GUIDE TO A GOOD RITA PROCESS IN SURGERY

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1 Preface

All surgeons in the UK will have heard the term 'RITA' and some will, through involvement at various levels of training, be very familiar with the RITA process itself. The acronym was coined in the late 1990's when the Calman reforms to higher specialist training were introduced. In common use it is rarely given its full title, Record of In Training Assessments, and is not infrequently misnamed. One misnomer, 'Review of In Training Assessment(s)', is probably a more accurate description of the process as it has evolved. The Guide to Specialist Registrar Training ('Orange Book') in the UK sets out the RITA process, its context, format and outcome categories[1].
Given its statutory function of regulating the progress or otherwise of trainees during training, the quality and thoroughness of the RITA process is clearly fundamental to the determination of standards of training and the overall quality of our newly trained surgeons. The Calman training framework has now been in operation since 1996 for most specialties and the importance of the RITA is becoming more widely appreciated. There remain, however, misconceptions regarding its purpose, its components and the manner in which it should be conducted. Between 1996 and 1999, the Open University Centre for Education in Medicine carried out an evaluation of the Calman reforms, commissioned by the Department of Health[2]. The authors found that there was a requirement for:

- Clear information to SpRs about the assessment process
- Documentation for Annual Review Panels in advance and time to study it
- Clear technical guidance for educational supervisors or other assessors
- Guidance for Annual Review Panels regarding the use of assessment results and classification of SpRs
- Proper development and testing of assessment instruments
- Standard setting for the classification of SpRs
- Rigorous decision-making

These deficiencies and others were confirmed during a workshop held in 2002 for SAC members, Programmes Directors and Chairmen of Training Committees in General Surgery. The need for development of the process and better assessment methods was emphasised and it was also apparent that there were widespread variations in the RITA process as conducted by different Deaneries.

During this symposium the then President of The Association of Surgeons in Training, Simon Cole stated in relation to General Surgery:

"From the trainee's perspective the most important aspects of in-training assessment are that it should be robust, fair, consistent, and open.

The RITA process remains something of a mystery to many surgical trainees and for this reason it is somewhat forbidding. This could easily be remedied by informing surgical trainees in their first year as a Specialist Registrar as to the form, process and purposes of the RITA. A particular case in point is the widespread misunderstanding of the award of a 'RITA D' by the panel. This is regarded by many as pejorative, whereas in the majority of cases it is intended to be helpful.

Moreover, the RITA process has been interpreted variably between regions. In some, the yellow (JCHST) form is completed after an informal discussion between the trainee and the Regional Adviser. In others there takes place a formal annual interview by members of the Training Committee, together with a paper exercise during the intervening six months. The process should surely be uniform.

It is crucially important for trainees that trainers complete the yellow JCHST forms honestly and objectively. If there is a problem it should be recorded, so that it may be discussed, accepted or rejected and properly addressed. The process should include an assessment of the training received, as well as the progress of the trainee. The former should be facilitated by data collection using the electronic log book. Trainees should understand that this is the main purpose of the electronic logbook. Also, that aggregated data will be available for the trainee, the trainer, the unit and national databases.

The moves towards competency based assessments are broadly welcomed by trainees. These should make the process more objective and consistent. It is, however, important that assessments of competence are reliable and valid.

Finally, clinical acumen and judgement are an important part of the make-up of a Consultant Surgeon and it is important not to lose sight of this when developing the range of assessments."

We should also bear in mind the imminent arrival of the Postgraduate Medical Education and Training Board (PMETB) in the UK. It will undoubtedly impact on many aspects of training and it makes sense when considering the RITA to try and anticipate how this is likely to shape our approach to assessment.

This short guide, a compendium of the contributions to that workshop, is intended to articulate some of the issues and clarify some of the bureaucracy associated with the RITA. Using examples of established practice, it makes some recommendations for the conduct of the RITA process that were supported during the workshop. Examples of assessment 'instruments' – new and old - are provided, in addition to a brief section that aims to explain and demystify some of the jargon used when discussing assessment methodology. For those who would explore further the background to in-training assessment please see Section 11
The 'Guide to a Good RITA Process in Surgery' is aimed at all those involved in training surgeons and conducting RITA panels, but may be of interest to those in a similar position in other specialties. This is intended to be a generic guide. However, relevant specialty specific topics have been included at the end of the document.

References

1. NHS Executive. (1998) *A Guide to Specialist Registrar Training*. Department of Health.

2. Evaluation of the Reforms to Higher Specialist Training: Key Findings on Assessment. Grant and Southgate. Open University Centre for Education in Medicine.

2 Assessment: Some Principles and Terminology

A detailed exposition here of the principles and practice of assessment would be out of place. Nonetheless, a brief exposition of relevant aspects is apposite, as an understanding of the principles of assessment is essential for all who are involved in training. For a more in depth briefing, the reader is referred to other publications[1,2]. Attendance at an appropriate course run by the Royal Colleges or one of the Deaneries is also to be highly recommended.
However, some draft principles and standards for assessment in postgraduate training have been developed[3] on behalf of but prior to the establishment of the Postgraduate Medical Education and Training Board. These provide guidance about the characteristics required of an assessment system. That system will comprise national examinations, such as the MRCS and the complementary in-training assessments, which are the basis of the RITA.

The Principles state that:

- The assessment system must be **fit** for a range of purposes
- The content of the assessment must be based on **curricula** which are referenced to the GMC document *Good Medical Practice*
- The assessment method should be selected in the light of its **purpose and content**
- The methods used for setting standards of classification of the trainee's performance/ competence must be **transparent** and in the public domain
- Assessment must provide relevant **feedback**
- **Assessors** will be recruited against criteria for performing the tasks they undertake
- There will be **lay input** into the development of assessment
- Documentation will be **standardised** and national
- There will be **resource** sufficient to support assessment

Purposes

As far as **purposes** go, it is often helpful to consider the characteristics of an assessment exercise under two main headings or categories. There are those designed to provide a robust reassurance to training and certifying bodies that standards of performance, knowledge etc. are being met at the appropriate stages in training. Such assessment methods usually have a strong external, independent component and are referred to as being **'summative'** in nature. A typical example would be a professional membership examination, a medical school final examination, a driving test, and so on.
Others are designed to provide an interim assessment of performance that is then used to inform trainer and trainee about the needs of that trainee. Such assessments are referred to as **'formative'**, and are usually conducted in the training environment. They are often relatively informal but should conform to the appropriate technical requirements of assessment. During a formative session trainer and trainee are **reviewing** the position on the basis of good evidence, engaging in **dialogue** and receiving **feedback** that will help direct future training needs. The setting may vary but there must be provision within the timetable for such sessions. However, many of us will recognise that even a few minutes spent in informal discussion at the end of a busy day or operating session can be used constructively for this sort of exercise.
Although it is difficult to design an assessment exercise (*cf.* assessment 'tool' or 'instrument') that performs both summative and formative functions equally well, most can contain elements of both. A familiar example would be the MRCS examination, which is designed as a 'summative' assessment exercise, but limited feedback to help direct future study for the failing candidate is provided by way of an examiners' report. It is often important to bear in mind this distinction when considering the main purpose of any particular assessment method and its overall strengths and weaknesses.

Content and curriculum

At whatever stage of training, establishing the level of **competence** of a trainee is clearly a major requirement of the RITA. The breadth and depth of what is to be learned and the level of performance to be expected from a trainee should be expressed in the **curriculum**. The assessment methods, their timing and how they are to be conducted should also be indicated within the curriculum and the Manual of Higher Surgical Training. The possible content of an assessment exercise such as an examination may be further defined in the course **syllabus,** through which the scope of the examination or its component parts is set out.

Standards, reliability and validity

Standards are expressed in relation to defined **criteria.** In the case of factual knowledge, it is a relatively straightforward matter to score a series of answers and arrive at a total. Setting the pass – or competency - mark, however, may present considerable challenges. In areas where complex skills and judgements are involved, setting standards for pass/fail is even more difficult. The score or mark in these cases will often be based on the judgement of suitably qualified observers. Here there are three important considerations. The first is the reliance that can be placed on that judgement (**reliability**); second is the accuracy (**validity)** of the data and judgment, the third is the level of performance that is to be expected **(standard**). It is commonsense that deriving a final score using marks given by several observers (raters, examiners) on several occasions, is much more reliable than taking the marks of a single observer from a single observation [4] This is an important principle and one that is of direct relevance to the assessment of many skills in specialty training. It should also be pointed out that there are accepted techniques for incorporating standards, based on professional judgements, into formal assessment processes[5,6]. The basis for this should be expressed as accurately as possible through the curriculum and/or relevant syllabus.

It follows that the assessment process during training should:

- Be based on the **relevant curriculum**
- Apply an agreed **standard**
- Judge progress against **defined criteria**
- Provide **feedback** to the trainee
- Enable **support** to be directed as required

Principles for work-based [in-training] assessments

The PMETB draft paper sets out the principles for work-based assessments, the results of which make up the RITA. These are as follows;

- The assessments must be subject to reliability and validity measures
- Evidence must be collected and documented systematically
- Evidence must be judged against pre-determined published criteria
- The blueprint and the quality of the evidence must determine the weight placed on different sources of evidence
- The synthesis of the evidence and the process of judging it must be made explicit

Some of the assessment instruments used in surgical training in the UK and Ireland are described in later chapters and a further discussion on assessment during training is provided in Section 11 on In Training Assessment: Issues and Challenges).

References

1. Jolly, B., Grant, J. Eds. (1997). The Good Assessment Guide. A practical guide to assessment and appraisal for higher specialist training. The Joint Centre for Medical Education. ISBN 1 873207 76 X

2. ACGME Outcomes Project (2000). Toolbox of Assessment Methods. ACGME and American Board of Medical Specialties. Version 1.1

3. Southgate,L, Grant,J. et al (2003) Draft Principles and Standards for an Assessment System for Postgraduate Medical Training. Unpublished, for presentation to the PMETB.

4. Keeves, J.P. Ed. (1988) Educational Research, Methodology and Measurement: An International Handbook. Oxford. Pergamon Press. P 241 – 330.

5. Angoff WH. Scales,norms,and equivalent score. In:Thorndike RL, ed. Educational Measurement. Washington DC: American Council on Education; 1971:508-600

6. Norcini JJ, Shea JA. The credibility and comparability of standards. Appl. Measurement Education 1997; **10** : 39-59

3 Understanding the RITA Process

As it has developed, the RITA process now comprises a number of stages as follows:

- Development of reliable and valid assessments and accompanying documentation.
- Implementation of the assessments at predetermined points
- Review of results as part of the appraisal process
- Submission of assessment results to the Deanery Annual Review meeting
- Classification of the trainee's performance on the basis of assessment results
- Wider discussion with the trainee of experience, achievements and plans as part of an Annual Review.

The pivotal position of assessment exercises in this process can be appreciated.

