JCST
Joint Committee on Surgical Training

JCST Newsletter – January 2015

Chairman's Update

Bill Allum, new JCST Chair

First of all, a very Happy New Year to everyone reading this newsletter. This is my first newsletter as JCST Chair since succeeding Ian Eardley on 1 January. I would like to start by paying tribute to the huge contribution Ian made during his term of office. He modestly describes some of them in his reflections later in the newsletter. What he does not describe, however, are the personal skills he brought to the post. He has been extremely insightful about the differing issues confronting surgical training. He has shown great leadership skills, with patience and diplomacy yet also decisiveness as chair. He has also been a very helpful colleague. He will be very difficult to follow and I wish him every success in his future endeavours.

You will read in Ian's comments about some of the challenges I face over the next three years. I am really looking forward to the work - this is an exciting time for surgical training. I hope that you will contact me at any time with your thoughts and comments, whether you are a trainee or trainer, as I want to be sure that I represent your views in discussions with our varying stakeholders.

There are a number of new JCST officeholders to introduce. Firstly, Gareth Griffiths succeeds me as ISCP Surgical Director. Gareth introduces himself here and writes about his time as Chair of the General Surgery Specialty Advisory Committee (SAC) as well as his plans for the ISCP. We hope to recruit Gareth's successor as SAC Chair in February.

Graham Haddock, our quality assurance (QA) lead, steps down this year and Joe O'Beirne will succeed him. Joe is from the Republic of Ireland and we look forward to the fresh perspective that he will bring to UK training. I would like to thank Graham for all his work developing our QA activity, which has really come a long way with great support from Helen Lewis, our QA Manager.

I should also like to welcome Mike Bradburn as the new Chair of the Confederation of Postgraduate Schools of Surgery and thank Humphrey Scott, the outgoing Chair, for all the support that he has given us.

There are still further changes afoot. Our thanks go to Steve Dover and Rowena Hitchcock, the outgoing Chairs of the OMFS and Paediatric Surgery SACs, and we welcome David Koppel and Mark Powis as their successors. We shall also be appointing a new Vascular Surgery SAC Chair in March, to succeed Cliff Shearman.

To Gareth's and Ian's pieces in this issue I add my own update on recent events and show you how our budget figures look for 2013-14.

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, our strategy 2013-18 and the intercollegiate equality and diversity policy on our newly revamped website (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). At the time of writing we are heading towards 1,300 followers, so do add to the total. Do also read our blogs – and if you would like to blog for us, we would love to hear from you.

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.

Shape of Training Review

We know from a variety of sources that many trainees are very worried about what may lie ahead. Discussions within the JCST itself demonstrate that many senior surgeons also feel the same way. At the same time, however, there are opportunities that we should grasp.

Workshops during the summer and autumn of 2014 explored a range of themes, including content of training programmes and credentialing, and we understand that the next step will be policy proposals to Ministers in the 4 nations. We do not yet know what those proposals will be, but we look forward to welcoming Professor Ian Finlay, Chair of the UK Shape Steering Group, to our January JCST meeting. I expect Shape of Training to be the prominent issue in the coming months.

Equality and Diversity

Like many other organisations we have been examining the way in which we work to ensure that we are as fair and transparent as possible. We have introduced mandatory equality and diversity training for all SAC and Core Surgical Training Committee (CSTC) members, run by a very experienced trainer and based on real-life scenarios. I am pleased to say that so far the training has not only been useful but also enormously enjoyable and intellectually stimulating.

I am part of a GMC working group that is looking at equality and diversity in curriculum design. There are 2 parts to this – ensuring that the diverse needs of different groups of patients are covered in curriculum content and ensuring that we consider the needs of different groups of trainees when planning any changes. Last November I also attended a British Medical Association (BMA) event exploring differential attainment within diverse groups. A common theme there was the tension between service and training and the need for trainers to have enough time to meet the needs of diverse groups of trainees and ensure fairness.

