ISCP INTERCOLLEGIATE SURGICAL CURRICULUM PROGRAMME

JCST Joint Committee on Surgical Training

Evaluation of the 2021 Surgical Curriculum

JCST / ISCP REPORT TO THE GMC JULY 2022

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1. Key points from the evaluation

This evaluation is a comprehensive and timely snapshot of activity, providing some indicative observations from the available data using quantitative and qualitative methodologies. Evaluation is ongoing.

Across all specialties at the time of extraction:

- 98% of trainees who should have transitioned to the new curriculum have done so
- 73% of midpoint MCRs were completed
- 96% of final MCRs were completed
- While midpoint and final MCRs took place in sequence, many were delayed
- 80% of final Learning Agreements were completed
- AES sign off comments in MCRs at the end of phase 2 show good quality engagement

Trainer participants (total 8) reported:

- A lack of local induction and training on the new curriculum
- Mixed opinions about the new curriculum and MCR but feeling it was too early to say
- Not receiving adequate recognition, time and funding for the new curriculum
- The need for training to be able to accurately assess the GPCs and provide feedback and support for trainee development in these areas

Trainee representatives (total 6) reported:

- Needing placement length (and the number of MCRs) to be standardised within specialties
- A lack of adequate local administrative support in terms of induction and training on the new curriculum
- Many cases where trainees were expected to train their trainers on the new curriculum
- Many cases where trainees were expected to organise the MCR on behalf of their trainers
- Engaged trainers were those who tended to be interested in medical education or worked in high functioning units
- Many cases of delays to the MCR because of the 2-week period for post-meeting comments
- That the GPCs were seen as too detailed and not well assessed
- Needing training on how to self-assess effectively

2. The move to an outcomes-based curriculum

In its 2017 standards document, *Excellence by Design*[1], the GMC mandated a transition from competency-based curricula in postgraduate medical education towards a training framework underpinned by outcomes. The GMC defined an 'outcome' as 'an area of professional practice that the trainee is trusted to do unsupervised'[2]. The rationale for this change was firstly, the need to re-establish the importance of professional judgement in the assessment of trainee capabilities and secondly, to better support trainees in understanding the standard to be reached at the end of their training programmes. Consequently, the JCST, in conjunction with the Specialty Advisory Committee (SAC) of each of the ten surgical specialties and core surgical training and with the involvement of a wide range of stakeholder groups, undertook a major revision of the surgical curriculum.

3. The new curriculum

From August 2021, the surgical curriculum began to assess trainees against fewer, high-level generic, shared and specialty-specific outcomes. Their purpose was to describe the fundamental capabilities required of a day-one consultant. The outcomes, referred to as Capabilities in Practice (CiPs) are defined as the ability to successfully manage the unselected emergency take, clinics and ward care, operating lists and multi-disciplinary working. Of equal importance are the Generic Professional Capabilities (GPCs) which express the standard of professional behaviours required of all doctors. The end of training would be reached when supervisors agreed that a trainee had the capabilities to perform autonomously at this level.

It was clear that becoming outcomes-based would necessitate a new approach to the assessment of trainees. An improved, more authentic, and simplified approach to assessing progress through the new curriculum aimed to place the assessment of outcomes and the professional judgement of consultant clinician supervisors who work with trainees every day at the heart of assessment. The goals of the new Multiple Consultant Report (MCR) were to help trainees stay on an appropriate trajectory, providing dedicated, targeted and timely feedback while minimising the burden of assessment for trainees who were progressing satisfactorily. Although the outcomes approach capitalised on supervisors' normal pattern of training, the MCR nonetheless represented a major change in how the administration of their professional judgement in this assessment was delivered.

3.1 The MCR

While Training Programme Directors (TPDs) are responsible for managing training programmes and Assigned Educational Supervisors (AESs) are responsible for the educational development of trainees, Clinical Supervisors (CSs) take responsibility for the day-to-day training and assessment of trainees. The MCR is a group assessment carried out by CSs, taking the form of a physical or online meeting of the CS group led by one 'Lead CS'. The aim of the meeting is for the CS group to reach a collective judgement on trainee performance, based on their direct knowledge of working with the trainee. As part of the MCR assessment, CSs consider whether or not they can delegate professional activities to the trainee by ascribing a specific supervision level for each CiP up to the level of unsupervised working (see supervision levels in appendix 3). The use of supervision levels emerged from the recognition that every day surgical trainers make decisions about the amount of supervision trainees need to perform to be able to undertake a surgical task or procedure. When trainees reach level IV or above in all the CiPs and are performing appropriately in all the GPCs, they are at the standard of a day-one consultant and ready for certification.

[1] Excellence by Design: standards for postgraduate curricula. General Medical Council. Published May 2017

[2] Generic professional capabilities: guidance on implementation for colleges and faculties. Published May 2017

The MCR incorporates a range of descriptors that the CS group can use as shortcuts to describe trainee performance in each CiP and GPC, for instance to highlight specific examples of excellence or development needs. Trainees are required to use a reflective Self-Assessment with identical content to identify their own view. The MCR and self-assessment are reviewed at a dedicated feedback meeting with the trainee after each MCR assessment.

To reflect the shift in focus towards the achievement of the GPCs and CiPs, it was also important that the Learning Agreement which set out and monitored trainee objectives, was re-structured to support this aim. Separate sections of the Learning Agreement are dedicated to setting objectives for attainment of professional behaviours linked to the GPCs and the clinical capabilities of each CiP (see appendix 2).

3.2 Transition to the new curriculum

Trainees were required to consciously transition to the new curriculum as they entered surgical training or moved up to a new level from August 2021. After trainees set up a new placement and before they could begin the Learning Agreement they had to choose whether to transition by clicking to opt in or out (see appendix 4) according to the transition rules (see also 5.1 below). Once trainees had transitioned, their dashboard and all assessments reflected the new curriculum. Those who remained on the old curriculum would continue to be presented with the option to transition each time they began a new placement until August 2023 when all trainees must have transitioned to the new curriculum.

3.3 The new sequence of assessment

The sequence of assessment is central to the design of the assessment system because of the importance of providing assessment and feedback for trainees at key points in each placement cycle. Therefore, the online training management system was designed to link the Learning Agreement and MCR in order to ensure performance against objectives was reviewed and fed back to trainees midway through a placement as well as at the end. Trainee dashboards and updated system alerts and reminders helped to navigate trainees and trainers through the process.

The MCR was designed to take place at two points in the training pathway; firstly, between the objective-setting and midpoint review of the Learning Agreement and secondly between the midpoint review and final review of the Learning Agreement. To ensure this happened, each stage in the process had to be completed before the next became available.

Under the new curriculum, the process is as follows.

Beginning of placement

Objective Setting Meeting (Learning Agreement)

- Trainee and AES select Lead CS
- Trainee and AES set objectives

Before midpoint of placement

Trainee midpoint Self-Assessment

Midpoint MCR

- Post-meeting CS comments
- AES final comments and sign off

Trainee feedback session held

Midpoint of placement	Midpoint Review Meeting (Learning Agreement) ▪ Trainee/AES review objectives (and can view the MCR and Self-Assessment)
Before end of placement	Trainee final Self-Assessment Final MCR ▪ Post-meeting CS comments on final MCR ▪ AES final comments and sign off Trainee feedback session held
End of placement	Final Review Meeting (Learning Agreement) ▪ Trainee/AES review objectives (and can view final MCR and Self-Assessment)

The sequence of assessment is also illustrated in figure 1 below.

The MCR was designed as a faculty discussion, which traditionally excludes trainee participation and happens at the convenience of the supervisor body. It is, therefore, the responsibility of the Lead CS. Once the CS group has met and the MCR online form is submitted, it is available in a partially read-only format for a short period for additional comments after which it becomes available to the AES for final sign off. The MCR provides the primary formative assessment within trainee portfolios, alongside other evidence such as WBAs and summative examinations etc. Together, these assessments form the evidence ARCP panels use in their deliberation (see the assessment system diagram in appendix 1).

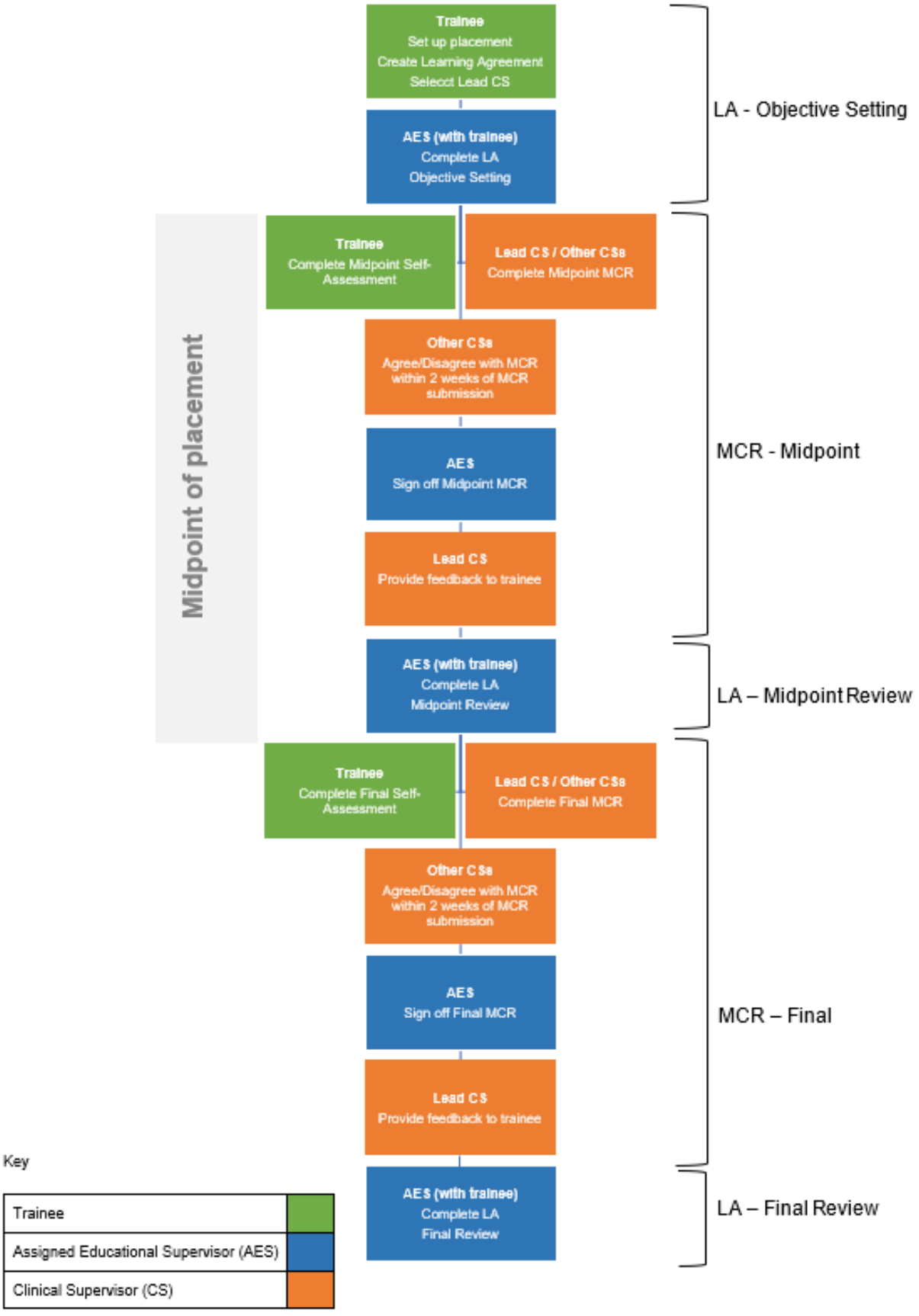


Figure1: Overview of the MCR and Learning Agreement process

4. Evaluation of the new curriculum

We undertook to evaluate how well the curriculum was being implemented within the first year. In line with our evaluation plan, the JCST Chair and ISCP Surgical Director had regular discussions with the Confederation of Postgraduate Schools of Surgery (CoPSS). They attended CoPSS meetings, agreeing where action, improvement or guidance were needed and worked together to provide joint communications and help with dissemination of information. An ISCP evaluation group of SAC Chairs and Curriculum Leads was initiated, chaired by the ISCP Surgical Director with the purpose of regularly reviewing feedback from various stakeholder sources. The regular (3-monthly) meetings invited feedback from regional and specialty representatives on experiences of implementation and the ISCP system. Reports from the evaluation group were forwarded to the ISCP Management Committee and JCST for wider stakeholder discussion. The JCST strategy group were involved in prioritising the methods of enquiry and the format of the evaluation. Data were then shared with the wider evaluation group and presented at the meetings of the JCST, ISCP Management Committee, SACs and CoPSS.

Our first year findings are presented below. Because the data included in this report were taken before a full year of training had been completed, this report answers a limited number of evaluation questions. Further investigation is ongoing to complete our evaluation (see section 7 on future work). The questions we aimed to answer in this report are shown in table 1 below and include transition rates, MCR and Learning Agreement adoption, trainee and trainer views and issues encountered to date. Each question demanded one of two approaches, the first, quantitative (to measure whether what should have been happening was happening) and the second, qualitative (to gain valuable insights into how the changes were being received). The qualitative methodology employed used a carefully selected cross-section of trainees and trainers to explore how the implementation of the new curriculum had been experienced. The use of a small sample size was appropriate because participants were selected to be very different except in their relevance to the topic of enquiry, about which their experiences were likely to be valid. Theoretical saturation was reached with the samples used. The aim was to provide in-depth information and context around behaviours. The research was conducted rigorously, transparently and fairly and every effort was made to avoid subjective bias at each stage of the process (i.e., the creation of questions, recruitment and selection of participants, collation of data and the interpretation of the findings). Our mixed methods approach, therefore, aimed for a suitable balance between the two modes of enquiry. Each method is described briefly below and the findings reported in section 5.

Evaluation questions

Evaluation questions	Methods used	Approach
Have trainees complied with transition requirements?	ISCP database analysis	Quantitative
Have midpoint and final MCRs taken place?	ISCP database analysis	
Have midpoint and final Learning Agreements taken place?	ISCP database analysis	
How well were MCRs conducted?	Thematic analysis of AES sign off comments at a critical progression point	Qualitative

What has the supervisor experience of the new curriculum been?	Thematic analysis of semi-structured, in-depth interviews with clinical supervisors	
What has the trainee experience of the new curriculum been?	Thematic analysis of a trainee forum	
What issues were encountered during implementation and how were they addressed?	Systematic sampling and thematic analysis of ISCP user email queries and summary of our response	

Table 1: Evaluation questions mapped to research methods

Methods used

The ISCP database analysis: Trainees and their supervisors use the ISCP training management system to record evidence of progress in training. The structured table of data includes trainee specialty, training region, training level, supervisors assessments and placements within which training occurs. It is, therefore, a rich source of training data that we regularly utilise to measure, compare and contrast curriculum compliance by region, specialty and training level (see section 5.1).

Thematic analysis of trainer interviews: We invited all active ISCP trainers who were acting in key supervisory roles to volunteer to tell us their experiences of the new curriculum. The selection of a small group included ensuring a diverse mix of specialties, regions, ethnicities and gender. Applicants completed an application form, providing their consent and personal details. Semi-structured questions guided the interviews which were recorded, transcribed and analysed for common themes (see section 5.2).

Thematic analysis of a trainee forum: Trainee representatives from each specialty and core surgical training SAC were invited to a virtual focus group meeting so that we could gauge trainee experiences of the new curriculum. A semi-structured programme was used to guide the discussion which was recorded, transcribed and reviewed to identify what trainees had felt went well and needed improving in areas relating to curriculum implementation (see section 5.3).

Thematic analysis of AES comments: The final step to providing an MCR is the AES's commentary and sign off. These free text comments are recorded as a separate field in the ISCP database for MCRs and can be downloaded for analysis. Each text was subject to systematic coding to identify the kind of ideas that were recognisable within the texts after which the codes were clustered to provide an insight into their characteristic features (see section 5.4).

Thematic analysis of user email queries: The ISCP Helpdesk was primed to support trainees and trainers via email and phone assistance. In order to analyse the sort of issues being reported we systematically sampled emails received within a specific time period in each month from January to March 2022. Queries are collated and themed as shown in section 5.5 while section 5.6 details what our response to these queries were.

5. Evaluation findings

5.1 ISCP data on training

This section of the evaluation used extracts from the ISCP training management system database in order to produce the charts below and answer the following questions.

From the available data:
a. How many of the trainees who were required to transition to the new curriculum did so?
b. How many midpoint and final MCRs took place and when?
c. How many midpoint and final Learning Agreements took place?

Population

The population included in these analyses, illustrated by the charts below was limited to trainees with surgical appointment types (Core StR, Surgical StR, Surgical LAT and FTSTA) in placements created after the August 2021 start date in all UK regions and at all training levels required to transition to the new curriculum (see figure 2). It, therefore, excludes trainees on leave or out of programme and those not required to transition. The data set, taken on 28th June 2022, only counts data for placements that were completed at this time i.e., the end date was reached. While 4-month and 6-month placements that started in August/October are represented, 12-month placements are not included and, therefore, the data set does not reflect a full training year to August 2022.

Figure 2: The number of trainees who have transitioned to the new curriculum

How many trainees transitioned?

Trainees were required to use the new curriculum if they were entering surgical training at CT1/ST1. If moving into the second year they were not required to transition unless they were training in Cardiothoracic Surgery or Neurosurgery. All trainees entering specialty training at ST3 were required to transition as well as when moving into each level up to their penultimate year; ST6 for OMFS and Urology and ST7 for all other specialties. Therefore, all trainees moving into their final year of specialty training could remain on the previous curriculum. At the point of the data extraction the transition rate of those who were required to transition reached 98%. Individual rates of transition in each specialty are shown in figure 3 and by level in figure 4.

Entry level	Transition
CT1 / ST1	Yes
CT2 / ST2	No - except Cardio / Neuro
ST3	Yes
ST4	Yes
ST5	Yes
ST6	Yes
ST7	Yes - except OMFS / Urology
ST8	No

Table 2: Levels required and not required to transition to the new curriculum

Transition by specialty

Figure 3: Percentage of trainees transitioned (green) or remain on the previous curriculum (red) by specialty

Parent Specialty	Transitioned	Yet to transition
Cardiothoracic Surgery	59	13
Core Surgical Training	529	3
General Surgery	771	12
Neurosurgery	162	4
Oral and Maxillofacial Surgery	67	1
Otolaryngology	236	6
Paediatric Surgery	56	2
Plastic Surgery	201	11
Trauma and Orthopaedic Surgery	848	4
Urology	219	2
Vascular Surgery	116	2
Total	**3264**	**60**

Table 3: Precise numbers as illustrated in figure 3

Transition by level

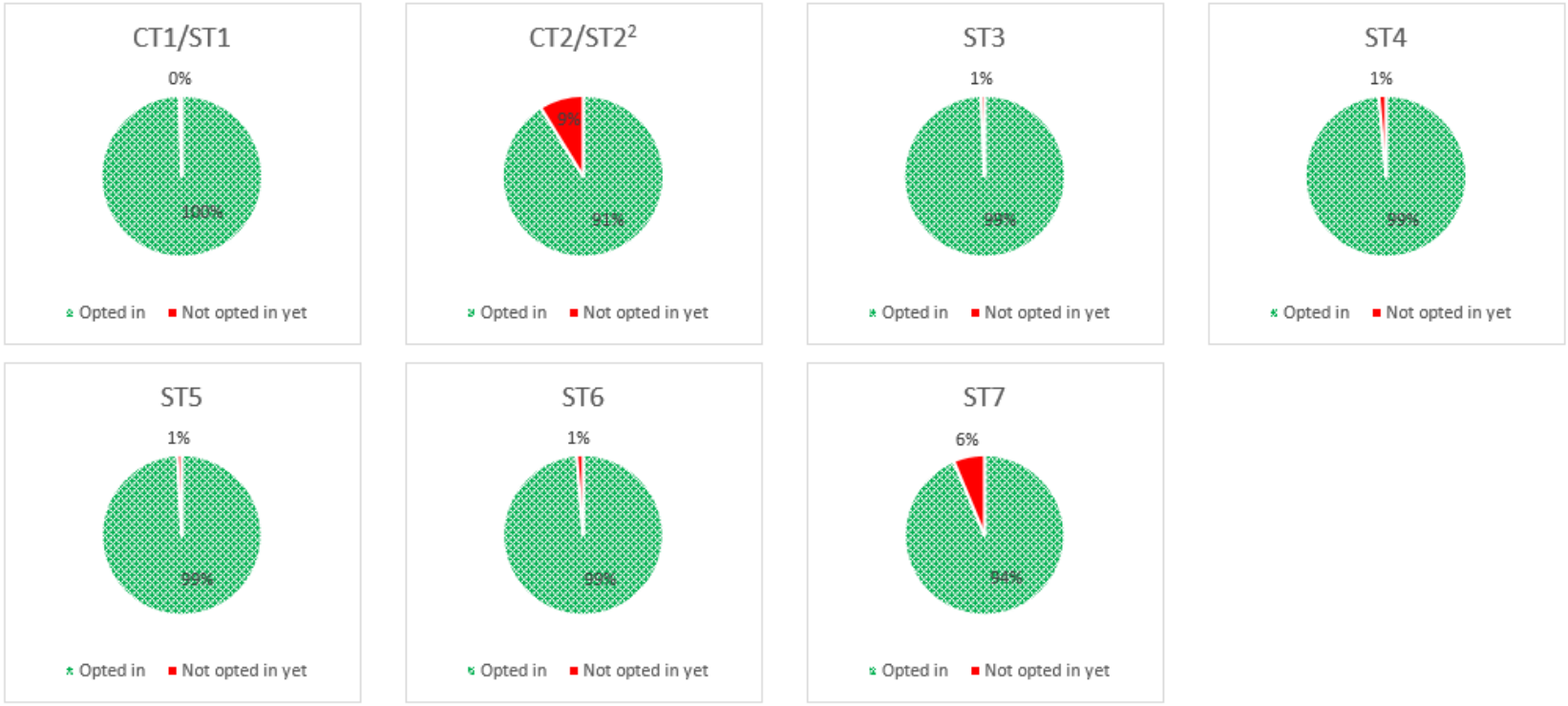


Figure 4: Percentage of trainees who transitioned (green) or remain on the previous curriculum (red) at each training level

Levels requiring transition	Opted in	Not yet opted in
CT1/ST1	617	3
CT2/ST2	31	3
ST3	569	4
ST4	490	7
ST5	561	5
ST6	534	7
ST7	462	31
Total	**3264**	**60**

Table 4: Precise numbers as illustrated in figure 4

How many midpoint and final MCRs took place?

Figures 5 to 8b and tables 5 to 8 illustrate the percentage completion rate of midpoint and final MCRs by specialty and region. The overall rate of completion is 73% for midpoint MCRs and 96% for final MCRs. It is important to note that the midpoint MCR is optional and recommended for placements of 6 months or longer and, therefore, a lower completion rate would be normal. The data extract upon which these charts are based includes 9% of placements that were shorter than 6 months. These completion rates are a snapshot of the assessment cycle and it is likely that there will be some improvement because of delayed MCRs. In the next evaluation period, we will be exploring the reasons for lower rates of completion, for example Paediatric Surgery (59% completion of final MCRs) as well as high rates of completion to identify good practice, for example Urology (91% completion of final MCRs).

When did midpoint and final MCRs take place?

Figures 9a/b illustrate how far into placements the midpoint MCRs (dark blue bar) and final MCRs (light blue bar) took place and the timing between them.

The x axis represents the percentage of time into placements that MCRs occurred irrespective of the placement length so that for example in a 4-month placement, MCRs taking place at a 40% time marker will have occurred 1.6 months into the placement while the same time marker would represent 2.4 months into a 6-month placement. While it would be expected that all MCRs would have been completed by the end date of the placement (i.e. at 100% of time), the time markers have been extended to 110% and beyond 110% to illustrate any delays and their extent i.e. if MCRs were completed soon after or long after the end date. The y axis shows that the number of MCRs varies between specialties. In each specialty the midpoint and final MCRs took place in sequence but many were delayed. Across specialties, the midpoint MCR began in small numbers as early as 20% into placements, peaking around 60% but continuing in smaller numbers throughout placements and beyond. Final MCRs began at 50% and occurred in greater numbers at the end of placements and later.

