinctly out of date, had included within it a model job plan for trainees which included time for research and audit. It was pointed out that the QIs for posts no longer contain such a specification. The SAC agreed that it would be appropriate to incorporate this into the QIs. A suitable wording has been submitted to the JCST quality assurance group, so hopefully you will see an appropriate update in relation to research in the near future.

AQP and surgical training. This had been discussed at the December SAC meeting in relation to the contract that BUPA/CSH had won for MSK services in coastal West Sussex. An update was received at the March SAC. In relation to the specific issues in Sussex, there is no longer a concern as BUPA/CSH have withdrawn from the contract. The SAC remains generally concerned about the potential effects of such contracts on surgical training and would wish to be notified of any areas where this is thought to be a concern. Some discussion in relation to this was put into the annual specialty report which goes to the GMC.

OOPT guidelines. Approximately one year ago the SAC stated its view that with the exception of the national interface fellowships, such as the hand fellowships, that all fellowship type training (OOPT) should be post CCT. The SAC came to this view as there was a clear consensus at the TPD forum that TPDs wanted this, and BOTA also wanted a level playing field for trainees. Since that position statement many TPDs have used the SACs statement as grounds for declining requests for OOPT. Unfortunately some programmes continue not to restrict applications for OOPT in effect making the playing field even more uneven than before. The SAC's view remains unchanged and the SAC will continue to monitor the situation, but would wish to encourage TPDs towards its view.

Winter pressures. The SAC chair is aware that the widespread pressure on beds across the NHS this winter has had a potentially adverse effect on the logbook experience of trainees up and down the country. He would wish to encourage ARCP panels to be aware of this when reviewing logbooks

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Core Surgical Training. The SAC had a presentation from Ms Stella Vig, chair of the core surgical training committee, on some of the issues currently facing core surgical training and how it prepares trainees for higher surgical training. She expressed general concern about the fact that T&O posts in core surgical training were not always preparing candidates appropriately for entry into ST3. Part of the issue here is the nature of the core surgery curriculum, which is shortly to be reviewed, and in part the fact that orthopaedic posts in core surgery often fall between 2 stools not being fully owned by orthopaedic TPDs nor by core programme directors. The SAC felt that the current standards for entry into ST3 did not need to be changed, but that there was potential for improving the posts themselves as well as improving what was delivered by core training by changing the curriculum.

SAC review. JCST has recently completed a review of the structure and function of SACs. The report and recommendations were accepted at the recent JCST meeting and shortly thereafter at a joint surgical colleges meeting. There were 27 recommendations in all. Many of you will have been aware of this review, and concerned by one of the proposals that had been on the table for a significant slimming down of the SACs. The size of the T&O SAC will remain largely unchanged and the report gives much clearer guidelines as to the overall structure and function of the SACs and the role and responsibilities of members. A similar review of the interface groups, such as the hand interface group, is currently underway.

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JCST has also been reviewing, in the light of some recent legal action, how it processes appeals. In the light of this review the importance of the presence of liaison members on ARCP panels has been underlined. It is particularly important that liaison members are present when: an ARCP panel is considering an ARCP outcomes 6 (recommendation for award of CCT); and where any period of OOPT is being reviewed. The emphasis here is clearly on the SAC advising the ARCP process rather than, as currently often happens, reviewing the outcome of the ARCP process.

Given this slight change in emphasis I would encourage programme directors to give liaison members as much advance warning as possible of the dates of ARCP panels. Given the fact that liaison members are busy people it is difficult to envisage them being available for 100% of all ARCP panels, no matter how much one would want that to be the case. Therefore, if a liaison member is unable to attend, programme directors should give their liaison member advance notice of any up and coming potential outcome 6s and review of OOPT. This will give the liaison member an opportunity to review the evidence in good time, and if there are concerns to arrange for a deputy to attend the panel.