Quality Improvement – Surveys and Guidance

Many thanks again to those of you who have completed our trainee survey. We ask you to complete one per placement and you will find the details on your ISCP account. We are currently analysing data from the 2013-14 survey, but early indications are that formal teaching remains an issue and that simulation-based training is not as widely available as we would like.

We also work closely with the GMC on its own national training survey. The GMC has recently released summary reports on the bullying/undermining and patient safety issues raised in its 2014 survey and you can read these here.

Please also look at the QA section of our website for our quality indicators (QIs) and certification guidelines. 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. Many SACs have now also completed benchmarking guidelines for ST4 and ST6, to help you and your trainers to measure your trajectory and ensure that you are on track.

JCST Finances

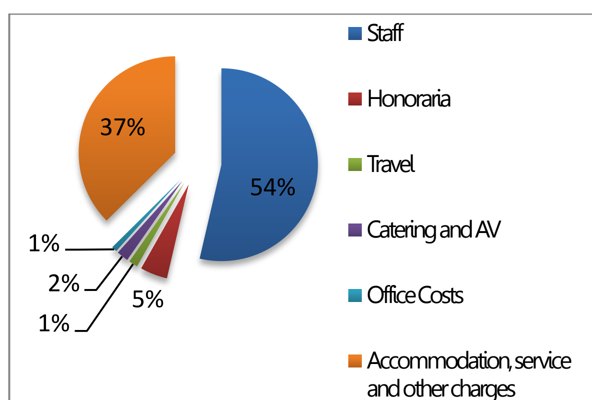
Trainees often ask us how we are funded and how we use the money from the trainee fee. Here are some figures from our 2013-14 financial year, which ended in June 2014. Figure 1 shows the functions of JCST, with the amount that is spent on each of these functions, while Figure 2 outlines actual ways in which the money is spent.

Figure 1 Outgoings of JCST (by JCST function)

Function	Expenditure (£)
Trainee enrolment and certification ISCP QA	1,421,893
CESR – equivalence work	109,082

Figure 2: Outgoings of JCST by Type of Spending

Area of Spending	Amount (£)
Staff	821,000
Honoraria	70,000
Travel	23,000
Catering and AV	30,000
Office Costs	14,000
Accommodation, service and other charges	573,000
Overall total	**1,531,000**



Notes: The Honoraria are paid to the employing Trusts or Health Boards of the JCST Chairman and the ISCP Surgical Director. The Chairman and Surgical Director also receive travel expenses. SAC Chairs receive a small amount of funding for secretarial support, but SAC Chairs and members receive no travel expenses.

The following table shows the way in which the JCST receives income, with any shortfall borne by the Surgical Colleges

Funding of JCST 2013-14

Source	Amount (£)
Trainee fee	1,203,048
GMC – for CESR work*	129,737
Total external income	1,332,785
Shortfall met by Joint Surgical Colleges	198,190
Overall total	1,539,975

* The GMC funds the contractual work that we do to evaluate CESR applications. There is no funding for any of the other non-contractual 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).

Tax Relief on Trainee Fee and MRCS

The trainee fee has been tax deductible since 2013. A more recent piece of good news is that trainees taking the MRCS exam will now also be able to claim tax relief. Read more here.

From SAC Chair to ISCP Surgical Director

Gareth Griffiths, new ISCP Surgical Director

I shall start by introducing myself. After Medical School in Manchester, I trained in the North West of England during which time I spent two years in Louisville, Kentucky, USA. After completing my general surgery training with a special interest in vascular surgery, I was appointed as a consultant vascular surgeon in Dundee.

I have always had an interest in training and how to improve it. As a trainee I was involved in ASiT and served in several roles, including President. After becoming a consultant I was appointed to the local Specialty Training Committee and, in time, took on the roles of Chair and Training Programme Director (TPD). When Modernising Medical Careers was introduced, I became involved with the selection process for general surgery trainees in Scotland and then, as an SAC member, in a pilot study for the re-introduction of national selection for England and Wales. I led the introduction of the live national selection process in 2011 and 2012. I was then appointed as Chair of the SAC in General Surgery.

