Response to the ISCP Review

A statement from

The Association of Surgeons in Training

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On behalf of the ASiT Executive and Council
# GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>AES</th>
<th>Approved Educational Supervisor</th>
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<tr>
<td>AoP</td>
<td>Assessment of Performance</td>
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<td>ASiT</td>
<td>Association of Surgeons in Training</td>
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<td>CCT</td>
<td>Certificate of Completion of Training</td>
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<td>CBD</td>
<td>Case-Based Discussion</td>
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<td>CS</td>
<td>Clinical Supervisor</td>
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<td>EWTD</td>
<td>European Working Time Directive</td>
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<td>FRCS</td>
<td>Fellow of the Royal College of Surgeons</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>ISCP</td>
<td>Integrated Surgical Curriculum Programme</td>
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<td>JAG</td>
<td>Joint Advisory Group of Endoscopy</td>
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<td>JCST</td>
<td>Joint Committee on Surgical Training</td>
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<td>JETS</td>
<td>JAG Endoscopy Training System</td>
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<td>CEX</td>
<td>Clinical Evaluation Exercise</td>
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<td>MRCS</td>
<td>Member of the Royal College of Surgeons</td>
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<td>MSF</td>
<td>Multi-source Feedback</td>
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<td>NTN</td>
<td>National Training Number</td>
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<td>OOPE</td>
<td>Out of Programme for Experience</td>
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<td>OOPR</td>
<td>Out of Programme for Research</td>
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<td>OOPT</td>
<td>Out of Programme for Training</td>
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<tr>
<td>PDF</td>
<td>Portable Document Format</td>
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<tr>
<td>DOPS</td>
<td>Direct Observation of Procedural Skill</td>
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<td>SAC</td>
<td>Specialty Advisory Committee</td>
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<td>SLE</td>
<td>Supervised Learning Event</td>
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<td>TPD</td>
<td>Training Programme Director</td>
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<td>WBA</td>
<td>Workplace Based Assessment</td>
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**ASiT** – the pursuit of excellence in training

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I  INTRODUCTION

1.1  The Association’s Mandate

ASiT is a charitable organisation supporting the professional development of surgical trainees. Our association represents UK trainees from all surgical specialties and is one of the largest specialty groups in the UK with over 2700 members. The ASiT council is composed of representatives elected by the membership and an executive elected by the council.

1.2  Our response

This document represents the consensus opinion of UK surgical trainees. The opinions herein were reached through face-to-face and online discussions amongst ASiT Council and the general membership.

1.3  Response layout

We respond in turn to the questions posed by Mr William Allum, Surgical Director of ISCP in his summary of Dr Gordon Watson’s report
2 ISCP BACKGROUND AND PRINCIPLES

2.1 Perception of training: what do trainees want out of surgical training?

2.1.1 UK surgical trainees want a world-renowned training programme that aims for excellence and whose fundamental aim is to produce competent surgeons capable of delivering the highest quality of care. Such a program will attract the best candidates and must be seen to be robust, well organised and maintain the highest standards.

2.1.2 Training programmes must include rigorous training in research methodology, service organisation & provision, management, leadership and teaching.

2.1.3 “Teacher training” must be to a level that gives trainees the confidence and ability to train future generations of surgeons.

2.1.4 ASiT has highlighted the many changes required to achieve these goals in the “Future of Surgical Training”.

2.1.5 With respect to ISCP the critical changes should address:

i. On-going and improved training and development of trainers in ISCP assessment and feedback methods. Gaining genuine “buy in” from more trainers is central to the success of this enterprise.

ii. A rethink of the way WBAs fit into training.

iii. The regular review of placements via ISCP and e-logbook – where practical and feasible, consideration should be given to withdrawing NTN-holding trainees from units failing to adequately provide training opportunities.

iv. Trainers’ use of ISCP should be audited and fed back.
v. ISCP should be developed as a comprehensive portal to other sources of training.

vi. A “no fault” ARCP outcome should be available for when training has been inadequate.

vii. Strengthened communications via ISCP between ARCP panels and trainers permitting more directed feedback and trainer goal-setting.

viii. Simulation curricula presented within ISCP must be robust and accessible.

2.2 Perception of training: how and where does ISCP fit into modern surgical training?

2.2.1 ASiT agrees that ISCP aids trainees but recognises that ISCP has frequently been perceived to be a source of frustration and hindrance to training.

2.2.2 With a compulsory fee, trainees have a right to expect ISCP to be fit for purpose. In retrospect, it would have been better for ISCP to start small and incrementally expand instead of being imposed centrally with little trainee consultation.

2.2.3 We welcome Dr Watson’s report, but found the content and style dense and the document as a whole difficult to digest. We are grateful for Mr William Allum’s summary. We agree with his summary of the problems and challenges facing the development of the next iteration of ISCP.

