JCST
Joint Committee on Surgical Training

## Core Surgical Training Committee Newsletter – May 2015

### Chair's Update: Stella Vig

It has been a year since my appointment as Chair of the Core Surgical Training Committee. We have built on the strong foundation laid by my predecessor, James Wheeler, who took this committee from a small forum to the unofficial 'SAC' with Core Surgery at its heart.

This meant developing strong relationships with the Colleges, SACs, HEE, GMC, CoPSS and ISCBE, as well as the trainee organisations, and we continue to do the same. The CSTC agreed that four work streams should be supported with leads and these were appointed last year as follows:

**Recruitment: Miss Elizabeth Sharp**

**Simulation: Professor Oscar Traynor**

**ISCP/Curriculum: Mr John Brecknell**

**ISCP/Curriculum: Mr Patrick Lintott**

**Quality Assurance: Mr Paul Renwick**

### Core Surgery

What has become apparent over the last year is that Core Surgery has great trainees, trainers and support within its programmes. What is disheartening for all is that the tension between service and training makes excellent training difficult to deliver within the current structures and organisations.

Core Surgery has a simple formula for success:

**The Right Trainee, Right Placement and Right Trainer would allow excellence in training and an enjoyable experience for trainees.**

The Core Surgical Trainee Committee wishes to work jointly with the GMC, Colleges, Heads of School and trainee groups to influence Core Surgery to achieve excellence nationally and therefore continue to attract the great surgeons of the future!

### Recruitment

In the 2014 recruitment round, there were 625 core jobs across the four nations. The programme achieved a 91% fill rate causing great concerns with regard to the future of surgery within the next generation.

It is felt that the experience and exposure of medical students and Foundation Year trainees is being diminished. This has led to a reduction in opportunities to develop very strong surgical portfolios. Anecdotally, it was felt that the portfolio station did not discriminate well and that there were a number of trainable trainees who were excluded from the 2014 recruitment process due to a failure to score within this station.

This was therefore reflected in the adjustments for the 2015 recruitment round, which Northern Ireland did not participate in. There were 3 interview stations: clinical, management and portfolio. The portfolio station attracted half of the available marks for content and the remainder for a presentation on leadership. The self-assessment exercise was not used as it had been found to be a poor discriminator. The 2015 appointability score was set using Angoff and had changed slightly from that used in 2014. The selection design group confirmed that there was no desire to fill all the posts at the expense of standards.

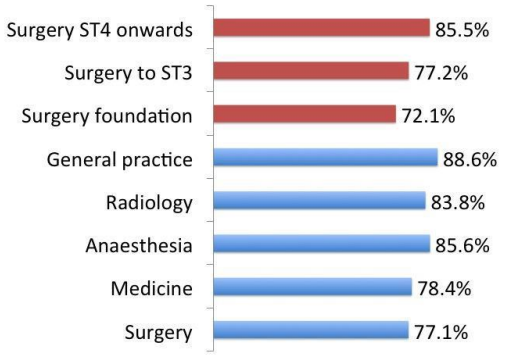
In 2015, there were 1527 applicants, 1218 were interviewed and 854 were deemed appointable, although a number withdrew to accept posts in other specialties. 595 of the 604 available posts were accepted with a fill rate of 99%.

The details of the posts by region are as follows:

| Region | Programmes | Accepted | Remaining | Fill Rate |
|---|---|---|---|---|
| HE East Midlands | 42 | 42 | 0 | 100% |
| HE East of England | 48 | 48 | 0 | 100% |
| HE KSS | 39 | 39 | 0 | 100% |
| HE North East | 28 | 28 | 0 | 100% |
| HE North West | 77 | 77 | 0 | 100% |
| HE South West | 41 | 41 | 0 | 100% |
| HE Thames Valley | 18 | 18 | 0 | 100% |
| HE Wessex | 24 | 24 | 0 | 100% |
| HE West Midlands | 56 | 56 | 0 | 100% |
| HE Yorkshire & the Humber | 54 | 53 | 1 | 98% |
| London | 81 | 81 | 0 | 100% |
| Scotland (Inc 12 LATs) | 60 | 52 | 8 | 86% |
| Wales | 36 | 36 | 0 | 100% |
| **TOTAL** | **604** | **595** | **9** | **99%** |

## Core Quality Indicators

The QIs (available here) describe what a post should be providing for the trainee and this is the bare minimum. Sadly you will have seen that the GMC has published the key findings of its 2014 training survey – available here. Those in core surgical training registered low levels of satisfaction (77.2%) and those in foundation training the lowest of all (72.1%).




