

**JCST Newsletter – January 2014**  
**Chairman's Update**



Ian Eardley, JCST Chairman

First of all, a very Happy New Year to all of you. Sadly, this is my last year as JCST Chairman. All being well, the College Presidents plan to appoint my successor in April and there will be an extended handover before I step down at the end of the year. There is plenty to do in the meantime, however, and I hope to meet or hear from as many of you as possible before I go.

There are changes in our Specialty Advisory Committees (SACs) too. We welcome David Large as the new Chair of the Trauma and Orthopaedic Surgery SAC, Sion Barnard as Chair of the Cardiothoracic Surgery SAC and Tom Cadoux-Hudson as Chair of the Neurosurgery SAC. They replace Mark Goodwin, Steve Livesey and Owen Sparrow respectively, and my thanks go to these last for all that they have done during their terms of office.

James Wheeler will also be stepping down as Chair of our Core Surgical Training Committee (CSTC) and we hope to appoint his successor in February. James has built the CSTC up from scratch, and my thanks go to him too.

In this issue I shall give an update on recent developments, not least the Shape of Training review, and also show you how our budget figures look for 2012-13. Bill Allum, our Intercollegiate Surgical Curriculum Programme (ISCP) Surgical Director, will give the latest news about the curriculum and we also look at what an SAC does and introduce you to a member of our staff team.

**About the JCST**

For anyone new to the JCST, we are an intercollegiate body, working on behalf of the 4 Surgical Colleges of the UK and Ireland to enhance the quality of surgical training and to support trainees and trainers. You can read more about us and find previous newsletters on our website ([www.jcst.org](http://www.jcst.org)) or on the website of the ISCP, for which we are the parent body ([here](#)). You can also follow us on Twitter (@JCST\_Surgery) and I shall shortly be launching a blog about training issues.

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

I wrote in our July 2013 newsletter about our strategy for 2013-18 and please do look at this [here](#).

The 4 Surgical Colleges have now also approved a specific equality and diversity policy to cover the activities of the intercollegiate training and examination bodies. You can view this [here](#).

**Shape of Training Review**

Clearly one of the big events for those of us involved in training was the publication of the Shape of Training report in October 2013. If you have not yet read it, you can do so [here](#).

The report concludes that patients and the public need more doctors who can provide general care in broad specialties in a range of different settings. There will still be a need for doctors trained in more specialised areas, although numbers must match local workforce needs. Training also needs to be more flexible, so that doctors are more able to change roles and specialties throughout their careers if they want or need to. Some specific proposals are as follows:

- Full registration to happen at graduation from medical school;
- Following the 2-year Foundation Programme, doctors to enter broad-based specialty training;

- Specialties or areas of practice to be grouped together according to themes;
- Broad-based specialty training to last 4-6 years, culminating in a Certificate of Specialty Training (CST);
- Further special interest or subspecialty training to take place post-CST and to lead to specific credentialing.

Reactions to the report have ranged from the enthusiastic to the extremely sceptical, but many of us have wondered how surgery can fit into the proposed model. One of the problems is that the report is very “broad brush”, and our task over the coming year will be to work out how it can be adjusted to suit the specific needs of surgical training and particularly the need to maintain the quality of surgical outcomes. Initial discussions with the GMC and others have suggested that surgery (and indeed other craft specialties) might have some leeway to modify the basic proposals if we feel it appropriate.

This is a 4-nation exercise, and at the time of writing we are still waiting to hear how ministers in the 4 administrations wish to take the proposals forward. It seems clear, however, that a group will be set up to flesh out detail and there will be an 18-month period for this to happen rather than a “big bang”. It will probably come as no surprise that all proposals must be cost-neutral.

I shall keep in touch as things develop, but in the meantime my colleagues and I would also love to hear what you think. Please do get in touch if you have ideas that you think we should be exploring.

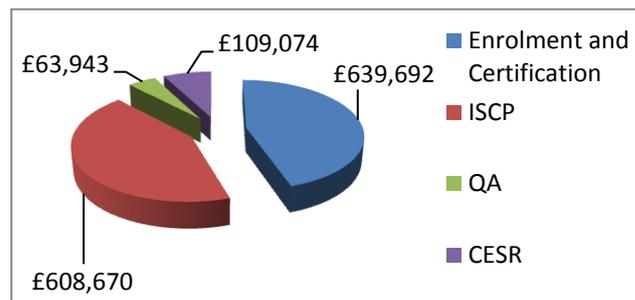
### Training in Ireland

The JCST’s remit includes Ireland as well as the UK, so we are very interested to hear about the new training pathway introduced recently by the Royal College of Surgeons in Ireland (RCSI). This will run ST1-8 with competitive entry to ST3 – one chance only. You can read more about the new pathway on the RCSI website [here](#).