2.2.4 We feel that ISCP has, and will have, a major positive role to play in the following domains:

i. ISCP as a Curriculum and Syllabus Reference Tool

ISCP is now the de facto curriculum management system and currently functions reasonably well in this respect. Having a nationally controlled, easily accessed and navigated summary of what is required of trainees in terms of knowledge and skills, at every stage of training on a per specialty basis is essential and well delivered by ISCP.

Research and academic knowledge and skills domains should be afforded a clearer position
in the syllabus. These are areas that all trainees will inevitably involved in, yet they do not appear to be as formally reflected in ISCP as clinical, technical and other professional skills.

ii. **ISCP as a Personal Record of Training and Career Portfolio**

ISCP has a largely positive record: it provides a good framework for learning agreements designed to facilitate training and career strategy. ISCP usefully facilitates training governance and reflective practice. However, it remains somewhat unwieldy and overburdened with detail.

iii. **ISCP as a Training Portal**

ISCP does not take advantage of its universal use by trainees to act as a single portal through which to access further training opportunities, i.e. courses, fellowships, research opportunities. Integrated links with other online training portfolios and management systems such as that being developed for the JETS system would be welcome.

iv. **ISCP as a Communications Medium**

ISCP is set up as a communications channel between its stakeholders. Whist this is clearly desirable, it is basic in its functionality with significant room for improvement, for example: enhanced basic functions (e.g. the ability to CC), better interfacing with email systems (e.g. to allow automatic forwarding) and the addition of some simple text editing facilities could easily be added.

v. **ISCP Training Management and Assessment**

Rather than fostering a close working relationship between trainee and trainer, ISCP has sometimes driven a wedge between them principally as a result of certain WBAs and the adversarial ARCP. This has compromised the more flexible and responsive traditional master/apprentice relationship. This is the biggest area of contention and is addressed in detail subsequently in this document.
3  APPRENTICESHIP

3.1  What was best and what worked about the previous apprenticeship model?

3.1.1  The apprenticeship model enabled trainees to learn on the job. This more 'longitudinal' model fostered trust and understanding between trainee and trainer through a sense of working together as a team. As a result of the permitted flexibility, the training relationship was more sensitive to an individual’s training needs. Both trainer and trainee could play to their strengths and train or be trained in a manner suited to them. This led to greater depth in training.

3.1.2  The major challenge came from the EWTD. This reduced trainee elective and emergency exposure and in order to staff EWTD compliant rotas increased the number of trainees within departments thus further reducing access to training opportunities.

3.2  What should a 21st century apprenticeship model look like?

3.2.1  The model would involve supplementing on the job apprenticeship training with simulated training and courses to bridge gaps in current training. To facilitate this, training budgets should follow trainees and not be devolved to Trusts. This will enable trainees to manage their own training more effectively. Training should be as high on the agenda as targets and service provision.

3.3  Coaching and mentoring

3.3.1  Mentoring is underutilised in surgical training and ASiT supports an expanded role in training. Mentoring can maximise trainees’ potential and enhance leadership skills. In some Deaneries, mentoring has been used to help trainees in difficulty. Results have been positive.

3.3.2  Greater emphasis should be placed on coaching and mentoring. Junior and senior trainees should be encouraged to access mentoring. Senior trainees will also benefit from mentoring.
junior trainees. The GMC’s Good Medical Practice and The Royal College of Surgeons mentoring statement emphasise the importance of mentoring. ISCP should make available the facility to document participation in mentoring within the “Evidence” section.

3.4 Trainer-trainee relationship

3.4.1 The trainer-trainee relationship is variable. Some relationships continue to resemble the old master/apprentice form whilst others do not. This variability is not new and is mainly related to the individual trainer or trainee’s personality, style and aptitudes. The other important factor that has influenced the trainer-trainee relationship is the EWTD.

3.5 Role of ISCP in supporting this relationship

3.5.1 ISCP at present does not necessarily support the trainer-trainee relationship. Engaged and motivated trainers will continue to provide good training in the absence of ISCP; poor trainers will remain poor despite its presence.

3.5.2 We acknowledge that some trainers, who might otherwise not engage with ISCP, feel compelled to do so by the need for regular learning agreements, assessments and logbook training requirements, although these offer no guarantee of quality.

3.5.3 It is essential that ISCP act as a vehicle for the provision of meaningful trainer feedback as well as trainee feedback.
4 TRAINEES’ PERSPECTIVES

4.1 Improving the functionality of ISCP – its function as a personal training record

4.1.1 The ISCP achieves this function reasonably well.

4.1.2 As assessment of training has changed with the introduction of WBAs, ISCP has acted as the medium for recording this form of evidence of training and progression. It now also acts as a record of training placements and the results of ARCP. ISCP requires that the record of WBAs and ARCP is completed and stored online.