General Surgery SAC

The General Surgery SAC has had a busy time over the last 3 years. Much of the work centred on the development of the 2013 curriculum and related projects. In addition to these, the important and developing role of the SAC in quality improvement, liaison member support for Deaneries and Schools of Surgery, trainee assessment for certification and CESR evaluations have kept us busy.

- The **2013 General Surgery curriculum** has clarified the need to gain skills in both emergency surgery and in a special interest, and has clearly laid out the levels of knowledge and skill required in all components of General Surgery. It has introduced suggestions for simulation training and made the criteria for certification clear and transparent. I think this curriculum places General Surgery in a good position as the *Shape of Training* Review moves forward and I hope that we can continue to train future colleagues to provide a general emergency service and retain the advances brought about by special interest development;
- The separation of **Vascular Surgery** from General Surgery will enable vascular trainees to focus on the open and endovascular skills they will need as the new specialty develops over the coming years. I am personally pleased, however, that a link has been maintained between the two specialties, both in terms of curriculum content and in trainee selection. I believe these links enhance both specialties and they may form a template for possible future links as the changes recommended in the *Shape of Training* review are considered. The General and Vascular SACs have worked with the GMC to clarify the management of the transition process for trainees as the specialties separate and you can read the latest guidance here;
- **National Selection** has now developed into a regular and stable annual process. The Selection Board guides evolutionary development for the joint process between General and Vascular Surgery. The system uses interviewer training and robust statistical analysis not only to ensure fairness and reliability but also to account for, and balance out, the impacts of stringent and less stringent interviewers and of easy or difficult scenarios and questions. You can read my blog on selection here;
- While overall responsibility for **Quality Assurance** rests with the GMC, the annual regional SAC Liaison Member reports along with the JCST trainee survey map to the JCST Quality Indicators set for training posts. The SAC has added General Surgery specific questions to the trainee survey, and these are now starting to give very useful information about the state of training across the UK;
- The SAC has also maintained a high level of activity in the **Republic of Ireland**. Our Liaison Member undertakes regular visits to training units to ensure quality and assess trainees annually and at certification to the same standard as UK trainees. The news that Ireland will start using the ISCP during 2015 will further cement this positive and mutually beneficial working relationship;
- There is a regular stream of work to do with **trainee applications** for enrolment, time Out of Programme, ARCPs and certification. The great majority of these decisions are clear and straightforward but occasionally some are difficult and demand much thought. Each individual's circumstances are different, but the SAC aims to be fair and consistent to all while meeting patient safety and GMC regulatory requirements.
- After each SAC meeting I have sent **updates** to TPDs, Heads of School and ASiT. These have summarised the main topics of each meeting and have publicised the SAC's opinions and guidance. The workforce figures attached to these show the current state of the consultant job "market". Overall the number of general surgery consultant job adverts closely matches the numbers of trainees reaching certification, although there are some imbalances across the different components of general surgery. You can read these updates here

I have thoroughly enjoyed my time on the SAC and, although I shall be sorry to demit office, I'm greatly looking forward new challenges as the

Surgical Director of the ISCP. I would like to thank all the JCST office staff, particularly mentioning Paramjit Kaur our Specialty Manager, for all their hard work without which the SACs could not function.

Curriculum News

I am delighted and honoured to have been appointed to the role of Surgical Director of ISCP, taking over from Bill Allum as he moves on to chair the JCST. Bill and the ISCP team have worked tirelessly to develop the ISCP into one of the most advanced online surgical training portfolio management systems. I have a very hard act to follow but am looking forward to the challenge.