Midpoint MCR by specialty

Figure 5: Percentage of completed (green) and incomplete (red) midpoint MCRs by specialty

Midpoint MCR by specialty

Parent specialty	Midpoint MCR completed	Midpoint MCR not completed
Cardiothoracic Surgery	27	17
Core Surgical Training	490	274
General Surgery	422	130
Neurosurgery	67	29
Oral and Maxillofacial Surgery	27	17
Otolaryngology	86	24
Paediatric Surgery	11	11
Plastic Surgery	78	26
Trauma and Orthopaedic Surgery	647	170
Urology	60	17
Vascular Surgery	30	6
Total	**1945**	**721**

Table 5: Precise numbers as illustrated in figure 5

Midpoint MCR by deanery / HEE Local Office 1 of 2

Figure 6a: Percentage of midpoint MCRs completed (green) and incomplete (red) by region 1 of 2

Midpoint MCR by deanery / HEE Local Office 2 of 2

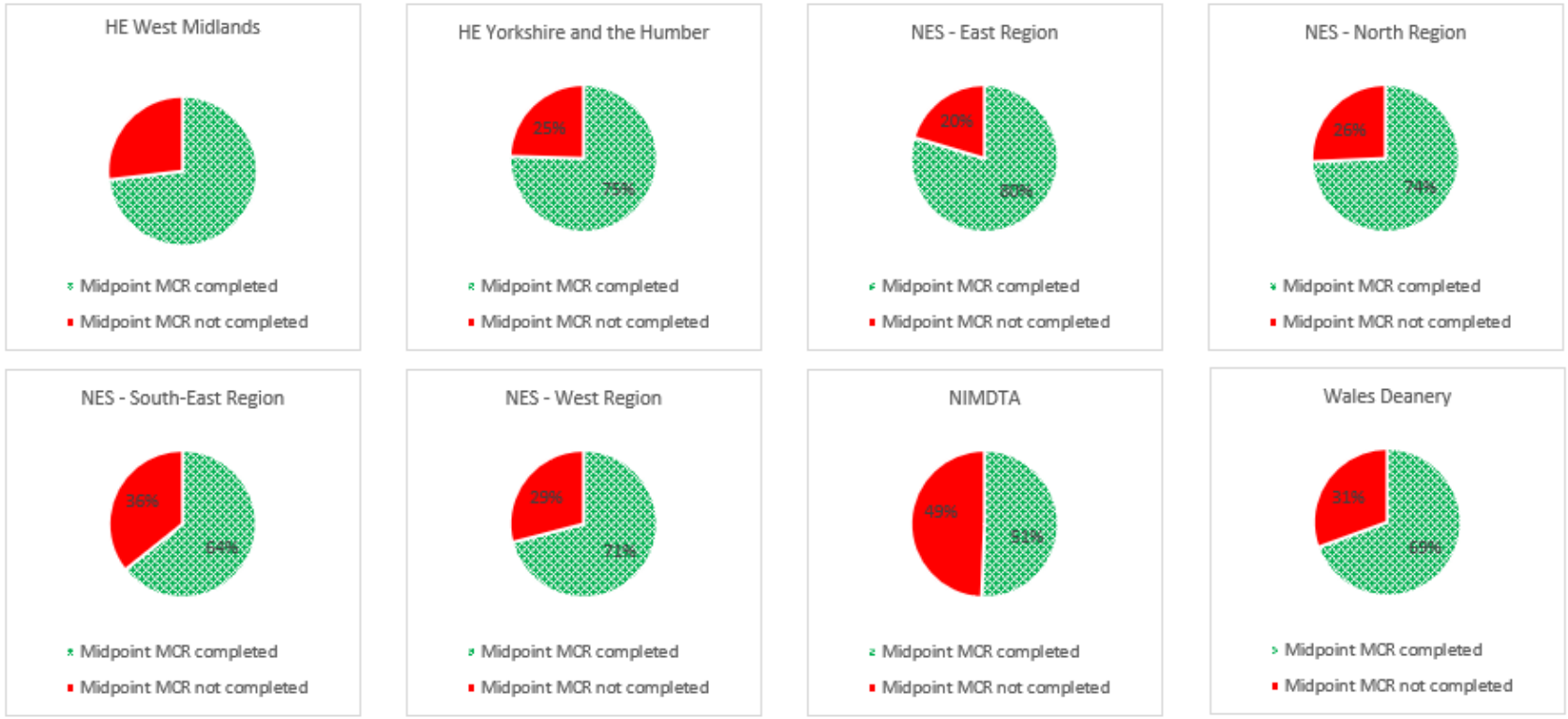


Figure 6b: Percentage of midpoint MCRs completed (green) and incomplete (red) by region 2 of 2

Midpoint MCR by deanery / HEE Local Office

Deanery / HEE Local Office	Midpoint MCR completed	Midpoint MCR not completed
Health Education East Midlands	133	61
Health Education East of England	132	26
Health Education Kent, Surrey and Sussex	105	31
Health Education North Central & East London	87	34
Health Education North East	174	55
Health Education North West (Mersey Sector)	124	22
Health Education North West (North West Sector)	170	44
Health Education North West London	62	46
Health Education South London	64	61
Health Education South West	181	31
Health Education Thames Valley	62	20
Health Education Wessex	67	43

Health Education West Midlands	147	54
Health Education Yorkshire and the Humber	123	40
NHS Education for Scotland - East Region	39	10
NHS Education for Scotland - North Region	26	9
NHS Education for Scotland - South-East Region	27	15
NHS Education for Scotland - West Region	66	27
Northern Ireland Medical & Dental Training Agency	40	39
Republic of Ireland Deanery	0	2
Wales Deanery	116	51
Total	**1945**	**721**

Table 6: Precise numbers as illustrated in figures 6a/b

Final MCR by specialty

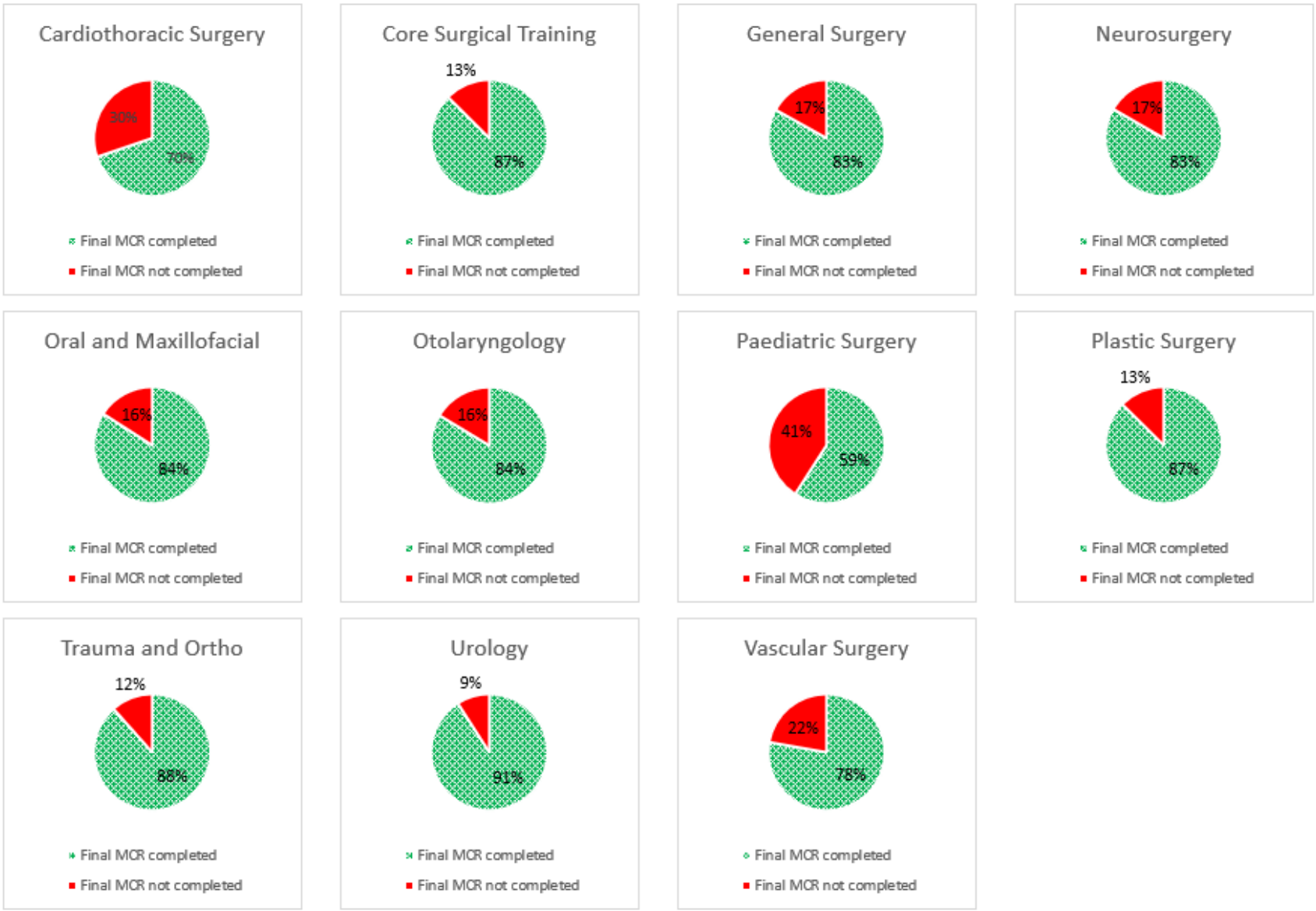


Figure 7: Percentage of final MCRs completed (green) and incomplete (red) by specialty

Final MCR by specialty

Parent Specialty	Final MCR completed	Final MCR not completed
Cardiothoracic Surgery	30	13
Core Surgical Training	668	96
General Surgery	457	93
Neurosurgery	80	16
Oral and Maxillofacial Surgery	37	7
Otolaryngology	92	18
Paediatric Surgery	13	9
Plastic Surgery	90	13
Trauma and Orthopaedic Surgery	719	94
Urology	70	7
Vascular Surgery	28	8
Total	**2284**	**374**

Table 7: Precise numbers as illustrated in figure 7

Final MCR by deanery ' HEE Local Office 1 of 2

Figure 8a: Percentage of final MCRs completed (green) and incomplete (red) by region 1 of 2

Final MCR by deanery ' HEE Local Office 2 of 2

Figure 8b: Percentage of final MCRs completed (green) and incomplete (red) by region 2 of 2

Final MCR by deanery / HEE Local Office

Deanery / HEE Local Office	Final MCR completed	Final MCR not completed
Health Education East Midlands	155	39
Health Education East of England	125	33
Health Education Kent, Surrey and Sussex	116	20
Health Education North Central & East London	93	27
Health Education North East	196	32
Health Education North West (Mersey Sector)	138	7
Health Education North West (North West Sector)	202	12
Health Education North West London	90	17
Health Education South London	98	27
Health Education South West	185	27
Health Education Thames Valley	65	16
Health Education Wessex	84	26
Health Education West Midlands	184	17

Health Education Yorkshire and the Humber	147	15
NHS Education for Scotland - East Region	43	6
NHS Education for Scotland - North Region	33	2
NHS Education for Scotland - South-East Region	38	4
NHS Education for Scotland - West Region	83	10
Northern Ireland Medical & Dental Training Agency	72	7
Republic of Ireland Deanery	2	0
Wales Deanery	135	30
Total	**2284**	**374**

Table 8: Precise numbers as illustrated in figures 8a/b

Timing of midpoint & final MCRs by specialty 1 of 2

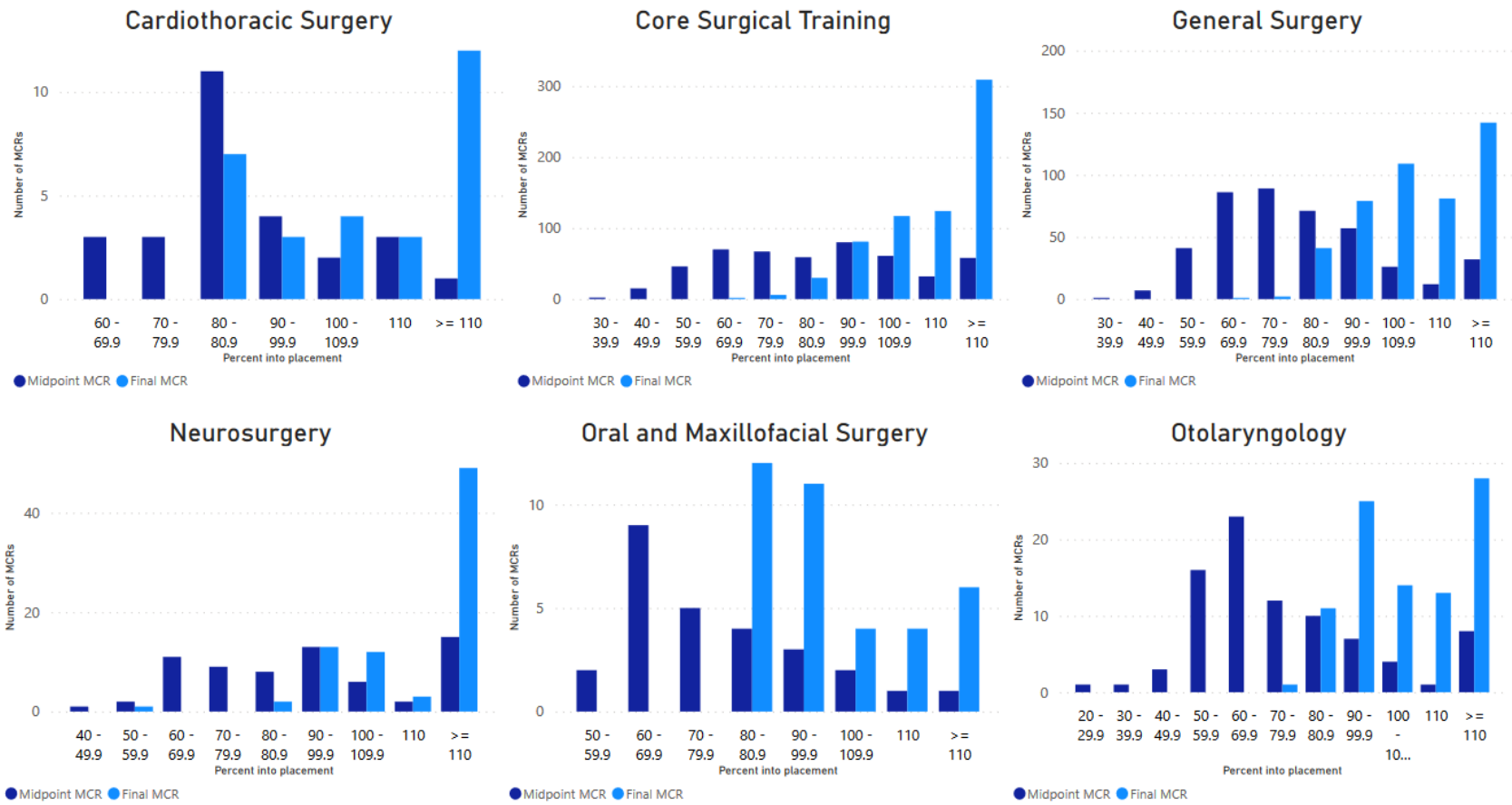


Figure 9a: Timing sequence of midpoint MCRs (dark blue) and final MCRs (light blue) by specialty 1 of 2

Timing of midpoint & final MCRs by specialty 2 of 2

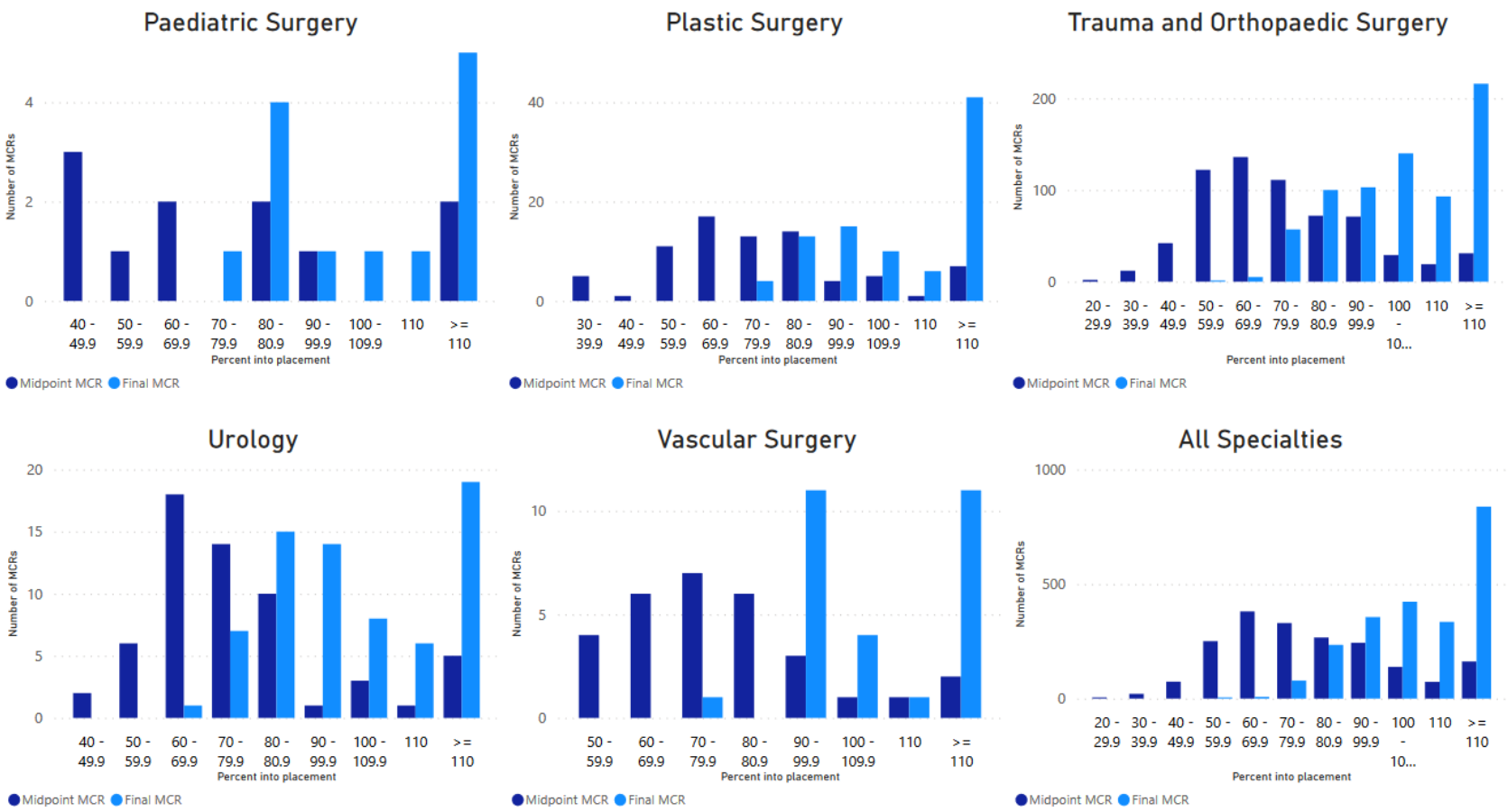


Figure 9b: Timing sequence of midpoint MCRs (dark blue) and final MCRs (light blue) by specialty 2 of 2

How many midpoint and final Learning Agreements took place?

Figures 10 to 13b and tables 9 to 12 illustrate the percentage completion rate of midpoint and final Learning Agreements by specialty and region. Across all specialties, the overall rate of completion of final Learning Agreements was 80%. Every Learning Agreement meeting is mandatory and each meeting must be signed off for the next meeting to become available online. Because of the key role trainees play in the Learning Agreement process, it is unlikely that these completion rates will improve after the end date of placements because trainees will have begun new placements. As with MCRs, in the next evaluation period, we will be exploring the reasons for lower rates of completion, for example Paediatric Surgery (50% completion of final Learning Agreements) as well as high rates of completion to identify good practice, for example Urology (88% completion).

Comparative final Learning Agreement data from 2018/19, a pre-covid, stable training period can be found in appendix 8.

Midpoint Learning Agreements by specialty

Figure 10: Percentage of midpoint Learning Agreements completed (green) and incomplete (red) by specialty

Midpoint Learning Agreements by specialty

Parent Specialty	Midpoint LA review completed	Midpoint LA review not completed
Cardiothoracic Surgery	35	8
Core Surgical Training	722	42
General Surgery	499	51
Neurosurgery	92	4
Oral and Maxillofacial Surgery	42	2
Otolaryngology	102	8
Paediatric Surgery	15	7
Plastic Surgery	94	9
Trauma and Orthopaedic Surgery	778	35
Urology	73	4
Vascular Surgery	32	4
Total	**2484**	**174**

Table 9: Precise numbers as illustrated in figure 10

Midpoint Learning Agreements by deanery / HEE Local Office 1 of 2

Figure 11a: Percentage of midpoint Learning Agreements completed (green) and incomplete (red) by region 1 of 2

Midpoint Learning Agreements by deanery / HEE Local Office 2 of 2

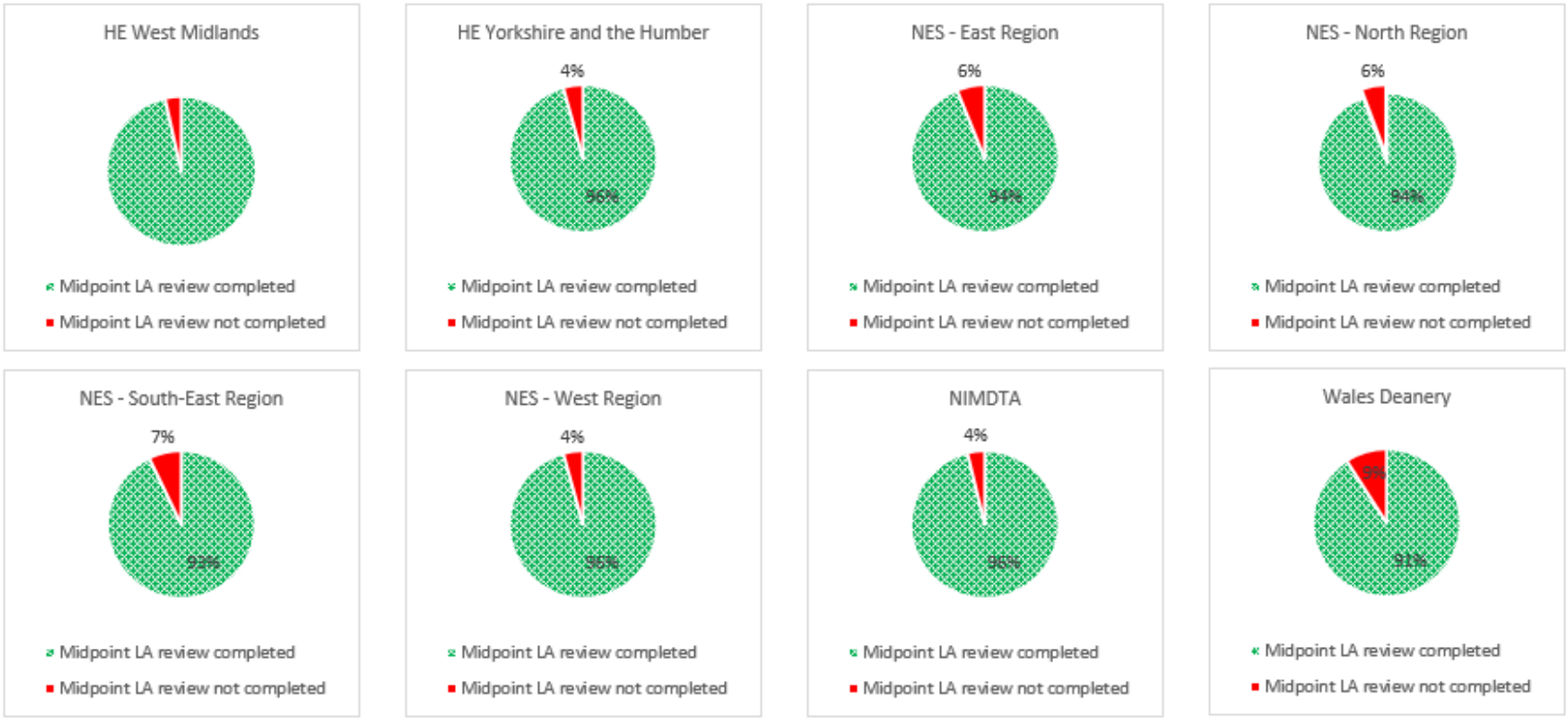


Figure 11b: Percentage of midpoint Learning Agreements completed (green) and incomplete (red) by region 2 of 2

Midpoint Learning Agreements by deanery / HEE Local Office

Deanery / HEE Local Office	Midpoint LA completed	Midpoint LA not completed
Health Education East Midlands	180	14
Health Education East of England	150	8
Health Education Kent, Surrey and Sussex	128	8
Health Education North Central & East London	108	12
Health Education North East	209	19
Health Education North West (Mersey Sector)	137	8
Health Education North West (North West Sector)	205	9
Health Education North West London	98	9
Health Education South London	114	11
Health Education South West	199	13
Health Education Thames Valley	75	6
Health Education Wessex	97	13
Health Education West Midlands	194	7
Health Education Yorkshire and the Humber	155	7

NHS Education for Scotland - East Region	46	3
NHS Education for Scotland - North Region	33	2
NHS Education for Scotland - South-East Region	39	3
NHS Education for Scotland - West Region	89	4
Northern Ireland Medical & Dental Training Agency	76	3
Republic of Ireland Deanery	2	0
Wales Deanery	150	15
Total	**2484**	**174**

Table 10: Precise numbers as illustrated in figure 11

Final Learning Agreements by specialty

Figure 12: Percentage of final Learning Agreements completed (green) and incomplete (red) by specialty

Final Learning Agreements by specialty

Parent Specialty	Final LA completed	Final LA not completed
Cardiothoracic Surgery	30	13
Core Surgical Training	635	129
General Surgery	427	123
Neurosurgery	73	23
Oral and Maxillofacial Surgery	34	10
Otolaryngology	89	21
Paediatric Surgery	11	11
Plastic Surgery	83	20
Trauma and Orthopaedic Surgery	659	154
Urology	68	9
Vascular Surgery	28	8
Total	**2137**	**521**

Table 11: Precise numbers as illustrated in figure 12

Final Learning Agreements by deanery / HEE Local Office 1 of 2

Figure 13a: Percentage of final Learning Agreements completed (green) and incomplete (red) by region 1 of 2

