JCST
Joint Committee on Surgical Training

General Surgery SAC Update
July 2014

This is a summary of the key points of discussion from the SAC meeting in July 2014. Any feedback or comments would be welcome.

National Selection

This has now been successfully completed and the SAC are very grateful to over 250 consultants who gave their time to help with interviewing. A total of 508 applicants were interviewed over 10 days; 148 NTNs and 93 LATs were appointed in general surgery and 20 NTNs in vascular surgery. Rasch analysis was applied to the scores this year in order to even out the effect of "Hawk and Dove" interviewers and easy or difficult scenarios. This has worked well and after review of the whole process the Selection Board Steering Group has decided it would like to continue using this method.

Jon Lund has led this process for the last two years in exemplary fashion and I would like to personally thank him for all his hard work. Jon has now demitted as Chair of the Selection Board and I'm pleased to say that Alison Waghorn has been appointed to take over. Alison will be introducing some adjustments, but the overall process will remain unchanged.

The National Selection process will be one of the topics for discussion at the SAC-TPD meeting in October.

Academic Training

As indicated in the last Update, the SAC are pleased that the National Institute for Health Research (NIHR) will require all Academic Clinical Fellows (ACFs) appointed at ST1 or ST3 to achieve the appointable score at the relevant national selection process (Core or Specialty).

The SAC remain concerned, however, about the transition of ACFs appointed at ST1 through into specialty training at ST3 and above. The SAC's view is that these trainees should be required to achieve the appointable score at ST3 National Selection (a benchmarking process).

Professor Jacky Hayden, Lead Dean for Academic Training, kindly came to the SAC to help inform us on this discussion. We identified a number of issues related to this issue which we now plan to take up directly with the NIHR with Professor Hayden's assistance.

Simulation

Simulation is now incorporated into the 2013 Curriculum and its use is described as "desirable" or "highly recommended" for a range of clinical and technical skills. The JCST Simulation Group are examining how Workplace Based Assessments can be used as part of simulated training.

Surveys of the availability of simulation training across the UK have been undertaken and the results are now being analysed. Before making any aspect of simulation training an essential component of the curriculum, the GMC would need to be satisfied regarding its

ready availability across the country. The SAC debated whether this is a realistic goal and recognises that making simulation essential may not be achievable.

Workplace Based Assessments

The new PBAs have now been uploaded onto the ISCP and are available for use. There is debate at JCST and the ISCP over whether a generic assessment suitable for any operative procedure is desirable and what form it should take. The General Surgery SAC has suggested a generic PBA, but further developments are awaited.

JCST is asking all specialties to develop a list of "Critical Conditions" where misdiagnosis or mismanagement would result in significant threat to life or limb. The intention would be to require trainees to achieve a level 4 CBD in these conditions by CCT. A list has been drawn up by the SAC and is in the process of being finalised.

Logbook

I'm very grateful to Tim Cook for his work on the eLogbook and, in particular, on developing two new consolidation sheets which are now available for use within the eLogbook programme. Tim has written this description of their use:

1) the **Operation Group Report** includes all operations listed by special interest group. This includes cases where the trainee has been the assistant as well as the main operator.
2) the **SAC Indicative Report** is linked to the indicative numbers required for CCT. This records a selection of indicative cases in each special interest but only includes those cases where the trainee has been the main operator (S-TS, S-TU, P or T); cases recorded as Assisting (A) are omitted from this report. The indicative numbers required for CCT are included in the report for reference. All trainees will be expected to achieve the indicative numbers within the general surgery section and will also be expected acquire the numbers within the special interest of their choice. These indicative numbers are included in the 2013 curriculum, but will be applied flexibly to those following the 2010 curriculum.

Filters can be set for both reports to include only cases performed between specific dates.

Trainees will need to submit a copy of both reports to the JCST when making an application for CCT. It is recommended that the reports are also used at ARCPs, particularly at ST4, ST6 and ST8 in conjunction with the respective SAC checklists to ensure that trainees are on the right trajectory for CCT.

TPDs can have access to the Directors' pages within the elogbook. This allows trainees' logbooks to be viewed in each format. Application for Director's access can be made through the elogbook website or by contacting the helpdesk. There is ongoing work to strengthen the link between elogbook and ISCP such that in the future the Operation Group Report and SAC Indicative Report format may be viewed directly through ISCP.

