JCST
Joint Committee on Surgical Training

Specialty Advisory Committee
Trauma & Orthopaedics

New Format: This is the 3rd edition of the T&O SAC newsletter. Whether or not I should continue with generating this was discussed at the most recent SAC meeting. It seems that the newsletter has been generally well-received, but a major comment from several people at the SAC was to reformat it into something more readable on a computer screen or tablet. The 2 column format was deemed to be difficult to read unless it was printed out, and it was felt that fewer people would wish to do that, and that most people would read it on screen. I hope this view was correct and that you find this 3rd edition easier to read than the previous versions.

Communication: one of the reasons that I started writing a newsletter for the SAC was to make sure that our stakeholders, the TPD's and trainees and trainers, had an increased awareness of what was discussed in SAC meetings. Prior to the introduction of this newsletter the only communication from the SAC was the occasional letter on a specific topic. In addition there has of course been the annual meeting of TPD's with the SAC and BOA which takes place in April of each year, and the TPD forum which has started meeting regularly at the BOA autumn meetings. Newsletters are only a one-way form of communication, and the above meetings are limited to TPD's and SAC members. I would like to take this opportunity to remind you of a third annual opportunity for face-to-face meeting, which also involves our other stakeholders, the trainees. That is the TPD forum that is part of the BOTA annual meeting which takes place in June. Many of you will probably get an invitation from BOTA to attend this weekend meeting which has for the last few years taken place at Carden Park golf resort near Chester. Despite these invitations, attendance at this meeting by TPD's has been limited, and BOTA have asked me to encourage you to attend. Many of you, like me, probably feel that weekends are sacrosanct and that you generally therefore avoid weekend meetings. I would urge you to make an exception for this meeting. The work component is minimal (a one-hour meeting before lunch on Sunday) and the social aspect is excellent and the resort itself wonderful, particularly if you are a golfer. I therefore hope that we will see many more of you at next year's meeting.

Research: Professor Amar Rangan, SAC member and member of the BOA Research Board has asked me to update you on the following.

Requirement for CCT: The T&O SAC has approved changes to its research curriculum requirements for CCT. Current GCP certification is mandatory and demonstration of recruitment of patients into REC-approved studies can be used as an alternative to peer-reviewed publications. The new requirements can be found at: http://www.jcst.org/quality-assurance/documents/cct-guidelines/

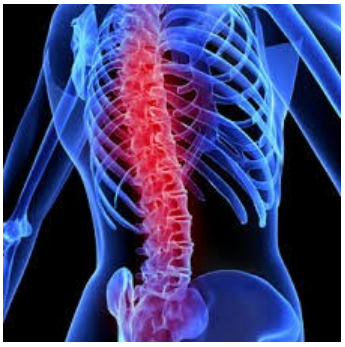
Good Clinical Practice in research (GCP) training may be offered within programmes or accessed via the regional UK Clinical Research Networks (UKCRN). GCP training will also be available at the BOA Annual Congress for attendees, but places will be limited and will need to be pre-booked at registration.

Trainee research networks such as CORNET and BONE are likely to become effective vehicles to achieve CCT requirements in the future. Trainees can get registered on delegation logs for on-going portfolio trials or other REC-approved studies to screen and recruit patients.

BOA Orthopaedic Surgery Research Centre (BOSRC) is now live and based at the York Trials

Unit. To help trainees interested in leading clinical research, the BOSRC will be running a two-day course on 13th and 14th April 2015: http://www.bota.org.uk/coursealert-topic.php?id=2535 Methodological support from the BOSRC for clinical research can be accessed via their website at: http://www.york.ac.uk/healthsciences/research/trials/bosrc/#tab-2

Training in Spinal Surgery. Prof Charles Greenough, National Clinical Director for Spinal Disorders, attended the September meeting of the T&O SAC to discuss issues in relation to training within spinal surgery and the effect on recruitment into the subspecialty area, and the delivery of service. Many spinal jobs are proving difficult to fill, and there is anecdotal evidence that the familiarity of newly appointed consultants with some spinal problems was inadequate and leading to poor patterns of referral.



It was clear from discussions that all involved felt that the current curriculum more than adequately covered the area of spinal surgery, but that the issues really related to delivery of that curriculum. In many areas the simple mathematics of the number of potential trainers and the number of trainees mean that it is impossible for every trainee to get exposure to spinal surgery. Attempts to get round this issue by using shorter attachments were not allowing trainees to work in units long enough to be trusted and consequently given hands-on experience. Trainee exposure to spinal emergencies was also being reduced by rota clashes in spinal tertiary referral centres which are often co-located in major trauma centres. In these units a separate spinal on-call rota was often staffed by fellows while trainees took part in the trauma on-call rota. One final issue that was felt to be impacting on recruitment was the practice of timing spinal attachments close to the exam, at a stage when trainees have often decided on their career path.

A number of solutions to the above problems were discussed. In the long run properly functioning spinal networks which would allow the delivery of some service and particularly training in more peripheral units will significantly address all of these issues. These will take time to establish and in the short term solutions such as mixed attachments e.g. scoliosis surgery as part of paediatric orthopaedics or 2 days a week in spines with 3 days a week in another specialty, may go some way to addressing the issues. In addition units providing spinal training should investigate alternative ways of running the various rotas to try and improve trainees exposure to spinal emergencies. The SAC in T&O, along with the national clinical director and the SAC in Neurosurgery will explore the possibility of setting up interface fellowships along the lines of the hand interface fellowships. Simulation may also have a role to play in improving training experience in spinal surgery.