4.1.3 The ISCP website offers useful space for trainees to record many of the other aspects of surgical training. It acts as an electronic record of offline events (courses, projects, audits, publications, teaching episodes etc.). There is currently a 40 MB storage limit for uploading files, a limit that is quickly reached once publication PDFs, presentation files and course certificates are uploaded. This is compounded by a single file size limit per entry of 5 MB. If ISCP is to become the single deposit for this information there needs to be an improved interface and a significantly increased data capacity.

4.1.4 The ability to cross-reference topics to assessments and other evidence is useful in theory, especially for specific clinical and knowledge-based fields. It would be interesting to know what the uptake of this facility is as we suspect it is variable.

4.1.5 For the ‘Professional Skills and Behaviours’ syllabus, the topics available for cross-reference are quite vague and could be sharpened. It may well be that these domains are best dealt with through a separate processes (such as reports form AESs and CSs, MSF and patient feedback). This area is key given the current climate following the Francis Report.2

4.1.6 In the topics section, the peer comparison feedback tool is of questionable face value given the continuing suspicion that WBAs are subject to gaming and therefore not representative. There is even anecdotal evidence of trainees completing their own ISCP assessment fields with their trainers' passwords.
4.1.7 The “Progress Against Topics” functionality is reasonably helpful and well laid out. It ensures that all the topics are at least considered in discussions with the AES with weaknesses not being avoided and strengths not being given undue prominence.

4.1.8 We wonder how widespread the uptake of the “Personal Development Plans” is. This is an activity that most trainees probably execute adequately without having to necessarily commit word to paper or computer. There is significant overlap with the learning agreement.

4.1.9 If a trainee is OOPR, OOPE, OOPT or OOPC there is no facility within ISCP to manage this efficiently. The arrangements are undefined; it requires multiple emails to ISCP support staff to discuss and arrange reduced payment in order to access the website to continue to accrue evidence and experience.

4.1.10 In terms of recording operative experience, after the frustrating confusion over the initial ISCP logbook, the current situation is an improvement although the e-logbook itself has a number of significant failings (section 9.7).

4.1.11 The e-logbook has benefitted from a third party iOS application to allow uploading of cases when no computer is available. This functionality is useful although in the e-logbook’s case carries a charge and remains unreliable. The newly released ISCP app is most welcome and we look forward to working with ISCP to develop this further.

4.1.12 Finally and critically, as a personal training record, the ISCP website should be fit for purpose with regards to revalidation and needs to neatly dovetail with, and transfer data to, the Surgeons’ Portfolio on completion of training.

4.2 Role of educational courses – local and regional. Would trainee-led courses be appropriate at local level and how could they be integrated?

4.2.1 With such limited study leave budgets, trainees should not be required to undertake unfunded compulsory courses. Trainees should be allowed to identify deficits in their
training and attend appropriate courses to supplement these.

4.2.2. ASiT promotes trainee-led courses. We facilitate numerous high-quality, affordable courses and support others with regional grants. Such courses are appropriate for junior trainees and some of the management courses are appropriate for higher surgical trainees. Although the courses are trainee-led, many have Consultant or appropriate professional faculty. Integration into ISCP on a formal basis would of course be welcome.

4.1 Need for change in ISCP as a training management system?

4.1.1 Watson’s report highlights the adversarial nature of the ARCP process. The ISCP process has certainly catalysed this change; trainees’ progress often being reduced to the number of WBAs completed. The ARCP process for many now occurs entirely online with an outcome being decided on e-portfolio evidence alone. Trainees, acutely aware of this, now work towards acquiring enough “training evidence” within the e-portfolio to satisfy the panel rather than necessarily setting themselves more personally relevant and motivated goals. As such, it is possible for trainees, who may be struggling to acquire the skills to become a good surgeon, to creep under the radar by ticking the boxes for their WBAs.

4.1.2 As formalised CCT requirements have been published by the various specialties, it is clear that the SACs have not felt that ISCP competency evidence is enough alone to ensure that trainees are ready for independent practice with non-ISCP evidence being required (e.g. record of emergency referrals in Otorhinolaryngology).

4.1.3 The way that the learning agreements, interim and final reviews and supervisor report sections are presented and structured is useful and instructive.

4.3 How to introduce and communicate changes

4.3.1 There is room for improvement. Changes to the website interface, as well as being flagged on the welcome page, could be explained with rudimentary interactive modules and tutorial videos, something that would help both trainees and trainers.
5  TRAINEES' PROGRESSION

5.1  Confidence of trainers in ISCP – reliability of processes to support training progression

5.1.1  This is the major flaw in ISCP as a medium for Training Management and Assessment

5.1.2  No Consistency

The JCST report into ISCP acknowledges a “constructive dissonance” within the surgical community regarding the use and applicability of the ISCP with regards to practical skills training. From a trainee’s perspective, this manifests itself by highly polarised responses from trainers to the use of ISCP.