Indicative Logbook Numbers

The SAC have received a number of enquiries about the time period over which cases can be counted for the indicative numbers in the 2013 Curriculum. The GMC have stated that only training received in approved posts during specialty training may count towards a CCT. This indicates that only cases performed from ST3 to ST8 can be included. This was debated at length at the SAC and there are arguments in favour and against. There are concerns about including cases performed prior to ST3 if there was a significant gap between the earlier training and specialty training. A gap may result in loss of skills which may subsequently not be regained if that aspect of training is considered complete. This would not be an issue if the pre ST3 cases were carried out in posts which preceded ST3 with no gap.

The SAC agreed the suggestion that it would normally only consider ST3-8 training posts when assessing CCT applications but logbooks from GMC prospectively approved run

through or Core Surgery posts might also be considered. We will need to seek the GMC's guidance on this and a further update will be issued.

The SAC have reviewed the logbook experience of a cohort of 150 trainees who achieved their CCT in the year up to 31 December 2013. Although there are differences depending on the special interest of the trainees (particularly in upper GI surgery), overall the indicative logbook numbers were met or exceeded by 75% or more of the cohort for all procedures except axillary clearance, anterior resection and infra-inguinal bypass where the numbers were very nearly met. These data match the experience of the original cohort of CCT graduates on which the indicative numbers were based and show that a clinically important level of experience is achievable. The numbers will be kept under review but for the time being no changes are being made

ST4 and ST6 Checklists

These forms are intended to help assess trainee progress and experience at the key way points of ST4 and ST6 reflecting, as they do, the requirements of the 2013 curriculum. The Checklists are divided into Workplace Based Assessment, logbook and general evidence sections and contain what the SAC believe are appropriate and achievable general and special interest targets for trainees to meet at the relevant 'way points', if they are on course to meet their overall CCT requirements by the end of ST8.

It is hoped that the use of these checklists will help identify any trainees who may be at risk of not achieving the requirements of the curriculum at a stage which is early enough to address any issues. It would be of value to give trainees copies of the relevant checklist at the preceding year's ARCP in order to help them self assess their progress and plan their Learning Agreement with their Educational Supervisor.

Following experience of their use, the SAC discussed some amendments to the ST4 and ST6 forms. These will be incorporated into the forms after which they will be loaded onto the JCST website. The checklist for CCT (the ST8 checklist) has been available for some time and is already on the JCST website.

Several trainees have asked whether a Certificate, Diploma or Masters in Medical Education can be used instead of the Training the Trainers course to demonstrate the skills in education required by the curriculum. Following discussion, the SAC will ask these trainees to map the curriculum of their qualification to that of the Training the Trainers course (theoretical and practical aspects) and to submit that to the JCST. Liaison Members will then determine whether equivalence has been shown and, if it has, accept the alternative qualification. A list of approved qualifications will be drawn up and kept by the JCST office to help and advise trainees in the future.

Oncoplastic Breast Surgery Training Interface Group

The curriculum for the TIG fellowship is in the final stages of preparation before submission to the GMC. It will apply to both general surgery and plastic surgery trainees in these posts and is divided into 6 modules, 4 of which are essential and 2 optional. The aim is improve the knowledge and skills of general surgery trainees in reconstructive surgery and plastic surgery trainees in oncological surgery. It is recognised that it will not be possible for general surgery trainees to reach same skill levels that are required by Plastic Surgery trainees in reconstructive surgery and *vice versa* in oncology within a 12 month programme, but the intention is to significantly enhance knowledge and skills.

Trainees wanting to take up a TIG fellowship will be expected to have met all the requirements for CCT before starting the fellowship and to have passed the FRCS. These

posts will therefore be started towards the end of ST8 and the Certification date will be moved in order for the whole fellowship to be completed pre CCT / CESR CP.

General Surgery Trainees with a Special Interest in Vascular Surgery

As indicated previously these trainees form a special group in view of the separation of vascular surgery from general surgery. Discussions have been held between the General Surgery SAC, the Vascular Surgery SAC and the GMC over how best to manage these trainees. There is no capacity in the new vascular surgery training programmes to allow a wholesale transfer of these trainees to the new vascular curriculum. The particular concerns have been over the need for these trainees to meet the general surgery requirements of the 2013 curriculum should they have to transfer to that version.

Agreement has now been reached over the arrangements for these trainees and a summary is given below.