We know that trainees look back at surgical placements and realise that they learnt skills to be used in many disciplines. We do, however, need to address the message above. Our trainees (Foundation and Core) do not always enjoy their surgical experience and this is disappointing. It is now time to change. I would ask the Surgical Tutors to re-engage with the Foundation Programmes and look at the deliverables in conjunction with the Foundation Programme. This is now mandated within the new Surgical Tutor job description (available here).

Now that we have an almost 100% fill rate, we also need to enhance the experience of our new starters in August 2015. This will mean ensuring that our Core trainees get access to training lists and clinics. We also need to ensure departments understand the difference between Core, FY2, GPVTS and Trust doctors, who comprise the SHO tier of service, as they have different needs.

**It would be useful to consider adding the Core Quality Indicators for each specialty placement to ISCP for each trainee so that this could be considered by the AES and CS at the time the Learning Agreement is mutually agreed.**

## Quality Assurance

### *ASR*

The 2014 annual report for core surgical training, which can be found here, was based on responses to an e-survey of Core TPDs. I am keen we have a 100% response rate from the Core TPDs this year. The e-survey also proposed the introduction of a national training charter and a global objectives template for use in core trainees' learning agreements. Your thoughts would be welcome. It has been suggested that having a template available on the ISCP as an exemplar might help new TPDs to develop their own set of objectives.

### *JCST Survey*

The first annual report for the JCST survey results is available here. The JCST survey results for 2013/14 demonstrated that the majority of core posts were failing to meet the relevant QIs e.g. for theatre/clinic/ward round attendance. The overall results were poor and little progress had been made in comparison to the previous year. Although the responsibilities for the quality assurance and quality management of core training posts is clearly defined, 3-4 years' worth of JCST survey data suggest that the current processes are not working effectively and there really is a case for change. We need to address

the needs of our Core Surgical trainees to ensure the experience and training is excellent, albeit I am aware of the constraints of service in many organisations.

### *ARCPs*

It is apparent that ARCP processes, although in the remit of the Gold Guide, are still variable across the nations. An understanding of the current processes will be interrogated and we will report back to you.

### *Core Programmes*

Core posts have been decommissioned within individual regions based on regional need and quality. There needs to be a national overview and the following actions are proposed for 2015:

- To collate information on all core training programmes to determine whether they are generic or themed.
- To develop a descriptor template so trainees will be aware, prior to national selection, of what opportunities each post can offer them.

### *Success*

It is incredibly difficult to understand the progression of Core trainees immediately from CT2. In 2014, the results (206/245 Core posts) of the trainees suggested the following:

| Exit | Numbers | % |
|---|---|---|
| ST3 Surgery | 79 | 38.3 |
| LAT | 17 | 8.25 |
| LAS | 17 | 8.25 |
| OMFS | 1 | 0.49 |
| Radiology | 3 | 1.46 |
| Anaesthetics | 1 | 0.49 |
| GP | 1 | 0.49 |
| A & E | 3 | 1.46 |
| Overseas HST | 3 | 1.46 |
| Research | 11 | 5.34 |
| Repeaters | 30 | 14.6 |
| Leavers | 17 | 8.25 |
| Trust Posts | 10 | 4.85 |
| Unknown | 36 | 17.5 |
| Teaching | 3 | 1.46 |
| Exit at CT1 | 4 | 1.94 |

45% of our trainees are progressing to highly competitive career specialties and Core training remains able to deliver a pluripotential surgical trainee. There is concern that a quarter of our trainees are in LAT/LAS posts and that another 5% are in trust posts. This may be because trainees are unsure of career specialty or because they have not had the specialty training opportunities. Of more concern is that 15% are repeating and we are unaware of the progression of another 18%.

We need a robust dataset if Core Surgery is to continue to defend its position within workforce planning and HEE as well as with the potential implementation of Shape of Training.