Engaged trainers highlight potential training events and structure the event using the format provided by ISCP WBAs. This can help to add shape to training events and facilitates recording the learning achieved. Whilst many trainers may be so engaged, far too frequently the trainee has to approach their trainer in an apologetic stance requesting their participation in WBAs, which then quickly descend into retrospective tick box exercises. This form of assessment produces little constructive feedback and provides no medium for reflection from the trainee.

Furthermore, trainees insisting on participation from their trainers can erode an otherwise good training relationship. Some trainers have been known to completely disengage from the process leading to difficulties for trainees at ARCP who have had little recourse and have lost out through no fault of their own. Trainers who adopt this attitude do not appear to be sanctioned or offered further training. This sort of situation strongly reinforces the notion that the ISCP assessment process is of limited practical value, as it is clearly not valued by some trainer or, indeed, some members of the ARCP panel who appear reluctant to feedback to the trainer in question.

Furthermore and critically, as many consultants and trainees know that the assessment tools provided by ISCP are being used as tick box exercises their value as a record of training and progression is greatly reduced.
5.1.3 **Quantity not Quality**
Discussion with consultant trainers strongly suggests that the currency of progress is the number of assessments rather than quality of assessments. Anecdotally, it has been suggested that if a trainer felt a trainee was not fit for progress it would be easier to be unavailable to fill in assessments rather than giving difficult feedback to a struggling trainee. As such, a trainee would be allowed to fail on being unable to get any feedback rather than getting the feedback that might help them improve. This illustrates the difficult conditions that ISCP can put on a trainee and how it can be specifically used against the goals it has set out to achieve. Here, again, robust trainer feedback and audit of their use of the ISCP might go a long way to minimising this sort of problem.

5.2 **Role of ISCP in defining individual trainees’ training trajectories over the years of training**

5.2.1 In assessing the value of ISCP in defining training “trajectories” we must be able to see how the website could be used to assess change over time.

5.2.2 **WBAs as Assessment of Progress: Formative or Summative?**
What parameters does ISCP add from the pre-existing logbook that can be useful to this process? WBAs offer a mixed economy where some score trainees on their ability for their current level of training (CBDs, CEX, DOPS) whereas others offer a rating based on progression toward CCT (PBA).

ASiT stressed in the response to the Eraut report\(^3\) that trainees feel that the ISCP is a summative process rather than formative one. The Joint Committee on Higher Surgical Training (JCST) has highlighted the formative nature of ISCP but the opportunities for facilitated formative reflection on progress are rare. Trainees have three formal review meetings with their educational supervisor a year and the opportunities to use the assessment tools as a method of judging progress are therefore limited. Due to the quantity of WBAs required the opportunity to look into them at depth is diluted. A mid-year meeting with an educational supervisor is unlikely to have enough time to fully assess 20 WBAs.
5.2.3 **ARCP for assessment of progression – how ISCP has hamstrung this process.**

The ARCP process requires online review of a trainee’s ISCP portfolio to assess their training during the previous year. Their ARCP outcome is decided and given as final without necessarily involving the trainee face-to-face. The trainee is then invited into a room to receive the panel’s judgement with little opportunity for plea or mitigation. The analogy to a court of law is apt; many trainees have complained about the adversarial nature of the ARCP with little opportunity to justify or account for themselves despite the presence of significant personal or professional circumstances. The designers of ISCP must therefore understand that the e-portfolio and the validity of its assessments act as a central “advocate” for the trainee and may have a significant impact on life and career. The Executive Summary acknowledges:

“The ARCP has become an adversarial process from the perspective of some trainees rather than a mechanism to assess training progress and highlight good performance.”

Given that the ARCP is now an assessment of a trainee’s portfolio, it appears to be steering in the opposite direction from the formative goal of ISCP.
6  MAKING ISCP WORK FOR YOU

6.1  How do I use ISCP to my advantage?

6.1.1. Trainees principally use ISCP as a convenient way of accessing and referring to the syllabus for their chosen specialty and as an accessible and standardised way of maintaining an electronic portfolio and record of their training. It is also used as a way of communicating, albeit sub-optimally, with their training program directors and other members of the ARCP committee.

6.2  What does ISCP mean to me?

6.2.1 To most trainees ISCP means many things. In an ideal world it would be perceived as the trainee and trainer’s friend; providing a convenient means of maintaining a portfolio and training record and facilitating high quality training. The reality at present, however, is that ISCP frequently remains a source of frustration for reasons that have already been discussed.