General Surgery trainees with a special interest in vascular surgery and a certification (CCT / CESR CP) date on or before 31 December 2018

The GMC have agreed that these trainees may remain on the 2010 General Surgery curriculum to certification. Trainees will need to meet the requirements of this curriculum but the Guidelines for CCT will be flexibly applied. Trainees following this path will need to inform the JCST and the JCIE and they will be encouraged to complete their training programme without taking extensions (OOPR or OOPE).

Trainees whose CCT is extended beyond 31 December 2018 for valid statutory reasons (eg maternity leave) or because of less than full time working will be able to request transfer to the Vascular Surgery curriculum under the arrangements summarised below.

General Surgery trainees with a special interest in vascular surgery and a certification (CCT / CESR CP) date after 31 December 2018

Provided the trainee was appointed to an NTN or an academic NTN in general surgery prior to 1 January 2013 then these trainees may apply to be transferred to the new Vascular Surgery training programmes.

If accepted, then it is hoped this can arranged locally, but a move to another training region may be required if there is no local capacity. The transfer may not be possible if capacity is not available in any training region. In such a case the trainee will need to remain on the 2013 (or later) General Surgery curriculum with a special interest in vascular surgery.

The General and Vascular SACs are in discussion with the Lead Deans for each specialty to finalise the precise arrangements. More details and a description of how to effect these moves have now been circulated separately.

Advanced Trauma / Military Surgery

Military surgeons need formal command training in addition to gaining experience in the breadth of trauma surgery. Over the last several years this has been gained by placements in Afghanistan. Now that these operations are winding down, alternative arrangements need to be made. The Military Deanery has suggested a 6 month Military Training module, initially only for regular forces trainees. This would include a 2 month Staff and Command Course and 4 months in vascular surgery for general surgery trainees in order to enhance their trauma skills.

The SAC approved this module as appropriate for OOPT and the GMC have indicated that with this approval they are also likely to give final approval when applications are received. Trainees following this path should apply to their LETBs / Deaneries for OOPT in under the guidance of their local and Military TPDs and then forward the application to the JCST the normal way.

Endoscopy Training

Work is continuing between the ISCP and JETS logbook to create an "endoscopy" tab within ISCP into which a PDF file of a trainee's endoscopy logbook can be uploaded. It is hoped in due course that this can become a live link.

As has been discussed previously, there is general recognition that to include a requirement for JAG Certification in the next version of the general surgery curriculum carries with it too many issues to resolve at present.

FRCS (Gen Surg) Examination

The GMC have approved the changes to the exam so that it is now mapped to the 2013 curriculum. The general structure of the exam remains the same but the differences are described below:

Candidates will be required to choose their special interest from one of upper GI (includes both oesophagogastric and HPB), colorectal, breast, transplant or endocrine (or vascular – applicable only to trainees following the 2010 curriculum or those appointed before 1 January 2013 following the 2013 curriculum or to Republic of Ireland trainees). "General surgery" will no longer be accepted as a special interest, in keeping with the 2013 curriculum.

Section 1 will comprise two MCQ exams (single best answer and extended matching) which will be mapped to the knowledge levels required by the 2013 curriculum for all trainees across all components of general surgery.

Section 2 will comprise clinical and oral exams. There will be two clinical exams of 40 minutes each. One will cover general surgery (including emergencies) and the other the candidate's special interest. Each will have a 20 minute case along with 2 cases of 10 minutes each.

There will be four oral exams, each of 30 minutes, comprising 6 questions, each of 5 minutes:
1) Emergency Surgery, trauma and critical care
2) General Surgery principles and clinical practice covering knowledge across the full curriculum as in the MCQs
3) Special Interest clinical practice
4) Special Interest applied basic sciences (15 minutes) and critique of a published paper (15 minutes)

Knowledge of the seminal papers providing evidence for practice in Emergency Surgery and in the applicant's special interest will be expected as will be the ability to assess relevant radiographic images to the level expected of a consultant general surgeon. Applied Basic Science knowledge will also be expected throughout, as indicated in the curriculum.

The first diet of Section 1 will be in November 2014 and Section 2 in January 2015. The old style exam will not be run in parallel. Candidates will be able to sit Section 1 after achieving an ARCP 1 for ST6. Confirmation of equivalent knowledge and skills from referees will be accepted for non-trainees. Once Section 1 has been passed, candidates may progress to Section 2 at the next available diet.

