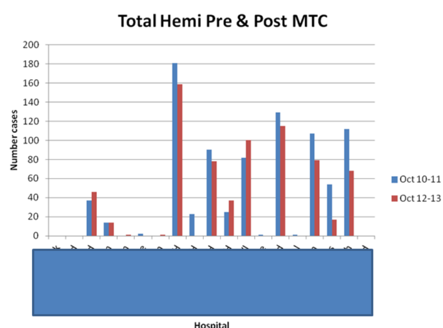
JCST

Joint Committee on Surgical Training

Specialty Advisory Committee
Trauma & Orthopaedics

The topic of training in major trauma centres has been a significant subject of discussion at the last two SAC meetings. In addition the subject has come up at the BOA training standards committee, and a roundtable discussion on the topic took place prior to the BOA council meeting in December 2013. All of this was initially prompted by an approach from the National clinical director for trauma suggesting that the SAC should make training in major trauma centres mandatory. This was discussed at the December SAC meeting, and although the proposal was superficially attractive a number of potential issues with making such training mandatory were raised, and the balance of opinion went against making such training mandatory.



Further discussion took place after it was pointed out that there was evidence that a proportion of cases, which could be appropriately treated in a designated trauma unit, were bypassing such units and going direct to major trauma centres. Such a change could potentially have a significant impact on training in trauma surgery.

There was widespread agreement between all parties that the introduction of major trauma centres and trauma networks had resulted in a dramatic improvement in the care of the seriously injured, and that it was therefore important to train CCT holders to a level where they could function appropriately as a part of such networks. It was agreed that the appropriate level for this training should be so that all CCT holders could function in a designated trauma unit and be able to receive, resuscitate, assess and triage major trauma cases and perform surgery as appropriate for such a unit.

Much more debate centred on how such training should be delivered. While it was widely accepted that training in major trauma centres has huge potential to allow trainees to achieve their educational goals in this area, both as a senior and Junior trainees, it was also recognised that there were a number of challenges associated with delivering training in major trauma centres. Not least, because, currently, major trauma centres do not form a part of every training rotation. Most of the other challenges related to the intensity of the workload in MTC's and the associated need to be compliant with the EWTD. The numbers of doctors required to make up a compliant rota has the potential to dilute each individual trainees operative numbers, as does the required compensatory rest, which can also impact on daytime elective experience, where this is part of an attachment in an MTC.

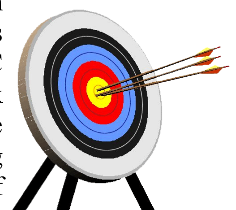
The conclusion of all of the discussion on the topic was that this was an important and changing area which needs careful monitoring to ensure that trainees approaching their CCT have attained all their goals in relation to trauma management. At the moment there is no one size fits all policy, and therefore it would be down to training programme directors to ensure that training rotations delivered appropriate experience.

In order to help training programme directors in this task, trainees have to play their part in keeping their logbooks up-to-date and ensuring that they seek every available opportunity, particularly in relation to the reception of major trauma cases, to record CBD's and CEX on such patients. A good opportunity for having the discussion and getting feedback for these WBAs is when the patient is in the CT scanner. Trainees should also remember that such WBAs do not need to be done by a consultant orthopaedic surgeon. They can be just as valuable when done by an emergency medicine consultant or an anaesthetist.

The SAC also has its part to play in assisting programme directors. I hope that over the next year TPDs will have access to a new report in the e-logbook which will allow them to look at the experience provided by a hospital for a given time period. This will help them to evaluate changes in service delivery over time and adjust rotations accordingly. In addition the SAC will help in the dissemination of best practice and to this end, Mr Paul Fearon, a trauma surgeon from Newcastle spoke on training in MTC's at the annual TPD's meeting in May.