6.3  Use at individual, local and regional level – how much flexibility can, or should, there be?

6.3.1 Resource and opportunity will vary according to local and regional circumstance. ISCP cannot therefore be rigid in terms of its demands of trainees, trainers and TPDs. Conversely, it is of central importance that it also functions as a national benchmark for the same stakeholders to ensure that training is, at the very least, adequate and comparable between different parts of the country. A balance needs to be struck: the ISCP should set standards but TPDs must retain the autonomy to consider local training opportunities and circumstances when deciding whether to pass or fail a trainee. In other words, numbers should not be absolute and a “no fault” ARCP outcome should be available.
6.4 How can I get the best out of specific areas – knowledge; clinical and technical skills; professional skills and clinical judgement?

6.4.1 Knowledge
ISCP functions reasonably well in this respect. Having the various syllabuses for the difference stages of training laid out in an easily searched and referenced manner is very useful. The portal function we have previously alluded to will enhance this aspect.

6.4.2 Clinical and Technical Skills
Re-thinking the nature of the trainee-trainer relationship and how it is enhanced through ISCP is important. The best way to improve in these domains is through regular supervision in theatre, on the ward and in clinic. WBAs (in particular PBA) should be rethought and offered in such a manner as to become less proscriptive (more sensitive) and provide more flexibility (more specific) in the way that the trainer can provide feedback (see section 9.1). Again, the proposed portal function may be of value here by providing links to high-quality skills courses.

6.4.3 Professional and Clinical Judgement
ISCP should act as a nexus for mentors and mentees. It should also continue to facilitate the documentation of MSF, patient feedback, learning agreements and feedback from AES and CS. These areas could be rendered more functional. For example: MSF completion remains laborious, with too many steps required for the nominated rater. It should be simplified such that the trainee need only enter the rater’s credentials and email address. The rater would then automatically receive a single email with a direct link to the site where they could immediately complete the on-line form.
7  INDUCTION PROGRAMMES

7.1  Technical induction to ISCP, as the training management system, and to E-logbook

7.1.1  This is limited and could easily be improved without the need for a course or manned session by contracting a third party to produce interactive e-learning modules that including video. Appropriate media for both trainees and trainers should be made available. This might be an excellent place to cite the research supporting the validity and use of WBAs.

7.1.2  Disappointingly, only until recently has the “Help” section had any documentation attached to it. The ‘Step-by-step’ PDF guides are a step in the right direction.

7.2  Where does ISCP fit into induction to professionalism and being a surgeon and team player, i.e. becoming a trainee within a community of surgeons?

7.2.1  The degree to which an online tool can make a trainee genuinely reflect on these aspects of surgical life is limited. Professionalism and teamwork are largely attitudinal dimensions to being a surgeon where there is a big gap between knowing and doing or, said otherwise, preaching and practicing. Certainly, the moral duties of a surgeon, the definitions of professionalism, the required interpersonal and interprofessional skills and expected attitudes should be clearly stated and defined for reference within ISCP, but the crucial factor will always be the example set by trainers and peers.

7.3  Trainer role in induction to professional and personal activities

7.3.1  The trainer plays the critical role in developing the new trainee’s sense of professionalism and teamwork. This can only be effectively done through example. It is therefore essential to guarantee high-quality training of trainers and to foster a culture of professionalism, teamwork and patient-centred practice in the surgical community as a whole.
8 PORTFOLIO BUILDING

8.1 How can ISCP help build a portfolio?

8.1.1 This encompasses two separate issues. Firstly, how ISCP allows a trainee to construct an e-portfolio that faithfully and usefully documents training related activity. Secondly, it can also refer to the extent to which ISCP facilitates the training process that is documented within the e-portfolio. In the first case the current iteration of the portfolio does a reasonable job albeit with some limitations. The second issue is more contentious. Whilst a structured curriculum and clear goals may facilitate the development of a strong portfolio and more importantly a competent surgeon at the end of training, ISCP as it currently exists anecdotally fails to do so. This is partly due to the limitations of a distributed training curriculum and program, but principally because of the many problems that exist in delivering first class surgical training consistently in the majority of settings. More important to portfolio building, which is intimately related to an individual trainee’s needs and aptitudes, are mentoring, opportunities and commitment to training from the training program in general and individual trainers.

8.2 How does that help plan training?

8.2.1 The provision of clear goals and training requirements (both specific and generic) are critical to good training and ISCP performs reasonably well in this regard at least as far as the core components of surgical and subspecialty training are concerned. With respect to latter stage or highly specialised training, ISCP performs less well. This is due to the rapidly changing nature of training at this level and the need for a highly personalised programme. Arguably such training is peripheral to the aims of ISCP and is better managed by SACs, TPDs and individual trainers. There should however be a greater emphasis on supporting aspirational but realistic training and career planning particularly approaching CCT and in the immediate post-CCT period.
8.3 How can ISCP prepare for post-CCT revalidation?