Applications for Certification in Advance of the Expected Date
The JCST receive a small number of these applications and the principles applied in their assessment are:

1) the trainee must be supported by their TPD
2) the trainee must have been performing demonstrably ahead of their chronological training level throughout training and that the possibility of shortening training should be identifiable at the ST6 ARCP
3) the GMC have indicated in exploratory discussions that they would expect the great majority of trainees to need the full indicative 6 years of specialty training to meet curriculum requirements, although, in exceptional cases, some may only need 5 to 5½ years (for a 6 year programme)

Quality Assurance
The GMC is undertaking a review of the format of the Annual Specialty Report that it requests from each specialty. In the meantime, preparation of reports will continue as before.

The JCST has issued its first annual report based on the JCST survey. The QA group are considering whether to break this down into regional reports.

The SAC have included general surgery specific questions on the GMC trainees' survey but the GMC are yet to release the results. It is planned to discuss these at the SAC-TPD meeting in October, part of which will be devoted to QA.

JSCT Review of SAC Terms of Reference
This was explained in the January 2014 Update. Analysis of the surveys of the stakeholders in the SACs has now been completed and options for revision of the SACs are being assessed. A proposal paper will be prepared for comment by December 2014.

Workforce Update
As before, updated cumulative and annualised numbers for consultant adverts and CCT graduates have been appended for your information.

SAC Membership
I would like to personally thank the demitting members - Professor Nariman Karanjia, Mr Jeremy Bannister and Group Captain Tim Whitbread. I'm very grateful to each of them for the work they have done on behalf of the SAC.

Three new members (Miss Aileen McKinley, Surgeon Captain Christopher Streets and Mr Andrew Wyman) were welcomed to their first meeting and we look forward to Mr Giles Toogood attending his first meeting in October. Miss McKinley will become the Liaison Member for North West Thames, Mr Wyman for South West Thames and Mr Toogood for Mersey.

Vacancies arise on the SAC each year as members demit after completing their five year term. Posts are advertised on the JCST and ISCP websites in the autumn and we are grateful to the ASGBI who also email the advert to their membership. Application is by completion of a structured application form which is then assessed by the most senior SAC members who are not demitting against the person specification using the JCST scoring system.

Gareth Griffiths
Chair, SAC in General Surgery

Consultant Adverts 5 May 2012 to 30 June 2014 (excl Jan 2014, 25 months)