**Core TPDs please collect progression data for CT2 trainees prospectively within the ARCP processes at the end of the 2014/15 training year in order to get a national picture**.

### General/Vascular Surgery National Selection 2016

Please note that from 2016, the General/Vascular Surgery ST3 National Selection board will not interview any candidates who took their MRCS exam more than 7 years previously. This is in keeping with guidance from HEE. In addition, from 2016, ATLS will be an essential requirement on the ST3 personal specification for General/Vascular Surgery.

### Shape of Training Review

The 4 UK Governments have set up a steering group to consider the recommendations of SOT. There may well be opportunities developed within SOT for Core Surgery and Core Surgical Training will be at the centre of our conversations.

### ISCP/Curriculum

### *Curriculum*

The current core curriculum was last rewritten in 2007. It is unable to support training in the generality of surgery as well as prepare trainees for ST3 posts and appears to disadvantage those trainees who are unsure of which career path to take or who wish to switch specialties. The curriculum requires a rewrite and the following is proposed:

- The curriculum could become modular in format.
- The professional skills/competencies module and the majority of the current curriculum

content will be retained as the 'generality of surgery'.
- Elements of the general surgery of childhood and acute urology will also be included.
- In order to get an ARCP outcome 6 at CT2, trainees will be required to provide evidence of: competence in all the modules in the 'generality of surgery'; competence in the early years' topics of 3 specialties; and competence in the ST3 requirements for one specialty.

Trainees will be more broadly trained and will undertake placements in at least 2 specialties, for example, undertaking 3 x 4 month / 2 x 6 month placements in CT1 and 1 x 12 month placement in CT2. This approach will enable trainees to gain better defined transferable skills, which may be credited if they decide to switch to a non-surgical specialty at ST3 level.

It is recognised that the concept of modular training would help to address the requirements of the Shape of Training. The curriculum amendment process will require a high level of consultation with the SACs and the Heads of School and I will update you as the work progresses.

### *ISCP*

There is strong representation of the CSTC within the ISCP Committee. Version 10 of the ISCP is awaited, but the Non-Technical Skills for Surgeons (NoTSS) formative assessment tool is now accessible via the ISCP. In addition, Workplace-based assessment (WBA) forms now include a checkbox for simulation. Please note the updates to Annual Review of Competence Progression (ARCP) documentation, in line with recent changes agreed by the Conference of Postgraduate Medical Deans (COPMeD). Progression through Core Training culminates with an Outcome 6 on ISCP at the ARCP panel.

### *Work based assessments*

I was disappointed at the ASIT conference to get an overwhelming sense that the assessments are still seen as summative not formative. In addition, they are felt to be formal rather than a record of a learning conversation. I would be grateful if trainees started to record episodes of concordance and discordance with senior decision makers and discuss why in partnership with another individual. In addition, there is a suggestion that there should be some mandatory WBAs e.g. DOPS for scrubbing, prepping and draping a patient, CEX for the WHO check list and a CBD for organisation of a theatre list. Again comments would be very welcome.

### Simulation

The report of the National Simulation Development Project, produced by the Higher Education Academy (HEA), the Association for Simulated Practice in Healthcare (ASPiH) and Health Education England (HEE), into the use of simulation in healthcare has been published. This report has found that the UK is well-provided with simulation centres, but that networking needs to improve. There are also problems with funding and the availability of trained faculty. This has caused the paradox of mandating simulation as part of the surgical curricula as the GMC will not mandate it unless it is available everywhere and the JCST is unable to ensure it is available everywhere until it is mandated.

The CSTC advocates the use of 'bootcamps' to deliver core generic surgical skills. Individual Schools of Surgery have reported that they are running bootcamps and this may lead to a national roll out if found useful to all. This is based on Professor Traynor's reports of the excellent bootcamps available to his trainees in the Republic of Ireland. We will update you on the progress and are really keen to hear from you if you have any local initiatives.

### ICBSE

The MRCS and the DOHNS exams continue to be mandatory for an outcome 6 at CT2 ARCP. The ICBSE is concerned about the level of anatomical knowledge demonstrated by MRCS candidates and is therefore proposing to increase the number of anatomy questions in Part A from 45 to 75.