8.3.1 This is key. ISCP should build towards a format that mirrors the requirements for revalidation so that when new consultants first revalidate the process is already familiar. In essence ISCP should be, in part, a template for revalidation, especially in the latter stages of training. Central to this function will be the seamless transfer of data to the Surgeons’ Portfolio and much improved functionality and integration of the e-logbook.
9 ASSESSMENT

9.1 When, What, Why and How Many?

9.1.1 We understand this question to relate to WBAs and the ARCP. WBAs as implemented within ISCP have been perceived to offer little to trainees by some. Many feel that they are token exercises serving only to enable members of the ARCP committee to pass a trainee if enough boxes have been ticked. Their formative benefit has been transformed into an unproven summative hurdle. It is widely acknowledged that WBAs are frequently gamed. This has fed the notion that they fail to aid training, fail to flag-up struggling trainees and fail to identify successful trainees. The positive case for WBAs in their present form has not been adequately made to either trainees or trainers.

The mandated number of assessments appears arbitrary and the controversy surrounding the unilateral increased requirement in the London Deanery highlights the contentiousness of the assessment process. Such regional variation is at odds with the notion of nationally standardised training. More importantly the value of these exercises as formative tools is lost as the previously flexible relationship that would normally have developed between individual trainees and trainers will be adversely affected by this unpopular and probably ineffective bureaucratic burden. The need to complete a large number of WBAs can become an onerous task if either trainer or trainee does not buy into the process. Assessments may be signed off with little thought or feedback, indeed, as has already been alluded to, there are even reports of trainers who have given trainees access to their ISCP accounts.

These factors lead to cynicism about the entire process. The implementation of WBAs also varies significantly. These assessments are, nevertheless, being used to pass or fail trainees with quantity used as an inappropriate surrogate for quality.

It is clear however that WBAs are likely to have an on-going role. ASiT calls for reform of their structure and their implementation.
9.1.2 **When?**

When possible. Both trainer and trainee need to be flexible, need to plan and need to make time to complete assessments. Clearly WBAs should be completed as close to the SLE as possible.

9.1.2 **What?**

CEX, CBD, MSF, and DOPS presently exist in a reasonable format. They are not over prescriptive and are useful in stimulating an SLE when a good trainer is involved. PBAs however are presently not in a good format. Whilst clearly useful in principal, they are cumbersome and over-detailed.

Requiring in excess of 55 separate fields for even minor surgery is counter-productive. A lot of the ‘generic’ domains (such as or ‘Explains likely outcome and time to recovery and checks understanding’ or ‘Ensures the patient is transferred safely from the operating table to bed’ or even ‘Controls bleeding promptly by an appropriate method’)) add little to the discussion of a specific procedure. Some of these could be reformulated into assessments of specific tasks (e.g. positioning patients) or assessed with other tools (e.g. CEX for consent).

The over-emphasis on minimally relevant detail may detract from the more meaningful, trainer-trainee directed discussion about specific events during a SLE. PBA assessment domains should be therefore be limited to more specifically relevant issues to the operation in question, allowing for less time spent ticking boxes.

Another solution would be to remove tick boxes entirely (leaving SAC determined steps for specific procedures as guidance notes for discussion) and simply relying on the experience of trainers to rate trainees using the current Level 0-4 or similar system plus free text comments. This functionality could also theoretically be integrated with the logbook and in either case would allow more frequent documentation of SLEs due to greater efficiency. More frequent completion of simplified assessment documents by experienced trainers might produce a more reliable and useful record of training.
9.1.3 Why?
We don’t question the need for assessment. We agree that WBAs can supplement and aid training. Clearly an annual assessment is essential – the ARCP delivers this sub-optimally at present as discussed in other sections.

9.1.4 How Many?
Certainly this should be standardised nationally. ASiT suggests that a national minimum number be set to permit an ARCP pass (~30 with the type-mix dependent upon training stage), but that bonus points should be awardable for going further than the minimum (contributing to an ‘enhanced’ ARCP outcome, e.g. with ‘commendation’, ‘merit’, ‘distinction’ etc.). This will provide a more positive impetus to seek out SLE.

9.1.5 Alternative
WBAs still strongly rely on the goodwill and personal opinion of the trainer. Non-evidence based nationally set minimum numbers with or without bonuses will still be worth nothing without engaged and motivated trainers. ASiT would also support the more radical step of an abolition of the WBA and a return to an assessment approach based on the logbook and regular structured written reports from a dedicated trainer in the context of a master/apprentice relationship where the trainer felt more personal responsibility toward their trainee – a tried and tested method without the false objectivity that WBAs appear to proffer.

9.2 Assessment for learning (formative) versus assessment of learning (summative) - driving lesson (supervised learning event) or driving test (assessment of performance)

9.2.1 Clearly trainees require both summative and formative assessment during their training. A further change in the assessment infrastructure and new nomenclature so soon after launch of the programme would not seem to be helpful. This is particularly true given the recent ISCP evaluation acknowledging a persistent problem with engagement by trainers. The most important factor in training remains an engaged and motivated trainer and trainee – no amount of novel taxonomy will change this.
9.2.2 Another difficulty in assessment is the distortion that may occur in documenting a trainee’s progress. This is often evident when recording areas for development that, anecdotally, can escalate from constructive feedback to areas of concern, particularly when formal documentation (in the portfolio) is viewed remotely and in isolation.