Final Learning Agreements by deanery / HEE Local Office 2 of 2

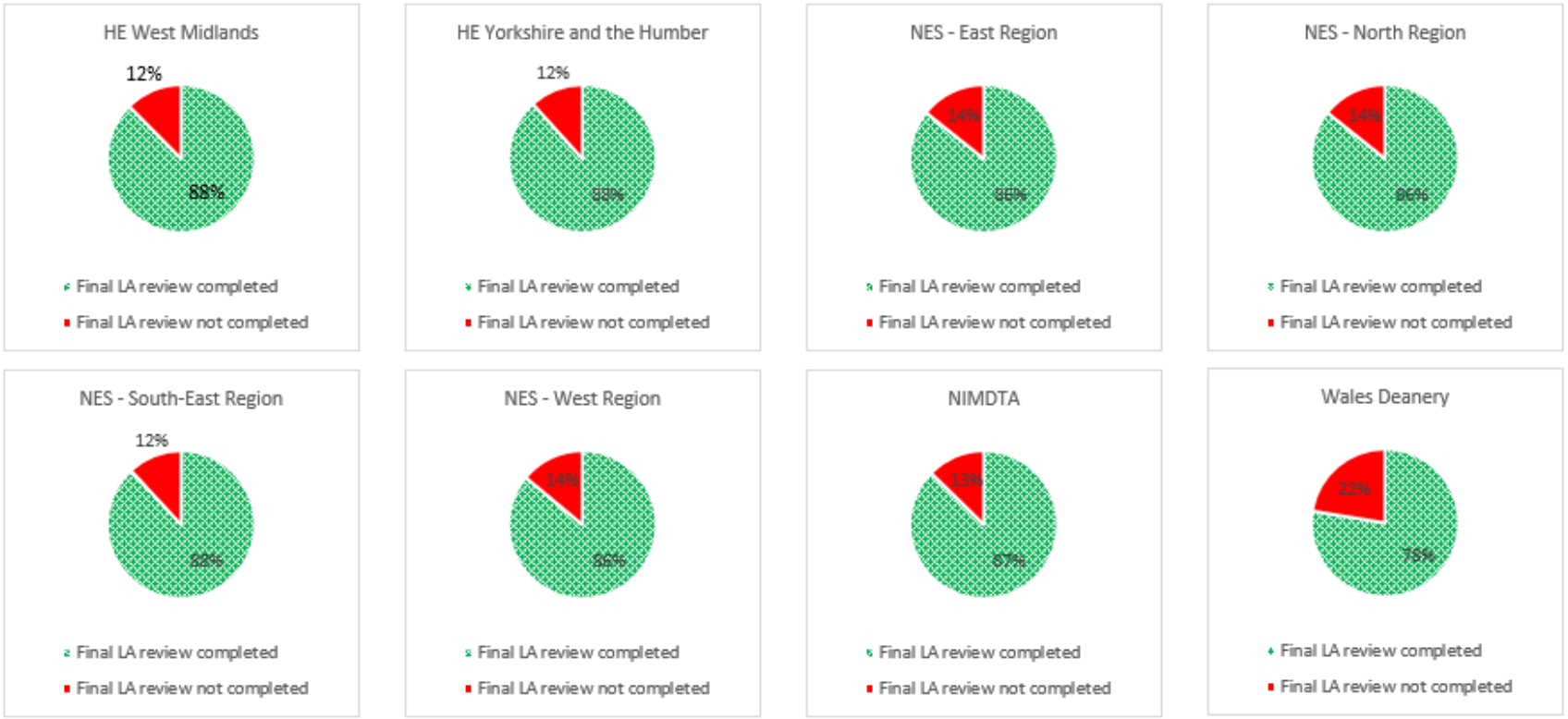


Figure 13b: Percentage of final Learning Agreements completed (green) and incomplete (red) by region 2 of 2

Final Learning Agreements by deanery / HEE Local Office

Deanery / HEE Local Office	Final LA completed	Final LA not completed
Health Education East Midlands	147	47
Health Education East of England	109	49
Health Education Kent, Surrey and Sussex	106	30
Health Education North Central & East London	81	39
Health Education North East	181	47
Health Education North West (Mersey Sector)	136	9
Health Education North West (North West Sector)	201	13
Health Education North West London	82	25
Health Education South London	82	43
Health Education South West	175	37
Health Education Thames Valley	57	24
Health Education Wessex	73	37
Health Education West Midlands	176	25

Health Education Yorkshire and the Humber	143	19
NHS Education for Scotland - East Region	42	7
NHS Education for Scotland - North Region	30	5
NHS Education for Scotland - South-East Region	37	5
NHS Education for Scotland - West Region	80	13
Northern Ireland Medical & Dental Training Agency	69	10
Republic of Ireland Deanery	2	0
Wales Deanery	128	37
Total	**2137**	**521**

Table 12: Precise numbers as illustrated in figure 13a/b

5.2 Trainer interviews

This part of the evaluation sought to ascertain how consultant trainers were adapting to the new curriculum. We wanted to know whether and how they were coping with the changes. Consultation was sought therefore to assess whether the implementation to date had been smooth and/or if any problems were being experienced.

The purpose of the study was therefore to gain an understanding of how well or not the new curriculum was being embraced by consultants in their capacity as trainers and what barriers, if any, were preventing its successful implementation. As a consequence of this study, remedial action could be developed and provided to those experiencing any identified problem areas.

Method

In March we sent a direct email invitation to all active CSs, AESs and TPDs to ask if they would be willing to share their experiences of the new curriculum. As this study sought a non-biased approach in terms of equality and diversity, a careful selection of consultants was undertaken. A sample base of eight consultants was chosen from a diverse pool to represent as many protected characteristic groups as possible. Differences in ethnic origin, gender, geographical region, surgical specialty, and surgical roles were all considered in order to create a robust diversity for the study (see table 13 below). Details of ethnic backgrounds have been withheld to prevent identification. This cross-section of data ensured that the results of the study would be strengthened and applicable to as many of the protected groups as possible. The consultants were all willing participants who had previously indicated their interest in surgical education and who willingly volunteered their time to participate in this study. One participant in a CS role, had not yet had direct experience of MCRs although he had knowledge of the new curriculum and understood the process involved in undertaking an MCR.

The semi-structured interviews with the 8 consultant trainers were conducted over a period of 2 months – June and July 2022. The hour-long, online interviews took place via Teams at a mutually convenient time of day. Permission to record the interviews was obtained from each consultant so that a written transcript of each interview was available. This process allowed full focus on the consultant and the content of each interview.

Focussed questions relating to the new curriculum and the MCR had previously been crafted. They included both open and closed questions which were tailored to each trainer role, for example, questions for a consultant working as an AES were a little different to those asked of a CS and so on. The interviewer kept loosely to the structure of the interview, and also allowed the consultants to freely voice their opinions as and when they chose to do so at any time during the interview. This allowed more in-depth data to come forward which might not have been the case during a rigidly-structured interview. What was important was to capture each consultant's individual and personal opinions as they naturally arose.

The broad categories of questions are provided here under the main headings. A more detailed list of questions is available on request:

- Induction - Whether the consultant had received adequate induction on the new curriculum or not and if so, what had been most helpful.

- New Curriculum and Transition - Whether the consultant liked the new curriculum, and whether it was a positive development, as well as any issues surrounding transition.

- MCR - How much experience the consultant had had with MCRs, what the barriers were, and whether they felt the MCR allowed professional judgements to form, whether the meetings were face-to-face or online and why, and how any divergent views, if any, were resolved.

- Logistics - How hard it was to arrange MCR meetings – whether online or face-to-face, how many CSs were present, what the right number of CSs was, and whether it was right, in their opinion, for an AES and a CS be the one and same person.

- CiPs and GPCs - Whether the consultants found the CiPs to be valid, and how easy or hard was it to agree on supervision levels, and any barriers they were experiencing. And for the GPCs, for example, how they found assessing the professional development skills, what the difficulties were, and whether they found the language prompts useful or not.

- Learning Agreement (LA) - Whether they found the LA in general and the Objective Setting in particular useful, and whether or not they understood the timing of each interlocking part of the LA process.

- Self-Assessment - Whether the consultant had experience of this in relation to their trainees, whether or not the trainees had completed them, and whether or not they felt that it aided discussion in the feedback meeting.

- Further Guidance - Whether further training was required and the type, delivery and content of that training.

- Advice - What advice they would give to other consultant trainers about the new curriculum and MCR.

Participant	**Specialty**	**Gender**	**Region**	**Role**s
C1	Otolaryngology	Female	East Midlands	CS
C2	Plastic Surgery	Male	Oxford/Wessex	AES; CS; Lead CS
C3	General Surgery	Female	Kent, Surrey and Sussex	AES
C4	Cardiothoracic Surgery	Male	London	TPD
C5	General Surgery	Male	Scotland	CS; Lead CS
C6	Urology	Male	East of England	CS
C7	Trauma & Orthopaedics	Female	South West England	AES; CS; Lead CS
C8	Paediatric Surgery	Male	London	AES; CS; Lead CS

Table 13: Demographics of the participant consultant group

Analysis

As well as the written transcripts, notes were taken during each interview. After each interview, these notes were written up in more structured form and cross-checked against the transcripts to ensure accuracy and validity of data. All interview data were collated in July 2022.

Information was categorised into concepts and further into themes using thematic analysis. Patterns, consistencies and repetitions were noted as well as any contradictions or dissonant viewpoints. This process was achieved by returning repeatedly to the same data to link certain words, phrases and whole sentences to similar groupings. Groupings were then linked to concepts until the data could not be thematised any further and saturation had occurred.

Results

Induction

Most participants felt that they had not received adequate induction on the new curriculum. Many said they had to teach themselves by looking at the videos on the ISCP website and/or asking their colleagues about it. One participant said that

> '*The new curriculum and the MCR was a surprise for me and everyone in our region.'* (C7)

Disappointingly, most had not heard of the training Webinars on the new curriculum and the MCR, that the ISCP Surgical Director had regularly presented throughout 2021. These online training Webinars delivered via Teams had been tailored for specified audiences such as trainer and trainee groups. Nor did the participants know about the '*Ask Keith'* online 'drop-in' sessions in which the Surgical Director answered any questions about the new curriculum from trainers and trainees.

New Curriculum

Opinions about the new curriculum were mixed. Some said it was a step forward, while others indicated that it was '*pretty much the same as the old, not much has changed*' (C3). Some said that the COVID pandemic had had a big impact on hindering the uptake of the new curriculum and MCR. Another participant felt that the new curriculum had been downgraded – that requirements for more complex technical skills had decreased and higher competencies were no longer required. Another participant said that the new curriculum '*may increase competition between trainees – I'm going to CCT before you'* (C5). One participant said that the addition of training pathways in 3 phases was particularly helpful (C4).

A principal theme that many participants voiced was that trainers were not preparing for the new curriculum because they felt they were not being adequately recognised. Engagement with the new curriculum was therefore minimal they said, because trainers were not receiving adequate time or money to do so, as illustrated by this comment –

> *'The problem with the MCR and the time needed to devote to it is that CSs are not afforded time and remuneration. It takes a lot of time and energy to do an MCR properly and yet we're not paid to do it.' (C1)*

Another main theme was that it was still too early to do an evaluation. Many felt that it was premature to make definite and well-thought out comments. This quote sums up the prevalent attitude –

> *'It's too early to do the evaluation. Everyone is still working out how to do an MCR, transition, self-assessment and feedback meeting. I think the best time to do the interview/GMC evaluation would be in October, 2023.' (C4)*

MCR

Comments about the MCR ranged from positive to neutral to negative. The positive ones reflected a liking for the way the MCR allowed a trainer to discuss multiple aspects of their trainee's development, and this was especially so if the trainee needed extra help. They also liked the visibility of the MCR and the way it removed inherent bias, part of previous assessment tools, due to its consensus nature – that of collecting multiple viewpoints.

The negative comments told of an inflexibility aspect to the MCR – that it was a '*one size fits all*' tool. They didn't like the rigidity of it, and felt that because of that, it was ineffective. Many also found it complex and too time-consuming to fill out.

Here are some comments expressed which sum up the participants' range of attitudes.

Positive –

> *'It gives trainees more things (feedback) to reflect on (C3)*
> *It's less biased' (C4)*
>
> *'I like it' (C4, C3 , C5)*
>
> *'It's helpful as you can see progression' (C3)*
>
> *'It gives more options about how to improve a trainee's competency' (C5, C7)*
>
> *'It removes assumptions between trainee and trainer which may be hindering progression' (C7)*
>
> *'It's good for trainees who need extra help' (C3)*
>
> *'It gives a chance to reflect on a trainee and gives a step forward for improvement' (C5*)
>
> *'And it also gives more options about how to improve a trainee's competencies' (C5)*
>
> *'The contributing comments worked well. All my trainees have added all the CSs in the hospital/unit as their CSs on their MCR and this works well – there's about 20 of them' (C7)*

Neutral –

> *'The MCR is just a formalised way of doing what we have always done (C6, C2)*
>
> *'I and other trainers have been doing this anyway for years – gathering professional opinions about a trainee informally - in a corridor or at a meeting and so on' (C6)*

Negative –

> *'The MCR is a rigid tool and a tick-box exercise. It's clunky, unwieldy and doesn't have the necessary flexibility for assessing a trainee. It has no relevance other than a requirement for ARCP.' (C2)*

> *'Again, it's another one of those things that leads to disengagement, because trainers recognise that they're being asked questions that frankly they shouldn't be asked at this stage and therefore their answers aren't relevant and it's treated as such.' (C2)*

> *'I haven't seen anyone who enjoys doing them and everyone avoids MCRs – they are too complex and time-consuming, the form is complicated and it's not welcome.' (C8)*

> *'(It) misses the mark and I can understand that because if you apply rigidity in any system, it's only ever going to be accurate for certain aspects or certain elements being assessed.' (C2)*

Some participants mentioned individual problems they were having with their MCRs. Here are their main stumbling blocks with comments to illustrate -

Too frequent –

> *'MCR meetings come around too frequently. I think 2 MCRs per 6 month placement is too much.' (C1)*

> *'The frequency of MCR is tiring – 2 per 6 month'. (C8)*

> *'Doing 2 MCRs in a 4 month placement is too many.' (C2)*

Too time-consuming –

> *'The problem is that the CSs don't get additional time to do MCRs and it takes a lot of time – longer than the AES meetings.' (C8)*

> *'The problem with the MCR and the time needed to devote to it is that CSs are not afforded time and remuneration. It takes a lot of time and energy to do an MCR properly and yet we're not paid to do it.' (C1)*

Too much uncertainty -

> '(*I) still don't know much about how to start an MCR.' (C8)*

Too inflexible –

> *'I think it (MCR) should be different for different stages of training e.g. MCR 1 for ST1; MCR 2 for ST2; and MCR 3 for ST3 etc. to show progression.' (C4)*

'One size doesn't fit all - In giving the supervision levels it is easier to assess the SHOs (Senior House Officers) than the registrars as they are different groups with different levels of assessment so it's a slight stretch to judge the supervision levels of both with the one instrument – 'one size fits all' is stretched a bit too much.' (C7)

Logistics

Face-to-face MCR meetings were the preferred option for most participants. This was the case for both the MCR meeting as well as the feedback meeting. Even though participants acknowledged that they were hard to arrange, labour intensive and the logistics difficult, a face-to-face meeting was the best and most useful way to do an MCR, as summed up by this comment.

'The best way by far to do a MCR is to have multiple clinical supervisors sitting in the one room discussing a trainee – to hear what the other supervisors have to say about the trainee and to come to a consensus. Otherwise, it just becomes another tick-boxing exercise when the Lead CS completes and sends it to other CSs and they just tick a box to say they agree'. (C5)

Face-to-face meetings were more productive too, according to one participant –

'FTF meetings are more productive I think than online ones – In Teams you can only have one person speaking at one time whereas FTF meetings you can have others speaking at same time so it's more productive – more comments are made.' (C7)

One solution to the problem of getting all CSs into the one room to discuss trainees and complete their MCRs was to include an informal eating arrangement. For example, one participant (C1) told of how she has had one of her MCR meetings at the local '*Burger Shack*'. It was a night out at the hamburger shop for all the CSs to discuss the trainees and it proved helpful and enjoyable, she said. Another participant had the same idea but instead of hamburgers, she ordered 'pizzas' in –

'We usually have one meeting to do the MCRs for all trainees in one meeting. That works well. Often I order in pizzas - we have a pizza evening at a special teaching/learning room at the hospital where the MCR is up on screen for us to look at. The pizza is a good motivator - our goal is to get everyone at the meeting to discuss FTF our trainees. If other CSs can't get to the pizza evening, they can join in online for their input at same time.' (C7)

CiPs and GPCs

There was a positive reaction to the CiPs. Most participants liked the rationale behind them – they understood that the intentions of the CiPs were good, that they increased the holistic nature of training and that they included all the skills needed to become a consultant. Many participants felt they were easier to assess and comment on than the GPCs. Several participants however, said that the '*one size fits all'* aspect of the CiPs may hinder their effectiveness. For example, CiP 3 – *Manages ward rounds and the on-going care of in-patients* - didn't really apply to some participants because in their work, there was no opportunity to go on a ward round to judge their trainees (C7, C8, C5). Another participant volunteered that when assessing supervision levels of CiPs, he always asks himself:

'Is the trainee ready to move to the next stage of training or not: Am I happy to have him/her as a colleague? That is, is that trainee a safe surgeon? Is he/she a team-player? Are they a good communicator?' (C6)

In the interviews, there was little evidence of instances of disagreement among the clinical supervisors about choosing supervision levels for their trainees, as shown in these comments.

'There has been some discussion - I wouldn't call it disagreement - among supervisors about how CiPs should be graded and what the supervision levels should be.' (C3)

'I've never been in an MCR meeting where there was any disagreement among the clinical supervisors – generally there has been cooperation and a general consensus of opinion about a trainee.' (C3)

On the other hand, many participants voiced concerns about how to assess the GPCs. It was one common area where uncertainty was evident and problems were being experienced.

For example, several participants said that the GPCs were too subjective. GPCs, they said, were affected by other multiple factors such as the hospital culture, personality of consultant and the trainee and so on. Some said that it was too hard to provide evidence to support any areas of development marked against a trainee. Lack of tangible evidence created anxiety in a few participants, as they felt responsibility when signing off their trainee's MCR.

'It's very difficult to have evidence to support an area of professional development for a trainee – how do we judge that? How do we give evidence to support that?' (C8)

Some felt it was challenging to accurately assess the GPCs, and others said they were harder to define, and difficult to comment on. It was a woolly area and could not be quantified, they said.

One participant voiced his concerns about not having the necessary skills to be able to undertake this task. '*I'm a surgeon, not a life coach'* (C8). This same participant went on to say -

'I am not trained to give personal development training (GPCs) - It's not part of my job and you need another trained person to do this – maybe not a surgeon. I don't have time to train a trainee on how, for example, not to be late to appointments – that's personal development training and where is the time to support this activity?' (C8)

Perhaps as a result, many participants were choosing the default – '*Appropriate for stage of training'* unless there were significant problems with the trainee, they said.

On the positive side, participants volunteered these comments about the GPCs –

'GPCs allow you to talk to your trainee about certain behaviours which is a good thing' (C4)

'GPCs - They are good, and allow leadership qualities to develop' (C1)

'The prompts are good though for the GPCs when you need sensitive language if a trainee has problems in professional behaviour' (C3)

'Language prompts are helpful' (C5)

One participant (C7) said that her way to help trainees in both the CiPs and the GPCs was to pair up two trainees of a similar training level who do not know each other and who have similar development needs – like a 'buddy' system. The two trainees can get together to learn from and about each other on how to improve their surgical skills and competencies.

Roles

A lot of the participants in this study had multiple trainer roles. That is, some participants were assessing their trainee as both an AES and a CS. Others had all three roles at the one time – AES, CS and Lead CS**.** Another still had only a TPD role**.** Participants were asked about whether they thought an AES and a CS should be the same person during a MCR assessment or whether they should be two different people performing two different roles. Opinions were roughly evenly divided.

Some participants considered it a good thing for one person to have two roles as these comments show –

> *'Yes, I am an AES and a CS at the same time I think it's good to be one person for both roles – you get to know the trainee more and have a better understanding – you know the things the trainee has done and the things not done yet.' (C3)*
>
> *'Being an AES and a CS at the same time has got advantages and disadvantages - The good thing is that you can track the progress of the trainee and oversee all corrections so you get a better idea of his development.' (C8)*
>
> *'The bad thing is that you don't have control and you have to rely on the AES report for trainee development.' (C8)*

Others on the other hand, did not approve of the AES and the CS being the same person during an MCR. This is what they said –

> *'No, I don't think the AES and the CS should be the same person – it is a multiple consultant report, after all.' (C4)*
>
> *'I personally don't like it if the same person is the AES and the Lead CS.' (C5)*
>
> *'It gives one person too much power.' (C5)*
>
> *'These roles should be kept separate – therefore it gives a mechanism for a multiple consultant report.' (C5)*
>
> *'I think the AES and Lead CS should be two different people – cannot be the judge and the jury at same time.' (C6)*
>
> *'I had one trainee who came to me in tears because he didn't like the feedback that had been given to him by the one consultant being both AES and Lead CS. The trainee felt it was unfair feedback but there was no other person he could approach who had been in the MCR meeting. So he came to me, and I approached that consultant (AES and Lead CS combined) and said to him that that feedback wasn't right about that*

trainee. This is an example of how too much power can be given to a person if they take on multiple roles in an MCR.' (C5)

Learning Agreement

Participants generally understood the process of the LA. There seemed to be no problems and many said it was much like the old LA. Setting objectives was a useful way to achieve realistic training targets. Participants also said that the LA was useful in the way it documented progress.

One participant thought the MCR should be separate from the LA –

'The MCR should be 'devolved' from the LA – they are separate and should be completed separately. The LA is a contract and the MCR is something else – it is separate – they are different aspects of the same process but they are linked via the Learning Agreement.' (C6)

Self-Assessment

Confusion around the Self-Assessment (SA) was evident from many participants. They expressed the thought that 'we are all still learning as we go' and 'we are only beginning to reflect on what is the truth' (C4, C5). These participants reported that their trainees too, did not know how to complete their SAs (C5, C4), and that it was just another complicated form (C8).

Even though participants said that the SA was a good idea in principle and that it helped develop insight skills, there was some doubt as to its effectiveness as a learning tool. Issues around levels of self-confidence hindered the effectiveness of the SA, they said, as well as fears some trainees had of 'rocking the boat' or not wanting to 'stand out from the crowd'. These comments illustrate what many participants said.

Confidence issues -

'I find my trainees either under-rank themselves hugely or over-rank themselves hugely.' (C7)

'But you must ask yourself if there is concordance with what you say about yourself and what others say of you. Are you overestimating yourself and your skills?' (C6)

'The trainees don't really know how to assess themselves because they don't know how they're getting on compared to their peers because they don't work alongside other trainees much – they work with consultants so it's hard for them to get a benchmark.' (C7)

'I find the SA makes the under-confident trainee more under-confident and the over-confident trainee more over-confident.' (C2)

Fears of 'rocking the boat' –

'Trainees just want to progress and so they don't really fill out the SA with insight – they just go for the middle (average) on every question whether that's appropriate for them or not. They just say 'no comment'. (C1)

'I haven't seen a SA yet but trainees make themselves average because they don't want any controversy – it's just a tick-box for them.' (C8)

'Trainees don't highlight any excellence or mark any areas for development, due to fear of admitting failures.' (C4)

During the interviews, some participants volunteered their own thoughts about 'making mistakes'. In an honest way, a few expressed the view that 'no one talks about their mistakes and failures in surgery – only the successes'. It is part of the culture of surgery, as these comments illustrate.

'I find no one talks about their failures/mistakes in surgery - only the successes. And this is wrong – it's OK to make mistakes – there is a lot of bravado in surgery – "fake it till you make it", type of thing.' (C7)

'But if a trainee knows that a consultant has his back even when he makes mistakes that's powerful for the trainee'. (C3)

One participant volunteered a good way she had discovered to encourage trainees to talk about their mistakes. It happens at an annual 'registrars' dinner' that she organises every year. During this event, trainees gather at the tables, and the consultants address the group and talk about what it is like to be a consultant. These consultants are also encouraged to talk honestly and openly about the mistakes they made as trainees. This gives reassurance to the trainees, she said, as they learn that it is not just they who make mistakes in their training.

<u>Further Guidance</u>

Towards the end of each interview, participants were asked if they wanted or needed any further guidance about the new curriculum and MCR, and if so, what type of guidance and on what topic. Once again the issue of consultant trainers not being recognised or given time and money to complete the MCRs was forthcoming, as these comments indicate –

'I would like CPD points and a certificate for all this training and extra work doing the MCRs.' (C1)

'ISCP is not doing enough to engage trainers – no one is recognising what we are doing and a lot of trainers don't want to hear about it.' (C1)

'We have to make sure trainers are paid.' (C3)

'Trainers are getting disenfranchised because there is not enough recognition for them. I have trouble getting my trainers to train themselves and others because of this.' (C4)

Other participants said they would like further guidance on how to assess GPCs – and how to give proper feedback about the GPCs to the trainee. It was a grey area that needed exploration and further guidance for many participants. A few also expressed a desire for help on how to coach or teach their trainees on how to improve those 'areas of development' marked on the GPCs.

'It should be in a FTF group and everyone can ask questions and interact – we need a demonstration.' (C8)

Another requested a 'refresher' course about the MCR and another wanted to know the expectations that the ISCP had of them.

At the end of the interview, some participants offered advice. Their thoughts on how to improve the new curriculum and its user-friendliness are listed here:

> *'The 2 day window for 'sign off' should be reinstated to 2 weeks.' (C8)*
>
> *'5 days for 'contributor comments' is good.' (C7)*
>
> *'Do the MCRs earlier than later.' (C3)*
>
> *'MCR gets easier as you gain experience and have used the form.' (C7)*
>
> *'I think there should be evaluation of it on a year-to-year basis.' (C4)*
>
> *'Try to make an extra effort to have the feedback meeting soon after the MCR meeting as it can be difficult to remember discussion about trainee and what supervisors said.' (C5)*
>
> *'I'm trying to simplify the new curriculum and MCR - but I think it's too complicated and therefore there is less engagement.' (C8)*
>
> *'My suggestion would be to make it simplified.' (C4)*

Summary

The participants felt that extra guidance is required to help trainers come to terms with the new curriculum and MCR. This is especially so in the non-technical skills aspects of the GPCs. It was evident that consultant trainers would like assistance in not only how to choose the right GPCs for their trainees, but also in how to show/teach their trainees ways to improve any professional behaviours requiring development. It appears too, that trainees may need assistance in completing their own Self-Assessment forms and understanding the advantages of honesty in doing so.