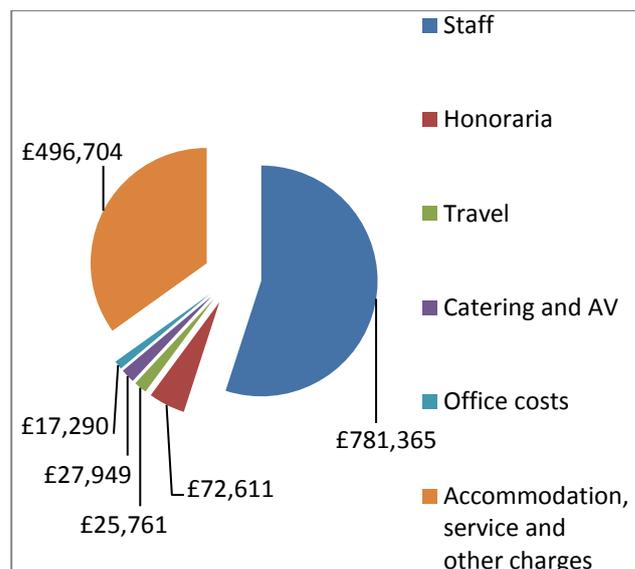
### JCST Finances

We know that trainees are keen to know more about how we are funded and how we use the money from the trainee fee. Here are some figures from our 2012-13 financial year, which ended in June. Figure 1 shows the functions of JCST, with the amount that is spent on each of these functions, while Figure 2 outlines actual ways in which the money is spent.

**Figure 1 Outgoings of JCST (by JCST function)**



**Figure 2 Outgoings of JCST (by type of spending)**



Notes: The Honoraria support the JCST Chairman and the ISCP Surgical Director, who also receive travel expenses. SAC Chairs also receive a small amount of funding for secretarial support, but SAC Chairs and members currently do not receive travel expenses.

Table 1 shows the way in which JCST receives income, with any shortfall borne by the Surgical Colleges.

**Table 1: Funding of JCST 2012-13**

Source	Amount (£)
Trainee fee	1,027,482
GMC – for CESR <sup>1</sup> work*	109,074
COPDEND - Incorporation of dental specialties in ISCP. Second of 2 instalments	10,000
Academy of Medical Royal Colleges – integration of leadership into ISCP. Second of 2 instalments	13,793
One-off funding for curriculum development work for Modernising Scientific Careers (MSC) Developing Higher Specialist Scientific Training (HSST) programme.	100,000
<b>Total external income</b>	<b>1,260,349</b>
<b>Shortfall met by Joint Surgical Colleges</b>	<b>161,330</b>
<b>Overall total</b>	<b>1,421,697</b>

\* The GMC funds work that we do to evaluate CESR applications, with the UK Colleges meeting any shortfall in the past. There is no funding for any of the other work that we carry out on behalf of the GMC (including enrolment of trainees, CCT and CESR (CP) recommendations and writing and maintaining the curriculum).

### JCST and GMC Trainee Surveys

As ever, thanks to all of you who have completed our regular JCST trainee survey. Our target is a 90% participation rate and we are very pleased to have reached 79% already. We ask you to complete one per placement and you will find the details on your ISCP account. We keep the survey under regular review and have recently added new questions on issues related to less than full time training, patient safety and on the availability of simulation-based training. The surveys are one of the most important tools that we use to measure the quality of surgical training and

<sup>1</sup> Certificate of Eligibility for Specialist Registration – the “equivalence” route.

complement the reports that we get from SAC liaison members.

At the time of writing we are working to analyse data for the 2012-13 training year. We shall be aiming to publish the results once we have discussed them with the relevant SACs.

We also work closely with the GMC on its annual trainee surveys. You may know that the GMC has recently published special reports on the findings of its 2013 surveys in relation to patient safety and bullying and undermining. You can read both reports [here](#)

### Quality Indicators (QIs) and Certification Guidelines

Still on the subject of the quality of training, you can find our QIs [here](#) and our certification guidelines [here](#). The QIs describe what your current post should be providing for you, and the certification guidelines provide advice for those of you approaching CCT or CESR (CP) about what is expected of you. We are now working on benchmarking guidelines for ST4 and ST6, so watch this space. The chief purpose of these guidelines are to ensure that your training trajectory is appropriate and that, by the time you reach the end of training, your experience and competence are appropriate for the award of a CCT or CESR (CP).