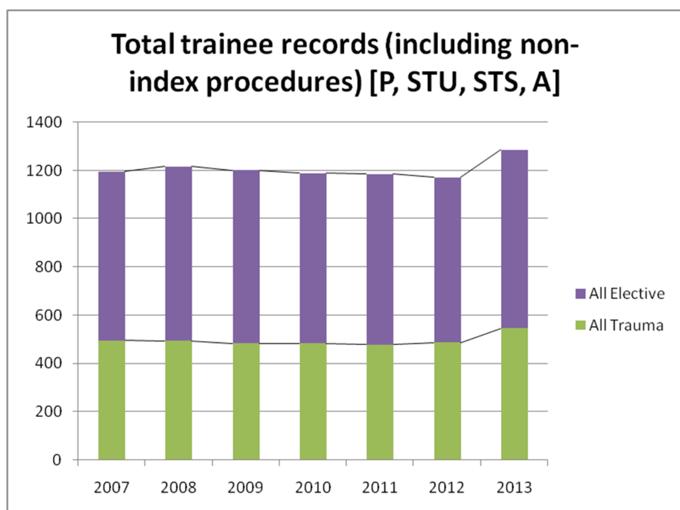
Finally, while all of this article has been about the delivery of trauma training, we have to remember that CCT holders also need a complete training in elective surgery. Changes in the delivery of trauma training are likely to have knock-on effects on elective training. Minimising such effects may require some lateral thinking in relation to rotation planning on the part of TPDs. For example, it is almost set in stone that orthopaedic rotations take place every 6 months. It might be that in some places an alternate duration of rotations might help strike a balance between trauma and elective training. Just a thought!

CCT guidelines and indicative numbers



These continue to be a source of worry and concern for trainees particularly as they approach their CCT date, and the whole topic was reviewed by the SAC recently. The SAC reviewed evidence from the logbook relating to the average numbers of these procedures that trainees were achieving over a six-year training, in each year of their training (ST3-ST8), and how this has changed over a seven-year period. These figures showed that for all the indicative procedures the numbers being achieved by trainees were low and had shown a slow steady

decline from 2007 to 2012. Following the introduction of the indicative numbers in 2012 there was a significant increase in these numbers for all procedures. It is difficult to ignore this change which is a strong indicator that the targets of indicative numbers are having an effect on training. While it



is perhaps open to debate whether this effect is simply target chasing or something more positive, the general view of the SAC was that this was a positive effect.

The SAC also discussed whether or not any of these targets should be changed. In addition to considering the current indicative procedures and their numbers, we considered whether or not there should be further targets for the number of procedures done as S-TS or greater, the number of elective procedures, and the number of emergency procedures. The balance of the opinion expressed was that making any of these changes would add complexity, and furthermore that it would be difficult to know what set of indicative numbers would apply to any particular trainee. It was however agreed that these targets were beneficial, that they would remain unchanged for the time being, and that they should be kept under regular review.

While on the subject of indicative numbers, all of you will be aware that a number of procedures are aggregated to produce the total for each indicator. (The full list of what aggregates to which indicator can be viewed at: https://www.iscp.ac.uk/static/syllabus2013/to_sac_report_indicative%20groups_dec_12.pdf) I regularly hear concerns expressed along the lines of; why does such and such a procedure count towards an indicator and another one doesn't? The procedures that are aggregated towards each indicator have all been carefully considered by the SAC. They have been selected to reflect the complex end of the spectrum of procedures that fall within the broad heading and do their best to exclude high-volume low complexity procedures. That way we feel the indicators are likely to be a better reflection of a trainees competence and breadth of experience.

The SAC is also aware that there are specific difficulties in achieving some of the indicators. For example, the target in 1st ray surgery is known to be a difficult one for some trainees to achieve, and that local practice in some regions may make it is difficult to achieve the target for intra-medullary nailing while at the same time significantly exceeding the target for external fixation. We therefore expect to have to exercise a degree of professional judgement in relation to these targets for some time to come, however trainees should not expect this to give them a huge amount of leeway.

Trajectory of Training.

I mentioned this briefly in the last newsletter. The assessment sheets were approved at the SAC meeting in March, and became available on the JCST website shortly thereafter. They consist of 2 MS Word documents, one to be used in the ST4 ARCP and the other in the ST6 ARCP. The top part of the form should completed by the trainee (using MS Word) prior to the relevant ARCP and then printed out and submitted to the panel for review. As you will see from the graph below the term "trajectory of training" is somewhat euphemistic. Progress is often stepwise, depending on placements, and not always a smooth line. Therefore, a degree of professional judgement has to be employed in the evaluation of progress against the waypoint assessment. Despite that, however, I believe that these assessments will keep trainers and trainees focused on achieving what is

ST6 Waypoint Checklist For:

Complete by trainee: in Microsoft Word and then print out for ARCP panel

Breadth of experience:

Operative Experience:
Number of Emergency/Trauma cases in 4 y to date Number of elective cases in 4 y to date

Index Procedures:

Numbers of Work Place Based Assessments in last 4y (ST3 – ST6):
PBA/DOPS: CEX: CBD: MSF:

Critical conditions:

Audit / Research / Study Leave
How many audit projects (against a clear standard) have you done in last 4y
Name one in which the audit loop closed.
Have you undertaken a GCP course that is current & valid ... No
How many posters and presentations of work in the last 4y
How many research projects have you got underway at moment
ATLS® valid until
How many days of study leave have you taken in the last 4y
How was this used? # days courses # days Exam prep private study # days other e.g.prof lve.
Have you done or do you have plans for Leadership & Management courses? ... No

Sign off by ARCP panel – using appropriate professional judgement

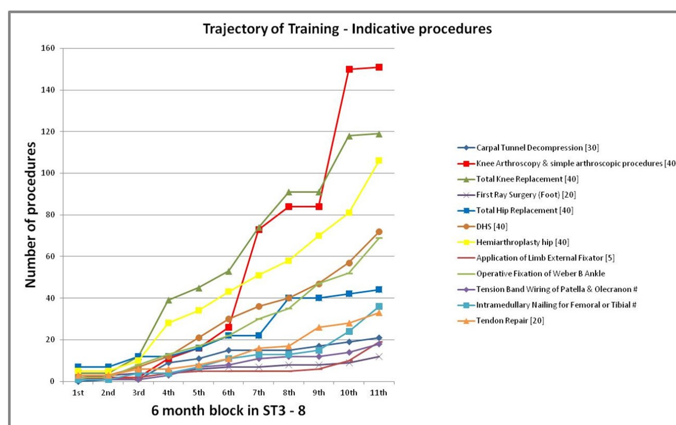
Breadth of experience:
Covered 6 subspecialty areas ☐

Operative Experience:
Overall volume: averaging 300 cases per year ☐
Index Procedures: ~66% of way to meet indicative numbers ☐
Trauma elective split last 4y appropriate for jobs and heading towards – 33%:66% ☐
Logbook shows appropriate proportion of supervised cases in subspecialty areas ☐
(i.e. – not just assisting)

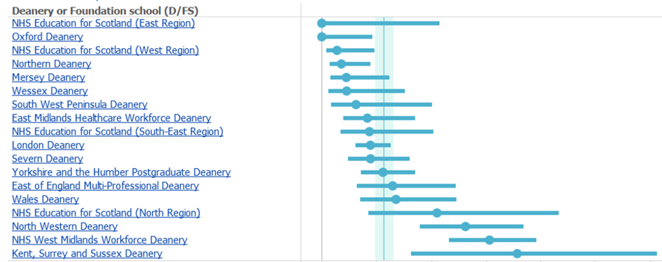
Work Place Based Assessments:
Using full range of WBAs with appropriate balance*(50% procedure based:50% other)* ☐
1x MSF / year ☐
Numbers in region of 40/year over last 4 years ☐
Is showing progression in PBA's with some primary PBAs at level 4 ☐
Has encouraged formative feedback in all WBA's ☐
Is spreading WBAs over attachments ☐

Critical conditions:
Has recorded CBD's in ALL of the critical conditions ☐

Audit/Research/ Study Leave:
Has undertaken 4 audit projects ☐
Has 1 audit project with loop closure ☐
Has undertaken a GCP course ☐
1 presentation / Poster & 1 submission to peer reviewed journal ☐
Reasonable prospect of publication in next year ☐
1 other project underway and likely to lead to presentation & publication ☐
ATLS® in date & L&M courses done or planned ☐
Good attendance at core curriculum & has otherwise made full use of study leave ☐



expected at the end of training, and thereby avoid the potentially awkward decisions that may need to be made if a trainee applies for their CCT significantly short of some of the guideline targets. In addition, I would hope that it might



achieve somewhat less variability in the rate of unsatisfactory ARCP outcomes than is currently the case. The GMC have recently put on their website a reporting tool that allows review of ARCP outcomes in a variety of ways . To see this search ARCP on the GMC website.

. As you can see from the nearby chart for the 2013 ARCPs in trauma and orthopaedics there is a significant variation in the rate of unsatisfactory outcomes which is currently difficult to explain.

Evidence for CCT.

It would be a mistake for trainees to assume that when they receive their ARCP 6 at the end of training, that the award of CCT thereafter as a mere formality. All the paperwork from the deanery then goes to the JCST who then send it out to the relevant liaison member. In addition to reviewing the paperwork, the liaison member will also wish to review the trainees portfolio in ISCP, and satisfy themselves that the applicant meets the criteria within the guidelines for the award of CCT. There is currently a problem in relation to this process which relates to the fact that use of ISCP by orthopaedic trainees was not mandatory prior to 2012 and was patchy for a period thereafter. Several liaison members have therefore found that there can be a dearth of evidence online with which to inform their decision. A number of trainees have therefore been asked to send in significant extra paperwork which is bulky, expensive to send, and adds time the whole process.