Other views suggested that the MCR is seen as too inflexible. According to some participants in this study it was a '*one size fits all'* approach which did not seem efficient when assessing complex and individual skills across different levels and types of training. Others felt that simplifying the MCR may help to reduce some of the perceived inflexibility and complexity of this new assessment tool.

CSs felt the need to be given some recognition for the time and effort they expend in their training endeavours. They are seeking adequate time and money for the extra effort and time they expend in both training themselves on curriculum changes and also in completing MCR assessments and giving feedback. According to the participants in this study, engagement with and appreciation of the new curriculum and MCR would more likely increase with such recognition.

According to many of the participants, evaluation of the new curriculum and MCR should be done at a later date in the future. They expressed their views that, hardly one year on, it was still too early to form a comprehensive opinion or even to give relevant examples of their MCR experiences. Some participants advised that formal ongoing evaluations should also be undertaken on a yearly basis, at least for the foreseeable future.

5.3 Trainee forum

We invited trainee representatives from each of the ten surgical specialties and core surgical training to a focus group. We wanted to explore trainee experiences of the new curriculum, to understand what trainees thought went well and could be improved. We asked the trainee representatives to canvass opinions from their specialty peer group in advance to provide as broad a picture as possible. We held the virtual meeting in May 2022 at which point trainees should have completed at least one assessment cycle. The meeting was recorded to allow systematic analysis to take place before content was deleted to maintain confidentiality. Trainee names have been omitted so that the pseudonyms A-F are used below. Out of the 17 representatives invited, 6 took part. The trainee participants represented 5 specialties (Otolaryngology, Paediatric Surgery, Plastic Surgery, Trauma and Orthopaedic Surgery and Urology); 4 training levels (ST3 and ST5-ST7 with one trainee out of programme) and 5 regions (East of England, London, North-East, North-West and Wales).

The semi-structured meeting was facilitated by the ISCP Surgical Director so that the advertised programme was used only as a guide and stimulus for participants about areas that might be covered. These included:

- Induction and training
- Perceived trainer knowledge and ability
- ISCP guidance and resources
- Learning Agreement
- The MCR, Self-Assessment and MCR feedback session

Findings

<u>Induction and training on the new curriculum</u>

- Placements

The trainee group wanted clarity about what determined the length of a placement and felt that within specialties, the quality of training experiences varied widely depending on whether the midpoint and final MCR took place every 6 months or annually. They were also uncertain about who was responsible for setting these timescales; the specialty, deanery or trainee. A placement could be determined as the time spent in a specialty at a particular level, while working in a deanery or hospital unit or with a particular consultant in a specialism. Each deanery/local office had different regulations. For example, trainee D mentioned that if a placement was 6 months long and they moved hospital halfway through, the MCR would become due in the new location after only one or two months and was very unlikely to occur at all.

> *'the reality of getting a department to sit down within a three month period and do the MCR is quite difficult and also not at the recommendation of our Deanery'. [Trainee D] [1]*

Also, ARCPs were held at different times in different locations and did not necessarily fit with the timing of MCRs. The trainee group felt that it was unlikely that consultants would carry out MCRs more frequently than 6-monthly. More than one trainee felt happy with the informal feedback they continued to receive from their educational supervisors even though no formal MCRs or WBAs were recorded.

'that happens regularly from the bosses anyway, without being formally documented, so I feel that I've got a fair handle on what's happening, but I appreciate it from your perspective and from a documentation point of view, things may not be written down'. [Trainee A] [2]

Overall, the group felt that standardisation was needed at least within each specialty about both placement length and the number of MCRs required within them.

- Introduction of the curriculum

The trainee group agreed that the quality of the induction that trainees had received varied widely. While some geographical areas were thought to have engaged well with the new curriculum, others had not. Some of the trainee group had themselves not received any local training on the ISCP system. In one specialty it was thought that no trainee had received a specific induction at all. Trainee C felt that ST3s had been in particular need of guidance, having entered specialty training on the new curriculum without an introduction. They felt that it would have been helpful if at the beginning of training there had been a session involving trainees, the TPD and the educational supervisors where curriculum expectations were set out, enabling everyone to know what was expected of each other.

'[we] weren't really sure exactly what was expected of us for this first three months. So I think maybe having some sort of combined meeting where everyone [is] on the same page from the beginning might be quite helpful'. [Trainee C] [3]

Often trainees were being asked to find out and give their educational supervisors information about the new curriculum and the group felt that the general opinion among many supervisors was that trainees would be leading the change. In one specialty the trainee association had put together a webinar session for their trainer body.

'[supervisors], kind of just take your guidance on exactly what needs to happen when they're doing the reports and what needs to be put in' [Trainee A] [4]

Trainee E mentioned that, in their particular hospital, there had been an effort to have a weekday morning breakfast teaching meeting whenever a new registrar started and it involved the whole department. However, while the new curriculum was mentioned, the teaching session did not heavily focus on the curriculum or the use of the ISCP. The trainee group commented that webinars had been watched and discussion had been held within the trainee association but in terms of the job it was just seen as a need to get on with it.

'They were regarding the ISCP [as] more of a trial and error with my educational supervisor'. [Trainee E] [5]

Trainee F commented that while they had not heard of any specific inductions in their specialty, at regional and national level there had been fairly good coverage of the curriculum with webinars directed at both supervisors and trainees. There had been training orientated journal publications and the local TPD had given *training the trainer* educational sessions virtually. However, trainees and supervisors were still unclear about what they needed to do. Trainee D also recalled having been given a very good overview at one of the specialty's national training days by the SAC Chair who gave a talk on the curriculum. The talk did not include showing the ISCP website or tools, however.

'I was still seeing people coming to me and saying what do I need to know about the new curriculum and I don't really know how you reach those people who you know aren't seizing those opportunities'. [Trainee F] [6]

Asked about what further guidance would be useful, trainee A felt that supervisors needed to be trained on and more engaged with the new curriculum. The trainee group agreed that there was enough information online and that most people had been able to find the information they needed if they looked. Trainee E remarked that there had been events that had not been attended. Trainee B commented that lack of supervisor involvement could create anxiety for trainees. Trainee F added that when the supervisors' specific responsibility was deferred to trainees, the performance of that task became part of the trainees' assessment and impacted on their career progression.

'trainers have to do it and they need an understanding of the timelines it needs to be done in. I think that's possibly the most stressful bit for a trainee at the moment'. [Trainee B] [7]

- ISCP guidance

The trainee group felt that guidance had been good. Trainee C remarked that the videos, in particular the pop up ones, had been useful. Trainee F suggested making it compulsory to watch the videos when first entering the site, although perhaps irritating it would force people to engage. It was felt that in general trainees and supervisors tended to want to 'muddle through' but a two-minute video was helpful.

Trainee B felt that the webinars had been useful because people could ask questions, but that the people most in need of learning would not engage in any resource. However, national teaching sessions were good opportunities to capture a large number of trainees and give them the same information at the same time. Trainee B felt that most trainees liked to receive information direct from those who were leading the curriculum change, such as SAC Chairs and that because many trainees still had not had an MCR assessment, many still needed information.

Regional representatives were useful because they collected information from their specialty peers in their region, feeding into the trainee association or the SAC. Answers to questions could then be streamlined and disseminated to everyone. Trainee D agreed with the way regional representation worked, feeling that people engaged only when it became necessary. They felt that the best way of disseminating information was within the specialty including national training days, specialty induction and TPD/SAC days where a dedicated ISCP session should be included as standard. Trainee A also agreed, commenting that their trainee association had been active and were planning do more on instructing people on how to use the ISCP tools or direct people to them.

In general, it appeared that relatively few induction events had taken place and those that were held made little practical use of available resources. In many places trainees were expected to glean the information for themselves and lead their supervisors through the process, or to find their way through it when it became necessary. This tacit expectation of trainees was felt by trainees to impact on how they were judged and could be stressful. More practical training for trainees and supervisors was necessary and thought to be best delivered through national events with dedicated ISCP sessions.

Trainer engagement

- Training Programme Directors

Trainee D mentioned that their TPD had driven the MCR process entirely. However, only one MCR had been done at that time and only as a trial. Trainee A commented that in their specialty the TPD had signposted expectations very well and was very accessible to trainees through different media (e.g., WhatsApp). Trainee B felt that the level of engagement depended on the TPD and felt that it would be easier for TPDs to prompt consultants to carry out their responsibilities than it was for trainees and it was, therefore, important for TPDs to be aware of what was happening. The group felt that the TPDs who had engaged had taken the time to read information, given talks about what to do and were organised. However, some preferred to be more hands off and allow it to be trainee-led.

> *'They feel it's your responsibility to be in charge of your training' [Trainee B] [8]*

Asked about what trainees felt could be done to help them, trainee F mentioned the need for more time to get evidence signed off for ARCPs. For example, when clinical supervisors were given two weeks to record comments on the MCR, many ignored the invitation so that the full 2-week period applied, delaying the next part of the sequence. It was felt that TPDs, rather than trainees, should be responsible for impressing upon CSs the need to engage with contributing to the MCR.

- Assigned Educational Supervisors

Trainee E reported to have had a very good personal experience. Their AES had taken on the dual role of Lead CS and had a background in medical education. They had learned the MCR process and made sure it was completed.

> *'It's all just been done and I've had meetings booked and told what the feedback is and what my responsibilities [are] … that kind of dynamic and proactive [engagement] has steered the other consultants' [Trainee E] [9]*

Trainee E felt that their region had traditionally been good at managing trainee assessment so that they had been able to accommodate the new process, although not necessarily finding it easy. Trainee F concurred that the teams that had adopted the MCR most easily were those that had already previously been discussing trainees in a similar fashion to MCRs. Trainee A also agreed, commenting that there were many experienced and engaged supervisors. However, there had been a general recommendation to omit the midpoint MCR because of the time it took.

> *'several consultants said the MCR just formalises a process that already happens in any department where they talk about us and they share views on the training … but it's just making sure they stay, sit down and do it formally together' [Trainee A] [10]*

Trainee B commented that, in a similar way to good TPDs, the AESs who were engaged were doing things well.

> *'this is probably a far bigger problem that is harder to solve, but to me, it's not a problem with the new curriculum or a new assessment, because people who are on board will engage and do it … It's hard to get enough good trainers maybe'. [Trainee B] [11]*

Trainee B felt that the consultants who were willing to take the time to provide good assessments might need greater support and incentives.

> *'Some of the consultants in [specialty] are saying they don't have the time in their schedule to be able to do an MCR properly or to give all the feedback. They feel that it is taking time that they haven't been given'. [Trainee B] [12]*

However, trainees had not been given the choice over who acted as their AES or CS and were not invited to give feedback on their trainers or on the quality of the feedback from their supervisors. However, while the group agreed that two-way feedback should be normal, they felt that if trainees were given the ability to rate their trainers it would be difficult to give negative feedback because of the power imbalance. Trainee F was in agreement, commenting that trainees worried about being seen as 'problem trainees'.

> *'how do you raise that issue when that person is directly deciding the outcome of not only your current ARCP, but also impacting any future ARCP'. [Trainee F] [13]*

Trainee D added that giving feedback on trainers anonymously was impossible. Also, because data from less than three trainees were typically collated over a 3-5 year period it meant that resolution was delayed by that period.

- Clinical Supervisors

Trainee F commented that they had not received specific guidance on who to select as a Lead CS. Their AES had suggested that the trainee consider which CS would be most likely to complete the MCR. They also mentioned that within their region, trainees had selected all the supervisors in their departments so that all had consequently been invited to be involved in the MCR. However, because many did not attend or contribute afterwards, the MCR took a full two weeks to be completed. It was not possible to remove the CSs who had not contributed after the MCR took place to quicken the process. In future it was likely, therefore, that trainees would select only a few of the most engaged CSs.

Trainee F also mentioned that in smaller specialties there were only a few supervisors available so that everybody acted as a CS, Lead CS and AES between them. In larger departments it was important that CSs were those with whom you worked. However, AESs and Lead CSs needed to be people who had an understanding of the curriculum, were able to corral others and ensure the paperwork was completed. The trainee group felt that there were AESs who benefitted from the PA time but did not provide the allocated training and that because CSs were not allocated PA time, it was those most interested in education who tended to be chosen.

Generally, the supervisors who were more able to accommodate the new curriculum tended to be individuals who were interested in medical education or worked in training units that had always managed training well. The sequenced timing of assessments had sharply contrasted those who were able and willing from those who were not, and consequently trainees were more likely in future to limit their selection of CSs rather than include all those they trained with.

<u>Learning Agreement</u>

Trainee F put forward a suggestion received from one of their peer group about enabling the previous learning agreement to populate the current one in case goals had not changed. Otherwise, trainees had not felt that the learning agreement was very different from the previous version.

Trainees C, E and F agreed that generally people had felt that the GPCs were too detailed (nine domains with many associated descriptors). Trainee F felt that the GPC component was seen as a box-ticking exercise and that it was difficult to make decisions on each point in a 20-30 minute discussion so that it might be better to review smaller chunks over a shorter period. Trainee C suggested having a minimum competency requirement for the most relevant GPCs so that over time they were all worked through and were at a declared level. There was agreement that not all GPCs seemed relevant. Trainee E commented that trainees felt that the CiPs were more useful than the GPCs. Some consultants had thought they were too prescriptive, others thought they were useful.

Asked about who populated the learning agreement, the trainee group agreed that they tended to do that. Trainee A mentioned that once they had filled it in, it was streamlined with the AES. Trainee B agreed that that was a way of making the process easier for the AES.

Trainee C also felt that there needed to be more clarity about what was expected of trainees at certain levels, particularly in the early years. There was more clarity in specialty training because of the critical conditions and index procedures mapped to level 4 PBAs, CBDs and CEXs and while removing the mandatory number of WBAs had been helpful in reducing tick-boxing, it had reduced certainty in the early years. Trainee B mentioned that ARCPs in some regions were still asking for the annual mandatory number of WBAs which had caused some anxiety and confusion.

Generally, more information about experiences of the Learning Agreement is required. The use of the GPCs tended to be less well understood than the CiPs. Early years trainees may need more guidance in place of the removal of the target number of WBAs.

<u>MCR and Self-Assessment</u>

With regard to the trainee Self-Assessment, trainee C suggested allowing trainees to edit the pre-set descriptors as they were quite long statements and sometimes only part of the text might apply to an area of excellence or development. Trainee B commented that in comparison with the MSF self-assessment, the new Self-Assessment did not provide trainees with feedback on the quality of their self-assessments. While not having gauged many trainee opinions of the new Self-Assessment, it was generally felt that it was difficult to rate oneself too highly and that trainees would benefit from training on how to assess themselves. Others concurred.

> *'to use it properly is only as good as you kind of do it. And I don't really feel like I have either had training on that or really know how to do it'. [Trainee B] [14]*

Asked about to what degree trainees had been involved in helping their supervisors arrange MCRs, trainee F commented that it had been very much trainee driven in their own region. Although trainees were allocated an AES, they had to find their own Lead CS and select their CSs. It was felt that these roles should be in the supervisor job plans and should be assigned before training started. Adding everyone in the department as a CS was now seen as problematic (as had been mentioned under Clinical Supervisors above). Trainee B was in agreement that more needed to be set up in advance because trainees found it difficult to approach their trainers and to know who the best people were if they had started in a new hospital. Trainee E also mentioned uncertainty about how to compel Lead CSs to drive MCRs.

> *'in some departments, it's definitely already become the trainees' responsibility to chase people and make sure it happens' [Trainee E] [15]*

Trainee E mentioned that in some locations MCRs took place but without trainees' knowledge when trainees had themselves not yet completed their Self-Assessments. Trainee B commented positively about being told that an MCR had been signed off and within the portfolio but that feedback was not always as expected. Trainee B felt there was a danger that the CS group would not be fully aware of trainees' portfolio evidence and risk misjudging the outcome which had a very big impact on training opportunities for trainees going forward.

> *'what as a trainee [can you do] if you really disagree about it' [Trainee B] [16]*

Trainees B and D added that they had received a few comments from trainees who felt it was necessary for trainees to be involved in the MCR meeting in order to know what was being discussed about their performance. Comparing it with ARCPs, they felt that trainees should be allowed to enter the MCR meeting to have their say before the outcome was recorded. While there was supposed to be a feedback session afterwards, it could not be thought of as a discussion because there was no way of correcting any information that may have been misunderstood and wrongly recorded by the group.

> *'It doesn't feel like it's a discussion, you're just told it rather than having any way to say, well, actually that was because of this or I wasn't able to do that because of this'. [Trainee B] [17]*

Trainee F felt that the MCR collective discussion may help to address issues with a single trainer and that requirement for trainees to report on the quality of individual placements remained important. However, trainees D and E commented that trainees had been concerned about the increased subjectivity engendered because the MCR was entirely opinion based. Trainee D felt that a strong opinion from a single trainer could still transfer quite strongly through to the MCR. Trainees no longer knew which trainers had expressed particular views and were, therefore, unable to negotiate how these were represented on their records.

> *'previously you would have had time to speak to that person individually, it wouldn't necessarily have been on your permanent record'. [Trainee D] [18]*

Trainee C felt that supervision level III (Able and trusted to act with indirect supervision) needed more layers. While level II was sub-divided, level III remained undifferentiated for trainees over the course of the middle years without seeming to show training progress.

> *'when you start training there are often situations where you're managing, let's say, a clinic and you don't have a consultant directly there with you and so they might put you down as Level III, but there's perhaps no kind of way of showing progression within the levels'. [Trainee C] [19]*

Trainee B mentioned that not all trainees who had had an MCR had been given a dedicated feedback session so that it had not been felt to be useful yet. Also, because supervisors had felt that the MCR involved too many drop down boxes, they were merely ticking boxes and that was not providing for useful feedback in some regions.

Trainee E commented that the feedback session with their AES had been helpful and felt it would be beneficial if there was a time limit on giving the feedback session (e.g., through automatic reminders to consultants). Trainee E also felt there should be a way of documenting the feedback session so that it was known to have taken place. Trainee B concurred and added that feedback

when given tended to be about what needed to be improved and that trainees needed to receive encouragement and a record of what had been done well.

> *'So actually, having learning points and take home points based on the MCR and a way of formally documenting that so not just "oh, this is what we said, it's all fine" ... and saying "actually we think you're good at this, but actually you can do this next time". So having almost the learning agreement type thing based on the MCR feedback session'. [Trainee E] [20]*

Asked whether the Learning Agreement and feedback session should be combined, trainees E and D felt that would be feasible. However, trainee D felt that it would be important to specifically record it as MCR feedback and agreement on both sides. Trainee F commented on complying with the request to keep the AES and Lead CS as different people because of the distinct roles. The AES needed to provide a balanced opinion and would manage the feedback necessary from a less than satisfactory MCR.

Generally, it was felt that trainees would benefit from training on how to self-assess and from feedback on the quality of their self-assessments. The organisation of MCRs was often left to trainees but their involvement did not extend to attending the MCR meeting in contrast to trainee attendance at ARCPs. They felt that the feedback session at the end of the MCR could not, therefore, be called a discussion and that it was important that it be documented as having occurred.

Summary

Trainees reported that the MCR assessment was largely trainee driven at present so that how or whether the MCR happened impacted on how their career progression was judged. The supervisors who were most engaged were either those who were working in high functioning units or individuals with an interest in medical education. Training and induction events were thought to be best delivered at national level and to need practical sessions for both trainees and trainers focused on the new curriculum and use of the ISCP. It was thought that training for trainees on how to self-assess would also be welcomed by trainees. Trainee participants favoured the standardisation of placement length and the number of MCRs required within them. While the sequenced timing of assessments had been challenging, trainees thought it could be improved if documenting the MCR feedback session could occur.

Limitations

The group comprised self-selected trainee representatives who were more likely to be knowledgeable of and engaged with curriculum change and not all specialties were present. While the participants aimed to represent the views of their peers, the trainees most in need of support may be least represented. The focus group was held at an early point in implementation when trainees will not have experienced more than one cycle of assessment so that some aspects of their experience might change for the better or worse. Further feedback from the JCST trainee survey and focus groups will be necessary.

5.4 AES sign off comments in MCRs

In an effort to evaluate the quality of engagement with the new MCR, using qualitative assessment methodology, this area of the evaluation focused on one key element of the MCR, the AES sign off. It aimed to identify its characteristics and the quality of entries made in that part of the process.

The enquiry focused on final MCRs at the end of phase 2 of specialty training which was a crucial progression point for entry to the specialty examination.

This part of the study asked:

- What were the characteristic features of AES comments in final MCRs?
- How similar or different were texts from one another (such as when an AES was taking on more than one role; CS or Lead CS)?
- How rich were the texts in terms of comments?

The rationale for looking at AES comments in isolation from the MCR itself is that AESs have important educational responsibilities in surgical training and, for the new curriculum, in signing off the MCR. For the MCR, AESs are required to take an overview and address gaps where certain areas of trainee performance lay outside of the workplace (such as those covered by GPCs 6-9 on quality improvement, education and training and research).

As with all assessments, there is a need for time and care when constructing MCR comments. Surgical trainers are time-poor, having limited time in their job plans to devote to MCRs. They may fully engage with curriculum requirements or see the act of making comments as a purely administrative task. Although the MCR is formative the principal audience is not only the trainee but also the next AES and the ARCP. Unlike ARCPs, assessment through the MCR does not involve reference to trainee portfolio evidence. The MCR was designed as an exception report (reporting deviation between planned and actual performance), so that when trainees were on track, detailed commentary was not required. Insights from this study should point to where additional guidance from the ISCP is required.

Data specification

The dataset was extracted on 22nd April to allow analysis in time for the reporting deadline. The specification comprised:

- Placements starting from August 2021 (these will have been of varying length)
- UK surgical trainees in all specialties
- Final MCRs pertaining to the end of phase 2 of training (see table 14 below for the relevant training levels and figure 14 for where this occurs in the training pathway)
- AES free text comments
- Identification of whether the AES had multiple roles (AES / AES & CS / AES & Lead CS)

Specialty	**Level at end phase 2**
Cardiothoracic	ST6
General	ST6
Neurosurgery	ST7
OMFS	ST5
Otolaryngology	ST6

Paediatric	ST6
Plastic	ST6
T&O	ST6
Urology	ST5
Vascular	ST6

Table 14: End of phase 2 training levels included in the study

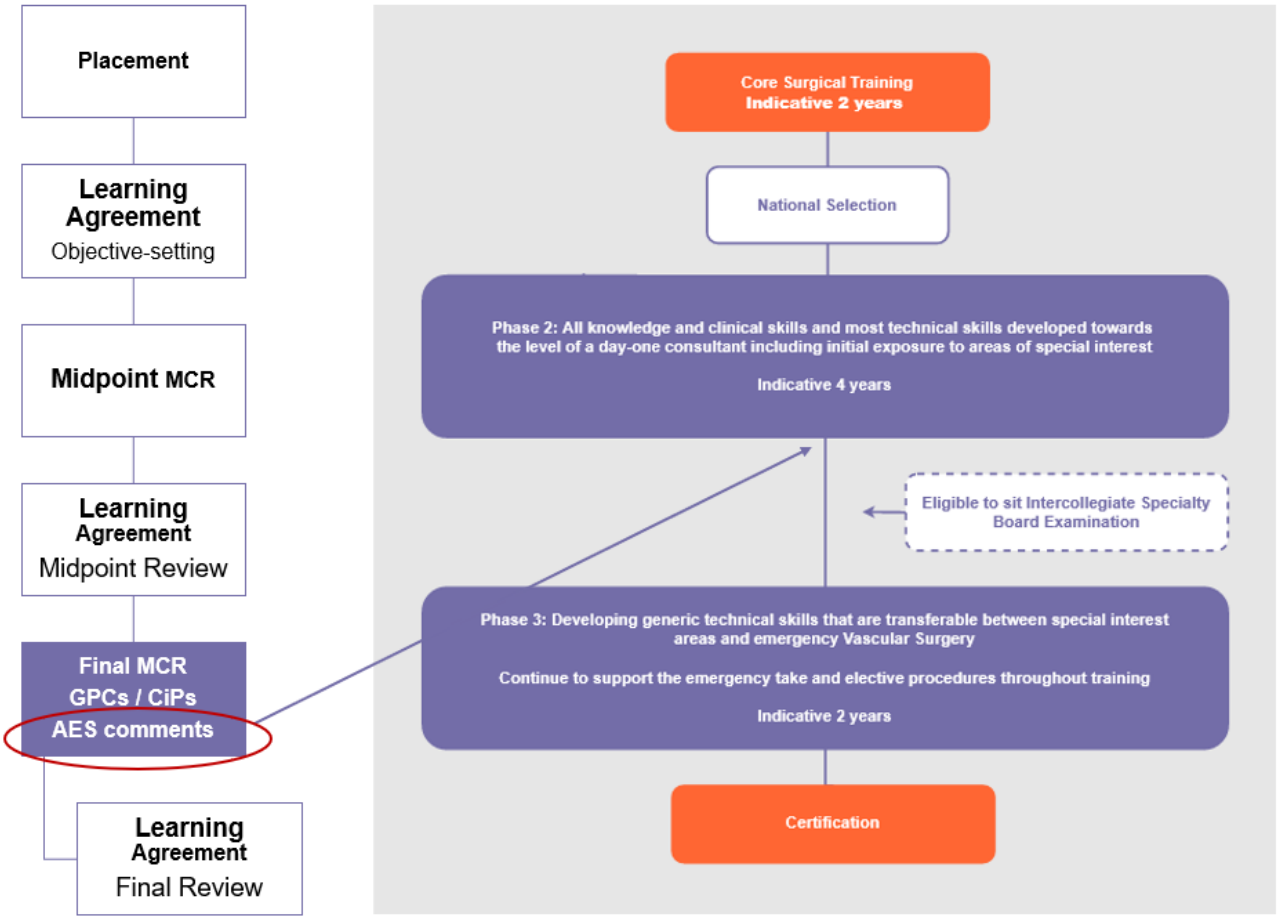


Figure 14: Location of Final MCRs in the training pathway

Qualitative method

Thematic analysis was used to sample the AESs' free text comments. The aim was to identify the characteristic features of these short texts (what sort of things were being said). NVivo version 12 was used to make use of systematic coding, to organise, analyse and find insights in the data. The process was systematic and iterative, identifying and exploring ideas about the language used. The complete data set offered records on approximately 237 trainees and 238 AES texts out of a total of 346 placements (69% of placements), table 15 below shows the spread of this number between specialties. A total of 138 (58% of) texts were from AESs who were identified as having no additional role, 20 (8%) were from AESs who were also CSs and 80 (34%) were from AESs who had also

undertaken to act as Lead CSs. Because of the small number of texts, all texts were sampled rather than focusing on sampling adequacy which would be more common with large volumes of data.

