Core Surgical Training Advisory Committee Newsletter: August 2018

Chair's Update: Mr John Brecknell

I am delighted to be able to bring you the latest updates from the Core Surgical Training Advisory Committee. This committee became a fully-fledged Specialty Advisory Committee (SAC) in November 2016. I took over as Chair from Miss Stella Vig in November 2017 and would like to take this opportunity to thank her for all the work she has done for the committee to get us to this point. I am looking forward to developing the CSTAC for the benefit of core surgical training throughout the UK.

To this end, there have been some changes to the structure and format of the CSTAC.

The CSTAC structure

We have appointed a Vice Chair, **Miss Helen Cattermole**, whose role is to deal with any problems that arise which might pose a conflict of interest with my other role as Head of the School of Surgery in London. She is also the **Lead for Less than Full Time Training (LTFT).**

We have also appointed leads in a number of important areas of training, and continue to develop our key work streams under our nominated leads:

National Recruitment Lead: Miss Elizabeth Sharp

Simulation / Bullying and Undermining Lead: Miss Stella Vig

ISCP/Curriculum Lead: Mr Patrick Lintott

ISCP/Curriculum Lead: Mr James Gilbert

Quality Assurance Lead: Mr Paul Renwick

eLogbook Lead: Mr Ajay Sharma

Defence medicine Lead: W/Cdr Wayne Sapsford

Additionally, a Core TPD from each UK training programme has been co-opted onto the CSTAC to ensure better regional representation. We also have representation from the ten higher surgical SACs.

Most importantly, we have worked with ASiT and BOTA as trainee associations to ensure that core surgical trainee voices are fully incorporated into committee membership. We have also moved trainee reports to the top of the committee's agenda, so that the trainee voice is heard strongly.

The benefits of becoming the CSTAC are as follows:

- The establishment of a formal system of externality.
- The authority to work with the JCST QA Group to set appropriate quality indicators and other guidance for core training posts in all surgical specialties, which will be monitored via the JCST trainee survey.
- The ability to work closely with the core TPDs to embed and deliver a joint national vision for core surgical training.
- The ability to more actively engage with our core surgical trainees and trainers and to support them in addressing concerns within the structures of local training programmes.

The success of the CSTAC's work will be contingent on continued strong relationships with the Surgical Royal Colleges, SACs, Health Education England and the equivalent bodies in the devolved nations, the GMC, the Confederation of the Postgraduate Schools of Surgery (CoPSS), the Intercollegiate Committee for the Basic Surgical Examinations (ICBSE), the trainee organisations, and public and patient stakeholder groups.

Core Surgical Training

We make no apology for repeating this paragraph, which was included in the last report, since the message is so important.

Core surgical training is provided by excellent trainers in well organised and supported regional training programmes. However, tensions between service delivery and training opportunities continue to make the effective delivery of the full scope of the curriculum difficult. These concerns continue to be evidenced in the JCST and GMC surveys, as they have been for a number of years.

The CSTAC has a simple formula for success in core training:

The Right Placement and Right Trainer for the Right Trainee better ensures excellence in training and an enjoyable experience for trainees.

What has become apparent is that rota gaps and NHS service requirements continually make the core programme challenging to deliver. In the face of these challenges, it is vital to maintain robust standards for training.

Core surgical training remains an attractive career progression option for trainees, but evidence suggests that trainees are considering the geographical location over the speciality of placement when choosing a post.

Recruitment

The 2018 round of core national selection took place at Stewart House, London, in late January/early February 2018. As well as recruiting to all CT1 training posts across England, Wales and Scotland, the process also recruited to run through (ST1) posts in General Surgery (via the Improving Surgical Training pilot) and ENT. Trainer interviewers reported that the process ran very well.

There were three interview stations: clinical, management and portfolio. The portfolio station attracted half of the total available marks. The selection design group confirmed that there was no desire to fill all the posts at the expense of standards.

At the 2018 round, there were 601 posts available across England, Wales and Scotland. The programme achieved a 100% fill rate.