9.3 How should these interactions be recorded?

9.3.1 The current assessment tools, although imperfect and open to improvement, can be used to adequately document the majority of training interactions.

9.3.2 The problem is how this documentation is interpreted and used to support the trainee’s development as well as the extent to which the burden is fairly distributed among trainers.

9.4 What is appropriate feedback and how should it be done?

9.4.1 Feedback is best given verbally and then backed up by written documentation, ideally contemporaneously. Again the practicalities of completing the documentation mean that verbal feedback can be given and then a different impression conveyed in written feedback completed remotely. This is difficult to avoid in the busy clinical environment and is generally not a problem in a healthy trainer-trainee partnership.

9.4.2 Negative feedback is often free and forthcoming when performance is below par, whilst lacking for trainees performing well or adequately.

9.4.3 The current supervision structure (AES, CS, TPD) can mean that feedback at formal assessment times can be from trainers very unfamiliar with the trainee. Consideration could be given to requiring local appraisal by a panel of trainers (a local ‘ARCP-lite’) at the mid point of the training year.
9.5 Where should knowledge, clinical skills and technical skills be assessed – workplace, exam, or course?

9.5.1 The MRCS and FRCS examinations should test core theoretical knowledge, but clinical supervisors are best placed to evaluate a trainee’s knowledge in practice. This can only happen if they are engaged in the process of training and challenge their trainees throughout training to justify their clinical judgement (much in the style of FRCS viva examinations).

9.5.2 Although technical skills are assessable to some extent in a simulated environment, for the vast majority of tasks the lack of fidelity, both physical and situational, limits the usefulness of simulation as an assessment tool. Again, clinical supervisors should be best placed to evaluate technical competence, but this requires close supervision that is not universal, particularly of more senior trainees perceived to be competent in certain tasks.

9.5.3 Clinical skills are even more poorly evaluated than technical skills and again this can be attributed to the rapid decrease in supervision/observation that follows perceptions of competence. This can mean in some settings that once a basic, safe level is achieved trainees receive less training to improve skills further, thereby missing the opportunity to develop mastery under the supervision of an experienced trainer.

9.6 What should be trainer-led and what should be trainer-guided?

9.6.1 This slightly artificial dichotomy will vary according to trainer and trainee. A flexible arrangement without too much interference or guidance from above would be sensible.

9.7 E-logbook - methods to include outcome of operative practice in assessment process

9.7.1 The e-logbook is not fit for purpose at present. The concept is sound and the potential is there, but the current implementation is neither as useful nor as functional as it needs to be. The procedure coding remains haphazard with little evidence that there is drive to significantly develop the logbook further. Many procedures are not available and must be coded as “other”. There is no way of differentiating between doing part of a procedure and doing a complete procedure under supervision.
9.7.2 Matching reliable, unbiased outcome data to procedures is a Sisyphean task. This is hardly managed within the NHS at present despite a multi-billion pound IT budget. This sort of functionality is beyond the scope of the e-logbook at present. This is unfortunate as procedure logbooks are critical to training, audit, research activities and revalidation and as such the e-logbook is both an underdeveloped and untapped resource.

9.8 Rating levels - assessment rating reflects feedback, evidence of skills achievement consistent with CCT and global rating scores - are these sufficient?

9.8.1 We are unsure of the validity of the assessment ratings, as compared to the traditional subjective model, but clearly it is difficult to truly measure performance at CCT level. That is not to say there should not be an attempt, but we feel this should not be so black and white or objectified. Alternatives need to be considered in the light of perceived inadequacies of the current system.

9.9 Excellence versus good versus average

9.9.1 Although there are elements of relative performance rating within the WBAs developed for the ISCP, such assessments are arbitrary and subjective. A trainee’s identical performance may be “outstanding” to one trainer and “satisfactory” to another. Again, only rigorous training, assessment and audit of the trainers/assessors can overcome such quality issues.

9.9.2 Differentiating between excellent, good and average has never been a strength of medical training. Much of the evidence for good or excellent performance arises from largely self-directed activity or from situational opportunities not open to all trainees. Stratification of applicants to training programs and trainees within programs is inevitable. However, what has been lacking is a general commitment to allowing each trainee the opportunity to develop to the best of their ability, a relative rather than absolute scale of excellence. It should be the goal of a training program to strive for this rather than necessarily aiming to elevate the most able further, as this will occur naturally in any case and such individuals tend to seek additional opportunities of their own volition.
9.9.3 The basic aim of the program should, of course, remain to train a competent workforce, but this is more likely to be achieved if the bar is set higher.
10 ISCP AND ARCP – FAILING TRAINEES?