Here are some of my priorities for the coming months:

- Work on **Version 10 (V10)** of the ISCP – a major upgrade – continues to top the list. The aims include improvements in the web interface and in functionality. As new features are developed by the web team they are being added to an alpha site, which we hope to release in the New Year alongside the current fully functional version. This will be available for all users to try out, so please send us your feedback as we will be able to incorporate modifications during the development phase. An important note though –portfolios will be visible in the alpha site and new data can be entered but ***any data entered into the alpha site will be lost when the final migration occurs to the fully functional v10; please continue to enter all information into the current version, from which everything will be transferred to v10***;
- **Feedback** is essential for a system such as ISCP and, in addition to the established routes, we will look at new ways in which this can be provided;
- From 2016 the GMC has in place arrangements for the **recognition of all trainers** with a specified role (Clinical Supervisor, Assigned Educational Supervisor, TPD). You can read more about this here. This brings hospital practice in line with general practice, which has had a similar system for many years, and we hope that it will bring about improvements in training. We are working closely with Craig McIlhenny, Director of the Faculty of Surgical Trainers (FST) of the Royal College of Surgeons of Edinburgh, to develop a site in ISCP for trainers. This will facilitate trainer professional development in accordance with the FST standards (available here), is consistent with the generic GMC training standards and shows how surgical training maps to the standards set by the GMC;
- Providing **feedback to trainees** about their performance and progress is an essential part of training. This is an integral part of all Workplace Based Assessments (WBAs) and an important role for Clinical and Educational Supervisors. We shall examine how we can improve this further, both through WBAs and with regular structured feedback processes;
- A number of new **curriculum submissions** are underway. In addition to specific developments in some specialties, the Core Surgery Curriculum (which is applicable to all uncoupled specialties – those with a separate selection process at ST3) will be updated with a module on **Health Promotion** including such conditions as obesity, exercise and dementia to name a few;
- The **Professional and Leadership Skills** section, applicable to all specialties, will also need to be updated once the GMC has finalised its guidance in this area. As well as audit, **Quality Improvement Programmes** using a number of quick “Plan, Do, Study, Act” cycles are likely to become more important;
- The **Non-Technical Skills for Surgeons (NOTSS)** formative assessment tool is now available via the ISCP, so please log on and have a go;
- Work continues to improve the link between the **eLogbook** and ISCP;
- We have launched a package of **faculty training material,** available here, and we plan to expand this using a variety of media;
- A particularly important development has been the appointment of an **ISCP Research Fellow**, funded by the Royal College of Surgeons of Edinburgh. A surgical trainee will be working with us to ask important questions about how surgical experience

relates to competence, how WBAs relate to training outcomes and how trainers carry out assessments, as well as simply cataloguing and classifying how the ISCP is used across all specialties;

- The **Royal College of Surgeons in Ireland** has decided that new specialty trainees starting in July 2015 will use the ISCP and WBAs. We are looking forward to this two-way collaboration and to learning from experience in Ireland;
- We will continue to develop the use of ISCP for **SAS doctors** and it may be possible to extend ISCP usage to other groups as well.

Looking Back –Thoughts from the Outgoing JCST Chair

Ian Eardley, immediate past JCST Chair

So, my time as chairman of JCST has come to an end. I have thoroughly enjoyed the role over the past 3 years and wish Bill Allum every success for the next 3. At a time like this, I am tempted to look back and try to see whether anything was actually achieved during my tenure or whether it has simply been a case of managing the organisation and responding to events.

Communication

When I started, I was keen to enhance communication with stakeholders and I'd like to think that we have achieved that. This newsletter was the first step in the process and we have subsequently launched our Twitter account and most recently the JCST blog. I have regularly attended meetings of the various trainee organisations and I think that our relationship with the regulator (the GMC) has improved. Importantly, the relationship between JCST and the Schools of Surgery has matured still further and we now work really well together for the benefit of surgical training in the UK. It seems to me that if the Schools and JCST agree on a particular subject, it is very difficult for others to oppose us.