The RITA process should judge the progress of a Specialist Registrar against criteria that are defined in the curriculum. An example would be the requirement to pass the Intercollegiate Board Examination. The broad 'Rules of Engagement' are set out in the training or learning agreement signed by the trainee, the Postgraduate Dean and the Regional Specialty Adviser or STC Chairman/Programme Director at the start of a training programme.
This agreement should be supplemented by a series of structured educational and training objectives agreed for each six or twelve-month appointment. For example, the successful completion of a short course or the completion of an audit project or thesis. These will be recorded and disseminated to the trainer and the trainee. The objectives for each segment should be structured in such a way that they fit with the curriculum, underpin key critical points or 'milestones' and form a logical sequence leading to completion of training and the award of the specialist qualification.
Most medical training curricula are to a degree flexible. Providing core objectives are being met, they are able to respond to an individual trainees preference in some areas. This facilitates personal development to the benefit of service and the individual, but these flexible elements, for example out of programme experience, should be assessed on completion as with the core components.
The RITA process hinges on the quality of assessment undertaken by the trainer(s) in a unit. Trainers must understand their responsibilities. Specifically, they should understand the training programme of which they are an integral member and the onerous responsibilities that they bear with regard to assessment. Individual trainers should recognise that they must work closely with their trainee and colleagues to ensure appropriate supervision at all times; with the unit's Educational Supervisor (Surgical or Departmental Tutor - if such an appointment has been made), and the Programme Director.
Accurate, honest and mature completion of the appropriate documentation by the trainer(s) and trainee is a prerequisite for a reliable assessment. Appraisal by the trainer during training will guide the trainee in developing his/her personal portfolio. This will contain some items that contribute to or record assessments and some that are particular to the individual trainee. Those that are concerned with specified assessments must be based on relevant documentation held within the portfolio including the educational and training objectives for the post in question. In this way the various in-training assessment forms can be completed against objective criteria.
The RITA process must be rigorous at every stage of training but it is particularly important to identify individuals who are unsuited for surgery as early as possible. The RITA process must be structured in such a way that deficiencies in progress (or aptitude) do not pass through unchallenged into the later years of training, when they become a major problem for all concerned. In the words of the Indian proverb *'Do not let a mouse grow into an elephant'*.
Trainers and Programme Directors must be particularly vigilant during the early years of higher specialist training so that trainees who are failing for whatever reason, are identified

and effective action taken. Particular care should also be taken during the penultimate year of training when final certification is imminent.
It will be emphasised at many points during this guide, that the RITA process cannot take place without detailed preparations, which involve the whole team i.e. Deanery STC, Hospital Training Support Unit, the Programme Director, the Regional Specialty Adviser and of course the trainers and trainees.

Summary

Taken literally the Record of In Training Assessments (RITA) is, as its name suggests, merely a record of those assessments carried out by others from time to time during training. These would include the examinations conducted by 'external' bodies and the assessments made by trainers. It is inseparable from the curriculum, which should dictate when and how those assessments will be made. If confined to a comparison of actual as compared to required progress, the RITA itself could be accomplished by a paper-based exercise. This would be simplistic and it is apparent that the RITA in practice encompasses much more than a straightforward somewhat bureaucratic exercise on the basis of assessment results. It provides the basis for a dialogue between the trainee and those charged with his/her overall management through training.
At the completion of each cycle there should be a clear understanding between the two parties with regard to:

- The present position
- The aspirations of the trainee
- The requirements of the curriculum
- The actions that are to be taken by trainee and the training organisation(s)
- The progress and achievements that are expected by the next review

As such the RITA panel as it is conducted is not dissimilar in structure to a performance review or appraisal, with reliable and valid assessment data at its heart. The structure, therefore, follows the pattern:

- A **review** of assessments and achievements since the previous RITA panel.
- **Dialogue, Negotiation.**
- **The setting of learning/training objectives** plus **timetable**.
- A **record** of the outcome.
- **Dissemination of information** to the appropriate parties.

Above all, remember that the RITA process is only as robust as the assessments fed through to it by trainers.

The RITA Forms

The relevant RITA forms must be completed for all trainees who hold an NTN, a VTN, an FTN or a LAT appointment.

RITA A – Core Information on the Specialist Registrar

This document must be completed before the doctor is registered as participating in a training programme and before a Training Number is issued. This is a relatively non-contentious document in the surgical specialties where dual certification does not arise.

The qualifications of the entrant against the entry criteria laid down should be checked, and using these data and the curriculum at the initial RITA, an anticipated CCST date should be set for Type 1 trainees holding a NTN or VTN.

The immigration status of any doctor entering a training programme must be accurately documented on the RITA A form.

RITA B – Changes to Core Information

This document requires accurate completion, particularly when any changes or amendments take place to the trainee's agreed CCST date or contact details.

RITA C – Record of Satisfactory Progress

The great majority of trainees will receive a RITA C at their annual assessment. The RITA C should not be awarded without due consideration of all relevant information against which progress can be assessed. The RITA interview may include a brief presentation by the trainee as well as a review of all relevant paperwork.

This will include:

- The trainee's portfolio, incorporating -

- An up-to-date curriculum vitae demonstrating year on year progress
- An accurate log-book with a summary for the year in question and a cumulative summary for the entire training programme
  Review of the training slot time-table
- Educational and training objectives that have been agreed for the period under review, confirming whether they were achieved
- Evidence of the appropriate use of study leave and personal study time
- Evidence of completed audit projects

- .JCHST documentation, including -

- Trainee assessment form
- Training post assessment form

- Trainee presentation covering –

- Trainee's achievements and concerns for the previous year
- Trainee's ambitions for the subsequent year

At the interview it is essential to record all documents that were reviewed and the outcome of the interview. The record of the meeting should include the post(s) to which the trainee has been allocated, or aspires to, for the following year. This will be based on the educational and training opportunities available and the trainee's requirements.

RITA D - Recommendations for Targeted Training: Stage I of required additional training

The number of surgical trainees awarded a RITA D nationally is not known. A RITA panel recommending a trainee for targeted training will do so because they have confirmed that the trainee has displayed significant weaknesses in identified areas of their training programme. The weaknesses may arise as a result of the trainee failing to meet his/her targets for the previous year, or because a previously unrecognised deficiency in the training programme has been identified and appropriate remedial action is required. The record should confirm whether mitigating circumstances such as ill health, personal or domestic difficulties were considered by the panel when recommending a RITA D.

The RITA D should be looked on as an opportunity to strengthen a trainee's training programme by identifying specific targets to be met over an agreed period (three, six or twelve months).

These targets may be:

- Knowledge-based, e.g. passing examinations
- Academic, e.g. completing a thesis, publications or presentations
- Clinical, e.g. operative skills
- Professional, e.g. communication skills

In addition to the targets agreed for a RITA D, the trainee must be given a clear timetable after which the targets will be assessed and the trainee subsequently awarded a RITA C or RITA E.

There is a clear perception among trainees that a RITA D is a "black mark". On most occasions a RITA D helps a trainee prioritise their educational and training development. The award of a RITA D places significant pressure upon the trainee's consultant trainers and educational supervisor, who must endeavour to ensure that the trainee meets the identified targets within the proposed time-table as well as maintaining his/her overall progress.

A trainee may request review of a RITA D awarded by the panel in the light of new information becoming available but no formal appeal process applies to a RITA D.
It has been suggested that RITA form D should be further subdivided into D (trainee) and D (training). These are however statutory forms and categories and at the time of writing no subdivision is possible. It should be borne in mind that the presence or otherwise of a RITA D on a record has no significance outside of the RITA process and training record and will not figure in job applications etc as it does not delay the award of a CCST.

Problem Areas/Commonly Asked Questions

Should a RITA D be awarded prior to a significant hurdle (e.g. Intercollegiate Examination) just because training time is running short?
Answer-no. RITA D is generally to be used only where an educational objective or need has been attempted without success.

RITA E –Recommendation for Intensified Supervision/Repeat Experience: Stage II for required additional training

The number of trainees who have been given stage II intensified supervision/repeat experience nationally in the surgical specialties is not known.

Awarding a RITA E to a trainee is a serious step and will, by definition, delay the award of a CCST by an additional period of three, six or twelve months at the end of which a RITA C will indicate that the trainee has achieved the required standard, has met the agreed targets and may progress to the next step of their training programme.

A RITA E will only be awarded following the assessment process identified above but in circumstances whereby the trainee has displayed persistent significant weaknesses in consistent areas of their educational and training programme and/or have failed to meet the targets identified on a RITA D programme. It would be most unusual to award a RITA E as a result of identifying definitive gaps in the educational and training opportunities provided by a training programme. Issuing a RITA E would almost certainly be associated with the trainee failing to make progress in any of the four fields identified above, i.e. knowledge, academic development, clinical progress or professional skills.

Accurate minutes of the RITA meeting, including all documentation that has been considered and the trainee's interview is essential when issuing a RITA E should the trainee choose to appeal against this decision.

A two-step appeal process is available to the trainee who does not accept the award of a RITA E, see below.

In addition the decision should be drawn to the attention of the trainee's employers to revise his/her contract.

The targets the trainee must meet should be clearly identified and recorded not only for the benefit of the trainee but also for the Programme Director, and the consultant trainers and educational supervisor with whom the trainee will undergo his/her period of intensified supervision and repeat training. These targets will be the basis on which trainers will carry out their appraisal and assessment processes during the re-training period. Regular meetings should take place between the relevant trainers, educational supervisor and Programme Director to monitor the trainee's progress during this time to ensure that every opportunity is taken to help the trainee make progress or to clearly define whether the trainee should leave the training programme.

The trainee and trainers involved in a period of stage II additional training should recognise that failure to meet agreed objectives within the timetable will lead to withdrawal of the trainee's Training Number. Alternatively, the trainee can be awarded a RITA C indicating that they have met the targets and may progress to the next stage of their training programme. Awarding a RITA D at the end of this period would be inappropriate.

Problem Area/Question: What RITA should be awarded if a trainee, through his/her own neglect, fails to either appear for the RITA or fails to produce the appropriate documentation in time for that panel?

Answer: It depends very much on the circumstances. A 'one off' lapse such as this may be viewed leniently and the RITA deferred if practical, for a short period.

If this is a lapse that forms part of a pattern of behaviour/attitude displayed by that trainee, a RITA E whereby training time is repeated through to the next available opportunity for a RITA panel may be appropriate. As pointed out in the foregoing a RITA E is a serious step that places the trainee in a precarious position and great care has to be taken before one is issued. There must be no doubt that due process has been followed, appropriate notice given and received etc.

It is clear, however, that a RITA C cannot be issued unless the panel has been provided with all the appropriate information.

Appeal Process

The Orange Book describes the two step process that applies to the award of a RITA E and withdrawal of a trainee from a training programme. Step 1 of the appeal process is a discussion co-ordinated by the local Deanery between the trainee, the relevant Regional Specialty Advisor and Programme Director to review the award of the RITA E or withdrawal from training and to try and reach a common understanding. This step in the appeal process is essentially a further meeting of individuals who have almost certainly discussed the issues causing concern on many previous occasions.

If the step one meeting is unsuccessful or rejected by the trainee as he/she feels it will be unproductive, a second stage appeal involving outside, independent and cross-specialty consultants, a separate Regional Specialty Advisor and a trainee is co-ordinated by the Deanery. At this appeal panel meeting, the trainee is entitled to be accompanied by a friend, colleague or legal representative. Preparation by the Deanery and all relevant parties for a RITA E or step 2 appeal panel must be meticulous.

RITA F -Report of "Out-of-Programme Experience (OOPE)"

(See also Section 7)

Type 1 trainees can retain their Training Number when they take time out for research, as long as the research programme has been prospectively agreed with their Programme Director, the Postgraduate Dean and the Specialty Advisory Committee (SAC). The criteria for measuring the success of a research programme must be agreed in advance. The RITA F form should also be completed by a trainee on maternity leave.