Specialty	AES texts
Cardiothoracic	4
General	52
Neurosurgery	5
OMFS	8
Otolaryngology	11
Paediatric	5
Plastic	15
T&O	117
Urology	17
Vascular	4

Table 15: Number of AES texts by specialty included in the analysis

Analysis

Coding involved reflective exploration of each text, asking what kinds of ideas were recognisable. The aim of creating codes was to 'break open' the text. Each text had the potential to evoke several codes. Some phrases were assigned to multiple codes e.g., AESs commonly used the phrase '*No concerns*' as a summative judgement and the phrase was considered significant enough to justify an independent code. However, the phrase was also used administratively as a final act and was, therefore, also assigned to the code '*Sign off*'. Sentences may also have applied to several codes e.g., '*Progressing well, in agreement with colleagues'* was coded to '*Reference to progression*' and '*Agreement with MCR'*.

The result was a list of codes which captured different characteristics of the texts. The codes were then clustered for similarity of content, resulting in first and second level codes. Codes were considered first level if they captured an important feature, see coding table and diagram below.

First level codes	Second level codes	References Green tint indicates where codes applied to all three types of AES role (AES, AES & CS, AES & Lead CS
Agreement with MCR (Refs 77)	Agree with MCR	46
	Praise for quality of MCR	24

	Disagree with MCR	5
	Consensus	2
Objectives going forward (Refs 87)	Objectives going forward	36
	Eligibility for exam	28
	Constructive criticism / concerns	15
	Aspirations	8
Competencies gained (Refs 54)	Competencies	50
	Reference to CiPs	4
Praise for trainee (Refs 125)	Praise for trainee	95
	Readiness for consultant practice	14
	Addressed to trainee	10
	Performing above level expected	6
GPCs (Refs 41)		41
Sign off (Refs 62)		62
No concerns (Refs 60)		60
Summarising the MCR (Refs 229)	Reference to progressing	75
	Good/excellent feedback	31
	Reference to phase of training	27
	Summarising	26
	Continue as you are	12
	Well wishing	11
	Work in progress	10
	Supervision level	8
	Giving examples	8
	Adding detail to MCR	7
	Feedback given/received	7
	Portfolio assessment	2
	WBA	2
	Non sign off	2
	Reference to what not observed	1
Process issues (Refs 23)		23

Table 16: Codes used in the analysis

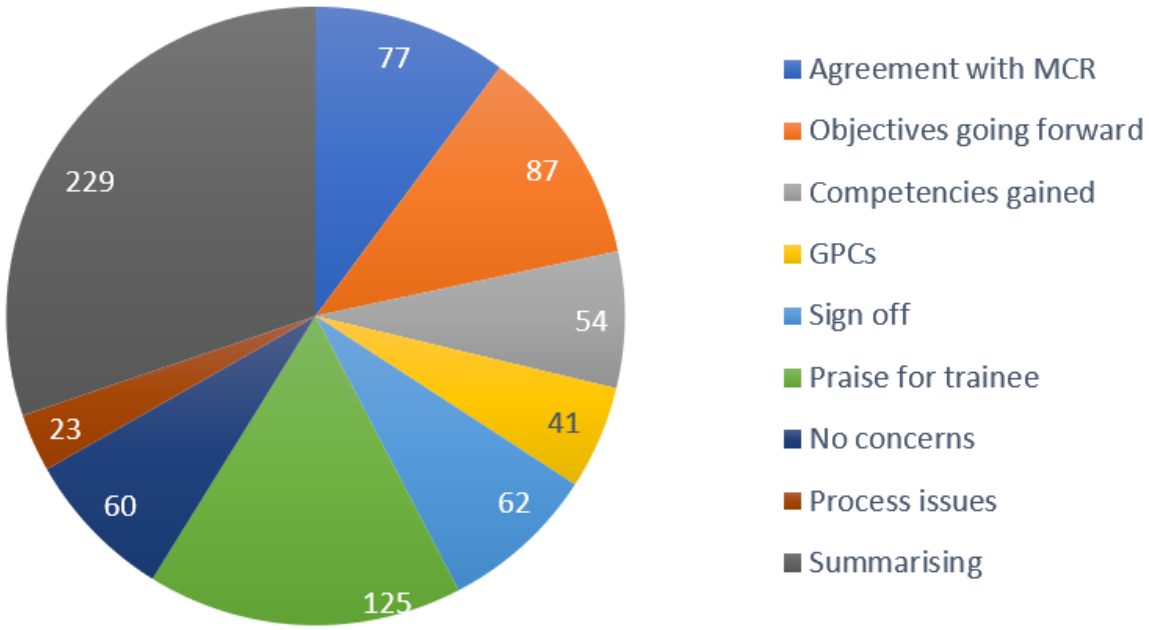


Figure 15: Characteristics of AES comments and proportion of references

Findings

The AES texts, as sign off mechanisms, were characteristically short, succinct and factual with varying levels of detail. The language was generally positive. There appeared to be no significant differences in the characteristics across the three different AES types.

Code 1: Agreement with MCR (Refs 77)

This code reflected a tendency for AESs to indicate agreement or disagreement with the MCR (Refs 53). Most agreed, and common phrases across all AES types were:

> *'agree with colleague's comments'*
> *'as described'*
> *'in keeping with my assessment'*

This type of comment may have been used as a sign off phrase, often combined with '*can add no more*' so that nothing further was said (see the code for '*Sign off'*). However, many included additional detail such as summarising the MCR, stating whether or not there were concerns or praising the trainee (see codes for '*Summarising*' and '*Praise for trainee'*). The few texts that disagreed included opinions on whether CSs had rated areas for development or areas of excellence sufficiently or commented fairly.

In some cases, AESs made a point of praising the content of the MCR itself (Refs 24) using phrases such as:

'Well thought out',
'Summed up performance well'
'Highlighting good clinical care, strengths and weaknesses'
'Good pointers for improvement'.

There were a few references to the MCR being used to re-integrate trainees returning to clinical practice e.g., '*fully re-integrated … as supported by this MCR'*.

Code 2: Objectives going forward (Refs 87)

Where AESs added further detail to the above, this often included picking out objectives for the next period of training, for example:

'suggest engages in formal teaching and gain feedback on this via an OoT'
'In the next six months should concentrate on further advancement of operative skills'
'would benefit from doing a quality improvement project next month'

Objectives were also combined with constructive criticism (Refs 15) in terms of development needs and concerns and were mainly specific, for example:

'needs to focus on improving theoretical knowledge'
'still needs to progress more in operative skills … perform straightforward lobectomy by VATS and open technique under direct supervision'
'desperately needs to work on leading and presenting patients at an MDT'

Texts also referenced support for trainee aspirations (Refs 8) such as chosen special interests and fellowships, for example:

'I support this application for additional elective arthroplasty experience'
'wants exposure to foot and ankle paediatrics'
'expressed interest in completing a PGCCE'

At this critical progression point, texts also referred to eligibility for the specialty examination (Refs 28). References included the need to make time for exam revision, to make preparation for the exam the main goal and the need to schedule when to sit. Most references showed that trainees were thought to be ready for the exam.

Code 3: Competencies gained (Refs 54)

As well as constructive criticism, texts also referred to the competencies trainees had achieved (Refs 54). Competencies that were worthy of mention included knowledge-base and reading; team-working; teaching and being patient with juniors; organisational and management skills; operative confidence; communication with patients and colleagues; ability to respond well to feedback as well as actively seek and reflect on it; decision-making; working under pressure; a focus on patient safety and having compassion; patient management and management planning; experience in elective and emergency cases; clinical judgement and leadership.

Code 4: Praise for trainee (Refs 125)

Generally, across all three AES types, there was a strong tendency to praise trainees and there was more praise than criticism. Many AES texts picked out specific qualities that trainees demonstrated that were highly valued and tended to be more global and personal in nature than listing competencies gained, for example:

> *'we (as trainers) have all enjoyed working alongside [trainee name]'*
> *'has been an exceptional trainee in this post'*
> *'has gained the respect of the consultant body'*

Trainee qualities mentioned included intelligence; being organised; being good to work with; doing well across all areas; managing time; working well under pressure; being diligent and conscientious; being dependable, approachable and affable; having good feedback from colleagues and being well-regarded; being eager to learn and face challenges; being enthusiastic and proactive; knowing when to ask for help and team fit.

Some praise was addressed directly to the trainee as the primary receiver, for example:

> *'well done'*
> *'keep up the hard work'*
> *'you are maturing into a well respected senior Registrar'*

Some praise included reference to trainee readiness for consultant practice (Refs 14) or performing above the level expected (Refs 6), for example:

> *'decision-making skills are also en par with consultant level'*
> *'exhibits all the positive traits one would wish for in a consultant colleague'*
> *'demonstrated on this firm to practice as a Day 1 Consultant'*

Code 5: GPCs (Refs 41)

AESs were asked to add information about trainee performance that is not typically observed or assessed in the workplace e.g., research skills. Many of the texts included performance encompassed by the GPC domains (see also the code for '*Competencies gained'*). Two texts listed each GPC domain 6-9, commenting against each. Others picked out detailed achievements in teaching others (Refs 8), audit/quality improvement (Refs 7), a focus on patient safety (Refs 2), research (Refs 6), publications or presentations (Refs 7), awareness of vulnerable groups (Refs 3) and others included having an educational role, showing leadership and management skills, postgraduate degrees, projects and audits, for example:

> *'actively involved in training and teaching'*
> *'shows leadership with management of lists/clinics'*
> *'very good audit on reviewing patients with [congenital condition]'*

As mentioned under '*constructive criticism'* above, texts also alluded to where there were areas for development or concern, for example:

> *'has just started working on writing papers and needs to do more on this front'*
> *'main concern is in the areas outside of direct patient care such as audit, research, teaching … may wish to discuss extending his training to help with this'*

As well as GPCs, a few texts referenced specific CiPs (Refs 4) although AESs were not required to do so, for example:

> *'can make a reliable assessment with appropriate management plans'*
> *'actively involved in the complex planning of both clinics and lists … local, national and international referrals'*
> *'able to handle the general surgical emergency take competently'*

Code 6: Sign off (Refs 62)

AES texts function as the final sign off of MCRs and particular expressions were used as a seal of approval for the MCRs so that no further detail was required (Refs 62), for example:

> *'Nothing to add' or 'No comments' or 'No real change'*
> *'Happy' or 'Agree' or 'Satisfied'*
> *'No concerns'*
> *'Developed well', 'Very good', 'Satisfactory', 'Excellent'*
> *'As previous' and 'As in MCR'*

Two texts referred to AESs not feeling able to sign off, the first because the rotation had not been completed and the second preferring to wait for more portfolio evidence.

Code 7: No concerns (Refs 60)

Because AES texts act as the final sign off of MCRs, they are likely to be more summative. Texts showed that AESs were willing to make a more summative type of professional judgement in their overall comments. The phrase '*No concerns'* was very commonly used (Refs 60) and, as above, was often an expression for a seal of approval of MCRs or to summarise an MCR or to conclude an AES's summary. It was also combined with agreement with the MCR, with setting out objectives as well as when alluding to work in progress and with praise for trainees. While the majority of AES texts indicated trainees were on track, others raised concerns (see the code for 'Constructive criticism').

Code 8: Summarising (Refs 229)

Many of the AES texts undertook to draw together messages from the MCR such as summing up trainee qualities or competencies, that the trainee is on track or giving detail about where there may have been lack of exposure and progress made in other areas, for example:

> *'exceptional trainee … enthusiasm is matched by increasing operative confidence … good to see he is actively engaged in reading … evidenced by his patient management plans'*
> *'As mentioned in comments … needs to focus on completing research, WBAs, preparing for the FRCS'*
> *'has performed very strongly over the last 6 months … feedback from a range of senior and junior colleagues … has been positive …'*

These were often combined by lists of trainee qualities such as mentioned above under '*Competencies gained'* and '*Praise for trainee'* e.g., 'is well organised, communicates effectively, demonstrates good leadership skills'.

The level of supervision was occasionally included (Refs 8), for example:

'*demonstrated that she is at either level III or IV for all CiPs'*
'*achieved level IV in managing clinics and conducting ward rounds by his MCR raters*'

Summarising also sometimes featured encouragement to continue in the same way (Refs 12), for example:

'*should just keep doing what she is doing*'.

As well as summarising the MCR, some AES texts gave supplementary information (see also '*GPCs*' above).

'the current training period has presented specific challenges, particularly in relation to …'
'I would go further to say that she … is aware of vulnerable patients and patient safety is her top priority'
'from an AES point of view needs to improve performance in viva and oral exams …'
'I would comment that … managing our complex operating lists have improved considerably'

Unsurprisingly, as AES texts refer to trainees as learners moving through levels in a programme, the word 'progress' was frequently used in texts (75 Refs), for example:

'good', 'great' 'steady', 'sound', 'sufficient', 'satisfactory', 'excellent' - progress
'happy with' or 'pleased with' - progress
'progressed to …'
'continues to progress'
'should have no difficulty progressing'

Some AES texts also made reference to the trainee's phase of training (Refs 27), for example:

'acceptable for his level'
'functions at a level noticeably greater than expected for his stage'
'as he moves into the later phase of his training … important to build CiPs towards level 4'

Although the AESs were not required to refer to trainee portfolio evidence, there were a few references to inclusion of detail from the portfolio, for example:

'he has 20 PBAs/DOPS (inc Level 4 for common index procedures …)'
'his MSF was also excellent'
'60 laparotomies were performed … with minimal complications as main operator'

Some additional information alluded to where the AES might have had a unique overview of the trainee's performance, for example:

'has worked around options to access appropriate cases … gone the extra mile to travel'
' very supportive of the team after which was an extraordinarily traumatic episode'

Other additional information alluded to work in progress (Refs 10), for example:

'has been allocated a research project which is currently ongoing'
'is in the process of writing a case report with a colleague'
'is nearing completion of data collection for a publication'

A few AES texts included an element of well wishing (Refs 11), some of which were addressed directly to the trainee for example:

'We wish him all the best for his future career'
'Good luck in your new job'
'Good luck with the FRCS'

Code 9: Process issues (Refs 23)

Finally, there were a few references to process issues, covering the ISCP (2 Refs), difficulty engaging colleagues or their lack of understanding (5 Refs) and difficulties with the timing of the ARCP (2 Refs). The pandemic was alluded to a few times in terms of challenges but mostly in terms of how well trainees had coped.

Summary

This area of the evaluation focused on identifying the main characteristics of AESs' sign off comments in the final MCRs and the quality of AES engagement at a critical progression point into phase 3 of training.

Several codes indicated that AESs were generally very engaged. They showed knowledge of trainees and the tailoring of comments so that they were quite specific and formative. They provided feed-forward information to future AESs and ARCPs. These codes were:

- *Objectives going forward*
- *Constructive criticism*
- *Aspirations*
- *Competencies gained*
- *GPCs* - including areas outside of direct patient care
- *Summarising*

Codes also showed that MCRs were in some cases used as an exception report. AESs were willing to provide a summative view of trainee performance and an overall seal of approval of the MCR without further detail if the trainee was on track. These codes included:

- *Agreement with MCR* – attesting to the quality of MCR content
- *Sign off* – when trainees are on track
- *No concerns* – a common phrase that showed the willingness of AESs to make an overall professional judgement of performance.

Limitations

There are two main limitations to this component of the evaluation. Firstly, because the approach is interpretive, it provides one perspective of the material under review. However, the study aimed to be rigorous and transparent. Secondly, analysing AES comments independently of the MCRs to which they refer might have risked missing their full meaning. However, as a lot of weight is given to AES sign off, it holds an important standalone position. It is important that it is scrutinised in that vein; in other words, it should be researched in the same format as it is received by those who judge and make key decisions about the trainee's future; the ARCPs. The findings should, therefore, help

to determine whether AES sign off remains an important component of the MCR. With these limitations in mind, findings should be treated tentatively and should be seen as a useful starting point for further discussion.

Conclusion

From the analysis of this small data set, AES texts at this progression point appear to have specific features across all three AES types. The texts appear to coincide well with MCR intentions and, while there is variation in their detail, the approach taken lies within the boundaries of the AES role. Comments were generally positive and constructive, specific and tailored to trainees. There was richness to the texts in terms of addressing GPCs 6-9, setting out objectives for the future and listing competencies gained or needing development. Overall, completed MCRs at this progression point appear to have had good engagement from AESs. The findings from this study support the conclusion drawn from a 2017 study on the quality of written feedback in WBA. At that time, it was found that the majority of WBA tended to provide trainees with superficial feedback about their performance, lacking the perspective needed for trainee development[3]. Therefore, the evidence in this study suggests that the AES component of the MCR corresponds with the desire to move assessment away from tick-boxing competencies towards a more holistic assessment of trainee capabilities.

However, while the MCRs appear to be completed well, not all MCRs were completed (328 out of 346 placements). While further investigation is planned to take a more in-depth look at the quality of the content of the MCRs themselves when more data are available, a necessary next step will be to encourage better engagement, including exploring what worked and did not work as well as good practice exercised by those who were able to finalise MCRs.

5.5 ISCP user queries

All surgical trainers and trainees are able to contact the Helpdesk for advice about any problems they may be having with the curriculum or the ISCP online management system. As part of the evaluation, a review was conducted on a sample of emails sent into the Helpdesk to ascertain how surgical trainees and trainers were adapting to it. Consequently, over a three month period in early 2022, 164 emails were sampled and collated. Only those emails requesting advice about the new curriculum and its assessment tool, the MCR, were selected in order to find out the exact nature of each email query.

The purpose of this research therefore was to gain an impression of how surgical trainees and trainers were coping with the new curriculum, so that any problem areas, flagged up by an analysis of the emails, could be targeted. Areas shown to be requiring necessary changes and/or additional assistance or training could therefore be addressed.

Method

We sampled user emails sent into the ISCP Helpdesk in the first three months of 2022, logging them in an Excel spreadsheet in order to categorise them and analyse their content. The sample dataset included the emails sent to the Helpdesk within the first seven days of each month, a total of 164 emails. The numbers of emails were roughly equally divided over the three months - January 80

[3] Bussey, Maria, and Griffiths Gareth. "Mentor, Examiner, Administrator: What kind of assessor are you?." *The Bulletin of the Royal College of Surgeons of England* 99.5 (2017): 180-18

emails or 49% of total, February 65 emails or 40% of total and March 19 emails or 11% of total, as shown in the following diagram:

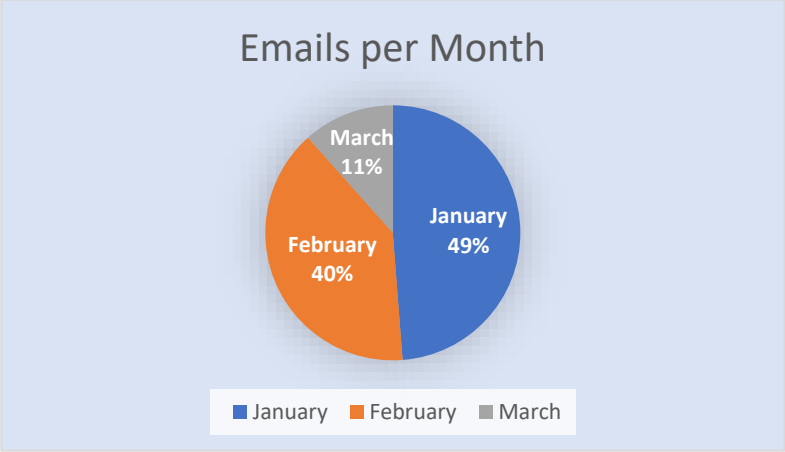


Figure 16: Percentage of emails sampled Jan-Mar 2022

There were six subject categories into which each email query was slotted, these were:

1. Transition
2. Learning Agreement
3. MCR
4. Self-Assessment
5. Critical Conditions/Index Procedures/PBAs, and
6. Other

Within these categories, the following information was sought from each email:

a. Who sent the email (Audience)
b. Category of query (Category) and
c. Summary of what the query was about (Summary)

The following graphs illustrate the numbers for each of these three factors:

<u>Audience</u>

As can be seen in figure 17, the majority of emails were sent from trainees - 113 emails or 69% of total, while consultants (trainers) sent in 51 queries or 31% of total to the Helpdesk during the timeframe.

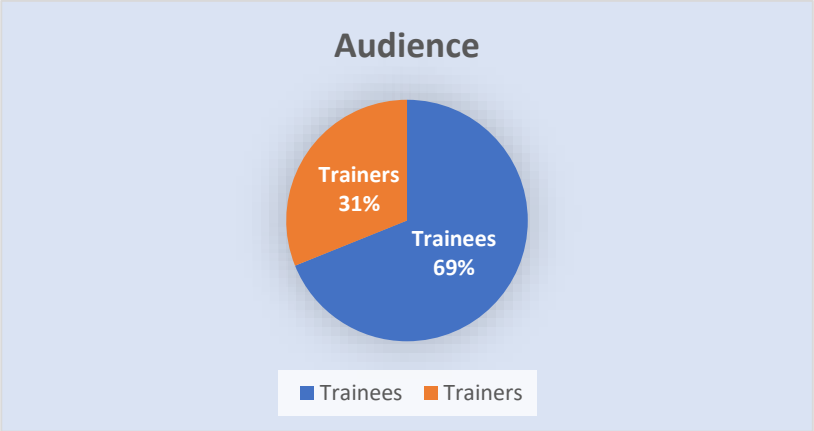


Figure 17: Authors of the emails

Category

The totals for each of the six categories above are highlighted in figure 19 below. As can be seen in figure 18, the vast majority of email queries were about the MCR (119 or 72% of total). Many trainees had questions about the MCR, such as how to start the process and what to do about CSs not contributing comments, or doing so late. Many queries were also about wanting to remove some CSs from the MCR to avoid delaying the process and also queries about how to sign-off the MCR.

Queries about the Learning Agreement were the second most common email category (18 or 11% of total). But these queries also concerned the MCR; such as how a later signing-off of the MCR was delaying the whole Learning Agreement process. Concerns about the Critical Conditions/Index Procedures/PBAs accounted for 9 queries (5%) from the sample base. Concerns about the process of Transition amounted to 6 (4%) and only one query was about the Self-Assessment process (1%). Eleven more, unable to be categorised, were slotted into Other (7%).

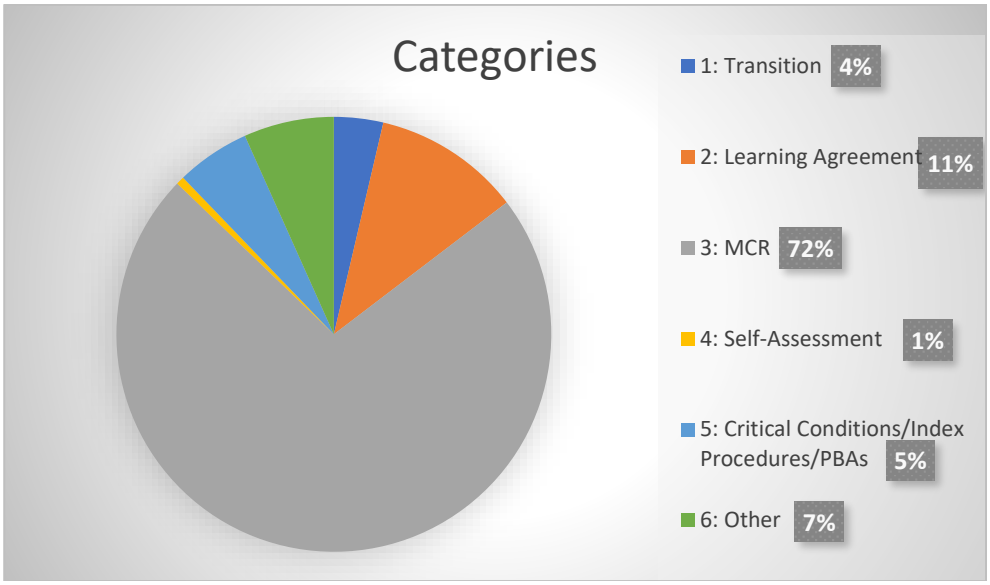


Figure 18: Categories of emails analysed

Summary

The essence of each email query was extracted and logged onto the Excel file and from this dataset, a systematic analysis of their content was conducted. Common themes running through and across different emails were isolated. The following 10 themes were identified.