### Interface Training Fellowships

As well as its 10 SACs and Core Surgical Training Committee (CSTC), the JCST has 5 Training Interface Groups (TIGs), which oversee training in highly specialised areas straddling more than one specialty. These are oncoplastic breast surgery, hand surgery, head and neck oncological surgery, cleft lip and palate surgery and reconstructive cosmetic surgery.

We have recently been reviewing the workings of these fellowships and have found that they are well run, valued and popular, with excellent support from the Severn Deanery. We are now looking at whether the outcomes are the same for all specialties involved and are also surveying past fellowship holders to gain a clearer picture of their experience of the fellowships and the impact of fellowship

training on their subsequent careers. I hope to have more to report in the near future.

### **Reminder – New Time Limit on CCT and CESR (CP) Applications**

Do not forget that all trainees applying for either a CCT or a CESR CP must now do so within 12 months of their expected certification date. If you delay beyond 12 months, your only route to the Specialist Register will be by applying for a full Certificate of Eligibility for Specialist Registration (CESR). See GMC statement [here](#).

This is especially important now as the GMC rule came into force on 31 March 2013 and the first cohort of (ex)-trainees is now approaching the cut-off point. The GMC will also ask you for further evidence if you apply more than 6 months after your certification date.

### **Core Surgical Trainees – New Opportunities in Emergency Medicine**

The College of Emergency Medicine and the JCST are delighted to announce a new career option for surgical trainees. In the past many surgical trainees pursued careers in Emergency Medicine, but curriculum changes in recent years made this more difficult. This month the GMC has approved a training programme allowing doctors who have successfully completed core surgical training to enter Emergency Medicine training at ST3 level.

Following an initial year in Emergency Medicine, trainees will complete up to one year of training in Anaesthesia, Intensive Care and Acute Medicine before entering the ST4-6 training programme leading to a CCT in Emergency Medicine. To be eligible for this you must have passed the MRCS. Your transferable competencies will be assessed to determine your individual training needs.

If you think this may be the career for you, speak to the EM Consultants in your local hospital or your School of Emergency Medicine. More details are available on the Health Education Yorkshire and Humber and College of Emergency Medicine websites ([here](#) and [here](#)). The posts will be advertised in February 2014, with interviews in early April.

### **ISCP Update**



Bill Allum, Surgical Director of ISCP

A Happy New Year from me as well and thanks to all those of you who have been in touch with feedback and suggestions over the past year. I have just heard that the ISCP now has 100,000 registered users (across all categories) and has recorded over 1 million workplace-based assessments (WBAs), so we have come a long way since it went live in 2007.

Following the recent Evaluation of the ISCP, about which I wrote in July 2013, we are working flat out on a two-year programme of work to upgrade the ISCP, taking on board as many of your suggestions as we can. We are also working with the Royal College of Surgeons of Edinburgh (RCSEd) to see how we can improve links between the e-logbook and the ISCP and to make the Non-Technical Skills for Surgeons (NOTSS) resources available via the ISCP. We shall be working with Schools of Surgery and other national equivalents to support local use of ISCP with a portfolio of learning materials and training for Deanery/School staff.

On the policy side, we are currently re-examining our approach to workplace-based assessments (WBAs). The evaluation clearly identified the risks of the “tick box” mentality. We should be using WBAs not only to assess learning but also, and perhaps more importantly, to support learning. The follow-up paper on the implementation of the Evaluation discussions has now been published in the *RCSEng Bulletin* and *RCSEd Surgeons’ News* and I shall write more next time on how we propose that WBAs should be used.

### **Curriculum Changes – Simulation and Other**

Since my last update, the GMC has approved changes to the curriculum for Cardiothoracic Surgery, which will now include new statements about levels of competence in the

generality of the specialty and higher levels that trainees may acquire post-CCT. We shall be uploading the revised curriculum in the near future.

The GMC has now also approved the T and O curriculum mapped for simulation, which means that 9 out of 10 of our specialty curricula are now mapped and approved and will take effect in August 2014. For the moment simulation techniques will not be compulsory, but are classified as “strongly recommended” or “desirable”. The GMC wishes to ensure equity of access before making simulation compulsory and has asked us to carry out an audit of availability over the next 2-3 years.