The same principles apply to trainees taking leave of absence to gain experience abroad, provided it is compatible with their future training requirements. The overseas training unit to be visited must be recognised by the national authorities in the country concerned. It must be an approved and appropriately supervised training post offering agreed experience with agreed outcome and assessment measures established. These measures will be the basis of a report to be submitted by the educational supervisor in the visited unit to the trainee's parent Deanery, RITA panel and the relevant SAC.

Irrespective of the nature of the "out-of-programme experience" (OOPE) undertaken by a trainee, he/she must submit a report on their OOPE at intervals no longer than one year. Currently the RITA form F does not adequately outline the agreed criteria whereby a period

of research or working overseas will be assessed to confirm whether it has made a useful contribution to the trainee's overall training programme.

Trainees undertaking training in another Deanery within the United Kingdom for educational purposes must be assessed in the usual manner by the consultant trainers in the unit to which they are attached and by a RITA panel within the visited Deanery. That RITA panel **must submit a report with the appropriate documentation to the trainee's parent Deanery**, Training Committee and the SAC.

RITA G- Final Record of Satisfactory Progress

Completion of this document confirms that a trainee has in the opinion of the Chairman of the Specialty Training Committee satisfactorily completed their CCST programme. In practical terms this document indicates that the individual concerned is now ready for consultant practice in the National Health Service.

The RITA panel must ensure that the award of a RITA G is not seen as a "formality" at the end of training. The panel must be confident that the trainee's technical and non-technical skills have been adequately developed and are appropriately supported by a sound academic and knowledge base.

The final RITA meeting will be seen as an opportunity for the trainee and the members of the panel to review the overall quality of the training programme. However, it may be more appropriate for this discussion to be restricted to the Chairman of the training committee and the Postgraduate Dean/ Associate Postgraduate Dean.

Common Problems/Questions: The RITA G that is issued by a panel before the trainee has completed all the requirements of the curriculum.

There are three circumstances under which a trainee may leave a training scheme viz: By satisfactory completion of training (CCST), by resigning or by withdrawal of the training number.

If, for example, a trainee has completed the training programme, but has not passed the Intercollegiate Examination, he/she cannot be awarded a RITA G. Neither can the training number be withdrawn from that trainee and/or employment terminated unless stages 1 & 2 of the required additional training process has been carried out.

RITA H -Withdrawal from the Training Programme

Why is there is no RITA H?

The processes whereby a trainee's Training Number is withdrawn and its consequences are not well defined in the Orange Guide. The trainee's contract indicates that it is dependent on the trainee holding a Training Number. Accordingly, the employing Lead Trust holding a trainee's contract should be informed when a trainee is given a RITA E or stage II period of required additional training, one of the outcomes of which may be withdrawal of the Training Number. The numbers of trainees who have had their Training Number withdrawn is not known. The RITA panel recommending the removal of a Training Number to a Postgraduate Dean should ensure that they adopt best practice by checking that all appropriate documentation is in place and that the two-step appeals procedure can be set in motion without any concerns.

The RITA panel should therefore ensure that the following documentation has been reviewed:

- Training/learning agreement
- Placements – has there been a structured programme of placements with appropriate educational and training objectives?
- Assessment – for each placement, have there been appropriately documented appraisals supplemented by an informal six-monthly and formal annual RITA assessment?
- Are the key areas of failure to make satisfactory progress consistent; have they been identified in each placement; are they unresolved and are they appropriately documented?

The RITA Committee recommending the removal of a Training Number must check:

- The key areas of failure to make satisfactory progress are consistent.
- Have they been identified in each placement?
- Do they remain unresolved?
- Have they been appropriately documented?

Reference: ***A Guide To Specialist Registrar Training, 1998, Sections 12, 13 and 14***

Available from www.jchst.org **

4 The RITA Panel

Constitution

National recommendations adopted by the Deaneries stipulate the constitution of the panel.

The JCHST Manual of Higher Surgical Training states that the annual RITA process should comprise a minimum of four members from the following:

Programme Director
A representative from the appropriate Royal College or Faculty, preferably from outside the geographical area of the training scheme. This is usually the SAC liaison member.
A representative of the consultant trainers
Chairman of the STC (if not the Programme Director or Regional Specialty Adviser)
Regional Specialty Adviser
Postgraduate Dean or his representative (usually the Associate Dean for the Specialty)
University representative

There is a risk if the panel comprises merely the office bearers of the STC, that it will be seen as too remote, particularly as far as the trainers are concerned. If it is too large and, even though it has a great deal of work and decision making to accommodate, it will be criticised as too intimidating for trainees. A balance in the composition must be struck but it is important that there is adequate representation from among the broad body of trainers, whose perspectives may be invaluable and who can also share the considerable workload involved. Inviting one or two trainers has the benefit of involving and educating new colleagues in the process, maintaining transparency, and providing a level of ownership among trainer colleagues.

In larger specialties one additional regular consultant member charged solely with supervising the information needs of the panel, the STC and the trainees, has been found to be extremely helpful. Such a long-term STC appointment combines well with the tasks of a consultant responsible for supporting trainees in the region in the use of an electronic logbook. Not all programmes may be fortunate to find such an enthusiast with the appropriate technical skills in their midst, but it is worth going to considerable lengths to achieve this as the benefits to the training programme as a whole and those administering it are substantial. (See Section 12 for more information on the role of the Regional STC Information Officer as used in General Surgery)

The Chairman of the panel may be either the Chairman of the Regional STC or the Programme Director. The advantage of the STC Chairman acting as Chairman of the panel is that he/she can attend to the conduct of the panel whilst the Programme Director, who is the most important and busy member of the panel, is left free to run the process. It falls to the Chairman of the STC to 'sign off' the appropriate RITA form at the end of the proceedings. Either model can work well.

Summary of Key Points in constituting the RITA panel
Conform to the minimum constitution as laid out in the 'Orange Book'
Involve trainers as well as members of the STC
Consider who should chair the panel well in advance
Consider appointing a 'Programme (STC) Information Officer'

Setting up a RITA Panel

Planning for a RITA panel meeting requires careful coordination of all concerned. There needs to be adequate advanced warning of the date(s) of the meeting. The panel must be appropriately constituted (see Section 4) with roles allocated to the panel members. Trainees should be made fully aware of the importance of the meeting and their responsibility for the completion of the necessary paperwork. Finally, arrangements for a suitable venue and appropriate facilities should be put in hand.

Date and Timing of RITA Meetings

As the RITA meetings are part of the Deanery training responsibilities, coordination of the process requires close liaison with the designated Deanery Medical Workforce Officer. For practical purposes, either the Chair of the Regional Specialty Training Committee (STCs) or the Programme Director is responsible for ensuring that the process takes place. In most Deaneries a pattern has been established and as long as the system works it does not much matter which of these office bearers takes the lead. Many STCs set dates after discussion at their regular meetings, but consideration should be given to fixing future date(s) at the RITA panel meeting itself (see below).

Notification of the date must be given well in advance and **should be set 12 months ahead** so that the diaries of panel members and of trainees can be kept clear for these important dates. Attendance at the RITA is mandatory for the trainee and holidays, work schedules, etc. must be worked around the dates. This requires adequate notice for all concerned.

Part of the function of the RITA is to help the Programme Director decide on placements for the commencement of the following training year. A RITA held late in the academic year does not provide trainees with sufficient notice to make appropriate domestic arrangements, nor does it allow those Trusts that will be making LAT or LAS appointments sufficient time to convene appointment panels. For this reason the panels in some specialties in the UK convene during early Spring as their training year begins in the Autumn.

Most training programmes will require an additional RITA during the year for trainees who need more frequent review. These can often be accommodated during the morning of the day on which the Specialty Training Committee is convened. This may need to expand to a full day particularly if there have been a number of new recruits who are to be seen during their first six months. In rotations where there are two recruitment exercises annually, RITA panels may need to be held more frequently.

The Medical Workforce Officer needs to inform each trainee of the date of the RITA panel as soon as it is set. Trainees should confirm receipt of the date of the meeting. E-mail is emerging as the most satisfactory form of communication with this fairly mobile group of young surgeons. Short notice of a RITA panel inevitably leads to fragmentation in attendance. Furthermore, these qualify as “high stakes” interviews and failure to attend is likely to result in serious consequences for the trainee. The administrative process, therefore, must be extremely rigorous and well supported.

A Deanery web site is invaluable for keeping trainees in touch with dates, timetables and special announcements. It can also act as a repository for documents such as assessment forms, which can then be downloaded as required.

The Medical Workforce Officer must provide all members of the panel with details of the timetable well in advance.

The minimum time to be allowed for each trainee is 30 minutes. If there are likely to be particularly contentious interviews it may be wise to anticipate this by allowing extra time. As LATs and FTTAs are to be included in this process the time commitment for the panel members is considerable. It may necessitate separating out the RITA panel days in order to mitigate the impact on key individuals and their own clinical commitments. Thought should be given to this well in advance. A further option is to consider grouping the RITAs according to their years of placement on the programme. Those in the first three years have similar requirements, which are different from those in years 4, 5 & 6. Subdividing the trainee groups in this way is well worth considering as it can make the process more efficient.

Summary of Key Points when setting up the RITA panel

- *Process conducted through the Deanery*
- *Set dates for the RITA panel and notify all concerned 12 months in advance*
- *Trainees to confirm receipt of the date*
- *Extra dates may be accommodated conveniently on the morning of an STC meeting*
- *Consider the time commitment for individual panel members and consider grouping the trainees according to stages of training and apportioning the work between key members*
- *Minimum time per trainee is 30 minutes, and consider extra for known problem cases*
- *Make clear to trainees that non-attendance is unacceptable for all but exceptional reasons and will result in a 'fail'.*
- *Robust and efficient administrative support is essential*
- *E-mail and Deanery websites have emerged as the most successful method of contacting trainees. Mobile phone numbers should also be kept on file.*

Arrangements and Facilities

Most panels are held centrally, often within Deanery premises. This ensures access to training records and any other reference material that may be necessary. Such premises may be geographically remote for many and consideration should be given to holding the meetings at venues which are mutually convenient for trainers and trainees. This may mean holding the meetings on two separate occasions a couple of weeks apart, possibly at one central venue and one more geographically distant. This minimises inconvenience and allows for late alterations due to unavoidable absences.

In the larger specialties panels will usually need to convene for at least two days at a time and in this context it is worth emphasising that conditions should be made as comfortable as possible for the members. Cramped, stuffy, hot/cold, drab rooms do not help the humour of panel members or trainees. There should be adequate space for trainees to wait in reasonable comfort and dignity. Attention should also be given to provision of appropriate refreshment for all concerned.

Panel members may need to stay overnight bearing in mind early starts and long days of interviewing. Proper accommodation and a good meal taken together are important *douceurs*. RITA panels are a major landmark in the training programme diary. The provision of proper facilities and comforts go a long way towards maintaining this image, and may also increase the chances that hard pressed consultant trainers will continue to give up their time for this voluntary exercise.

Key Points when selecting facilities

- *Geographically accessible for the majority of members and trainees*
- *Properly appointed rooms that are well ventilated, quiet, spacious and have appropriate, comfortable furniture*
- *Comfortable waiting facilities for trainees (not just a hard chair outside the interview room)*
- *Consider team aspects of the exercise by providing social components(dinner)*
- *Consider whether computer, OHP and computer projection facilities are required*
- *Hotel accommodation to a good standard for panel members if early starts/late finishes expected*

5 The Paperwork for the RITA

The paperwork for the panels can be considerable. It is important that this is received from the trainees in good time so that as much as possible of it can be circulated to panel members well in advance of the panel date. The Medical Workforce Officer in consultation with the programme director is best placed to coordinate this. We live in an imperfect world, however, and the reality is that information is sometimes submitted late or close to deadlines. Expert and well resourced administration, clear lines of communication, appropriate use of electronic media and careful attention to the format of the data will make it possible for the panel to assimilate this on most of these occasions if it is so minded. For example, case-mix or operative data presented in histogram format and projected via PC onto a wall takes a few moments to review; whereas a non-consolidated logbook is extremely time consuming and tedious to analyse and share amongst the panel. RITA panels should not fall into the trap of accepting tabled unprocessed data that it is impossible to evaluate during the interview.