Fellowships: Although the SAC discourage these pre-CCT, those who have them arranged need to be aware of the very hard line now being taken by the GMC in relation to prospective approval of out of programme training. In the past they used to give some leeway and if paperwork was completed shortly after the start of OOPT, they would still recognise the whole time. They are no longer giving this leeway, and all the paperwork **MUST** be completed **BEFORE** the period of training for which recognition is being sought. Given the critical importance of this I would wish to remind trainees that they should not rely on someone else sending the paperwork into the GMC on their behalf and they should therefore actively check that this has been done. Two such clerical errors have occurred recently resulting in trainees not having the entire period of OOPT recognised and as a consequence had to have their anticipated CCT dates extended.

Numbers: 2014 saw the largest number recruited into T&O for quite a number of years. This was because HEE removed the cap on numbers and allowed LETBs to recruit to all unfilled posts. For 2015 HEE have adopted a more formal strategy for deciding recruitment numbers and have held a number of stakeholder engagement meetings. I am extremely grateful to Mr Mark Bowditch who has represented the SAC and the BOA at these meetings and presented the case for the numbers that we seek to recruit next year, which was 170. This figure and Mark's presentation has been heavily informed by the GIRFT project that has been led by Prof Briggs. The data from that project would suggest a continuing need for evermore orthopaedic surgeons, but the recent stock take by the Centre for Workforce Intelligence while in part recognising that trend also concludes that currently there might be a degree of oversupply of trainees. While we all would wish to see good job opportunities for our junior trainees and the needs of the population being met, equally we should try and avoid the potential for unemployed CCT holders. The final conclusions of the HEE stakeholder engagement exercise will hopefully be known sometime in October. At the time of writing it appears that we may be recruiting some quite large numbers again next year

National selection 2014: The selection design group for national selection met in August 2014 to review the statistical analysis of this year's selection process. The results of this have subsequently been presented to the whole SAC, to BOA Council and to the TPD forum.

The analysis concluded that the whole process was fair, reliable, and had a good ability to discriminate between candidates. In addition there were no significant differences between the scores of candidates depending on either day of week or time of day of interview. The Angoff-derived cut off scores have also been discussed at the BOA educational board. An independent psychometrician was party to those discussions and concluded that the methodology for calculating these scores was robust.

The impact of the way that the clinical station score was used was reviewed in detail. While this methodology broadly had the expected effect there were some aspects that had not worked as anticipated, and this year's data will therefore be used to inform alternative models for deriving a cut off score for next year. Our priority in selection is always to select the best, but there will always be debate as to how you define best.

A number of other aspects of this year's selection were also discussed. There is a limited potential for short listing in future years, but probably not next year. In addition, we looked at the performance of candidates coming direct from core training compared to other candidates. Proportionately, this year, candidates coming straight from core did better than any other group of candidates.

The dates for next years national selection interviews have been confirmed as 23rd to 27th March 2015 in Elland road as before. If we can get enough interviewers I hope we may be able to complete the process in 4 days rather than 5. So book your leave now please. .

Casting training: I'm sure that there will be few readers of this newsletter who would disagree with the importance of being able to put on a good plaster cast. Despite this, however, it is a topic that seems to have received less attention in recent years and a requirement that used to exist a number of years ago, for early years surgical trainees to have put on at least 9 casts, no longer exists. There are also important patient safety aspects to ensuring skill in this area with 7.3% of all paediatric litigation involving casts and their problems. This whole topic was discussed at the recent SAC meeting, where Ms Sue Miles, the BOA casting training adviser gave a presentation. All those involved in the discussion accepted the importance of this type of training. A number of strategies to improve training in this area were discussed. In the first instance attendance at a specific casting course has been added desirable requirement to the person specification. Currently there are not that many such courses and those that there are are quite variable in their format, so it would be difficult to make this an essential requirement, but we would hope to move slowly in that direction. In addition, some curriculum changes may appear in the next revision of the curriculum in relation to WBA's on casting technique. We will also be drawing the matter to the attention of the core surgical training committee.

GOSLE: Many of you may have heard of the general operative supervised learning event, a new workplace-based assessment that was developed by a trainee in the north-west, Mr Ronnie Davies, along with Prof Phil Turner. A year ago the SAC agreed to a pilot evaluation of this new assessment. The results of this pilot, from three centres, were presented at the recent SAC meeting. The results presented were favourable, and showed that the new instrument encourages better and more structured formative feedback. It was agreed, despite some reservations about the confusion that might arise from yet another workplace-based assessment, that trainees could use this new instrument and count up to 25% or 5 towards the WBA total of procedural assessments. These can be recorded at http://www.orthosurgery.co.uk and then uploaded to the Other Evidence section in ISCP.

Which curriculum? The 2013/14 curriculum was introduced in August of last year and with it a number of quite significant changes. Along with the curriculum, JCST published guidance about transferring to the new curriculum. It seems from a number of recent enquiries that this guidance has either been forgotten or poorly understood. It is in keeping with the GMC guidance on trainees moving to the latest curriculum.

ISCP INTERCOLLEGIATE SURGICAL CURRICULUM PROGRAMME

Given the apparent confusion, may I first state that anyone who is currently following the 2013 curriculum should continue to follow the 2013 curriculum. The JCST guidance, however, defined 2 points of transfer into the 2013 curriculum. Those points of transfer were: entry into ST3 and entry into ST7 (the final phase of the curriculum). If that guidance had been followed to the letter then the only trainees not on the 2013 curriculum right now would be trainees in ST5 and ST6. Those in ST6 should transfer to the 2013 curriculum next year and those in ST5 the year after, but all trainees have to be following the 2013 curriculum by 1 January 2016 in keeping with the GMC position statement. That includes any Calman trainees who might still be in training at the time.