10.1 How can ISCP identify and support trainees in difficulty?

10.1.1 ISCP may be able to help identify trainees that are failing to progress. However, as has already been discussed, given the limitations of WBAs and other aspects of the ISCP process, we have concerns about the sensitivity and specificity of ISCP per se to identify trainees experiencing difficulty in their training. Trainees are largely free to select when SLEs and AoPs occur and, as such, can game outcomes to avoid the painful process of a difficult ISCP review – in effect, ISCP may offer a way for many struggling or borderline trainees to scrape by instead of being flagged up by a consultant who has had the opportunity to directly observe and reflect on a trainee’s performance over a reasonable period of time. ISCP methodology itself may dislocate responsibility and distract some trainers from really scrutinising and dealing with a trainee as they might have done previously (section 5.1). Nevertheless, ISCP does offer trainers opportunities to flag up struggling trainees and other than to suggest strengthening the links between trainers and ARCP panels (to facilitate the reporting of concerns) and providing more training for trainers, it is difficult to think of specific ideas that might help in this context with respect to ISCP. Nothing will replace the experienced opinion of a good trainer both in identifying and supporting trainees who could perform better but also in avoiding inappropriate escalation after anecdotal allegations or concerns.

10.2 Role of written feedback

10.2.1 Written feedback can be very helpful, if constructive in its intent. Providing written feedback allows a trainee to review comments at a later date, to appreciate the points that were made at the time of initial encounter, and also to reflect on progress made from that point. Written feedback is concrete and effectively permanent and should therefore be carefully considered, balanced and fair, particularly in the case of negative feedback or even constructive criticism for development. There should be consideration of any ramifications in the context of individual circumstances and past training experience, without compromising the ability of the program to identify genuine problems.
10.3 How can ISCP prevent trainees from failing to progress?

10.3.1 Early identification is key. This should not be left until the end when less can be done to turn circumstances around.

10.3.2 ISCP provides a structured way for trainees to demonstrate evidence of their progress in various domains. ISCP mandates a goal-setting learning agreement and interim meetings to see if these goals are being met. Each WBA, if done properly, allows trainer and trainee to discuss current progress and identify a problems or deficits in training early on and instigate changes to counter them.

10.3.3 One important feature, as already discussed, would be the addition of a “no fault” outcome at ARCP if a trainee’s placement has failed to provided adequate training.

10.3.4 Another feature might involve using e-logbook to flag up trainees to the TPD who are not getting adequate numbers of procedures. This could theoretically be automated, with pre-arranged thresholds setting alerts and would be facilitated by improved e-logbook functionality and anonymised appraisal of training trajectories in procedural skills.

10.4 How to encourage trainers and trainees to engage in process?

10.4.1 The ISCP process must be simple, intuitive, easy to navigate and rewarding. Feedback on individual use of the ISCP system should be provided to both trainers and trainees. It is essential for trainers to see how their input into ISCP compares to other trainers.

10.4.2 Fundamentally, the case for the benefit of WBAs and ISCP must be made. As with any medical intervention, training should be evidence based. An authoritative review might go a long way to convincing the many sceptics. This must not however prevent WBAs being appropriately redeveloped.
10.5 Does lack of engagement indicate likely poor progress?

10.5.1 Possibly. A lack of engagement on the part of the trainee could be due to numerous reasons other than inadequacy or unsuitability for a career in surgery, e.g. a lack of understanding of what is required, a lack of support from trainers, or a busy unit where both trainee and trainer struggle to make time to fill in portfolios.
## QUALITY ASSURANCE (QA)

### 11.1 Clarify the role of ISCP in quality assurance, quality management and quality control

#### 11.1.1 ISCP’s biggest drawback is that there is no quality assurance. The data entered into ISCP is heterogeneous and of highly variable quality; the interpretation of the results must therefore be made with caution. The fact that “data” as opposed to an opinion is generated after a period in training is no guarantee of quality, repeatability, comparability or reliability; indeed we believe this false objectivity is a fundamental weakness of many aspects of the ISCP assessment methodology.

#### 11.1.2 It is unclear what quality management infrastructure is in place. Monitoring would appear to be the preserve of the ISCP data group which, judging by reports to ASiT, is only recently addressing the ramifications of data analysis as it relates to the ISCP.

#### 11.1.3 True indicators of training quality are required to supplement the subjective data from the now mandatory JCST survey returns. Parameters might include:

i. Proportion of operative opportunities converted to supervised learning events allowing for complexity/trainee experience.

ii. WBAs completed by trainer/trainee.

iii. Availability of index cases.

iv. Unit profiles describing clinical activity and therefore opportunities available to trainees.

v. Academic output/activity indices.
12 References


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