Two to three months ahead of the date, each trainee should receive notification of what they need to provide. Some of these forms will provide additional information (c.v., GMC certificates, training post evaluation form, etc.); some will contain the results of assessments carried out by trainers or others during training and in some instances the detailed assessment itself will be required. For surgery SpRs are likely to be asked to provide:
A training portfolio containing:

- The current learning agreement.
- An up to date CV;
- The logbook in a format suitable for electronic analysis;
- A summary of the past year's activities (publications, academic work in progress, courses attended etc) as part of the learning agreement
- Completed and countersigned assessment forms commonly known as the 'Yellow'(Trainee) and 'Green'(Training Post) forms that are issued by the Joint Committee on Higher Surgical Training (JCHST);
- Other relevant documentation

The RITA panel cannot function if the data is incomplete. Failure to present the data in time for the panel to consider is likely to result in a "failed" RITA assessment and there must be no room for doubt regarding the requirements, arrangements for submission and deadlines.

The development of electronic logbooks in some specialties facilitates a more longitudinal overview of trainees, trainers and training institutions. Analysis of logbooks takes time and it is important to establish how much time is required in order that the logbooks can be submitted, analysed and data made available for the meeting. This may mean that only the first six months of an attachment is available for detailed discussion. There are moves to quantify the minimum levels of experience that are acceptable during different stages of training, but at the time of writing these have not been determined by all specialties and agreed with training bodies.

A recurring theme heard at RITA panels when data/paperwork is incomplete, runs along the following lines:

"My trainer has had the papers and has failed to complete the assessments." Alternatively, *"I have been unable to fix a time with my trainer when we can sit down and discuss my training."*

Whilst one can have every sympathy with a trainee who finds him/herself in this position, it must be made clear that the onus is on the trainee to complete the paperwork. In the case of failure on the part of the trainer, it is incumbent upon the trainee to send in the paperwork that

he/she does have in his/her possession. Also to submit in writing ahead of the RITA that they have attempted to see the trainer with a view to completing the paperwork, but with no success. Such a letter should be copied to the trainer who will doubtless respond directly to the panel and/or take action to rectify the situation.
It is becoming entirely practical to record (and submit) the relevant data electronically. This greatly facilitates the work of the Medical Workforce Officer who otherwise may have to transport large amounts of paper records. Electronic formatting of the data also permits projection of data (e.g. analysis of logbooks, past training records, etc) from a PC during the proceedings. Those who have tried this can testify to its impact and the improvement in efficiency that is produced. An STC information expert is one way of achieving this (see Section 12)

Due attention should be given to the provision of appropriate hardware and software for this purpose.

Finally there is an argument for each panel member to be responsible for a particular section(s) of the paperwork before and during a session. The easier aspects are the summary sheet of the year's activities and the logbook with analysis. It is therefore important to identify which member has which responsibility and to ensure that the Deanery Medical Workforce Officer circulates the information in good time. Failing this, at the outset of the session the Chairman will usually allocate tasks equitably around the table and agree the sequence.

6 The Conduct of the RITA Interview

The panel convenes in good time prior to the first interview.
The paperwork/data is checked; and the day's proceedings reviewed.
The interviews require structure, and it is essential that each section is covered systematically within an agreed framework. The framework suggested is as follows:

Review of the learner's present position
Dialogue
Setting of objectives and timeframe
Record keeping

Panels divide these tasks between their members, but it is usual for the Programme Director or the Chairman to start and conclude the proceedings.

Increasingly, the various documents will be presented by the trainee as a portfolio. The logbook data should be available, ideally from an electronic logbook, as a consolidation sheet. The ideal method of display for this is using computer projection directly from a lap top PC and the trainee's logbook disc, but if this is not practicable then a consolidation sheet is a minimum requirement. Many SACs and programmes have additional standardised requirements such as the Operative Competence forms.

Prior to the trainee coming into the room the panel should be alerted to any specific concerns or points that need covering and agree between themselves how these will be covered.

The trainee is then invited in, welcomed by the chairman and the format explained. Remember that trainees have criticised the RITA panel as being intimidating and one sided. Regardless of the training situation, a friendly introduction and conversational exchanges can go a long way towards breaking the ice. Panel members then settle down to business and work through the various assessments and supporting documentation that have been provided. The aim here is to review progress against objectives set at the last RITA (learning agreements) and outlined in the curriculum. Material that may be used here includes:

- Trainers' reports and assessment forms (e.g. JCHST Yellow Form)
- The training portfolio, including CV, publications, research
- Logbook analysis
- Operative Competence Assessments
- Other relevant data

At the completion of this section it is convenient to discuss with the trainee the "green" form, i.e. his/her evaluation of the training post. Bear in mind that this may not be appropriate if the form is critical and the trainee's consultant trainer is present, as the information given by the trainee is confidential.

With this stage of the process complete it is best that the trainee is asked to leave the room while a panel discussion ensues. For most this will be fairly brief. A review of progress made against milestones set down in the curriculum will result in a consensus that satisfactory progress is being made. A minority of trainees will require a more detailed evaluation and it is here that trainers' reports, the results of reliable assessments, the requirements of the curriculum and the quality of the training received must be balanced during the discussion. At this point the panel will have agreed whether a RITA C, D, E or F is appropriate (See Section 3).

The trainee is asked to return, and the dialogue commences to set the next stages of training. The Programme Director leads this discussion and the points to be covered include the following:

- The general requirements of the curriculum;
- Specific requirements such as examinations, when, where, and the necessary preparation.
- Other appropriate aspirations of the trainee and the panel set against the headings in the learning agreement.

This is a very important aspect of the panel and handled well can be the most fruitful and productive section. It is usually possible to hold a brief but constructive discussion that results in a consensus among the panel and the trainee on the next stage of training.

The Programme Director and/or Chairman of the Committee then terminates the interview by setting out the objectives that will be required by the next RITA or an alternative time frame. These objectives should be **specific**, e.g. one presentation at a regional meeting or a particular course to be attended, completion of a thesis, a pass in the Intercollegiate Examination etc. They should be set in a **time frame** and a written **record** must be made. This record will then be sent to the trainee, kept at the Deanery and a copy also sent to the trainers. An example of a framework used by some STCs is appended. A lap top PC and/or proforma can be helpful in structuring this discussion and at the same time providing a convenient and efficient method of recording and disseminating this information. A checklist can help to ensure that all the tasks are completed.

CHECKLIST FOR RITA PANEL

Name of Trainee: .....**Date of RITA**……

Chairman of the Panel…….

	Tick
1. Progress sheet, postgraduate education, exams etc. updated	☐
2. Updated CV	☐
3. Review of presentations and publications	☐
4. Log book and consolidation sheets checked, countersigned by Trainer(s)	☐
5. Operative competency charts (as appropriate)	☐
6. Review of previous learning agreements.	☐
7. Trainee assessment form(s), completed by Trainer(s) & countersigned by Trainee.	☐
8. Training post assessment form(s), completed & signed by Trainee.	☐
9. RITA form(s), completed and signed by Programme Director and Trainee.	☐
10. Review of preference form and learning agreement for the next year.	☐
General Surgery Logbook summary completed for general surgery / subspecialty	☐

Comments by Programme Director:

……

……

Date of next review:

…….....

Signature of Chairman of RITA Panel

7 Dealing with Out of Programme Experience (OOPE)

Trainees are encouraged to take a year out of programme during their flexible year of training where this will benefit their training. This period can prove to be one of the most formative and worthwhile experiences for a developing surgeon. Trainees are given the greatest freedom to choose how they wish to spend this year, but in essence must demonstrate to their Programme Director and Dean that the year is going to be productive. It falls into one of two categories namely, additional specialist medical training or research. Most trainees who are enrolled on to training programmes will be well aware of the system and start to plan several years in advance. The RITA panel should monitor this and ensure that the trainee is actively pursuing promising leads, is maintaining contact and dialogue with the Programme Director and is aware of deadlines. Regardless of how the time is to be spent, an application form must be completed in sufficient time so that the STC and Deanery can consider the matter, give their approval or otherwise. Prospective approval must also be obtained from the relevant SAC. Failure to obtain prospective approval for periods of out of programme experience through the Dean and the SAC still regularly causes problems and delays with the issue of CCSTs. At the time of writing, the regulations certainly permit substantial periods of training additional to the flexible year, to be conducted out of programme providing that they are negotiated well in advance, are appropriate for the trainee and are assessed through the RITA process

Regardless of the provisional approval given prior to taking the period out of programme, the RITA panel also assess and sign off the amount of time that it feels is actually appropriate to count towards the CCST when it has considered the reports and after it has been completed. This recommendation should then be forwarded to the relevant SAC for consideration. For more details on how to obtain prospective SAC approval for periods of out of programme experience please refer to the JCHST website www.jchst.org

Clinical Out of Programme Experience

A clear indication of how the time is to be spent must be provided. For clinical periods the minimum requirement will be for an appropriate timetable, confirmation by the prospective trainers that proper supervision will be given and that an annual report will be provided. At the RITA panel prior to the period out of programme, there must be a written agreement on the objectives for this time and how they will be assessed. At the RITA following the period out of programme experience, material should be available to the panel by way of portfolio documentation, trainer reports, validated logbook and research output sufficient to enable the panel to make a balanced judgement on what has or has not been achieved and to sign off the amount of time that it feels should count towards the CCST.

Research Periods

The maximum period of research that can be recognised towards a CCST during training in surgery is 12 months. A high proportion of trainees undertake a period of research prior to appointment. However, prospective approval must be obtained from both the Deanery and the relevant SAC for research undertaken during higher surgical training. Regardless of when it is taken, for most SpRs the goal is either an M.D. or a Ph.D. A shorter period of more structured training in research methodology, which leads to an M.Sc., is becoming more widely available.

For research periods taken during higher specialist training, the minimum requirements will include a named supervisor, a structured programme and clear objectives.

Following the reforms to higher specialist training, the RITA panels and universities noted a high rate of failure to complete theses. The universities are now justifiably taking a much harder line on completion and submission of registered degrees, not least of all because of the

effects on the research assessment exercise. Local rules should be in place to ensure that the process is much more tightly regulated and that there is appropriate support for the postgraduate student. One large UK Medical School recently introduced the following system, with clear benefits to progress.

- The thesis proposals are agreed.
- All students are expected to attend a taught course on professional skills and techniques in research.
- Two independent assessors (appointed from outside the student's department and often non medical scientists) undertake a progress meeting after receiving a written report from the student and a written report of progress from the supervisor. This takes place at 9 – 12 months and revolves around a discussion of a written and illustrated report of around 5000 words. This includes a statement of aims and a literature review together with a summary of methodology, results and discussions and an outline of future work.
- A recommendation is made to carry on or otherwise.
- Non-progress is taken seriously. Problems identified at interview are rectified if possible. If this is not possible, then extension of the timetable (with appropriate financial penalty) or termination of the project may be recommended.
- A second assessment at 18 months is carried out and comprises a 1000 word summary with similar outcome options.