Themes

1: How to start/finish an MCR
2: Wanting to add/remove contributors from an MCR
3: Problems adding contributor comments to an MCR
4: Human error in logging in details
5: Problems signing-off an MCR
6: Wanting to change details after event
7: Technical problems
8: Critical Conditions/Index Procedures/PBAs
9: Transition problems
10: Other

The number of emails which centred on each of these 10 themes are illustrated in figure 19 below.

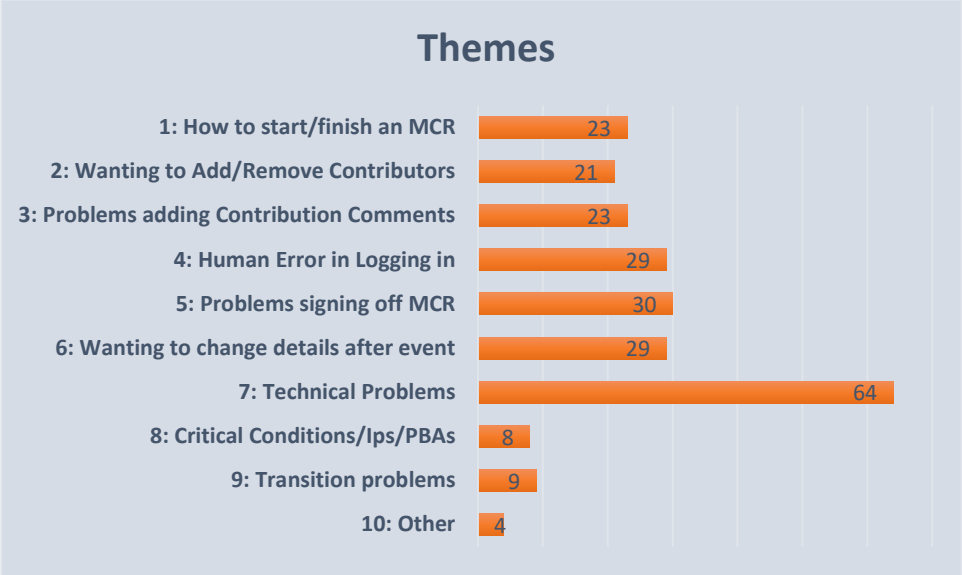


Figure 19: Numbers emails within each theme

Even though 10 broad themes were identified, some of the individual email queries fell into two or even three of the themes simultaneously. The example below could be themed within 'Human error in logging in details' (theme 4) and 'Wanting to change details after the event' (theme 6):

> *'Consultant wants to redo MCR as he has incorrectly completed it'*

The following query could be a 'IT problems (theme 7), a 'Human error in logging in details' (theme 4) or 'Problems signing-off an MCR' (theme 5).

> *'Trainee says that all her consultant contributors have signed-off MCR but it still says "awaiting contributor feedback' and this is holding up Learning Agreement process"'*

<u>Theme 2 – Wanting to add/remove contributors</u>

The Helpdesk received frequent requests from both trainers and trainees requesting a removal of those CSs who had not yet contributed comments, in order to expedite the process. The type of emails received showed that alarm set in as trainers and trainees realised time was running out as illustrated in the following examples-

- *Trainer requests contributor feedback to be bypassed for his trainee's MCR.*
- *A consultant is checking if the AES is able to sign-off his trainee's MCR without absolutely all CSs making comments?*
- *AES has requested he be allowed to sign-off MCR without getting other supervisors to add comments. And he would also like it to be concluded quickly.*
- *Trainee says that her Learning Agreement is locked at mid-MCR stage. One contributor, CS, is not responding and is holding up the process – trainee would like to remove that contributor.*

- *Trainee wants two CS contributors to be removed from his MCR - one has Covid and the other is on Sabbatical.*

- *Trainee says that all her consultant contributors have signed-off MCR but it still says 'awaiting contributor feedback' – and it's holding up process.*

- *Trainee waiting for her mid-point MCR to be completed, but she needs access to final MCR and the end of placement meeting (the mid-point MCR is currently awaiting AES sign-off).*

Theme 6 - Wanting to change details after the event

Some trainees and trainers wanted to redo or retract some of their already completed parts of the MCR, examples include:

- *Trainee wants to change AES but can't work out how to do it on ISCP.*

- *Can comments be changed on MCR once written by Clinical Supervisor?*

- *Trainee wants to retract and reset a completed MCR as trainee says it was done in error and it did not include all CSs listed.*

- *MCR filled-in in error – it was filled by one supervisor only and not with fellow CSs - can it be retracted?*

Theme 7 – Technical problems

As can be seen in figure 19 above, the majority of email queries centred on technical problems that trainees and trainers perceived to be a malfunction of the ISCP system. Complaints within this theme included:

a) Links not working

For example:

- *Trainee cannot access link for Final Review Meeting - does not have an MCR and has no option to start one in his account. Says MCR is not of great use as his current rotation has only one consultant.*

- *Trainee unable to get MCR signed-off by other consultants (not Lead CS) – he says an alert does not appear on their emails – the link is greyed out.*

- *Link not working for Lead CS to complete MCR – requesting other active link.*

- *Trainer says that he can't access link to contribute comments as Clinical Supervisor within the 2 week window.*

- *Trainer says all Supervisors can't open the link to MCR on their Trust computers – how can they progress forward?*

- *Trainee says his Lead Clinical Supervisor can't complete the MCR because the link has expired – how can he reactivate the link to allow him to fill in his MCR?*

b) Being locked out

For example:

- *AES could not get access to his trainee's MCR - may have locked it accidentally.*
- *Lead CS says all consultants have signed off MCR but it is still greyed out and stopping further progress.*
- *Trainer cannot locate mid-point MCR that had previously been completed for a trainee.*
- *Cannot open the MCR on trainee's ISCP account.*
- *Trainee had a meeting with his AES but could not enter details about the agreed plan of action before next AES meeting.*
- *Trouble getting placement signed off - maybe stuck on MCR stage. MCR says 'CS still working on report' but the CS is unable to see it to finalise it.*

c) Error messages appearing

For example:

- *Gets error messages about adding comments to an MCR within 2 weeks – so unable to sign-off final LA.*
- *Email incorrectly sent to wrong AES and wrong hospital - maybe sent in error*?
- *Lead CS gets an error message when he tries to open his trainee's MCR to complete.*

In theme 4 '*Human error in logging in*,' it is not certain whether the problems are with the user interacting incorrectly with the online system or with the ISCP technology itself, some examples include:

- *Trainee says his AES has used an incorrect name in his midpoint review – He wants to have it sent back for amendment and then resubmission.*
- *Information about wrong trainee has been uploaded onto this trainee's MCR. The consultant wants to delete the whole MCR and start again.*
- *Trainer says she accidentally pressed the wrong button after adding comments on her trainee's MCR which said that trainer did not accept the report. Can MCR be reinstated because she does accept the Report? Trainer says it was the fault of using a tablet and her finger got too close to the line - the icon just whirrs round and round and does nothing.*

Some trainees were not sure how to initiate or complete an MCR, examples include:

- *When does an alert happen to create an MCR? Is this initiated by AES?*

- *Trainee is not sure on how to complete MCR and how to submit to invited contributors*

Theme 8 - Critical Conditions/Index Procedures/PBAs

Problems here involved matching index procedures with PBAs, or critical conditions with CEX/CBDs and knowing how many were required for Certification, examples include:

- *Trainee says a lot of her assessments did involve critical conditions that were not linked (to critical conditions tab). She wants to add Critical Conditions tab in retrospect.*

- *Trainer says his trainee has not added any PBAs required for certification - wants to make sure it's not a glitch in ISCP system as there are gaps in this trainee's training.*

- *Trainee has accidentally logged the same PBA twice - can she remove one of them?*

Theme 9 – Transition problems

Some problems migrating to the new curriculum were encountered by trainees, examples include:

- *Trainee says he wasn't given option to transfer (to new curriculum) in his new placement.*

- *Trainee says there was an inability to migrate to new curriculum in Oct, 21. He said it would result in losing content in portfolio.*

- *Trainee is in final year of training (CESR route). Could I revert back to old curriculum? It was a big mistake transitioning to new curriculum.*

Theme 10 – Other

Examples of queries unable to be categorised include:

- *Trainee is requesting a PDF report of last ARCP outcome.*

- *Trainee wants to know if virtual conferences count and can be added to her portfolio e.g. participating in virtual courses and webinars*

Summary

The analysis suggests that many trainers and trainees did experience specific types of problems in the process flow that is inherent in the new curriculum's assessment system. Many did not fully understand the inter-relatedness of each component part. For example, if the final MCR was late and awaiting contributor comments, the ability to move onto the final Learning Agreement and provide the AES's end of placement report for the ARCP was impacted.

5.6 Our response to user issues

It is anticipated that in the early phase of such a large curriculum re-structure, that there would be issues that needed to be resolved in order to smooth user experience. The manner in which we have approached user issues is detailed below under each the key themes identified in section 5.5 above.

Theme 1: How to start/finish an MCR

In preparation for the release of the curriculum we provided a range of training events such as webinars and drop in clinics. We also released a range of very short (approx. 2-minute) 'pop up' videos which appear within user dashboards and on relevant online landing pages as users use these areas. The subjects covered include Transition, the Learning Agreement, the MCR and the Self-Assessment. As users queries were received and answered we added to our collection of FAQs. We also used Tweets, Latest News items and direct group emails to make trainees and trainers aware of what they needed to do, when to do it and how. We continue to update or add to our collection of videos which can be viewed on the ISCP website or the JCST YouTube channel.

Theme 2: Wanting to add/remove contributors from an MCR

The online MCR provides CSs with a way of commenting on the MCR within a 2-week window following the MCR meeting. It offers them the opportunity to add their perspective, which may be enhanced by a short period of reflection. However, we received comments that the window was too long and caused delays in completing the MCR. Users were requesting that we remove the names of CSs who had not commented in order to enable faster sign off. Pre-emptively removing any individual from the assessment would undermine the standard that the MCR was designed to create, but nevertheless we were aware that delays would risk the shortage of evidence for ARCPs. In discussion with CoPSS, we agreed to shorten the time period to 48 hours, taking effect on 22nd June. All users were informed of the change by direct email as well as other channels. We will monitor how far this change affects the quality of the MCR and the MCR completion rate.

Theme 3: Problems adding contributor comments to an MCR
Theme 4: Human error in logging in details
Theme 5: Problems signing-off an MCR
Theme 6: Wanting to change details after event
Theme 7: Technical problems

The largest concern of users, illustrated by themes 3-7, was around technical issues. Following release of the new curriculum, our main focus was on monitoring queries and enhancing instructional and navigational aids (see appendix 7). The ISCP is a bespoke system and Helpdesk staff are able to report issues quickly and directly to our team of web developers so that bugs and other IT issues can be resolved rapidly. Additionally, Helpdesk staff have a range of back office tools which we are developing concurrently with our understanding of the types of query being received. Web team assistance is used in cases where back office tools do not exist. We monitor how often each type of request is made to determine whether they are frequent enough to warrant either developing a new back office tool or a new user feature. There will always be system limits to how far a user's actions can be undone, this particular type of error could only be fixed up to when the final Learning Agreement had been signed off.

Bugs we resolved quickly included:

- Direct emails to users which contained links that did not work for some in their Trust computers, were improved by providing the link with the full URL so that users could paste it into their browser.
- Cases where the Lead CS was unable to select themselves as a contributor
- Trainee dashboard not updating to show correct Learning Agreement status

Complex bugs, taking a few months to resolve included:

- Cases where MCR CiP descriptors were not saving, giving an error message and resulting in the Lead CS being unable to progress the MCR
- Cases where alerts were not disappearing from user dashboard as planned (hanging alerts)
- Users being able to create multiple MCRs

The Helpdesk back office services include:

- The ability to transition trainees who wrongly opted out of the new curriculum (and vice versa)
- The ability to retract signed off Learning Agreements in cases where information needed to be changed or added (when only the first signatory had signed off).
- The ability to unlock AES sign off of the MCR in cases where AES needed to add or change details (up to when the next Learning Agreement meeting is signed off).
- The ability to unlock trainee Self-Assessment sign off in cases where trainees needed to add or change details (up to when the next Learning Agreement meeting is signed off).

Improvements made:

- Because of requests for further information about the status of MCRs and Learning Agreements, we provided help text that appeared when hovering over navigational icons to show whether a stage was e.g., 'Awaiting AES sign off' or 'In progress'. We also provided TPDs, AESs, CSs and trainees with an additional page of information giving more detail on the progress and status of MCRs such as dates of completion. This allowed each party to track progress with assessments, enabling them to detect and resolve hold-ups where necessary.
- We added a progress bar/icons as an additional navigational aid through the MCR online pages.
- We provided a new dashboard alert for CSs showing the from/to date range within which contributions could be made.
- We made trainee and AES sign off comments mandatory in the Learning Agreement at the request of the evaluation group. The aim was to encourage the provision of trainee and AES views.
- We added text to the midpoint Learning Agreement sign off page to ensure that AESs were aware that creating a Learning Agreement before the optional midpoint MCR superseded any *not started* or *in progress* midpoint MCRs which otherwise could be lost.
- We moved the MCR Trial tool away from the main menu because a few users confused this with the real assessment. It continues to be available for users who want to trial the assessment and full process flow before first using it.
- We added a link to the curriculum certification requirements on the ARCP pages for reference purposes.
- To help guard against user errors in selecting the date of Learning Agreement meetings, we restricted the start/end dates to be between placement start/end dates.

Theme 8: Critical Conditions/Index Procedures/PBAs

- The new curriculum provided a more defined set of index procedures and critical conditions linked to PBAs and CBD/CEXs, these are shown in appendices 3 and 4 of all parent specialty

curricula. This supported the move away from 40 WBAs per year towards mandating evidence of trainee learning of index procedures and critical conditions by the time of certification. To help trainees demonstrate how they were meeting these requirements we released a new portfolio report called *WBAs Required for Certification*. The report presents a count of all index PBAs and critical condition CBDs and CEXs and shows how far trainees are meeting the certification requirements for their parent specialty as they proceed through training. These functions were released a year before the new curriculum so that the reports would include sufficient counts to be useful to the first ARCPs under the new curriculum. Unfortunately, assessments done prior to this time could not be counted because they had been defined differently. The inability to show the prior count impacted most on trainees at advanced levels of training who were advised to collate for themselves a list of all earlier index PBAs and critical condition CBDs/CEXs which they could upload to their portfolios for reference. This could be easily done with reference to the portfolio as a one-off exercise and we provided an Excel template for their use. Some trainees worried that because this report included WBAs from August 2020 onwards, all other WBAs were lost and we reassured them that all WBAs remained in their portfolios and that there was no need to repeat procedures or WBAs merely because they were not previously marked as index procedures.

Theme 9: Transition problems

- Most trainees who were required to transition to the new curriculum did so. While we provided help text within the transition pages, some trainees were confused about whether they could stay on the old curriculum if they wanted to. We simplified the guidance on the transition screen to ensure trainees better understood the transition rules. We re-worded *'opt in'/ 'opt out'* which gave the impression that transitioning was optional, to read *'Yes, I am eligible to transfer'* and *'No, I am permitted to remain'*. The uptake rate is now at 98% of those who were required to transition. We have written to all the individuals who wrongly remain un-transitioned.

Summary

We consider it vital that users have confidence in the training management system and find it easy to use when recording their day-to-day training activity. We will continue to listen to user feedback through all our evaluation channels, provide guidance and make improvements to ease implementation. The curriculum assessment system is still relatively new and many trainers and trainees are still coming to terms with how to navigate it. We hope that, as familiarity increases over time, technical issues and human errors will decrease, and the process may flow more smoothly.

6. Summary of evaluation

The new surgical curriculum, introduced in August 2021, assesses trainees against the fundamental capabilities required of a day-one consultant and, through a new tool, the MCR, places the professional judgement of consultant clinician supervisors at the heart of assessment. The MCR gives equal weight to the high-level outcomes of the curriculum; the CiPs and the GPCs, while the Learning Agreement ensures that the objectives trainees work towards in their training placements align with achieving them. The goals of the MCR are to help trainees stay on an appropriate trajectory, providing dedicated, targeted and timely feedback while minimising the burden of assessment for trainees who are progressing satisfactorily. The approach capitalises on supervisors' normal pattern of training but nonetheless represents a major change in how the administration of their professional judgement in this assessment is delivered.

This evaluation is a comprehensive and timely snapshot of activity but because its introduction was recent and the dataset not reflective of a full year, we cannot yet provide a complete picture of what the impact on training will be. The full effects have yet to emerge and ongoing evaluation will be necessary as set out in section 7. We have, however, provided some indicative observations from the available data using quantitative and qualitative methodologies.

The first observation is that, at a key progression point, where MCRs were being undertaken, the quality of AES engagement was high in terms of both detail and personalisation for trainees. There was good uptake in some specialties and regions (e.g., final MCRs in Urology 91%, T&O 88%, Plastic Surgery and CST 87%, ENT and OMFS 84%, General Surgery 83%, Mersey 95%, North West 94% and KSS 85%). However, there were regions and specialties where completion rates were poor (e.g., HEE Wessex 76% and Paediatric Surgery 59%).

The second is that trainees reported that there were many cases when they had had to take the initiative in areas that were not their responsibility, sometimes having to train their trainers and organise MCRs. Both trainers and trainees highlighted that full engagement from CSs was unlikely unless it was better resourced. CSs needed to be those who worked directly with trainees and the Lead CS had to be someone who would be willing to corral others and ensure the paperwork was completed. Examples of good practice tended to be from people or in units placing medical education high on a list of priorities. Overall, the problems with trainer engagement related to a feeling that they were ill equipped for their responsibilities because of a lack of time, funding and training.

Thirdly, the ISCP made every effort to organise, promote and guide trainees and trainers in the run up to the launch and beyond. These initiatives included an information hub, webinars, step guides, videos and direct emails to all involved in training (see appendix 7). Our webinar series was also directed at local trainee and trainer champions (trainee representatives SACs, TPDs, Surgical Tutors and Schools of Surgery). We provided resources including slide presentations with accompanying notes, the relevant theoretical background and standards frameworks, FAQs, demo accounts and MCR guidance. These resources were intended to be used by champions to cascade training locally.

Despite these resources, both trainees and trainers in the study reported a lack of adequate administrative support at a local level in terms of induction and direction. Trainers who participated highlighted the need for guidance on how to assess trainees on the GPCs in particular. They found it challenging to adequately assess and support trainees on areas of performance they felt were more intangible. Trainee representatives who participated pointed to a need for standardisation with regard to placement length (and, therefore the number of MCRs) as well as guidance on how to assess themselves effectively.

Overall, the new curriculum is the biggest change in surgical training and its assessment since 2007 and, although work remains to be done, we believe that the curriculum implementation has started well and will continue to bed in; the MCR and Learning Agreement adding value to training by necessitating improved formative feedback to trainees by their trainers and themselves. This evaluation is an intermediate step and we will continue to evaluate the performance of the new curriculum. Coupled with this will be consideration of how those involved in training can be encouraged or motivated to better engage with the curriculum.

7. Future work

In the next phases of our evaluation, we aim to:

Immediate term

- Systems meetings to review trainee and trainer feedback for the development of the online training management system – From Autumn 2022

- Report on the use of specialty-specific CiPs (Cardiothoracic Surgery, Paediatric Surgery, Plastic Surgery) August 2021-2022 (*early 2023*)

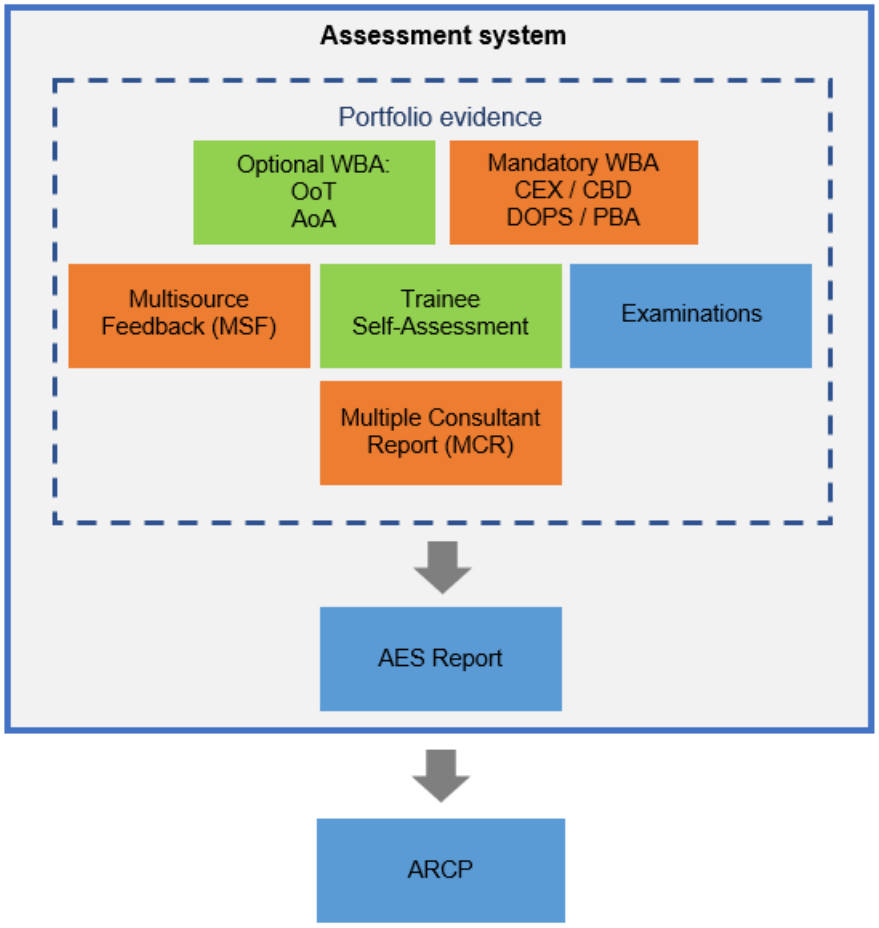
Medium term (reporting no earlier than by December 2023)

- Trainee and trainer views via the JCST trainee and trainer surveys
- Frequent, shorter trainee forum events on different topics
- ISCP days covering different topics with different stakeholder groups
- Review of MCR data to examine the quality of MCRs, including the use of GPCs, CiP supervision levels, descriptors and free-text comments
- Review of MCR data to examine the use of contributor comments, impact of the change to the 48 hours interval and use of invited contributors
- Review of MCR data to measure CS engagement in MCRs
- Examples of good practice use of MCRs
- Collaborative report on how endovascular training is being experienced in Vascular and Interventional Radiology training.

Longer term

- Review of the quality of Learning Agreements
- Review of MCRs to examine how trainees are progressing, comparing supervision levels over time with critical progression points
- Review of MCR data to examine the use of the specialty-specific CiPs in Cardiothoracic Surgery, Paediatric Surgery and Plastic Surgery
- Review TPD views of the quality and impact of MCRs on ARCPs.

Appendix 1: Assessment system framework



Key

Assessments providing formative feedback whilst contributing to summative feedback

Formative assessments

Summative assessments or mechanism with a feedback element

Appendix 2: Capabilities in Practice

SHARED CIPS

Shared Capability in Practice 1 **Manages an Outpatient Clinic** **Good Medical Practice Domains 1,2,3,4**
Description Able to perform all the administrative and clinical tasks required of a consultant surgeon in order that all patients presenting as outpatients in the specialty are cared for safely and appropriately.
Example descriptors: ● Assesses and prioritises GP and interdepartmental referrals and deals correctly with inappropriate referrals ● Assesses new and review patients, using a structured history and a focused clinical examination to perform a full clinical assessment and determines the appropriate plan of action, explains to patient and carries out the plan. ● Carries out syllabus defined practical investigations or procedures within the outpatient setting ● Adapts approach to accommodate all channels of communication (e.g. interpreter, sign language), communicates using language understandable to the patient and demonstrates communication skills with particular regard to breaking bad news. Appropriately involves relatives and friends. ● Takes comorbidities into account ● Requests appropriate investigations, does not investigate when not necessary and interprets results of investigations in context ● Selects patients with urgent conditions who should be admitted from clinic ● Manages potentially difficult or challenging interpersonal situations, including breaking bad news and complaints ● Completes all required documentation ● Makes good use of time ● Uses consultation to emphasise health promotion

Shared Capability in Practice 2 Manages the Unselected Emergency Take Good Medical Practice Domains 1,2,3,4
Description All patients with an emergency condition requiring management within the specialty. Able to perform all the administrative and clinical tasks required of a consultant surgeon in order that all patients presenting as emergencies in the specialty are cared for safely and appropriately.
Example descriptors: ● Promptly assesses acutely unwell and deteriorating patients and delivers resuscitative treatment and initial management and ensures sepsis is recognised and treated in compliance with protocol ● Makes a full assessment of patients by taking a structured history and by performing a focused clinical examination and requests, interprets and discusses appropriate investigations to synthesise findings into an appropriate overall impression and diagnosis ● Identifies, accounts for and manages co-morbidity in the context of the surgical presentation, referring for specialist advice when ● Selects patients for conservative and operative treatment plans as appropriate, explaining these to the patient, and carrying them out ● Demonstrates effective communication with colleagues, patients and relatives ● Makes appropriate peri- and post-operative management plans in conjunction with anaesthetic colleagues ● Delivers on-going postoperative surgical care in ward and critical care settings, recognising and appropriately managing medical and surgical complications, referring for specialist care when necessary ● Makes appropriate discharge and follow up arrangements ● Carries out all operative procedures as described in the syllabus ● Manages potentially difficult or challenging interpersonal situations ● Give and receive appropriate handover

Shared Capability in Practice 3
Manages Ward Rounds and Inpatients
Good Medical Practice Domains 1,2,3,4

Description

Manages all hospital inpatients with conditions requiring management within the specialty. Able to perform all the administrative and clinical tasks required of a consultant surgeon in order that all inpatients requiring care within the specialty are cared for safely and appropriately.