Quality

From my predecessor, Chris Munsch, I inherited an embryonic strategy for enhancing the role of JCST in the quality assurance (QA) of training. Under the leadership of the QA Committee, chaired by Graham Haddock, we have developed the JCST Quality Indicators, which are now the standards against which surgical training posts and training programmes can be measured. We have introduced the JCST trainee survey, linked to the ARCP, which the majority of trainees are now completing. This survey, with the 3rd year of results due, is giving us important data about the quality of surgical training in the UK. Finally, with the help of the Schools of Surgery, our template for external visiting has been accepted by the Academy of Medical Royal Colleges and by the Postgraduate Deans as the template for College involvement in Deanery visits for the future.

Curriculum

The introduction of simulation into the surgical curricula seemed to me to be a "no-brainer". Simulation would enhance the development of both technical and non-technical skills and would have obvious advantages in relation to patient safety. However, getting the GMC to accept it proved one of the more difficult political challenges of my tenure, given that a curriculum change can only be accepted if the change is deliverable everywhere. The investment in time and equipment has not been consistent across the UK; this is reflected in the recent results for the trainee survey, which seem to show that simulation has not been as widely introduced as we would have hoped. There is more work to do in this area.

Another area where there is "work in progress" is in the use of workplace-based assessments. These were introduced into all medical and surgical curricula as a "must do" in 2007, and in surgery we have sometimes struggled to use them properly in a way that is not seen as a tick box exercise. As trainees and, more importantly, trainers became more familiar with them, we hope that they will be used to better effect as the formative tools that they were intended to be.

Many trainers and trainees will not realise that the ISCP is a world leading innovation. As an e-

portfolio that records and manages the training of over 5000 surgical trainees in the UK, it is also an un-rivaled source of data for quality assurance and educational research. Only recently have we begun to tap into that, under the leadership of Bill Allum, not least because of the sheer volume of data. As we go forward, and as we identify resources to support the analysis and reporting, I am certain that the data from ISCP will be used for the benefit of surgical training in the UK and beyond.

Challenges – *Shape of Training*

What then are the challenges for my successor? Certainly the *Shape of Training* review (ShoT) is an important document that will potentially overshadow the next few years. Our trainees harbour considerable reservations about it, not least because of a fear that it presages the introduction of a sub-consultant grade. I am personally much more sanguine, seeing ShoT as an opportunity that surgery should grasp.

It would be fanciful to think that our system is perfect, and I remain concerned about the quality of some of our training, most notably core surgical training. I would hope that we can use the principles of ShoT to enhance the quality of surgical training. The principal problem is that we have a health service that depends upon trainees to deliver that service, most notably emergency work. The progressive reduction in trainee numbers and the constraints of the European Working Time Regulation have resulted in a training system that is often too much about service and not enough about training. This is not only a problem in core training, but in all those posts where full shift systems are in place, including the foundation posts that remain in surgery. I have significant concerns about the continued attractiveness of surgery as a career and we need to work hard to encourage future generations to enter a specialty that we all love.

On that note I'll sign off. I really have enjoyed the past three years and need to thank everyone who has helped me along the way, most notably the team in the JCST office. Finally I'd like to wish my successor, Bill Allum, every success in the next three years and am certain that he'll get just as much enjoyment from the post as I have.

Regulatory News and Reminders

- GMC certification fees, alongside the annual retention fee, are due to increase from April 2015. Details here;
- You can read the GMC's report on *The State of Medical Education and Practice 2014* here;
- A reminder that GMC guidance on out of programme training and research (OOPT/R) is available here. Be aware that the approach is very rigorous. If you want your OOPT/R to count towards your CCT/CESR CP, you need to plan well ahead. All approval paperwork must be complete before the post starts;
- And a further reminder of the new GMC rule that you must apply for your CCT or CESR (CP) within 12 months of your certification date. After that you will no longer be eligible and will have to apply for a full CESR (the "equivalence" route to specialist registration) instead. The JCST makes CCT/CESR (CP) recommendations to the GMC and we shall contact you 5 months before your certification date to explain what we need from you;
- Finally, the *Gold Guide* (fifth edition 2014), which sets out arrangements agreed by the 4 UK Health Departments for all UK trainees appointed from August 2007, is available here

JCST secretariat and ISCP helpdesk contact details

Our contact details are available here and here