Regardless of the local arrangements of the host academic institution, during and upon completion of the period the RITA panel will require evidence from the supervisors that the period is being or has been completed satisfactorily.
The importance of the RITA panel setting clear objectives at the outset, therefore, can be appreciated and cannot be overstated.

COPMeD Guidelines

In March 2003, the Conference of Postgraduate Medical Deans of the UK endorsed the following approach to cover all specialties.

The following principles should be adhered to when establishing Deanery documentation for the consideration of OOPE for Specialist Registrars.

The purpose of Out of Programme Experience is to allow an SpR:

- To gain additional clinical experience which will benefit the NHS as well as the individual
- To undertake a period of research

Criteria for Deanery Approval

The OOPE should:

1. Be prospectively approved by the relevant Specialty Training Committee
2. Form part of the trainee's Personal Learning Plan/Personal Development Plan
3. Count towards the trainee's CCST to the maximum allowed by the SAC
4. Be adequately supervised
5. Be subject to an annual RITA F

Further Points

- Though trainees should normally expect their OOPE to count towards their CCST to the maximum allowed by the SAC, (and this should be established in advance) their CCST date will, nonetheless, be re-assessed on their return to programme in the light of their current educational progress and the time left in programme.

- A trainee with a RITA D/E, or if unmet objectives were identified at their PYA, will not usually be granted a period of OOPE unless it can be demonstrated that their specific training objectives have been/will be met.
- A clinically based OOPE will not normally exceed the period approved by the SAC as contributing to training (i.e. will not normally result in a delay to the trainee's CCST date)
- If a research based OOPE will exceed the period approved by the SAC as contributing to training (i.e. will result in a delay to the CCST) it will:
  - Not normally exceed three years
  - Usually enable the trainee to submit for an appropriate higher qualification
- In their final year of training trainees will not usually be granted a research-based OOPE, which will result in a delay to their CCST date.
- Although the COPMED rules do not preclude OOPE in the final year, trainees must comply with College regulations (e.g. RCA requirement that the last six months of training must be spent in programme).

NOTE:
The Deans must retain the ability to make decisions regarding individual trainees whom they are responsible for supervising and under exceptional circumstances the Dean will consider requests for OOPE which do not fall within these guidelines.

Funding

Funding arrangements should be in place to ensure that the OOPE can be completed according to the conditions of the applications and in line with the SpR's PLP/PDP.

8 Summary of Role of Those Involved in the RITA Process

The important elements in the **Chairmanship** of the RITA panel are:

- Understanding the purpose of the panel
- Encouraging an appropriate, non-intimidating and constructive atmosphere
- Liaising with the Programme Director and the designated Deanery manager prior to the panel convening
- A clear focus on the tasks during the panel;
- Keeping the discussions moving and making progress;
- Ensuring that there is a clear resolution to the end of each interview, with a classification of the trainee against known criteria and standards;
- Keeping to time.
- Signing off the appropriate RITA form at the conclusion of the proceedings

The tasks of the Programme Director with regard to the RITA Panel

- To have a detailed knowledge of the situation of each trainee in his/her charge
- To play a major part in the proceedings of the panel by:
- Informing the panel of any specific problems pertaining to a trainee, either in advance of the interview or as appropriate
- Working with the Deanery officer and Chairman, to ensure that the process is administered effectively and properly (advanced notice, paperwork requirements, facilities, membership etc.)
- Prompting, informing and/or directing the discussions to ensure that all the points appropriate for a particular trainee are covered
- Ensuring that any concerns of the trainee are properly addressed during the proceedings and recorded as appropriate
- Ensuring, with the chairman as appropriate, that the proceedings are properly terminated for each trainee and that a correct record is made of the conclusions and any special features, including the learning agreement/objectives/timeframe for the next review)
- Ensuring that these conclusions are brought to the attention of the appropriate authority (Postgraduate Dean, Trainers, Trusts)

Tasks of the Trainers involved in the RITA process

- To attend the RITA panel if requested by the Chairman
- To prepare for the proceedings (reading the paperwork, raising any queries before or during the RITA panel)
- To take part in the proceedings as requested by the Programme Director
- To provide honest, comprehensive, timely and objective assessments as required by the curriculum and training bodies
- To discuss the assessments with the trainee prior to submission to the panel
- To maintain the confidentiality of the proceedings

Tasks of the Dean's representative on the RITA Panel

- To ensure that the proceedings of the panel are conducted fairly to all concerned
- To ensure that best practice with regard to interviewing and assessment are adhered to during the panel, and to bring to its attention through the Chairman any concerns in this regard at the outset and during proceedings
- To act as the conduit for appropriate information flow between the Dean and the panel.

Tasks of the SAC liaison member on the RITA panel

- To make every effort to attend for the whole or major part of the proceedings
- To offer advice on general matters of training, particularly those to do with the curriculum, learning objectives, agreement, competence e.g. highly specialist and special situations
- By bringing a College and national perspective, help to facilitate any special training needs of a trainee if they cannot be accommodated within the Deanery
- To act as a conduit for appropriate information between the SAC and the RITA panel
- With the Programme Director and Chairman of the STC, to note the trainees' assessments and comments regarding posts

Tasks of the University or academic member of the RITA panel

- To act as an ordinary member of the RITA Panel
- To advise the panel with regard to judgements concerning academic matters and the performance of a trainee.
- To advise the panel with regard to other academic matters
- To act as conduit to and from the Postgraduate Dean.

Tasks of the Information Officer of the RITA panel, if present

- To advise and work with the Programme Director, Trainees and the Workforce Development Officer of the Deanery on the RITA panel in matters concerning data collection and presentation.
- To assist the panel in the delivery of that data to the panel in appropriate, timely format.
- To supervise the presentation of data to the RITA panel

Tasks of the Workforce Development Officer/Administrator in the RITA panel

- To administer the RITA process
- To work with the appropriate STC officers in delivering a satisfactory RITA panel
- To prompt the STC officers according to an agreed timetable
- To understand the RITA process.
- To ensure that the RITA panel is conducted under satisfactory conditions
- To ensure that the RITA panel is informed of any matters relevant to the conduct of the interview with each trainee
- To act on any reasonable requests form the panel Chairman
- To bring to the attention of and inform the panel of any regulations relevant to the proceedings of the panel.

Tasks of the Trainee attending the RITA Panel

- To provide completed paperwork in timely fashion
- To have reviewed and updated his/her portfolio and archived old material as appropriate
- To have reviewed his/her own position with regard to training progress measured against the curriculum and objectives set at the previous review
- To have formulated personal preferences for the next period(s) of training
- To arrive in good time for the review

9 The Specialist Registrar, Contract and Employment Law

The appointment of Specialist Registrars is the responsibility of the Postgraduate Dean and guidance on the recruitment process is given in the Guide to Specialist Registrar Training (the Orange Book). The Trust is the employer of the majority of Specialist Registrars, and in many regions this will be a lead Trust on behalf of a number of Trusts involved in a rotational training programme. Other employers will include Universities, Medical Research Council, Health Boards and Health Authorities. In both recruitment and employment, the due process of employment law must be followed as well as the guidance set down in the Orange Book and the Terms and Conditions of Service for Medical and Dental Staff.

Recruitment

Specialist Registrars are appointed by an Appointments Committee set up by the Postgraduate Dean. The Committee, and in particular the Chairperson, must ensure that the process is carried out fairly and that there is no discrimination in terms of race, sex and disability. A model application form is set out in the Orange Book and this enables candidates to be compared on the same areas of relevant information, although it is common practice also to include a C.V. with the application. References are also structured. The job description should give potential applicants full information about the training programme, and the person specification enables candidates to consider whether they match up to the requirements of the post, in terms of qualifications, experience, skills, and professional knowledge. The person specification also enables the Appointments Committee to select candidates in a fair way, both at short listing and at interview, in order to choose the best person for the post.

Allocating the Training Number

The Appointments Committee, in offering the successful person a post, allocates a Training Number to that person. The year of training is determined, and where appropriate, the expected CCST date – though these will require further ratification with the relevant SAC if previous experience is to be taken into account.

The Contract and the RITA Process

Interestingly, the contract makes no direct reference to the RITA process itself. Nevertheless, it does state that: *'Your employment is dependent on you continuing to hold a National Training Number or a Visiting Training Number'* (there is a similar clause in the FTTA Type II contract). The year of training, length of training (e.g. to CCST) and also the expected date of completion of the contract are stated. For Type 1 trainees this latter date is six months after the completion of training or six months after notification of completion of training, whichever is the later. The latter date can be subject to change during the contract as the expected CCST date changes, for whatever reason.

The Specialist Registrar salary scale is a nine-point scale, and progression to the top two points of the scale is automatic except 'in cases of unsatisfactory performance.' These cases are taken to mean the issue of a RITA E.

Extension to Contract

There is a facility in the contract that allows the SpR to have his/her employment extended when the training has been completed but the trainee does not yet have a Consultant post. If the SpR's name has been forwarded to the Specialist Training Authority for the award of the CCST but he/she has been unable, after reasonable effort, to secure a consultant post, a new contract may be offered to the SpR.

Withdrawal of the Training Number – Effect on Contract

As the contract is the responsibility of the Trust (or other employer), *it is essential that the Postgraduate Dean keeps the trainee's employer informed of difficulties that may have arisen with a trainee, and of the steps taken to remedy these.* The Orange Book expects that the Trust or Deanery HR representative would be involved in proceedings to advise on the contractual position, equal opportunities and the Trust's own procedures for dealing with the position where it has been decided that the Training Number should be withdrawn. While the employer will instigate an enquiry to obtain full evidence on which to base a decision on whether to terminate the contract, the situation should come as no surprise to the Trust. *For this reason, it is essential that Steps 1 and 2 of the RITA E appeal process should be carefully minuted.*

10 Learning Agreements

Learning agreements are gaining recognition among the training fraternity as most useful "drivers". They perform several functions:

- They help the trainee to focus his/her efforts;
- They help discussions at the review panel;
- They provide a framework for dialogue between trainer and trainee;
- They provide a record of what has been agreed between trainer/trainee or trainee and RITA panel;
- Used as part of a system, they can ensure that the whole curriculum content is delivered;
- They can ensure that the needs of training and of the trainee are balanced out and recorded.

Learning agreements of one kind or another are in widespread use within specialist training. It is a matter of judgement as to how detailed or otherwise they are made. During design the following factors should be born in mind.

The purpose of the agreement:

- Is it to operate at the level of an individual trainer/trainee or in a more global manner between an annual RITA panel and the trainee?
- Does it conform to the curriculum requirement for the stage of training?
- What level of detail needs specifying?
- How easy will the instrument be to use?

Insofar as the RITA panel is concerned, it may be attractive to use a template on a PC during the RITA interviews. References to the advantages of computer projection of key documentation during the dialogue are made elsewhere in this guide. There must, however, be hard copy placed on file, ideally at the Deanery, and disseminated to:

- The trainee
- The trainer
- The Programme Director

It will form an important part of the individual trainee portfolio and will be one of the most important tools for the RITA Panel.

In general, the principle should be to keep it as simple as possible. The "negotiation" part of the dialogue during the RITA panel discussion should result in a sensible level of achievable learning objectives. This is best agreed and recorded at the time of the panel, so that there are no misunderstandings.