A short-life working group has been set up to compare the marking of examiners who remain on one exam station all day with those who switch stations. A paper has been published in British Journal of Surgery on the effects of human factors on examining during the MRCS OSCE (abstract available here).

The Joint Surgical Colleges Meeting has agreed to fund a research fellow to investigate the possible predictive correlation between the MRCS and FRCS exam results, MRCS and ARCP outcomes and, potentially, against the PLAB test results. The GMC is particularly interested in the value of the MRCS results in national recruitment.

At present, candidates are allowed a maximum of 4 attempts at the MRCS Part B and they have to declare any extenuating circumstances at the time of the exam and not when they receive their results. Anecdotal incidences have been reported of trainees failing the FRCS examination 4 times and then discovering that they had dyslexia, which retrospectively may have also affected their performance in the MRCS.

It has been suggested that trainees failing either exam should have access to educational assessment, potentially after their first failure, to assess whether they have an extenuating circumstance which affected their exam performance. It would be useful to know whether this was the major cause of the 30 trainees repeating the year in 2014.

### Constitution of the CSTC

There is a clear discrepancy between what core training programmes currently deliver and the expectations of both the core trainees and the SACs. Currently, trainees who complete core, but who do not obtain an ST3 post in surgery, including those who progress into higher training in an associated specialty, are deemed by HEE to be 'wastage' from core programmes.

A case for change to a formal SAC was discussed at the last CSTC meeting with the following main points for debate:

- The success of core training depends upon: the right trainee; the right placement; and the right trainer.
- The portfolio criteria were changed in the 2015 national selection process, which enabled a wider pool of candidates to be deemed 'appointable'. The 99% overall fill rate implies that core is attracting the 'right trainees'.
- The 'right trainers' are the remit of the GMC and the trusts providing core training.
- The CSTC should therefore focus on the 'right placement' and especially on whether core programmes should be generic or themed.
- The 'right curriculum' is crucial to the success of core training and the current curriculum needs amending to deliver an end product to match the expectations of the SACs at ST3 level.

The CTSC already fulfills most of the functions of an SAC, although this is not always acknowledged. There is strong support for the proposal for the CSTC to become an SAC and work, in an advisory capacity, with the LETBs to solve the issues in core training. The LETBs will bring a regional perspective and the CSTC, as an SAC, will bring a national perspective and will be able to offer a level of externality to core programmes which is currently missing.

I will drive this direction of travel to formally change the constitution of the committee. However, I am aware that extensive discussions and strong partnership working are needed with the Heads of School in relation to the externality function of a new SAC and the make-up of its membership.

### OMFS

OMFS is concerned with filling posts at ST3 level and evidence seems to suggest that OMFS trainees are not getting as much experience as previously, possibly due to a lack of OMFS posts at CT2 level. An e-survey was sent to all the Core TPDs to gain information on the availability of core posts in the specialty:

- 13 out of the 14 respondents currently have at least 1 core OMFS trainee.
- 9 respondents had received requests from trainees for more OMFS training, 5 were able to provide this.
- 9 indicated that they would consider converting a core post in another specialty into a core OMFS post.
- It was recognised that core OMFS posts could also be beneficial to trainees interested in training at ST3 in allied specialties e.g. ENT and Plastic Surgery.

**Please would Core TPDs consider whether Core OMFS jobs could be created within their regions**

**for the 2016 recruitment round?**

## Engagement

### *TPDs*

We are keen to engage you in all aspects of the CSTC work and you are reminded of the Friday 6 November 2015, which is a joint Core TPD and CSTC meeting. The last joint meeting held in December 2014 was vital in the development of the national vision for 2015/6.

### *AES/CS/Surgical Tutors*

There are various events at the Colleges and we can ensure you are on the emailing list if you let us know your details.

### *New Trainees*

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

## Social Media

Follow us on Twitter @JCST_Surgery or @svig2 for updates and debates! The recent discussion on improving Core Surgical training suggested that placements should be our priority.

If you have thoughts about surgical training that you would like to share with a wider audience, please get in touch by e-mailing jcst@jcst.org.

## JCST secretariat and ISCP helpdesk contact details

Our contact details are available here