The details of the posts by region are as follows:

Preference	Places	Accepted	Remainin	Fill rate
East Midlands	40	40	0	100%
East of England	51	51	0	100%
KSS	38	38	0	100%
North East	29	29	0	100%
North West	81	81	0	100%
South West	48	48	0	100%
Thames Valley	18	18	0	100%
Wessex	23	23	0	100%
West Midlands	51	51	0	100%
Yorkshire & the Humber	54	54	0	100%
London	77	77	0	100%
Scotland	47	47	0	100%
Wales	44	44	0	100%
TOTAL	**601**	**601**	**0**	**100%**

In 2018, there were 1686 applicants, 200 more than the previous year. 1014 applicants were deemed appointable compared to 926 in the previous year. All posts were filled, although a handful withdrew after accepting initial offers.

The national timeline for the 2019 recruitment round is yet to be finalised. The provisional interview dates are:

Monday 14th January – Friday 25th January 2019 (this is subject to change).

All information relating to the 2019 recruitment process will be found on the core surgical recruitment webpage when it opens later this year.

The Gold Guide

The Gold Guide, which is a reference guide for the management of postgraduate medical training, was revised and updated in November 2017. It sets out the standards and processes that training programmes across the four nations should follow. The Guide can be found here. A further revision is expected in late 2018.

Quality Assurance

There are a number of sources of data which help CSTAC to monitor the quality of training across the UK. Updates from specific tools will be highlighted below; background information is provided first for context.

In the past, core surgical trainees have expressed dissatisfaction with induction. As a result, many programmes have introduced an Enhanced Induction ('Boot Camp') at the start of the core programme or within the first months of the programme starting.

The CSTAC has an Enhanced Induction Framework for use by training programmes when designing their own core-specific inductions. Feedback from newly developed Enhanced Inductions has been excellent, with trainees reporting improvements in knowledge, skills and confidence as a result of the programmes. Unfortunately surveys may not always distinguish between local and regional inductions, so it is not always possible to quantify the difference these new inductions have made.

Other areas of concern raised by core surgical trainees in recent years include exposure to index cases and outpatient opportunities. This may be related to ward level rota gaps requiring the presence of core surgical trainees to run the ward. We would strongly **encourage** trainees in training programmes in England to use exception reporting to indicate to Trusts where these rota gaps are having an impact on training, and would **recommend** that trainees and trainers engage with this process to try and improve rotas and training.

The other area of concern raised in these surveys is that of feedback. This is almost certainly a reflection on squeezed clinical services and lack of time for formal meetings, but there may also be a generational imbalance here. There is evidence that younger generations of learners, familiar with frequent 'likes' on social media, value much more of a running commentary and frequent, 'bite-size' feedback from their trainers. Is it worth revisiting how we deliver feedback in the context of our clinical encounters with trainees?

We would also like to remind Surgical Tutors and AESs to continue to engage with Foundation Trainees and Foundation Schools to encourage these junior doctors into clinic and theatre, and to promote surgery as an inspiring career. Role modelling and behaviour of senior surgeons are significant factors in influencing career choices and these doctors should be nurtured and valued for their contribution to surgical care.

Surgical Tutors in particular should engage with the Foundation Programmes and look at the deliverables in conjunction with the Foundation Programme Office.

Quality Indicators

The JCST quality indicators provide recommended standards for training opportunities available within individual training posts. Updated versions were published for Core training in August 2018 and are available here.

We strongly **recommend** that trainers embed the principles in their services to promote UK-wide quality standards that might be monitored via the JCST survey. We also **recommend** that these are used to form the basis of trainee work schedules under the new junior doctor contract, and are included in each trainee's Learning Agreement. This will allow the Assigned Educational Supervisor and the Clinical Supervisor to monitor training, and will allow consistency when it comes to educational exception reporting.

GMC Training Survey

The GMC has just published the 2018 National Training Survey. The CSTAC is currently analysing the data relating to core surgical training and will report on this in the next newsletter.

JCST Survey

The third annual report of the JCST survey results, discussing the 2015/2016 surveys, is available here. Concerns with core highlighted in these previous surveys include working patterns that interfere with training, rota gaps, and doing routine work to the detriment of developing new skills. The survey continues to demonstrate that the majority of core posts are falling short of the relevant QI standards. It is important that Local Education Providers recognise the importance of appropriately targeting training opportunities to doctors in training across the training rotations. Surgical Tutors are **encouraged** to bring this survey to the attention of their Director of Medical Education and the Guardian of Safe Working (if applicable).

Pilot surveys of surgical trainers have indicated that trainers have very limited time for training and educational supervision, and, in particular, the administration of training, so the national survey could throw up some interesting data.