Although learning agreements are intended to be "formative" there is clearly an important "summative" element to them. In the sections on the use of RITA forms and employment law (Sections 3 and 9), reference is made to the importance of clear records that set out reasonable training objectives. Learning agreements are arguably the most important element of this documentation, as without such it will be difficult to produce evidence of failure of progress against agreed objectives.

11 In-Training Assessment: Issues and Challenges

In-training, or work-based, assessment is perhaps the least well developed of all forms of testing. Yet the differences demonstrated between what doctors do in controlled situations and in performance[1] suggests that work-based assessment is essential.

Logic dictates that as these are high-stakes assessments for the individual and the profession, thus the same standards of test-development, reliability and validity should be achieved. Currently, however, these assessments are often developed only to a fairly informal level. The draft Principles and Standards for Assessment to be submitted to the PMETB indicate that in future this will not do. They state that work-based assessments:

- Must be subject to reliability and validity measures
- Evidence must be collected and documented systematically
- Evidence must be judged against pre-determined published criteria
- The weight placed on different sources of evidence must be determined by the blueprint and the quality of the evidence
- The synthesis of the evidence and the process of judging it must be made explicit

Very few RITA panels at present can rely on evidence that would meet these standards.

Performance assessment has been portrayed[2] as a process of gathering information that describes what doctors do in the process of patient care and comparing that information with defined standards. **Standard-setting** for in-training assessment is currently perhaps the least developed of all of its aspects.

There is no agreed view about the best approach to performance assessment[3]. A wide variety of **methods** can be used for in-training assessment:

- Direct observation of consulting
- 360 degree assessment
- Case based discussions
- Patient questionnaires
- Teacher ratings
- Mini-CEX [clinical evaluation exercise]
- Portfolios
- Clinical records
- Logbooks[4]

Each has its advantages, disadvantages and purposes. Assessors, or those designing assessment systems, should be clear about these (Section 2). Those designing in-training assessments will find it advantageous to target specific and defined aspects of performance. For example:

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[1] For example: Ram,P., van der Vleuten,C., Rethans JJ., Schouten, B., Hobma,S. and Grol,R. [1999] Assessment in general practice: the predictive value of written-knowledge tests and multiple-station examination for actual medical performance in daily practice. *Medical Education*, 33, 197-203.

[2] Lew,SR., page,GG., Schuwirth,LWT., Baron-maldonado,M., lescop,JMJ, Paget,NS., Southgate,LJ. And Wade,WB. [2002] Procedures for establishing defensible programmes for assessing practice performance. *Medical Education*, 36, 936-941.

[3] This is true in other professions such as nursing. See Robb,Y., Fleming,V.. and Dietert,C. [2002] *Nurse Education Today*, 22, 293-300.

[4] Patient outcomes is not listed here as an assessment method since these are rarely attributable to the trainee alone, they would be peculiar to one trainee and all trainees should face the same assessments, and very large numbers would have to be sampled to provide any reasonable measure. So this is a potential method best avoided.

- Record-keeping
- Diagnosis
- Management and decision-making
- Knowledge
- Out-patient skills
- Communication with patients and colleagues
- Team-working
- Dealing with specific clinical problems
- Technical skills development
- Time management and personal organisation
- Teaching
- Professionalism.

Which of these is being assessed at any one time should be clear and the assessment method should be fit for that purpose and be measured against the qualities as listed above. The overarching purpose however, is to assess routine performance in practice.

The methods listed above, and many others, largely remain to be tested and developed in practice. For example, although portfolios might offer unique benefits for assessing some aspects of performance, they also will require careful structuring, and specific standards setting, reliability and validity testing for the component parts[5]. The work of determining how best this is to be carried out has not yet been undertaken.

Other methods are better developed. Observational assessments and ratings are acceptable, when:

- Refined and undertaken carefully using agreed **criteria**
- Replicated by **more than one observer** and on **multiple occasions**
- Display acceptable **characteristics**.

It may be of interest that the American Board of Internal Medicine[6] has sponsored a number of studies, which suggest that the mini-CEX can be made to have acceptable technical characteristics - although practical issues remain a challenge.

For the moment, in-training assessment should be considered as 'a project under active development'. Given the high-stakes nature of the RITA process, research into the validity and reliability of the process and its component assessments is now essential.

[5] Wilkinson,TJ., Challis,M., Hobma,SO., Newble,DI., Parboosingh,JT., Sibbald,RG and Wakeford,R. [2002] The use of portfolios for assessment of the competence and performance of doctors in practice. *Medical Education*, 36,918-924.

[6] See www.abim.org/minicex/default.htm

12 The Regional Specialty Information Officer

The panel cannot function properly in the absence of data that is accurate, complete, collated, and timely. One individual, preferably a member of the STC, best oversees this task. The post of regional Specialty Information Officer (SIO) has been developed by several training committees in response to this need. Such a post is not for the faint hearted or poorly organised as, by definition, such an individual needs to be enthusiastic and reasonably familiar with computers - or prepared to learn. Highly specialised knowledge of computer programming is not, however, required. The role can with advantage encompass the setting up and maintenance of a web site where trainees can access Deanery information, new developments and download essential data and proformas.

Electronic Logbook Data Collection

The electronic logbook where it has been implemented has proved to be a highly successful method of collecting data on trainees' surgical experience and exposure. For the first time national programmes operating to a uniform standard can collect data from the individual trainee and use these to inform him/her, the regional training organisation and national databases. Several specialties are developing or have developed their own systems. This can make the RITA panel meetings much easier, efficient and robust. A specialty-adopted system puts an end to previous data collection methods relating to surgical activity, which often resulted in a panoply of printouts that varied from trainee to trainee, none of which could be easily compared one with another. It also makes possible a proper analysis of the training opportunities offered with different consultant trainers and units and can inform accreditation visits by inspecting bodies.

Clearly a reference point for collection of data is essential for the purposes of compiling a comprehensive national database. The Association of Surgeons of Great Britain and Ireland provides this important service for general surgeons and operates a regional network of logbook advisors. Not withstanding this, it also makes great sense for the process to be managed at regional/Deanery level as much as possible so that:

- The lines of communication involve as few people as possible.
- Queries from trainees can be dealt with swiftly.
- There is a clear link into the STC
- Data collection for the RITA process can be managed to suit the local panel
- The STC can maintain some ownership of the data as it accumulates.

Various regional data can still be pooled centrally if desired. The computer programme allows for each trainee to "export" his own individual data onto a floppy disc (with a single key stroke), which can then be sent to the SIO. The floppy disc data is then easily imported into an Access database programme, which contains the summated data for all the trainees' activity over a period of years. Analysis of the data is equally straightforward and menus within the database allow printouts to be created instantly along the lines of (for instance):

(a) List of operations by subspecialty.
(b) Analysis of index operations.
(c) Analysis of operations presented as graphical charts and spreadsheets.

These printouts are sent back to the trainees by the SIO for filing in their portfolios. In addition the tables and graphs so produced can be recalled for display on a projected screen for the panel and trainee to view as a group during the RITA interviews. It is difficult to overestimate the value of having each trainee's data projected in an identical format.

Competence Assessment

Competence Assessment is still at an early stage of development across the surgical specialties. Where assessment instruments or records of such assessments have been developed as part of the training portfolio (e.g. procedural competencies, OpComp, triggered assessments etc.) these must be available for the panel in a form (chart or table is ideal) that is easily assimilated. Projected for common viewing during the interview and/or circulated beforehand, this information is invaluable.

The Website

Much of the routine documentation associated with training can be downloaded from various websites. The JCHST web site www.jchst.org is a good example and many postgraduate Deaneries now have their own with links into related sites.
The construction of a web site might appear daunting for the uninitiated but it is not unusual for an enthusiastic individual to rise to the challenge. The SIO is well placed to participate and/or supervise the specialty aspects of a Deanery website or if one is not available to act as a catalyst for one to be produced. Once constructed (with perhaps a little help from a professional from the computer services department) it runs itself to a large extent and rarely needs much attention form week to week. The rewards are huge and well worth the initial investment.

Preparation and Analysis of Data

Workload for the SIO each 6 months and especially in the weeks building up to the RITA, interviews is not insubstantial. Chasing up trainees to submit their data can prove quite time consuming but as trainees come to understand the importance of the data and the fact that non-submission in a timely fashion is reason enough to issue a 'D' or 'E' assessment, experience has shown it to be less of a problem. It is important for trainees to appreciate their responsibilities in this area and it must be made quite clear on enrolment to the training programme. Once submitted, data can be relatively quickly analysed by the SIO; 15-20 minutes per trainee is usually sufficient.

The RITA Interviews

The SIO should be an ex-officio member of the RITA panel. Armed with a laptop and projector, the SIO can project the following data onto the screen or wall of the room:

(a) Demographic data. This would include the name, information about previous posts, previous training agreements, publications, previous RITA grading etc.
(b) Operative competence charts.
(c) Operative logbook charts.

Data is updated on the PC as the interview progresses.

The new learning agreement is completed on an electronic template as it is projected; stored, and hard copies produced for the appropriate parties and files.

Summary

A 'Specialty Information Officer' (SIO) servicing the needs of specialty trainees and the regional specialty training committee enhances the RITA process and is well worth considering.

Ideally a consultant trainer colleague, who has some expertise with computers or is willing to learn, is ideal.

The SIO should be an ex-officio member of the Specialty training Committee and RITA Panel and also local co-ordinator for the ASGBI Electronic Logbook.

The SIO supports the local implementation of the ASGBI Electronic Logbook, the RITA Panel and perhaps the local training website.

A small amount of funding from the training committee to support these activities is a good investment.

13 General Surgery Section
13.1 A Personal Portfolio for General Surgery

Context
The General Medical Council's plans for revalidation include personal portfolios for all doctors. This chapter briefly reviews the content of the personal training portfolio, discusses its use training and provides some examples.

Following the Bristol affair, demands grew for systems to ensure that doctors' standards of practice were maintained[1,2]. The GMC introduced annual appraisal for all senior hospital staff. This system, in which personal portfolios play a major role, provides the basis for periodic revalidation for all doctors on the Medical Register after 2002 [3] .

The GMC also indicated that revalidation for trainees should be incorporated into training programmes. Persuaded of the benefits of a well maintained portfolio on educational grounds, the JCHST recommended that Personal Training Portfolio should form part of the RITA process for higher surgical training schemes[4]. With various modifications, most STCs have for some time been requiring their trainees to maintain a portfolio that follows the content headings recommended by the JCHST. Some well-organised Basic Surgical Training Schemes have also used portfolios[5]. Paisley has summarised the purposes, construct and methodology of a training portfolio in the context of modern educational thinking[6].

The portfolio should comprise:
- a record of goals, development and achievement
- a framework for self assessment
- a framework for collaborative assessment with trainers and training committees
- a lead into appraisal and revalidation during consultant practice

Although a relatively recent innovation to surgical training, there is nothing very revolutionary about personal portfolios, which essentially add a little more formality to a process that successful practitioners carry out intuitively. A portfolio should work at several levels.