Example descriptors:

- Identifies at the start of a ward round if there are acutely unwell patients who require immediate attention
- Ensures that all necessary members of the multidisciplinary team are present, knows what is expected of them and what each other's' roles and contributions will be and contributes effectively to cross specialty working
- Ensures that all documentation (including results of investigations) will be available when required and interprets them appropriately
- Makes a full assessment of patients by taking a structured history and by performing a focused clinical examination and requests, interprets and discusses appropriate investigations to synthesise findings into an appropriate overall impression, management plan and diagnosis
-
- Identifies when the clinical course is progressing as expected and when medical or surgical complications are developing and recognises when operative intervention or re-intervention is required and ensures this is carried out
- Identifies and initially manages co-morbidity and medical complications, referring on to other specialties as appropriate
- Contributes effectively to level 2 and level 3 care
- Makes good use of time ensuring all necessary assessments are made and discussions held, while continuing to make progress with the overall workload of the ward round
- Identifies when further therapeutic manoeuvres are not in the patient's best interests, initiates palliative care, refers for specialist advice as required and discusses plans with the patient and their family
- Summarises important points at the end of the ward round and ensures all members of the multi-disciplinary team understand the management plans and their roles within them
- Gives appropriate advice for discharge documentation and follow-up

Shared Capability in Practice 4
Manages the Operating List
Good Medical Practice Domains 1,2,3,4

Description

All patients with conditions requiring operative treatment within the specialty. Able to perform all the administrative and clinical tasks required of a consultant surgeon in order that all patients requiring operative treatment receive it safely and appropriately.

Example descriptors:

- Selects patients appropriately for surgery, taking the surgical condition, comorbidities, medication and investigations into account and adds the patient to the waiting list with appropriate priority
- Negotiates reasonable treatment options and shares decision making with patients
- Takes informed consent in line with national legislation or applies national legislation for patients who are not competent to give consent
- Arranges anaesthetic assessment as required
- Undertakes the appropriate process to list the patient for surgery
- Prepares the operating list, accounting for case mix, skill mix, operating time, clinical priorities and patient co-morbidity
- Leads the brief and debrief and ensures all relevant points are covered for all patients on the operating list
- Ensures the WHO checklist (or equivalent) is completed for each patient at both beginning and end of each procedure
- Understands when prophylactic antibiotics should be prescribed, and follows local protocol
- Synthesises the patient's surgical condition, the technical details of the operation, comorbidities and medication into an appropriate operative plan for each patient
- Carries out the operative procedures to the required level for stage of training as described in the specialty syllabus
- Uses good judgement to adapt operative strategy to take account of pathological findings and any changes in clinical condition
- Undertakes the operation in a technically safe manner, using time efficiently
- Demonstrates good application of knowledge and non-technical skills in the operating theatre, including situation awareness, decision making, communication, leadership and teamwork

- Writes a full operation note for each patient, ensuring inclusion of all post-operative instructions
- Reviews all patients post-operatively
- Manages complications safely, requesting help from colleagues where required

Shared Capability in Practice 5
Manages Multi-Disciplinary Working
Good Medical Practice Domains 1,2,3,4

Description

All patients with conditions requiring interdisciplinary management (or multi-consultant input as in Trauma or Fracture Meetings in Trauma and Orthopaedics) including care within the specialty. Able to perform all the administrative and clinical tasks required of a consultant surgeon in order that safe and appropriate multi-disciplinary decisions are made on all patients with such conditions requiring care within the specialty.

Example Descriptors:

- Appropriately selects patients who require discussion at the MDT
- Follows the appropriate administrative process
- Deals correctly with inappropriate referrals for discussion (e.g. postpones discussion if information is incomplete or out of date)
- Presents relevant case history recognising important clinical features , co-morbidities and investigations
- Identifies patients with unusual, serious or urgent conditions
- Engages constructively with all members of the MDT in reaching an agreed management decision, taking comorbidities into account, recognising when uncertainty exists and being able to manage this
- Effectively manages potentially challenging situations such as conflicting opinions
- Develops a clear management plan and communicates discussion outcomes and subsequent plans by appropriate means to patient, GP and administrative staff as appropriate
- Manages time to ensure case list is discussed in the time available
- Arranges follow up investigations when appropriate and knows indications for follow up

Specialty specific Capability in Practice 6
Manages patients within the Critical Care Area
Good Medical Practice Domains 1,2,3,4

Description

Able to perform all administrative and clinical tasks required of a Consultant Surgeon in all patients within the intensive care and high dependency settings in both Cardiac and Thoracic Surgery to ensure they receive safe and appropriate care.

Example Descriptors:

- Assesses referrals to ICU or HDU, including regular review of patients
- Arranges urgent investigations as necessary and reviews in timely fashion.
- Works with appropriate specialties in the management of critically ill patients, referring on to other specialties as appropriate.
- Leads on surgical decisions for post-operative patients.
- Supports nursing and anaesthetic staff in managing patients.
- Plans discharges in a timely fashion to maintain patient flow.
- Communicates appropriately with family and next of kin.
- Communicates appropriately with consultant, nursing and anaesthetic colleagues.
- Delegates and trains other staff members on appropriate cases.
- Applies syllabus defined knowledge and clinical skills in all cases
- Carries out syllabus defined practical investigations or procedures within HDU and ICU
- Exercises good judgement in deciding on management plans and executes these within appropriate timescales.
- Effectively manages potentially challenging situations in patients.

Specialty specific Capability in Practice 7
Assesses surgical outcomes both at a personal and unit level
Good Medical Practice Domains 1,2,3,4

Description

Able to assess surgical outcomes in the specialty at a personal and unit level, and is able to respond or adapt practice, where appropriate, without compromising patient care

Example Descriptors:

- Assesses preoperative investigations to collect risk factors.
- Collects data at the time of surgery about patient demographics, procedure performed and risk factors.
- Enters data into local and national datasets, as appropriate.
- Collects postoperative data of outcomes following surgery.
- Analyses and presents surgical outcome data at local audit meetings.
- Describes both personal and unit outcomes during a prescribed audit period.
- Describes risk adjusted outcomes at personal and unit level.
- Demonstrates ability to recognise acceptable variations in practice as well as excellent and poor performance in self and others.
- Promotes excellence.
- Demonstrates ability to analyse reasons for poor performance and suggest means for adapting practice to improve patient care.
- Demonstrates knowledge of risk factors, current risk models (such as EuroSCORE, Thoracoscore etc.) and risk adjustment.
- Demonstrates knowledge of national and local audits (SCTS, NICOR, cancer registries etc.)
- Demonstrates skills in using IT and databases

Shared Capability in Practice 6
Ability to assess and manage an infant or child in intensive care
Good Medical Practice Domains 1,2,3,4

Description

Ability to assess infants and children on neonatal and intensive care units, recognise conditions that are best expectantly managed and the indications and timing for surgical intervention. To discuss with neonatologists and intensivists and to formulate an appropriate plan, from medical management to surgical (including intervention on the unit itself), initiating/participating in discussions about palliative care if appropriate. Communicating the current situation, prognosis and plans to the parents and family in an accessible and understandable manner.

Example descriptors:

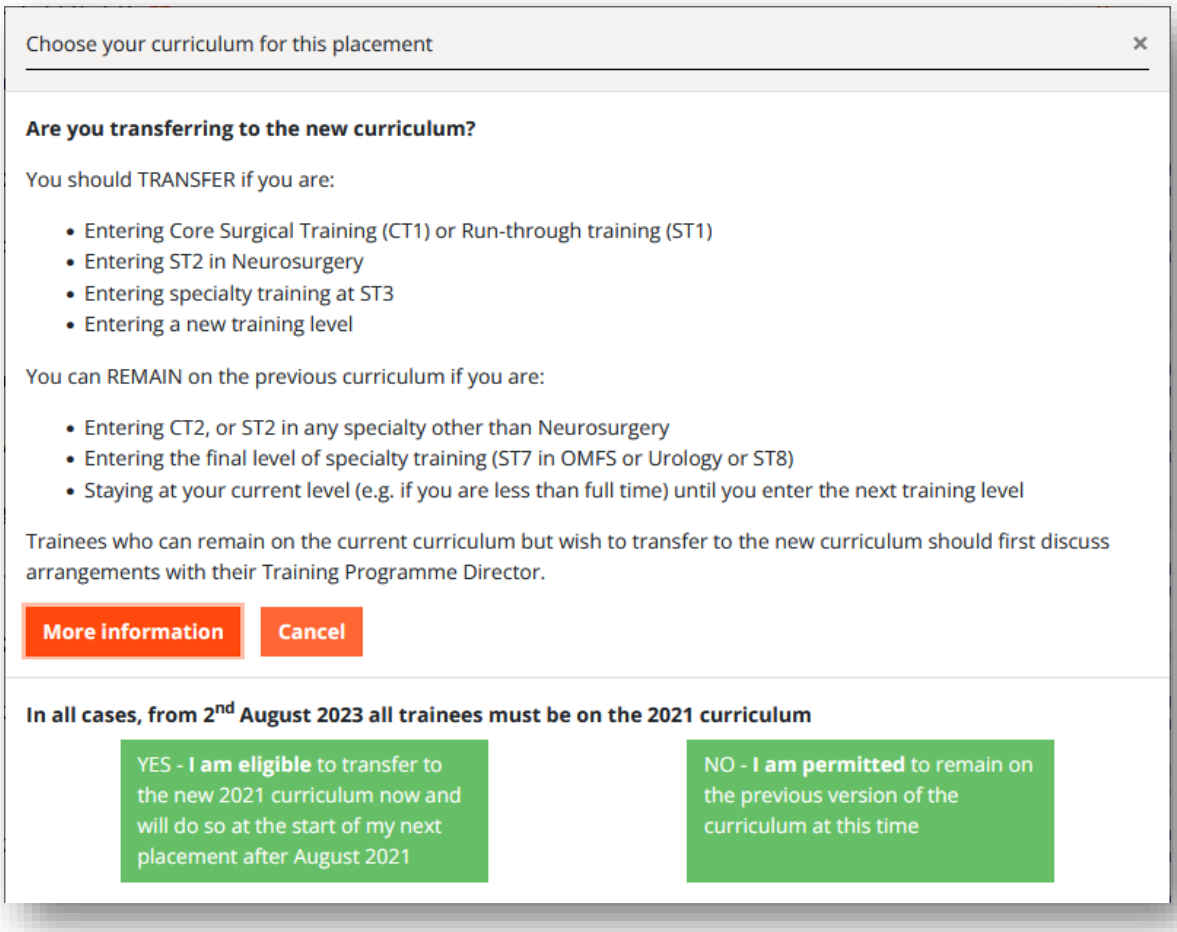
- Knowledge of normal physiology in premature infant, term infant and child: recognition of ill infant and child and signs of recovery or deterioration.
- Knowledge and experience of index neonatal conditions: indications and urgency for surgical intervention
- Makes a full assessment of patients by taking a structured history and by performing a focused clinical examination and requests, interprets and discusses appropriate investigations to synthesise findings into an appropriate overall impression, management plan and diagnosis
- Communicate with parents and families in a clear and understandable way: explaining current situation and ongoing plans, including any surgical intervention
- Recognises co-morbidity and medical complications, discussing management with neonatologists/intensivists, referring on to other specialties as appropriate
- Identifies when further therapeutic manoeuvres are not in the patient's best interests, discussion of palliative care, refers for specialist advice as required. Discusses plans with their parents, and neonatologists/intensivists.
- Ensures all members of the multi-disciplinary team understand the management plans and their roles within them. This plan needs to be explicit and agreed with other members of the MDT, taking into account the sometimes conflicting needs of the child, and may happen at any time (for example out-of-hours).
- Gives appropriate advice for discharge from the neonatal or intensive care unit, with appropriate documentation and follow-up

Specialty Specific Capability in Practice 6 **Able to safely assimilate new technologies and advancing techniques in the field of Plastic Surgery into practice** **Good Medical Practice Domains 1,2,3,4**
Description Plastic Surgery is primarily a specialty of technique, therefore Plastic Surgeons need to maintain familiarity with advances in techniques and be able to assimilate these into practice as appropriate. They need to be able to critically evaluate new techniques presented to them and be able to disseminate any advances that they have been able to achieve.
Example descriptors • Critical appraisal of evidence and published literature • Open minded approach to new techniques • Attendance and interest in conferences and courses • Awareness or the processes surrounding the safe introduction of new technologies or techniques • Ability to appraise the cost-effectiveness of particular techniques

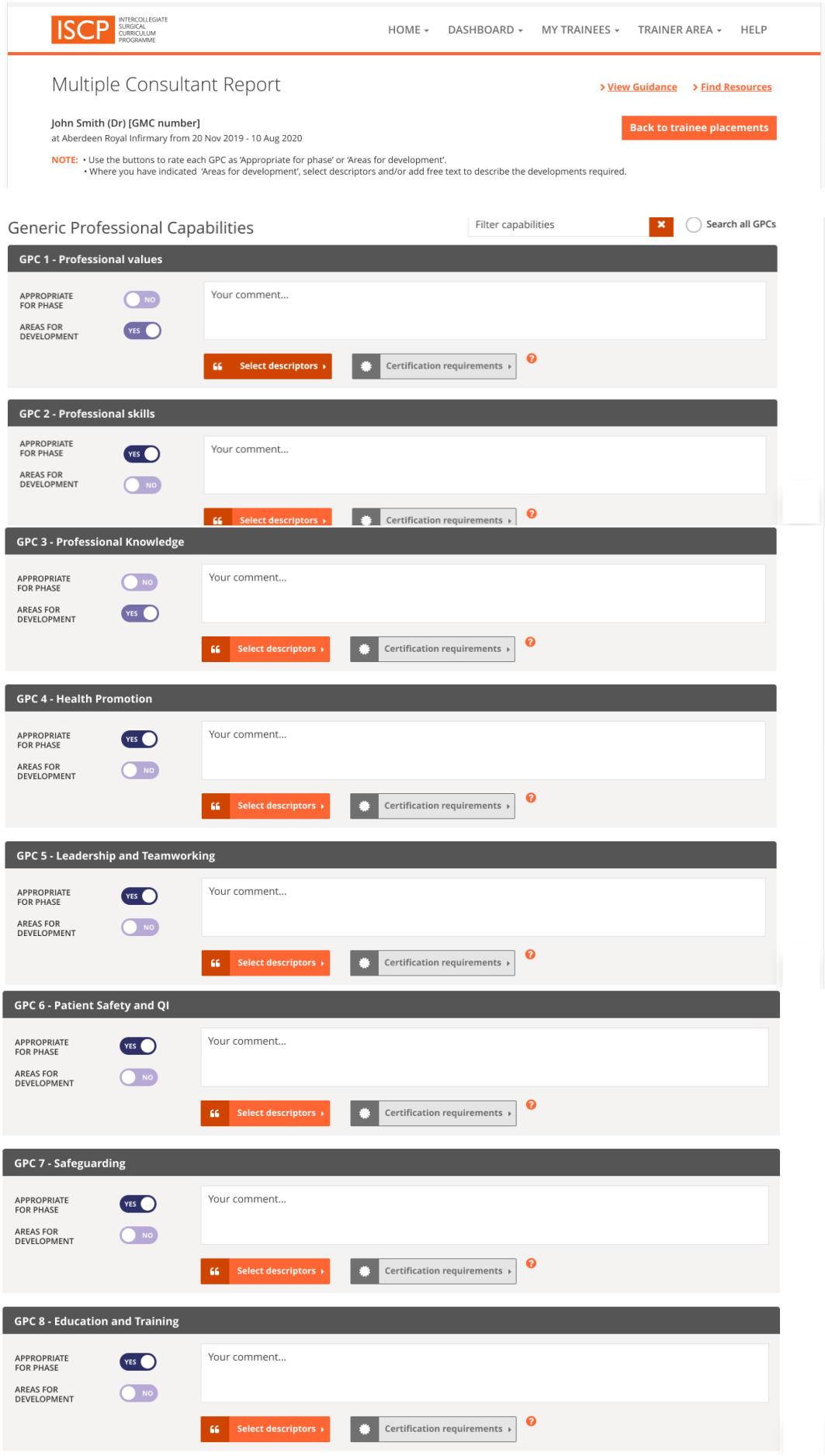
Appendix 3: Supervision levels (the scale upon which CiPs are judged)

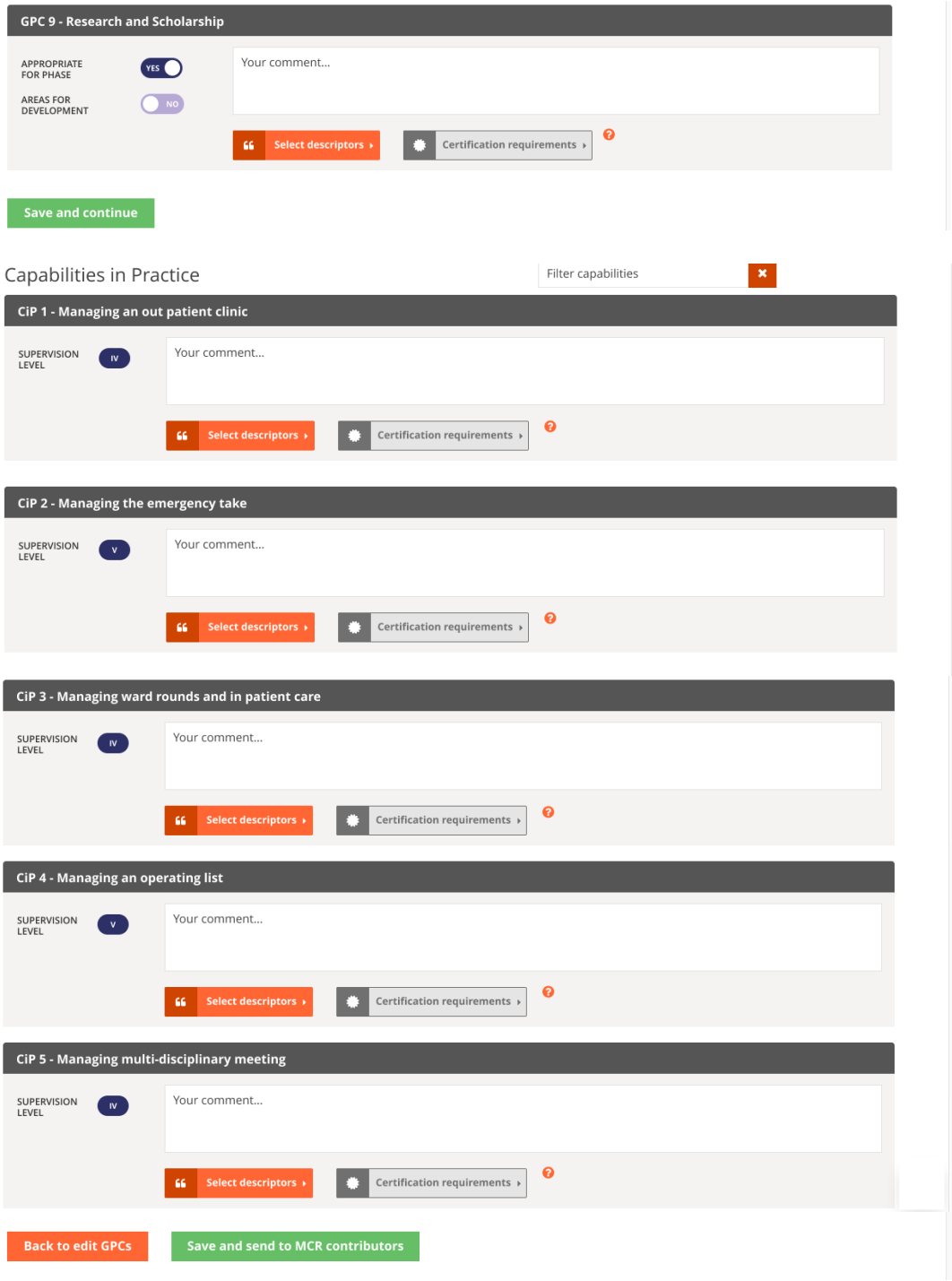
Rating scale	
Core training supervision levels	**Higher training supervision levels**
Level I: Able to observe only: no execution	
Level Ia: Able to observe passively only Level Ib: Able to observe actively: may engage in the activity to provide assistance or analyse and discuss what is observed	
Level IIa: Able and trusted to act with direct supervision: some of the activity is performed by the trainee	Level IIa: Able and trusted to act with direct supervision (The supervisor needs to be physically present throughout the activity to provide direct supervision)
Level IIb: Able and trusted to act with direct supervision: the trainee is able to string elements together into fluent parts of the task	Level IIb: Able and trusted to act with direct supervision (The supervisor needs to guide all aspects of the activity. This guidance may partly be given from another setting but the supervisor will need to be physically present for part of the activity)
Level IIc: Able and trusted to act with direct supervision: the trainee is able to complete the task	
Level III: Able and trusted to act with indirect supervision: the supervisor will want to provide guidance for, and oversight of most aspects of the activity. Guidance may be remote or provided in advance of the activity	Level III: Able and trusted to act with indirect supervision (The supervisor does not need to guide all aspects of the activity. For those aspects which do need guidance, this may be given from another setting. The supervisor may be required to be physically present on occasions).
	Level IV: Perform at the level of a day 1 consultant
	Level V: Performs beyond the level expected of a day one consultant

Appendix 4: Online transition to the new curriculum

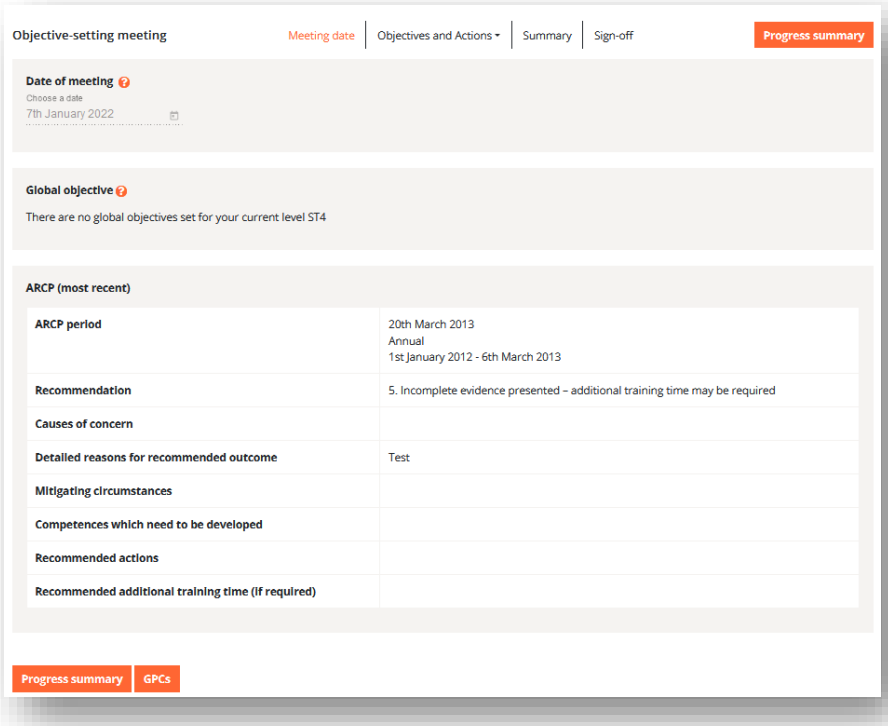


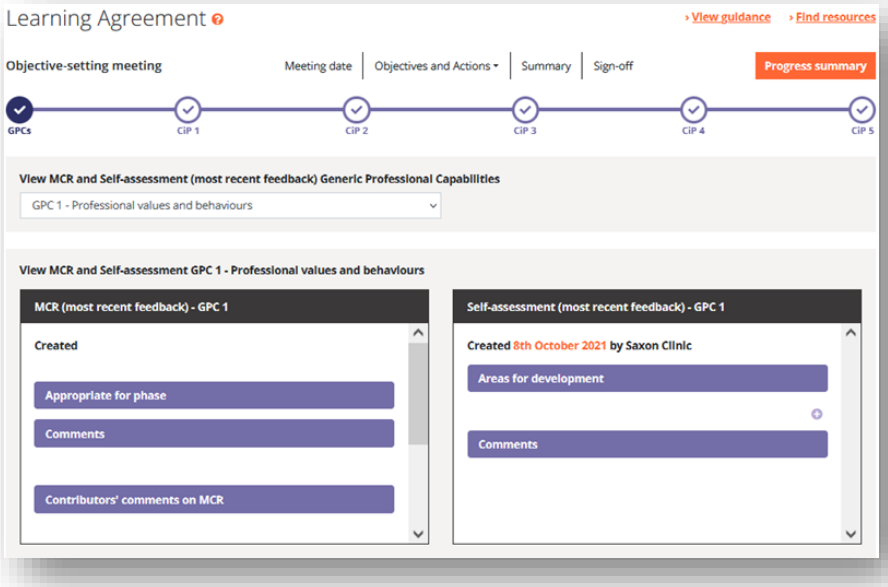
Appendix 5: MCR online tool

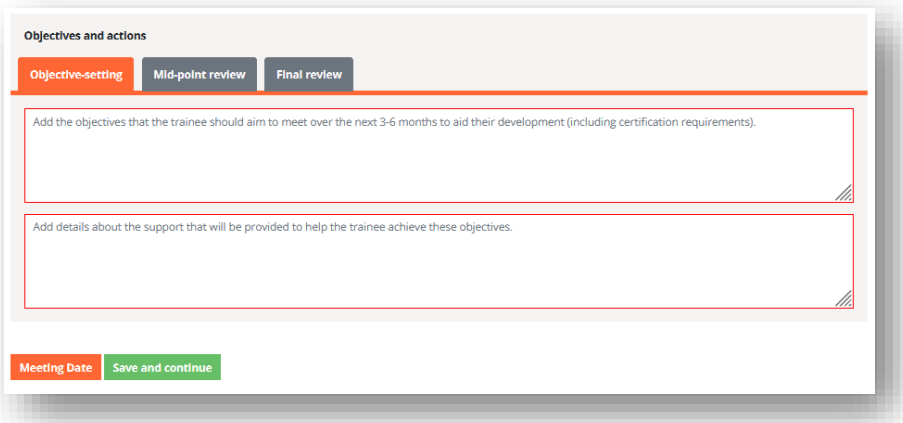



GPC 9 - Research and Scholarship
APPROPRIATE FOR PHASE
YES
AREAS FOR DEVELOPMENT
NO
Your comment...
Select descriptors
Certification requirements
Save and continue
Capabilities in Practice
Filter capabilities
CiP 1 - Managing an out patient clinic
SUPERVISION LEVEL
IV
Your comment...
Select descriptors
Certification requirements
CiP 2 - Managing the emergency take
SUPERVISION LEVEL
V
Your comment...
Select descriptors
Certification requirements
CiP 3 - Managing ward rounds and in patient care
SUPERVISION LEVEL
IV
Your comment...
Select descriptors
Certification requirements
CiP 4 - Managing an operating list
SUPERVISION LEVEL
V
Your comment...
Select descriptors
Certification requirements
CiP 5 - Managing multi-disciplinary meeting
SUPERVISION LEVEL
IV
Your comment...
Select descriptors
Certification requirements
Back to edit GPCs
Save and send to MCR contributors