We are in the process of rolling out the mapped syllabuses on the ISCP website, with the Core Surgical Training and Professional and Leadership Skills syllabuses completed at the time of writing.

For the future, we are currently working to revise the Professional Behaviour and Leadership Skills syllabus to ensure that the emphasis on patient safety is as strong as it should be and to map to the GMC’s updated *Good Medical Practice*.

### **Apps**

Thanks to all of you who told us what you wanted from an app. Our consultation has just closed and we are analysing the results and hope to give you an update as soon as possible.

Note that T and O has its own separate app, independent of the ISCP – details available [here](#).

### **ISCP Database**

Finally, we are working on a research programme to review and analyse the essentially unique database of broad and specific information that we hold on surgical training in the UK.

### **ICOSET 2014**

The International Conference on Surgical Education and Training will take place in

Harrogate on 29 and 30 April 2014 in Harrogate. Find out how to register [here](#).

### **What do SACs Do?**

The JCST has 10 SACs – one for each of the main specialties. At present most members are appointed either by the Joint Surgical Colleges in the UK or by the relevant specialty association. They apply for the places in open competition and have to meet the requirements of a person specification. The RCSI also appoints a representative to each SAC and other members are sometimes co-opted for particular areas of expertise (for instance because they have a leading role in the intercollegiate examination for that specialty). Each SAC also has a trainee representative and is supported and advised by the Lead Dean for the specialty.

The main functions of the SACs include the following:

- **Curriculum:** Developing and maintaining the surgical curricula and syllabuses, including workplace based assessment tools, and ensuring that the content of the ISCP website is up to date for their specialty;
- **Selection:** Working with Deaneries and Local Education and Training Boards (LETBs) to organise national recruitment and selection into specialty training programmes;
- **Trainee and trainer support:** Providing a network of Liaison Members to attend Deanery/LETB events (including ARCP meetings and Specialty Training Committees) and offer external and impartial advice and support to trainees and trainers;
- **Certification:** Recommending trainees to the GMC for the award of the Certificate of Completion of Training (CCT) and the Certificate of Eligibility for Specialist Registration via the Combined Programme (CESR CP);
- **Quality Assurance:** Working with the GMC, Deans and Schools of Surgery to quality assure surgical training. At present this involves the development of the survey, quality indicators, certification and

benchmarking guidelines as mentioned earlier in this newsletter;

- **Logbook:** Working to ensure that the surgical logbook records operative experience accurately, with appropriate links to ISCP.

All new SAC members are asked to attend an induction day run by the JCST with the support of the Confederation of Postgraduate Schools of Surgery (CoPSS). From 2014, this induction will be mandatory before any SAC member can take up their post.

### Staff Profile

**Name** – Judith Woodman  
**Job title** - Specialty Assistant for Otolaryngology and Plastic Surgery



**Role** - Support the work of the SACs by dealing with all the administrative processes and providing advice to trainees and Deaneries/LETBs about JCST and GMC guidance and regulations. Responsible for core trainees for Health Education South West, North East, Thames Valley and Wessex.

**Start date** – May 2013

#### 1. What did you do before starting your current job?

I completed my BSc Environmental Science degree in 2012. Since leaving university I have had various jobs such as working in security as a female body searcher for the London 2012 Olympics, waitress on the side for high profile events, did an internship with a conservation charity that does work in Madagascar, volunteered for ZSL London Zoo during my weekends and now I have been with JCST for 7 months.

#### 2. What is your favourite part of the job?

My favourite part of the job is dealing with all the medical organisations and professionals. I find it interesting learning about surgical training and all the procedures involved, in order to produce good surgeons to ensure patient safety. I also like working in the office as it is relaxed and I can have fun with my colleagues.

#### 3. And your least favourite part?

I dislike the photocopier; it is the most stressful part of my job when it breaks down.

#### 4. How many trainees do you work with?

Plastics: 330

ENT: 370

Core: 101

#### 5. How do you travel to work and how long does it take you?

It takes me an hour and a bit to get into work.

#### 6. What is your favourite TV show?

I am not currently watching a TV show but Breaking Bad, House of Cards and Game of Thrones were amazing series.

#### JCST secretariat and ISCP helpdesk contact details

Our contact details are available [here](#) and [here](#)