The portfolio as a record
This is the most obvious function. It is a fact that as society becomes ever more bureaucratic and regulated the volume of documentation increases. The fact that the RITA process itself adds significantly to this paper load will not have escaped the reader. Keeping track and order of documentation is important for all concerned, not least the trainee. A well designed folder containing appropriate sections should aid this task. There is, however, a great danger that the portfolio becomes overloaded with documents that are irrelevant, too detailed or out of date. The owner must, therefore, keep the folder under regular review bearing in mind its primary purposes, and be disciplined about what is included and what is filed elsewhere. In this respect an 'Archive' folder or folders are a useful adjunct into which redundant or accessory documents such as published papers, old learning agreements etc. can be transferred.
The sections of a portfolio should be carefully chosen so as to follow as closely as possible the major areas of professional development as set out in the curriculum. This not to state that the headings themselves should slavishly follow the different domains of the curriculum such as communication skills, attitudes, etc, but they should be coherent with them. For example, technical medical skills could be encompassed within several sections depending on the specialty. In the case of Surgery this may comprise clinical skills and operative skills, each of which may have its own sub-sections together with material in the section on courses attended.
The importance of a folder that is of adequate size and robustness, together with section

dividers that are fit for purpose, should not be underestimated. Dividers that do not have projecting, labelled tabs are irritating for the user. Plasticized dividers seem the most durable as the punched holes resist tearing better than the paper variety. Folders whose metal ring holders are of an inadequate diameter and/or easily become misaligned are also an irritation. Plastic see-through filing pockets are also not very convenient for someone trying to review the portfolio. The ASGBI has produced a purpose designed folder for General Surgery that should be available through programme directors at the time of writing. The minimum content is outlined below together with some suggested forms. At the time of writing, their status is one of a recommendation only, as it is recognised that several STCs have their own designs that have evolved during a period of years and work satisfactorily. Furthermore, the JCHST curriculum revision project is likely to produce a generic version for all surgical specialties in due course.

Self-Assessment

The ability to carry out regular, objective self-evaluation is an essential attribute for the young professional to acquire. At base level, the very exercise of keeping the portfolio up to date should stimulate the process of reflection, evaluation and goal-setting. This regular and, if one is honest, enforced review should lead the trainee to compare his/her progress, strengths, weakness, etc. against his/her personal career aspirations and requirements of the curriculum and trainers. From this exercise, the way forward should be clear to the trainee with little stimulation necessary from the educational supervisors.

Some would go further by requiring the trainee to make formal entries reviewing the position in each section, setting down a summary of achievements, strengths, weaknesses, aspirations and objectives.[6] Surgeons and their training committees do not seem minded to espouse this approach at the time of writing.

Assessment by Others

It is self evident that the portfolio is of particular value to the RITA Panel in a manner that has been described in previous sections. It should also be of great practical help in all reviews held between a trainee and his/her trainers or educational supervisors.

REFERENCES

1. **Treasure T.**
   Lessons from the Bristol case
   BMJ 1988: 316; 1685-1686
2. **Scally G., Donaldson L.J.**
   Clinical governance and the drive for quality improvement in the new NHS in England.BMJ 1998; 317: 61-65
3. **Southgate L., Pringle M.**
   Revalidation in the United Kingdom: General principles based on experience in general practice
   BMJ 1999; 319: 1180-1183
4. A Manual of Higher Surgical Training in the UK and Ireland: Joint Committee on Higher Surgical Training. Eighth Report. January 2003. Sections B8, B9
5. The Sheffield basic surgical training scheme
   Ann. R. Coll. Surg. Eng. (Suppl.) 1999; 81: 298-301; 307
6. **Paisley, A.**
   In a Paper for the Trainees' Specialty Advisory Board. Royal College of Surgeons of Edinburgh, July 2003.

CONTENTS OF A PORTFOLIO FOR HIGHER SPECIALIST TRAINING IN GENERAL SURGERY

1) Personal details
2) Regional Programme details
3) GMC Certificate
4) Contract of appointment
5) RITA forms, copies of green + yellow JCHST assessment forms
6) Operative Log Book Consolidation sheets (6 monthly)
7) Operative Competence forms
8) Timetables for posts
9) Educational Contracts
10) Publications and Presentations
11) Courses and Conferences
12) Audit Projects
13) Research Portfolio
14) Certificates
15) Out of Programme Experience
16) Intercollegiate Examination
17) Certificate of Completion of Specialist Training
18) Curriculum Vitae
19) Other
20) Other

Personal Portfolio – Notes for Trainees

- Details of the sections and various forms may be downloaded from the Association of Surgeons in Training website Other important information regarding training can be found in the portfolio section of the Manual of Surgical Training to be found on the Joint Committee of Higher Specialist Training website Trainees should also check with your local Deanery website (if available) for local information on your training programme.
- This portfolio has been generously sponsored by the Association of Surgeons of Great Britain and Ireland Please look after it, but if a replacement is required, it may be obtained through the ASGBI offices at:
  The Royal College of Surgeons of England, 35 – 43 Lincolns Inn Fields, London, WC2A 3PE. Telephone: 020 79730300.
  It is likely that there will be a charge for replacements.
- Contents/section headings are listed on the ASIT website together with examples of the various forms that are in use. Some of these forms are obligatory (JCHST yellow and green forms, operative competence charts, logbook). Others are SAC/ASIT suggestions and maybe superseded by arrangements already in place locally. The system will evolve and you are advised to check on the ASIT and JCHST websites from time to time for suggestions and modifications.
- It is very easy for a personal portfolio to become overloaded with documents to the extent that it becomes very difficult to use. Trainees are advised to ensure that the information that they enter is succinct, relevant and tidy. Wherever possible it should be in word processed form. Check the sections regularly and keep them updated by removing old or irrelevant material that is not required for the current year.
- Please read the notes from the SAC regarding your personal responsibilities with regard to the regulations of training. If they are neglected it is likely to cause you and others inconvenience, or worse, at a later date. Some of the key points are summarised on a separate sheet for ease of reference.

All those who have been involved with the development of this portfolio hope that you will find it useful and, when you have completed your training, will still be found a place on your bookshelves as part of your memorabilia.

PERSONAL DETAILS

NAME .....

DATE OF BIRTH .....

HOME ADDRESS .....

.....

.....

.....

.....

…….

Affix Passport Photograph Here

NATIONAL TRAINING NUMBER.....

GMC NUMBER.....

YEAR ONE POST(S).....

.....

YEAR TWO POST(S).....

.....

YEAR THREE POST(S).....

.....

YEAR FOUR POST(S).....

.....

YEAR FIVE POST(S).....

.....

YEAR SIX POST(S).....

.....

JCHST FORMS

		Tick box
Year One	Yellow	
	Green	
Year Two	Yellow	
	Green	
Year Three	Yellow	
	Green	
Year Four	Yellow	
	Green	
Year Five	Yellow	
	Green	
Year Six	Yellow	
	Green	

Green forms are those completed by trainees and yellow forms are those completed by trainers. It is a worthwhile exercise to copy and keep these for reference. It should be borne in mind however that these forms are confidential and are the property of the JCHST.

WEEKLY TIMETABLE

POST.....

	AM	PM
MON		
TUES		
WEDS		
THURS		
FRI		

EMERGENCY TAKE.....

EDUCATIONAL CONTRACT (i)

Trainee **……..**

Consultant Trainer **……..**

Post **Hospital……..**

Year……..

Date from…….. to……..

GOALS AGREED

Clinical	
Operative	
Audit	
Research Project(s)	
Course(s) & Conference(s)	
Other	

Signature of Trainee

Signature of Consultant Trainer

Date

EDUCATIONAL CONTRACT (ii)

Trainee **……..**

Consultant Trainer **……..**

Post **Hospital……..**

Year……..

Date from…….. to…….

ACHIEVEMENTS

Clinical	
Operative	
Audit	
Research Project(s)	
Course(s) & Conference(s)	
Other	

Signature of Trainee

Signature of Consultant Trainer

Date

LOG BOOK CONSOLIDATION SHEETS

The latest version of the Surgical Log Book is available to down load from www.asit.org/logbook/ or www.asgbi.org.uk

The log book serves two purposes. The first is to provide trainees with a facility for recording their own log book. The second more important purpose of the generic log book is that it enables submission of data for central analysis. Many trainees may have their own log book of some form, and may continue to keep this. Submission of log book data for analysis is however very useful to trainees as it provides a means of monitoring training which may lead to changes locally within Higher Surgical Training programmes. Log book consolidation sheets are a requirement for entry and examination in the Intercollegiate Examination.

Tick off as entered

Year one	
Year two	
Year three	
Year four	
Year five	
Year six	

RESEARCH PORTFOLIO

The contents of the research portfolio will vary from trainee to trainee. Suggested content is as follows:

Abstracts presented to regional, national and international meetings

Abstracts of publications (do not include more than one side of A4 for each publications

Protocols for proposed research projects

A summary of activity to date can be inserted here and/or found in the curriculum vitae.

AUDIT PROJECTS

Include protocols for proposed audit projects and abstracts of completed audit projects. The aim of the audit, its methodology, findings and the effects it had on practice (if any) should be outlined. Each should not exceed one side of A4.

Contents :-

13.2 Logbook for Specialist Registrars in General Surgery

The Association of Surgeons of Great Britain and Ireland

Introduction
The computerised Logbook for General Surgery was set up by Mr Ross Carter as an ASiT Councillor some ten years ago. This was initially funded by the British Journal of Surgery Society and a subsequent commercial version was produced by Irene Greene Associates. There is an integrated suite of programmes for the collection and analysis of surgical data for Specialist Registrars in General Surgery, which is now an SAC requirement.

Summary of the Logbook Software to Date

Version 1 syllabus (1998): Trainee Logbook available for the Psion 3a/c, the Psion 5 and the PC (in Delphi code). Now obsolete.

Version 2: The Trainee Logbook is available for the Psion 3 a/c, the Psion 5, the PC (in Delphi code), MS Access 97 and MS Access 2000. (Note that there are now two versions of the PC Logbook, one holding 500 records maximum and one holding 5,000 records max. – they have different "log.exe" files.)

The Logbook can be downloaded from the ASGBI website (www.asgbi.org.uk) or the ASiT website (www.asit.org). The Access versions are not interchangeable, so that the appropriate versions should be downloaded.

If Trainees are using their own PC and do not have MS Access, they may obtain this at a reduced student price from any supplier.

The database is password-protected and the password can be obtained from irenegreene@lineone.net (please note the "e" at the end of greene).

Data Entry
Operations: Courses:

Data Analysis
The software incorporates a data analysis package, the principal purpose of which is to analyse each trainee's Logbook for the annual RITA review. The summary, as well as giving the number of elective and emergency cases, the case mix and the given period of time, also indicates the level of supervision provided by the trainer. It is also possible to analyse the data by hospital and by individual trainer.

Analysis Support Facility
In order to support Regional Training Committees, the Association of Surgeons as well as providing a telephone and e-mail helpline, has now appointed a Data Co-ordinator who will collect, analyse and deliver data from each trainee in time for consideration of their RITA. Confidentiality of centrally analysed data is preserved by password-protected floppy disk or encrypted e-mail. As well as providing an important service to Regional Training Committees, this will monitor and improve training. The analysis of anonymised national data will also help to shape the new curriculum.

Version 3
When the new curriculum has been agreed during 2004, an upgraded version of the Logbook will be made available:

- This will be in MS Access
- It may be available in a Pocket PC version
- A web database may also be available.

Subject to changes in the curriculum, it is probable that the new version of the Logbook will include:

- a competency assessment of Index Operations
- part-performed operations
- complications: an extendable, drop-down list
- default for Date, Hospital and Consultant
- a field for intra-operative details
- tables for lectures and publications (as per the present Consultant version).

The following features may be deleted:

- Emergency as a sub-specialty: replace with tick-box
- Laparoscopic as a sub-specialty: replace with tick-box
- The ability to add new operations or procedures (any application will be referred to the relevant specialty's Education and Training Committee).