The next JCST trainee survey data is due in autumn 2018 and will be analysed by CSTAC when it becomes available. This data will be included in the next newsletter if possible.

ARCPs

The external liaison work undertaken by CSTAC members and core TPDs continues to highlight the variation between regional ARCP processes. The CSTAC has prepared a CT2 checklist, outlining suggested standards for all trainees completing core training.

There has also been national work undertaken by HEE into changes to the ARCP processes. This report can be found here. The work done by CSTAC to date will now be combined with the findings of this report and the processes in the new Gold Guide, and a streamlining exercise is now underway for all ARCP processes within core surgery.

Core Programmes

Evidence gathered on the progression of CT2 trainees across regions indicates that trainees approach the completion of training in a number of different mind-sets, including:

a. Trainee is decided on a career choice and is aware of what experience is required by the ST3 interview process.
b. Trainee is undecided on a career choice and wishes to experience many aspects of surgery before making a choice.
c. Trainee has decided that the experience gained within core surgical training will be of great value within another career speciality.

It is important that the content of core training posts is adequately flexible to be of value to the development of trainees with diverse career aspirations.

Progression

As an addition to our ongoing work to explore trainee career progression post completion of the core programme, we have been able to explore anonymised data collected by the GMC via the National Training Survey on career decisions taken by subsequent survey cohorts. This has allowed valuable insight into the trainee career choice, indicating that, as well pursuing further training in surgery, former core trainees go on to pursue training opportunities in a number of competitive medical careers, including GP and Radiology, and many take at least a short term break after completing core training while continuing to work within the NHS. These trends will provide a useful basis for future discussions about the surgical, and wider medical, workforce.

Improving Surgical Training

The Royal College of Surgeons of England is leading on an Improving Surgical Training (IST) pilot, which will be starting nationwide in August 2018. CSTAC is working in partnership with the IST team to roll out this programme.

Currently the pilot applies to posts in general surgery only, apart from in Scotland where all core surgical training posts have been entered into the pilot scheme. There are IST pilot posts in most UK regions, and these posts will run alongside standard core posts while the scheme is evaluated.

Trainees in the IST pilot will be allocated to an educational supervisor who will be with them throughout their core-level training. Trainees will be based in general surgery, with blocks or attachments for modular training in various other surgical specialties allowing them to achieve the competences of the core curriculum. There is increased emphasis on the professionalism of the trainer, with Trusts/Health Boards in the pilot sites being asked to sign up to protected educational time for trainer and trainee to work together. A key element of the pilot scheme is the use of the wider workforce to allow rotas to be less onerous and to allow trainees to take advantage of the training in the elective service as well as the emergency service. This development can only benefit all trainees on the rota, whether IST trainees or not.

All IST trainees appointed to general surgery posts have been appointed on a run-through basis.

Bids are already underway for IST pilot schemes to start in 2019 in vascular surgery and urology. Trauma & orthopaedic surgery is also discussing the benefits of undertaking a pilot of its own.

The results of the pilot scheme will be closely monitored and disseminated through the CSTAC and IST team.

Curriculum

The new core curriculum was rolled out in August 2017 after a huge amount of work by the CSTAC curriculum leads, the SACs and the Heads of School.

The new curriculum:

- Provides a flexible, modular format;
- Provides common core content with selected specialty content;
- Includes mandatory DOPS for completion by all core surgical trainees.

In order to get an ARCP outcome 6 at completion of core, trainees will be required to provide evidence of: competence in the full scope of the 'common content' module, competence in at least one of the 'core specialty' modules and successful completion of one 'ST3 preparation' module.

Trainees will be more broadly trained and will undertake placements in at least two specialties, for example, undertaking 3 x 4 month or 2 x 6 month placements in CT1 and 1 x 12 month placement in CT2. One of the benefits of this approach is that it will enable trainees to gain better defined transferable skills, which could potentially be credited if they decide to switch to a non-surgical specialty at ST3 level.

In line with all other medical 'specialties', the core curriculum will be subject to a further rewrite to align its content and purpose with the GMC's *Excellence by Design* standards and *Generic Professional Capabilities* framework. We will

provide regular updates on this area of work in the newsletter over the next two years.

In an exciting development, the core curriculum has now been adopted by the Icelandic surgical training programme, and we are developing formal links and quality assurance / externality with that programme.

Simulation

Training via simulation is available to all core trainees via courses and via training programmes and Trusts/Health Boards depending on local arrangements. It has further been agreed that some elements of simulation training might be incorporated into the core curriculum.