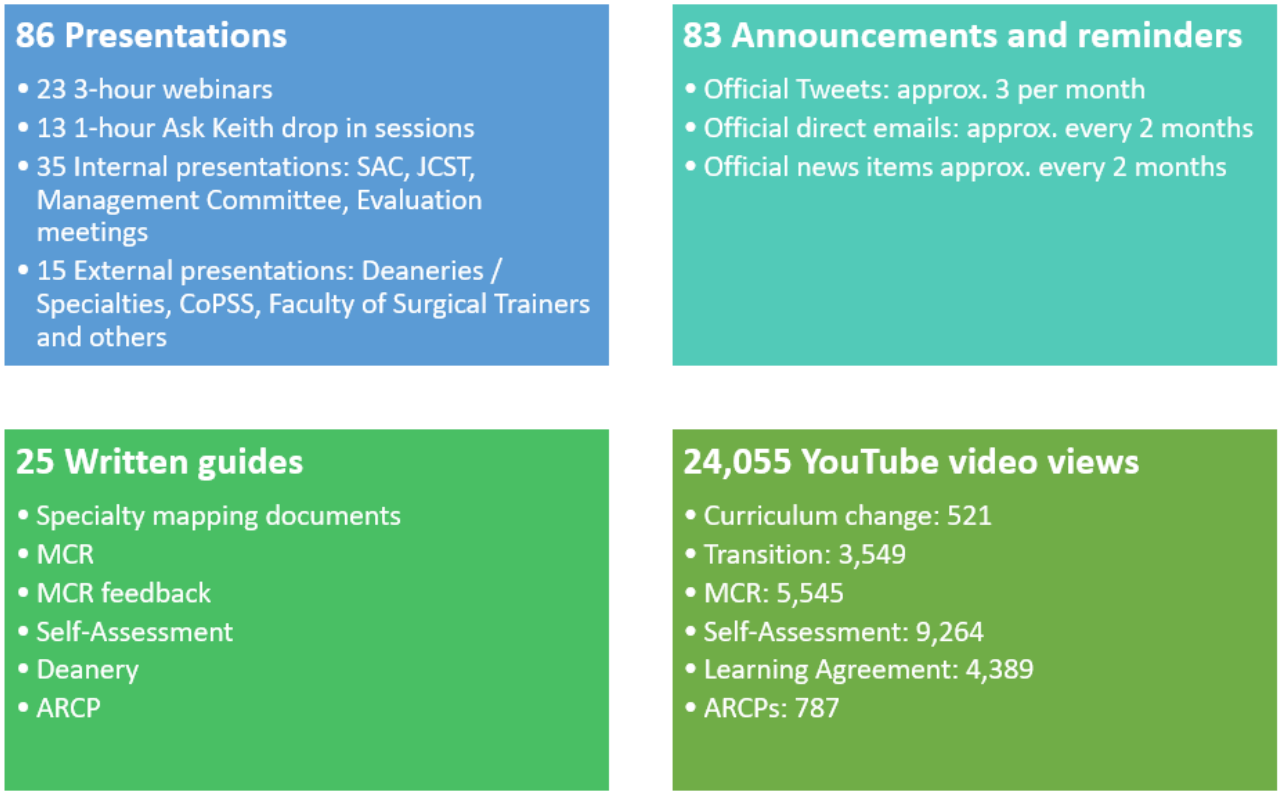
Appendix 6: Learning Agreement online tool







Appendix 7: Promotion strategy



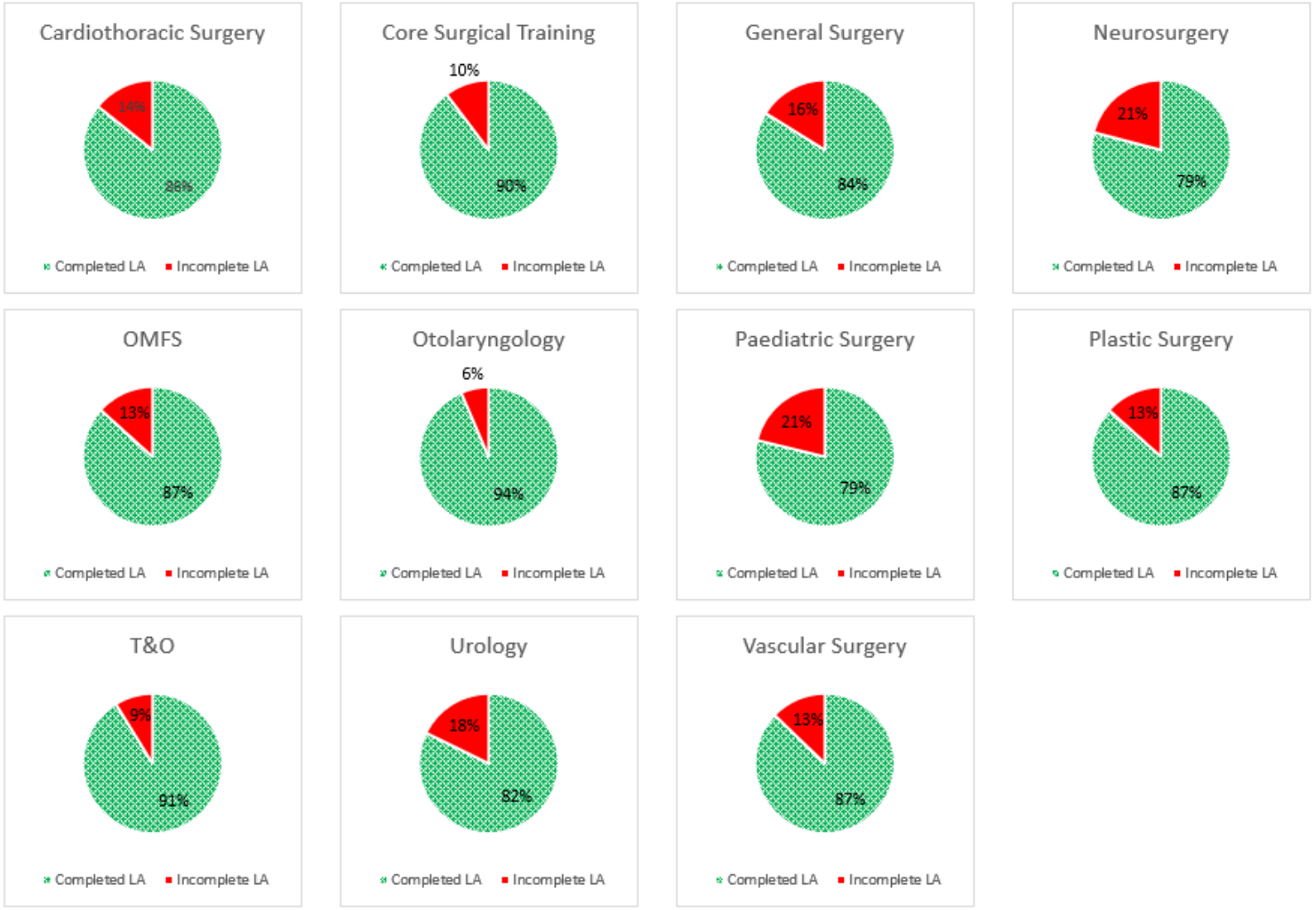
Useful links	
Written guidance	**Video guides**
General	
Curriculum information hub FAQs Supervisor and trainee roles and responsibilities Capabilities in practice (CiPs) Generic Professional Capabilities framework	
Transition	
Transition arrangements	Transition (pop up) video
MCR	
MCR guidance Supervision levels (core) see section 5.3.3 of curriculum Supervision levels_ (specialty)	MCR (pop up) video_ for Clinical Supervisors Demo of an MCR meeting_for Clinical Supervisors Capabilities in Practice (CiPs) explained

	Generic Professional Capabilities (GPCs) explained The Multiple Consultant Report (MCR) explained
Trainee Self-Assessment	
Guidance for trainee Self-Assessment	Trainee Self-Assessment (pop up) video
Learning Agreement	
	Learning Agreement (pop up) video Learning Agreement (longer video)
ARCP	
	ARCP preparation under the new curriculum ARCP preparation in Core Surgery ARCP preparation in Cardiothoracic Surgery ARCP preparation in Neurosurgery ARCP preparation in Otolaryngology ARCP preparation in Urology

Appendix 8: Comparative data (Learning Agreement) 2018/19

The charts below show comparative final Learning Agreement data from 2018/19, a pre-covid, stable training period. This previous period shows a difference in curriculum compliance of slightly over 10% on average. The new curriculum was introduced in a post-covid environment which increased work/life and pay/time and other pressures.

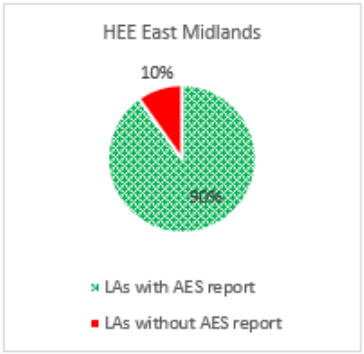
2018/19 Final Learning Agreements by specialty (chart)

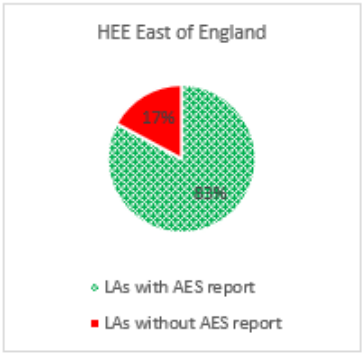


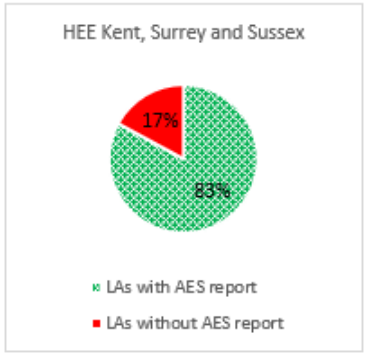
2018/19 Final Learning Agreements by specialty (table)

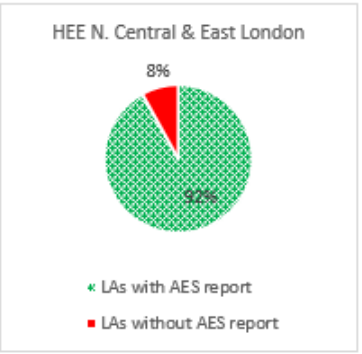
Parent specialty	Completed LA	Incomplete LA
Cardiothoracic Surgery	54	9
Core Surgical Training	1285	148
General Surgery	493	95
Neurosurgery	102	27
Oral and Maxillofacial Surgery	39	6
Otolaryngology	131	9
Paediatric Surgery	26	7
Plastic Surgery	136	21
Trauma and Orthopaedic Surgery	861	83
Urology	74	16
Vascular Surgery	34	5
Total	**3235**	**426**

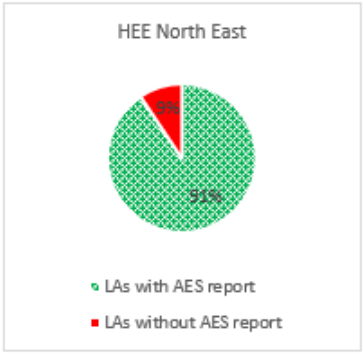
2018/19 Final Learning Agreements by Deanery / HEE Local Office 1 of 2 (chart)

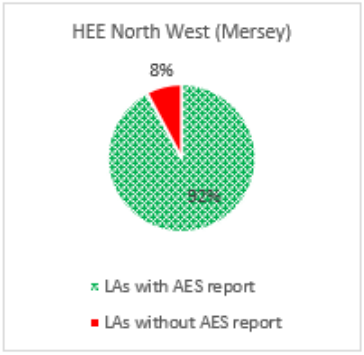


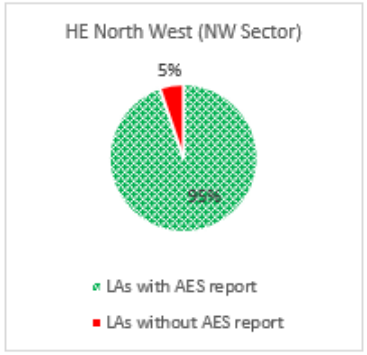


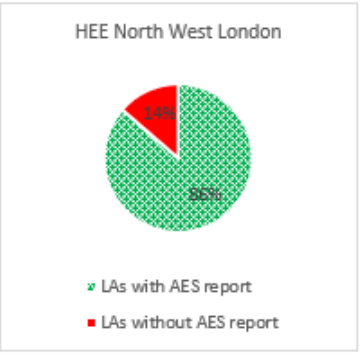


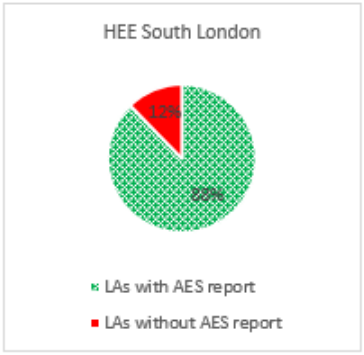


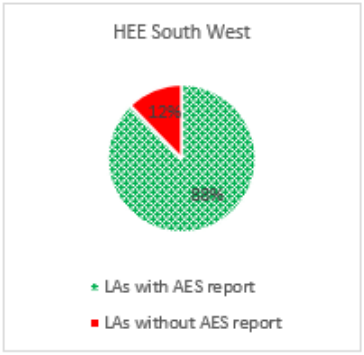


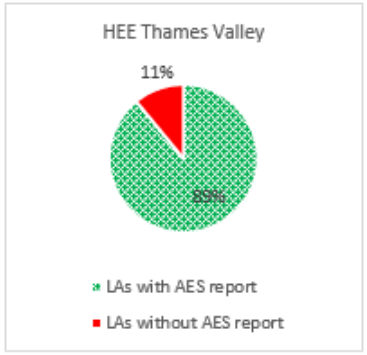


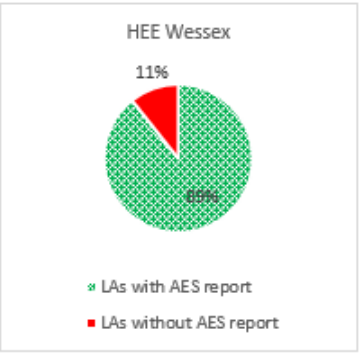




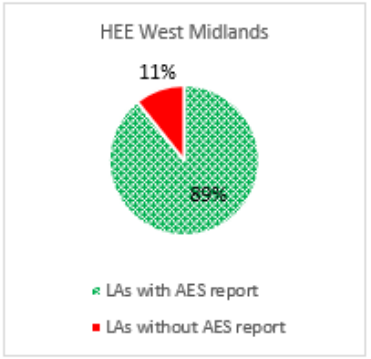


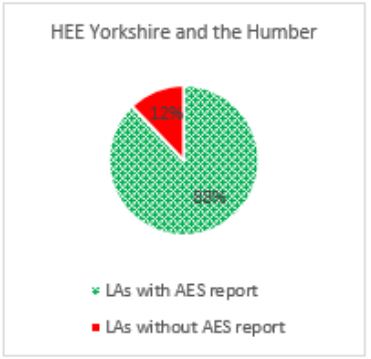


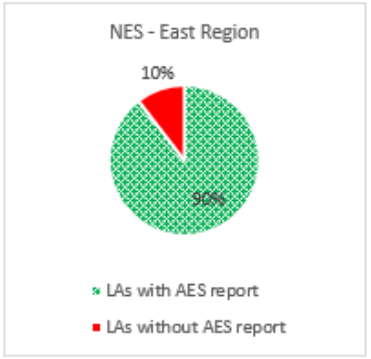


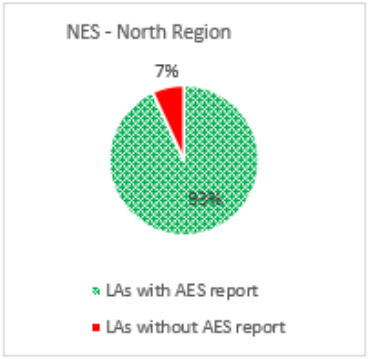


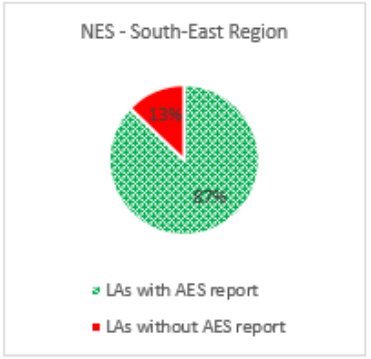
2018/19 Final Learning Agreements by Deanery / HEE Local Office 2 of 2 (chart)

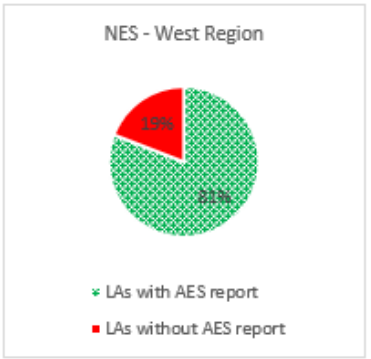


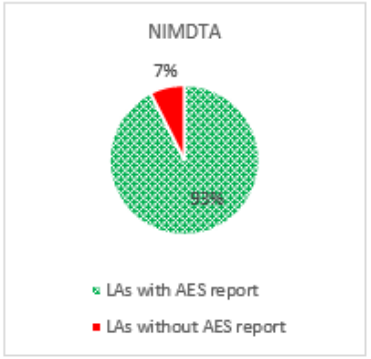


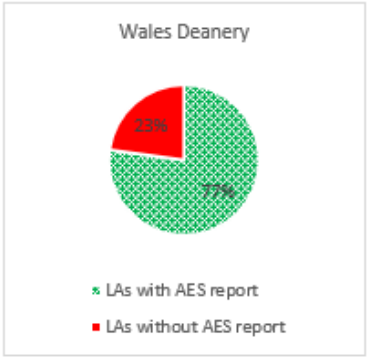












2018/19 Final Learning Agreements by Deanery / HEE Local Office (table)

Deanery	Completed LA	Incomplete LA
Health Education East Midlands	293	32
Health Education East of England	150	31
Health Education Kent, Surrey and Sussex	126	26
Health Education North Central & East London	160	14
Health Education North East	290	30
Health Education North West (Mersey Sector)	201	17
Health Education North West (North West Sector)	255	14
Health Education North West London	152	24
Health Education South London	164	23
Health Education South West	207	29
Health Education Thames Valley	81	10
Health Education Wessex	117	14
Health Education West Midlands	257	31
Health Education Yorkshire and the Humber	253	35
NHS Education for Scotland - East Region	60	7
NHS Education for Scotland - North Region	27	2
NHS Education for Scotland - South-East Region	61	9
NHS Education for Scotland - West Region	93	22
Northern Ireland Medical & Dental Training Agency	136	11
Wales Deanery	152	45
Total	**3235**	**426**

Appendix 9: Glossary of terms

Term	Definition
ARCP	The Annual Review of Competence Progression (ARCP) panel will recommend one of 8 outcomes to trainees. For further information, please see the Gold Guide).
Assigned Educational Supervisor (AES)	The consultant surgeon in this formal curriculum role has overall educational and supervisory responsibility for the trainee in a given placement. The role is also responsible for final sign off of the MCR.
Assigned Educational Supervisor Report	An end of placement report by the trainee's Assigned Educational Supervisor, providing key evidence for the trainee's ARCP.
Capability	The ability to be able to do something in a competent way.
Capabilities in Practice (CiP)	The high-level learning outcomes of the curriculum. Learning outcomes operationalise groups of competencies by describing them in terms of holistic professional activities. In surgery they are aligned to what a day-1 consultant will need to be able to know and do. Rather than learning inputs (what is learned they set out what the learner must be able to do as a result of the learning at the end of the training programme – a practical skill) and clarify the extent to which trainees should successfully perform to reach Certification.
Critical Condition	Any condition where a misdiagnosis could be associated with devastating consequences for life or limb. They are of significant importance for the demonstration of a safe breadth of practice.
Clinical Supervisor	The consultant surgeon in this formal curriculum role is responsible for delivering teaching and training under the delegated authority of the AES, including carrying out assessments and giving feedback to trainees. CSs are involved in the MCR assessment and may take on the role of Lead CS for the MCR.
Critical Progression Points	Key points during the curriculum where trainees will transition to a higher level of responsibility or enter a new area of practice. These points are frequently associated with increased risk, and so robust assessment is required. These points are at the end of phase 2 (transition to phase 3), and the end of phase 3 to achieve Certification.

Core Surgical Training	The early years of surgical training for all 10 surgical specialties.
Formative assessment	Assessment *for* learning including a feedback dialogue with the trainee. The assessment will not have a direct impact on the trainee's progression.
Generic	Applicable to *all* trainees regardless of specialty, discipline and level of training, e.g. generic professional capabilities.
Generic Professional Capabilities (GPCs)	A framework of educational outcomes that underpin medical professional practice for all doctors in the United Kingdom.
High-level Outcome	See Capability in Practice.
Index procedure	Common but important operations central to the specialty, competence in which is essential to the delivery of safe patient care. Taken together they form a representative sample of the breadth of operative procedures in the specialty. They are of significant importance for the demonstration of a safe breadth of practice.
Learning Agreement	The learning agreement is a written statement of the mutually agreed learning goals and strategies negotiated between a trainee (learner) and the trainee's Assigned Educational Supervisor (AES). It is agreed at the initial objective setting meeting and covers the period of the placement. The agreement is based on the learning needs of the individual trainee undertaking the learning as well as the formal requirements of the curriculum. The electronic Learning Agreement form is accessed through the secure area of the web site and is completed on-line. The AES and trainee complete the learning agreement together and are guided by the Training Programme Director's (PD) global objective.
Multiple Consultant Report (MCR)	An assessment by Clinical Supervisors that assesses trainees on the high-level outcomes of the curriculum. The MCR provides a supervision level for each of the 5 Capabilities in Practice (CiPs) as well as giving outcomes for the 9 Generic Professional Capabilities. The assessment will be at the midpoint of a placement (formative) and the end of a placement (summative). The MCR feeds into the AES Report. It also provides trainees with both formative and summative feedback.
Phase	An indicative period of training encompassing a number of indicative training levels. Phases are divided by critical progression points to ensure safe transitioning where patient or training risk may increase.

Placement	A surgical unit in which trainees work in order to gain experiential training and assessment under named supervisors.
Specialty Advisory Committee (SAC)	Under the jurisdiction of the JCST, there are currently 10 Specialty Advisory Committees (SAC) in operation - one for each GMC recognised surgical specialty - and a Core Surgical Training Advisory Committee (CSTAC), which oversees core surgical training. SAC responsibilities include trainee enrolment and support, certification, out of programme and less than full time training, curriculum and logbook development, quality assurance, national recruitment and providing externality.
Shared	Applicable to all specialties i.e. the 5 shared CiPs are identical to all 10 surgical specialties. In some specialties some additional CiPs may be specialty-specific.
Stakeholder groups	Individuals, groups or organisations who might be affected by the curriculum change, including: The four surgical Royal colleges of the UK and Ireland Trainees, trainee associations (e.g. ASiT and BOTA were involved throughout), trainee representatives on committees and trainee volunteers on working groups Specialty Advisory Committees Lead Deans in each surgical specialty / core surgical training and on the Conference of Postgraduate Medical Deans (COPMeD) Training Programme Directors in each specialty Heads of Schools of Surgery NHS Employers Patient/Lay representatives The General Medical Council
Summative assessment	Assessment *of* learning which may also have a formative feedback element. The assessment will have a direct impact on progression.
Supervision level	The level of supervision required by a trainee to undertake an activity, task or group of tasks, ranging from observe only through direct and indirect supervision to unsupervised.
Supervisors	Trainers with a supervisory role; Training Programme Directors, Assigned Educational Supervisors and Clinical Supervisors
Trainees	Postgraduate doctors in surgical training programmes.

Trainers	Consultant surgical trainers in general
Training programme	A rotation of placements in which training is provided under a Training Programme Director, an Assigned Educational Supervisor and one or more Clinical Supervisors.
Workplace-based assessment (WBA)	Formative assessment to support learning. More information can be found here.

Acknowledgements

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SAC Chairs and Curriculum Leads