Standard queries / reports (12)
Trainees:

- List of operations by data, by specialty, by urgency & time of day.
- List of procedures.
- Analysis of operations.
- Index operations by specialty and level of supervision
- Regional:
    - Analysis of current specialty interest of trainees & courses completed.
    - Analysis of trainers and hospitals by specialty and level of supervision.
    - Summary of Regional Data.

Data Protection Act

Current advice from the Information Commissioner's office (November 2002) confirmed that Trainees using the official ASGBI Logbook do not need to register personally under the Data Protection Act.
The three main points of concern are:
1. Notification (i.e. registration),
2. The security of the data, and
3. What constitutes personal data.

The three points are not separate but overlap and should be viewed as three aspects of one issue.
1. Because Specialist Registrars are employees of Trusts (which are registered) they do not need individual registration. This includes data stored on any computer including a laptop, whether at work or at home but it must be secure (e.g. the database is password protected).
2. As the Logbook is password protected, it is considered that the data are sufficiently secure, since the Logbook contains only the Hospital Number and Date of Birth, and not the name or address.
3. Personal data is defined in the Act as "data about identifiable living individuals". Since the Logbook contains only the Hospital Numbers and Dates of Birth, and cannot interface with hospital databases, it can only become identifiable information about individuals by someone with access to a Trust's patient information system. Only authorised hospital personnel would be able to do this and they are covered by the Trust's registration.

Please note that discussions with the IC staff concerned only the official ASGBI Logbook and not the consultant version or any other logbook.

The website www.dataprotection.gov.uk/principl.htm gives a full explanation of the 8 Principles of the Act. The Data Controllers' page is also helpful.

Useful contacts:

Helpline: www.irenegreene@lineone.net (please note "e" at end of greene)
Software: ASiT website at www.asit.org/logbook/ or www.asgbi.org.uk
Enquiries for data analysis:

Ms Elizabeth Cecil
ASGBI Data Manager
The Association of Surgeons of Great Britain and Ireland
At the Royal College of Surgeons
35-43 Lincoln's Inn Fields
London WC2A 3PE
Email: datamanager@logdata.demon.co.uk
Tel: 020 7973 0300

13.3 Operative Competence Assessment Instrument for General Surgery

Explanatory Notes

At a workshop on the RITA process in General Surgery held in February 2002, Programme Directors, Training Committee Chairmen and members of the SAC in General Surgery, asked that an updated operative competence assessment form be made available, for more widespread use in the UK and Ireland. The assessment form is a modification of the type first introduced by Savage and Darke[1,2]. They were first used by trainees in Vascular Surgery and subsequently underwent further development and evaluation in the South Western and Trent HST programmes by Messrs Beard, Markham, Wilkins and Grant[3]. The experience in these two regions was favourable. Face validity for the system is good, but at the time of writing reliability (inter rater variation) has not been fully established and work is ongoing in this area and will become better defined as data accumulates. These limitations must be recognised when making critical decisions

Clearly, competence across a range of skills is a requirement for any practising surgeon and of these, technical skill is absolutely essential. The operative competence forms should help:

- Trainers understand the existing levels of technical competence in trainees that are new to them;
- Trainers to assess the training in these areas that are required by such newly placed trainees;
- Inform the RITA panel discussions.

Some background notes on how to use the forms follows. Each form contains a list of procedures taken from the curriculum and appropriate to the stage of training. They are available for:

- Surgery in general (Appropriate for the first 3 years of training, but should be used during the subspecialty training years in addition to the subspecialty forms).
- Subspecialty years in:
  - Vascular surgery
  - Upper GI/HPB
  - Coloproctology
  - Transplantation,
  - Breast Surgery
  - Endocrine Surgery
  - Paediatric General Surgery (the General Surgery of Childhood)

References

1. Savage PEA. Competence assessment of senior house officers in general surgery. *Ann R Coll Surg Eng (Suppl)* 1995; **77**: 246-7.

2. Darke S. Training in operative vascular surgery: gaining experience and competence. *Ann R Coll Surg Eng (Suppl)* 2001; **83**: 258-60.

3. 'Evaluation of 'Continuous Assessment of Operative Competence in Higher Surgical Trainees' Chambers E, Maxted M, Owen H, Grant J. *Report publ. Centre for Education in Medicine, Open University, U.K*. Sept 2002

General points

1. The forms are designed to assist in charting the progress of higher surgical trainees towards achieving technical competence.
2. The procedures included on each form are based upon the current curriculum for higher surgical training.
3. The lists are not necessarily exhaustive but include a best estimate by the SAC and Specialty Associations of the most useful index procedures. Some procedures may be subdivided into sections that reflect the approach taken during training for that particular operation.
4. Copies of the forms are made available on the JCHST website and also as hard copy from the JCHST office.
5. Programme Directors or Deanery managers are asked to insert details of when and to whom a copy of the forms should be returned on completion. It is requested that one copy is returned to the JCHST office with the other JCHST assessment forms after the RITA panels.
6. The evaluation found that distinctive colouring helps trainers and trainees to identify the form. Pink is suggested for uniformity.

Suggestions for using the Forms

1. It is recommended that either:
    a) The forms are distributed, in the first instance with a covering note (*see below)* to each of the trainees in the higher surgical training scheme, including LATs, FTTAs.
    b) Or notification is sent to each trainee indicating that the forms should be downloaded from the JCHST (or local Deanery website as appropriate) and returned with the other paperwork required for the RITA panels by the specified date.
2. The forms should be returned as part of the routine paperwork for use by the RITA panel. Three copies should be made by the trainee:
    a) The top copy should be sent to the Deanery where it can form part of the training record.
    b) The next should be kept in the trainee's portfolio.
    c) The third copy should be sent to the JCHST office (SAC in General Surgery) at the Royal College of Surgeons of England.
    d) It is possible to collect and submit the op. comp forms to the Deaneries on disc if local arrangements can be made. The forms together with the electronic logbook data can then be displayed at the RITA panels, using computer projection, thereby cutting down on the volume of paperwork.*

    (*Setting up and supervising this process works well if one member of the STC takes on the important role of 'Specialty Information Officer' and acts as the supervisor for all matters relating to the data collection for that specialty – including servicing the electronic logbook and attending the RITA panels.)

Notes for Trainers and Trainees on Completion and Use of the "Op Comp" Forms

Introduction

- The operative competency forms are for the use of all Higher Surgical Trainees and their Trainers.
- These forms are intended to help inform trainee and trainer regarding progress in acquiring technical operative competence. They will also help to inform the RITA panels. On both counts they should be taken seriously.
- The forms themselves are available for downloading from the JCHST web site at jchst.org.uk
- The layout is straightforward and the trainee should be in possession of a form or forms containing a list of procedures that is appropriate to the stage of Higher Surgical Training.
- The reverse of the form contains further guidance notes on the completion of the form.
- In the left hand set of columns it is important that the trainee enters the cumulative total experience against each procedure. **This should include any experience of these procedures obtained during Basic Surgical Training**.
- Early on during each training attachment trainer and trainee should meet and use the information to plan the next stage of training.
- At the end of your attachment or after an appropriate shorter period the trainee should review the position with his/her trainer(s) and have procedures signed off as appropriate.
- Trainers, please consider all aspects of 'competence' when making your assessment. Remember that this assessment is intended to cover those **technical aspects of operative surgery that can be judged in the operating theatre.** Areas such as case selection, the process of taking consent, etc will be assessed elsewhere.
- Criteria will include not only the ability to perform the procedure to a sufficient standard but should also take into account factors such as **the approach to an operation, control of the environment (including handling of assistants), regard for safety factors (operator, assistants and the patient), tissue handling and time taken.** A list of these is included in the guidance notes (*vide infra)*, which should be included on the back of each form.
- Two trainers should ideally grade each procedure. Where there is disagreement between two trainers, the lower grading should be the one that is accepted and carried forward. This will act as a fail safe.
- If the trainee feels that the grading is inaccurate, he/she is encouraged to comment on an additional page or by annotating the form before it is signed off.
- The Programme Director/Deanery Specialty Manager will set deadlines for the return of all documents prior to the RITA assessments and it is important that this form, along with the others, is completed and returned in good time. Please note that the trainee should keep a copy for your portfolio and must also send a copy to the Specialty Manager in General Surgery at the JCHST offices, at the Royal College of Surgeons of England

JOINT COMMITTEE ON HIGHER SURGICAL TRAINING

General Surgery Operative Experience and Competence Summary

Name of Trainee: _____ **NTN/VTN/LAT/Other**

Hospital/Post: _____ **Year: 1 / 2 / 3 / 4 / 5 / 6 / 7**

Name(s) of Trainer(s): _____ **CCST DATE / /**

This form covers the period starting: / / and ending: / /

Total Experience (BST & HST)			Comp. Level	Procedure	Experience this post			Competence Level*	
P	PA	A			P	PA	A	Tr 1	Tr 2

Full instructions for the completion of this form can be found on the reverse side

(* *Where trainers disagree on the level of competence, the lowest level should be accepted)*

Signature of Trainee: _____ **Date:** /
/

Signature of Trainer 1 _____ **Date:** /
/

Signature of Trainer 2 _____ **Date:** /
/

When completed, please send the top copy to *(Insert Deanery Specialty Manager)*,retain a copy for your portfolio, and send the third copy to the Specialty Manager in General Surgery, Offices of the SAC in General Surgery, Royal College of Surgeons of England, Lincoln's Inn Fields, London WC2A 3PE.

Operative experience

Trainee: Enter your electronic logbook totals* for the total number of procedures that you have performed since you began surgical training (BST and HST) in the first three columns

Enter your electronic logbook totals* for the number of procedures that you have performed during this training period in the three 'Experience this period' columns.

* **P** Performed without direct supervision **(or supervising a junior trainee)**

PA Performed with supervision by a senior trainee or consultant (supervisor at table or in the theatre ie a consolidation of all logbook categories apart from P & A)

A Assisting a senior trainee or consultant

(Note: Regardless of their level of competence, trainers are reminded that trainees can only operate under the direction of a named consultant.)

Operative competence grading

Trainer(s): Rate the trainee's competence to perform each procedure at the end of this training period according to the following rating scale:

U Unknown (not assessed) during this training period

A Competent to perform the procedure unsupervised (can deal with complications)

B Does not usually require direct supervision but may need help occasionally

C Able to perform the procedure under supervision

D Unable to perform the entire procedure under supervision

Use the following checklist of core skills to help you when making your assessment*:

- Checks patient case record and that **consent** has been obtained
- **Communicates** well with the theatre team
- Thorough **preparation** (marking, catheter, antibiotics etc)
- Good **scrub** and aseptic technique
- **Positions** patient correctly on operating table
- Makes appropriate **incision(s)**
- Purposeful **dissection** in correct tissue planes
- Demonstrates sound knowledge of **anatomy**
- Familiar with all the **steps** of the procedure
- Uses the correct **instruments** efficiently
- Handles dangerous instruments **safely**

- Uses **assistant(s)** to the best advantage
- Possesses good hand-eye **co-ordination**
- Handles tissues **gently and dextrously**
- Reliable **suturing and knotting** techniques
- **Sound repair** or anastomosis
- Uses **diathermy** appropriately and safely
- Able to **control bleeding** by suction, clips or sutures
- **Closes wound** neatly and securely
- **Timeliness**: the procedure is unhurried but with no unnecessary delay
- Good documentation **(operation note and postop. instructions)**

(*Not all of these will apply to every procedure)

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