A range of useful simulation resources are available on the Royal College of Surgeons in Ireland's (RCSI) mSurgery website.

Courses

A common question for TPDs is about which courses are mandatory and recommended for core surgical training. It should be noted that the Advanced Trauma Life Support (ATLS) course is mandatory for completion of core training, and the Basic Surgical Skills (BSS) and Care of the Critically Ill Surgical Patient (CCrISP) courses are highly recommended.

Other courses are kept under close review by CSTAC, since the cost of these courses can be considerable. There is variability in the requirements for ST3 between specialties, and CSTAC is trying to achieve alignment between ST3 appointment panels and a successful outcome for core training. In many cases the skills required are taught at local or regional level, at little or no cost to the trainee. Trainees should approach their local TPD for advice.

Intercollegiate Committee for Basic Surgical Examinations (ICBSE)

The MRCS or MRCS(ENT) exams are mandatory for award of an ARCP outcome 6 at the completion of core training. The MRCS Part A exam has recently changed, with a greater emphasis on anatomy, an increased number of questions overall, and more detailed feedback for candidates.

It has been suggested that trainees failing either part of the exam should have access to an educational assessment, potentially after their first failure.

Core TPDs have no access to the results of the MRCS exams. Because of the limited number of allowable attempts, and the short timeframe of core surgical training, we **strongly recommend** that trainees inform their TPD if they are unsuccessful at either part of the exam, so that appropriate support and targeted training can be offered.

Additionally, in line with the results of published work looking at the success rates of the MRCS exam, we **strongly recommend** that Foundation trainees intending to enter surgical training only have a single attempt at the exam during FY1 and FY2 and, if unsuccessful, defer further attempts until they are in the core programme.

Engagement

TPDs

We are very grateful to core TPDs for their support of CSTAC. One TPD from each region is now invited to attend every meeting of CSTAC and the next meeting is due to be held on 21 September 2018 at RCS England.

Assigned Educational Supervisors, Clinical Supervisors & Surgical Tutors

There are a number of useful resources designed to support and promote the quality of core training available on the JCST website. If you have any questions, please do not hesitate to contact the JCST directly.

The ISCP has recently launched its Trainers Area. This resource can be used to gather evidence of trainer activity for appraisal and revalidation. Please see further information on the ISCP website. Trainers are encouraged to familiarise themselves with the Standards for Surgical Trainers published by the Faculty of Surgical Trainers.

New Trainees

If you are a new core trainee, please make sure that you register with the JCST as soon as you start your training programme. You can do this online via the ISCP.

Less than Full Time Training

The JCST has published a policy statement on Less than Full Time (LTFT) Training. Currently, only 1.5% of core surgical trainees are working less than Full Time (LTFT) but requests for LTFT training are increasing in all specialties and surgery is no exception.

Further information is available from the ASiT here. Most Trusts/Health Boards have now appointed a LTFT Champion who can be approached for advice and, in addition, each regional deanery/LETB office will have an Associate Postgraduate Dean with responsibility for LTFT trainees. The Medical Women's Federation has a number of useful resources (LTFT training is not just for women!).

Bullying and Harassment

Following on from BOTA's 'Hammer It Out' campaign and ASiT's anti-bullying work, the JCST has issued an interim policy statement. The Royal College of Surgeons of Edinburgh has a considerable resource bank, including an excellent e-learning course, and all trainers are **encouraged** to complete this course which can be found on their website here. We have asked all CSTAC members and core TPDs to do the same, and have a zero tolerance policy to disrespectful language at meetings.

Cultural Awareness

The ISCP has a number of new resources relating to cultural awareness. A short eCourse on Cultural Awareness Guidance is now available for surgeons on the ISCP website. Comprising three interactive modules, each with embedded videos, this professional development eCourse offers guidance and instruction on cultural difference and its impact on surgeons and patients. CPD points are available for each module.

Guidance on Avoiding Unconscious Bias is also available on the RCS England website.

Social Media

Follow us on Twitter @JCST_Surgery for updates. If you have thoughts about surgical training that you would like to share with a wider audience, please get in touch using the contact details below.

JCST secretariat and ISCP helpdesk contact details

The JCST Quality Manager and CSTAC Committee Manager is Mrs Sarah Lay. All relevant contact details can be found on the JCST website here.