Trainees must therefore ensure that there is adequate evidence online prior to applying for their CCT. Evidence in relation to research, courses & conferences, and audit would most easily be entered directly into the evidence section of ISCP retrospectively. It would be an excessively time-consuming exercise to enter PBAs and other WBAs that have not been recorded in ISCP retrospectively. Therefore, where there are a significant number of WBAs held either on paper or in the old OCAP system, a consolidation sheet for these assessments should be scanned to create a PDF file which can then be attached to the evidence section of the ISCP portfolio.

National selection & Manpower

This year was the 2nd year that selection into ST3 has been run on a national basis. Interviews were held over 5 days in Elland Road football stadium in Leeds between 28 April and 2 May. There were over 500 applicants, and just under 500 interviews booked. Almost 60 people who booked interviews, did not attend on the day and why they should have done so is unclear. On each of the 5 days there were over 100 interviewers in attendance.

Firstly therefore a very big thank you to all those interviewers who gave their time to help with the process, and I would also like to publicly thank the staff of HEE Yorkshire and the Humber for all their hard work and exceptional organisation, as well as the staff at Elland Road football stadium for their support with the organisation.

This year's selection process was a significant development from last year's exercise and represented the culmination of a huge amount of work that had taken place over 8 months, with several days of meetings in London, and the input of a wide range of people representing all stakeholders. The result was a recruitment process that now had a much wider scoring range with a much more comprehensive mapping to the person specification and included 2 new interview stations.

The process was extensively quality assured by both lay and orthopaedic observers so all concerned can be confident that the every interview was consistent and fair through out the five days of interviews

As most readers of this newsletter will be aware that for 2014, HEE removed the cap on the numbers of orthopaedic trainees that could be recruited. This meant therefore that there were (at the time of writing) 187 posts to be filled offering applicants their best statistical chance (2.35:1) of getting a job in the recent past and likely also the foreseeable future. As for numbers in future years, the CfWI did a stocktake exercise for T&O last summer which suggested a reduction in recruitment numbers from the 2013 level. Currently HEE has put out a call for evidence to support its decision over next years numbers. The CfWI report may inform that, but by the time they see the evidence, data from GIRFT and a full analysis of this years recruitment should also be available to further inform the debate. So the only certainty for the future is that there will be debate and that from 2015 there will be no LAT appointments.

Addendum: The main part of this newsletter was written some time ago prior to the recent SAC meeting. This part follows on from that meeting and discussions about the 2014 national selection process. In particular I wish to address some concerns that have been expressed about that process, especially in relation to the cut-off score.

The word un-appointable has frequently been used to describe unsuccessful candidates. While there was reference in some documents to determining scores for appointability, the word un-appointable was not used in any official communications to candidates as it is seen as an excessively negative term. I would wish to emphasise that lack of success on this occasion does not imply lack of success in the future.

Prior to the interviews candidates were informed that offers would be made on the basis of total score and individual station scores. At the interviews each interviewer was asked “What is the minimum score for your station that would allow a candidate to SAFELY take up an ST3 appointment in T&O” From those answers, using an Angoff methodology, cut off scores for each station and the total score were

derived. Given the fact that the whole process is open to public scrutiny, it was decided that it would be difficult to justify to the public, appointing people who had not demonstrated at interview a SAFE level of clinical knowledge as well as the overall total score. That is not saying that applicants who failed to achieve the cut-off score in the clinical station are unsafe, simply that they had failed to demonstrate a safe level of performance on that occasion. I use the word performance there because these interviews are not exams and each station tests other areas of the person specification and not simply knowledge.

The decision to use the cut-off scores in this manner was therefore in line with what candidates were told beforehand and for the reasons given above. A detailed analysis of the effect of that decision is being carried out and will be presented to the SAC in September.

I have heard rumours suggesting that some interviewers treated the interview, particularly the clinical station, as an exam. Great care was taken to ensure that on each day, each interviewer understood what each station was testing (this was not just knowledge) and that they followed the script of each question carefully. On top of this there were extensive quality control measures in place to check that interviewers conducted the process in the designed fashion. Therefore every possible measure to avoid this being treated as an exam was taken

Finally, I have heard allegations that some trainees must have known the questions beforehand. All those involved in the design of the selection process signed and were bound by a strict confidentiality agreement. Alleging a breach of that agreement is a most serious manner. Anyone making such allegations must have hard evidence to support them and should contact me directly rather than starting a rumour .