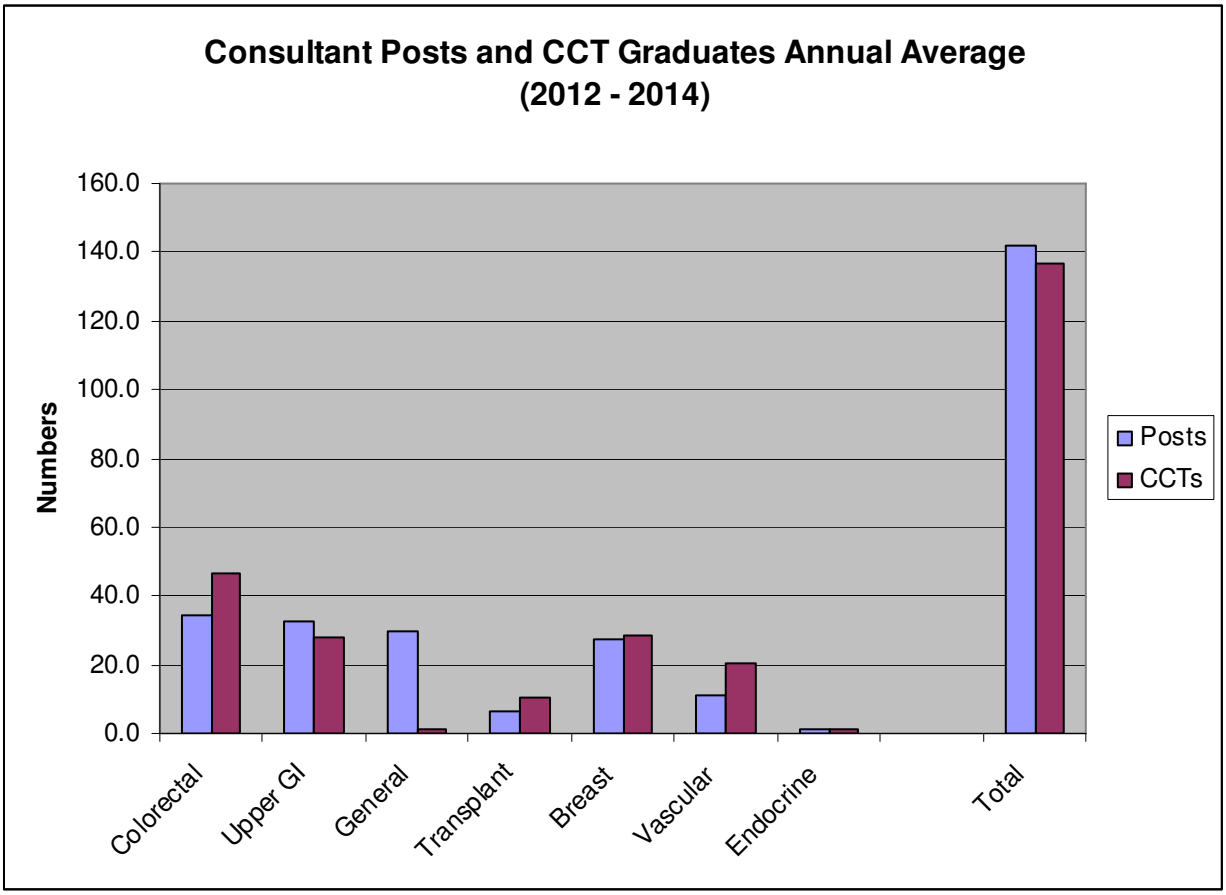
UK				Republic of Ireland	Annualised UK
CR		71			34.1
	CR		69	3	
	CR with EGS		2		
UGI		68			32.6
	UGI		23		
	benign		18		
	bariatric and resection		1		
	bariatric		5		
	OG		7		
	UGI with EGS		1		
	HPB		7		
	HPB and trauma		1		
	HPB benign		1		
	pancreatic		2		
	UGI and endocrine		1		
	intestinal failure		1		
General		62			29.8
	general surgery		27	1	
	general surgery, R&R		2		
	GI with laparoscopy		2		
	GI		6		
	ambulatory		2		
	EGS and laparoscopic		1		
	EGS		19		
	general surgery and endoscopy		1		
	general surgery with vascular		1	1	
	major trauma		1		
Transplant		13			6.2
	transplant		7		
	renal		1		
	renal and vascular		1		
	renal and endocrine		1		
	liver and HPB		2		
	retrieval and HPB		1		
Breast		57			27.4
	oncoplastic, EGS not specified		23		
	oncoplastic, no EGS		5		
	breast, EGS not specified		9		
	breast, no EGS		6		
	breast with EGS		10		
	breast, optional EGS		3		
	breast and endocrine		1		
Vascular		23			11.0
	vascular		21		
	vascular with trauma		2		
Endocrine		2			1.0
Total		296		5	142.1

CCT Graduates 9 November 2012 to 28 March 2014 (20 months)

		UK		Ireland	Annualised UK
CR		78		1	46.8
UGI		47			28.2
	UGI not specified		9		
	UGI benign		1		
	OG/HPB benign		1		
	benign/bariatric		8		
	OG		17	1	
	HPB		9		
	OG/HPB		1		
	UGI+paediatric		1		
General		2			1.2
	general		1		
	emergency and laparoscopic		1		
Transplant		17			10.2
	not specified		7		
	liver and HPB		7	1	
	transplant and HPB		3		
Breast		48			28.8
Vascular		34			20.4
	Vascular		33		
	Vascular and trauma		1		
Endocrine		2			1.2

Total	228	3	136.8

East Midlands	13
East of England	5
Ireland	4
KSS	9
London	49
Mersey	13
North West	15
Northern	16
Northern Ireland	7
Oxford	11
Scotland, East	3
Scotland, North	4
Scotland, South East	5
Scotland, West	12
South West / Peninsula	13
Wales	11
Wessex	7
West Midlands	12
Yorkshire and Humber	19
Total	228


Consultant Posts and CCT Graduates Annual Average
(2012 - 2014)
Numbers
160.0
140.0
120.0
100.0
80.0
60.0
40.0
20.0
0.0
Colorectal
Upper GI
General
Transplant
Breast
Vascular
Endocrine
Total
Posts
CCTs