

# **The ISCP Evaluation Report by Professor Michael Eraut**

Response to the JCST Discussion Document by  
the Association of Surgeons in Training

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On behalf of the ASiT Executive & Council

# 1 Introduction

- 1.1 The Association of Surgeons in Training (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 2200 members.
- 1.2 ASiT has previously noted the troubling content of the ISCP Evaluation Report by Professor Michael Eraut and welcomes the opportunity to contribute to the ongoing debate surrounding the ISCP and the future of surgical training.
- 1.3 We believe Professor Eraut's report correctly highlights the broad failings currently found in UK surgical training, over and above the original remit of his report. Given Professor Eraut's position as a non-surgical, independent observer of international standing in the field of education, this serves to emphasise the profound problems faced by surgical trainees, and which ASiT has sought to draw attention to for several years.
- 1.4 This response paper represents the consensus opinion of current surgical trainees following online discussion by ASiT Council.
- 1.5 Given the recent period of uncertainty regarding the use and implementation of the ISCP, ASiT would welcome further open debate in this area.
- 1.6 In the following document we respond in turn to questions posed by the JCST Discussion Document.

## 2 ASiT Response

- **Curriculum for surgical training**

- Allowing for the environmental factors identified in the Eraut Report, is the ISCP 'fit for purpose' as a curriculum for surgical training?
- What is good?
- What needs development?

2.0 The development of a surgical curriculum is to be welcomed but it is clear that this is work in progress and the finalised curriculum is still to be achieved. As such, it is not currently "fit for purpose" and unfortunately the principles of the ISCP have not translated into practice.

2.1 To use it properly is time-consuming and time is not allocated for this purpose.

2.3 The understanding of the customers (i.e. trainees and trainers) is sadly deficient in relation to the intentions of the ISCP. Workplace based assessments are generally not understood with regards to what they are actually for. All too often both the trainee and especially the trainer view these as summative and not formative tools; there is no clear validation of their utility for either role.

2.4 We do not believe that all Consultants that are allocated as trainers agree with the principles behind the ISCP and until this is achieved it will be difficult for trainees to gain the maximum benefit from it. This ultimately requires a paradigm cultural change to achieve understanding of this by both trainees and more so Consultant trainers.

2.5 The charging of a trainee fee for the JCST has unfortunately changed the whole emphasis of this initiative, with trainees rightly wanting the ISCP to be fully ready and "fit for purpose rather" than work in progress.

- **Quality of surgical training**

- What steps should be taken to ensure surgical trainers are 'engaged' with ISCP?
- Are surgical trainers equipped to deliver the ISCP?
- Is there a need for a new programme of faculty development, and if so who should deliver it?
- Should trainers be formally accredited? How and by whom?

3.0 Many trainees believe that the tools need to be fully developed and validated before it is worth developing the faculty and training them in these.

3.1 However, with regard to the faculty, "Training the Trainer" and TAIP are good but are often undertaken as a "cosmetic exercise" to certify ability to train. The role of Schools of Surgery should become more prominent; regular involvement and staff development should be a recurring theme.

3.2 Surgical trainers are frequently not equipped to use or deliver the ISCP. One major factor in trainee dissatisfaction with the website results from the current system of registering trainers with their trainees. Trainees email their educational supervisor, who then accepts them, and then the programme director activates this. This should happen automatically, as these steps are causing delays of months, making the website unusable during many four or six month attachments.

3.3 All users should require formal training and accreditation. Trainers need both a formal training 'carrot' and also a 'stick' approach to ensure they fully engage in the assessment process. This may be achieved through accreditation, incentivising and building training activities into Consultant job plans.

3.4 As trainees are now paying a fee, consumerism has been created. Trainees will demand that assessors are educated and accredited so they can provide the service that is now being paid for.

- **Culture of surgical training**

- Does the modern NHS provide a suitable training environment?
- How can a training culture be developed within a target driven service?

4.0 The current culture of the NHS has changed since many of our senior Consultants were trainees. The target driven and service orientated training culture that we all work in is not conducive to training. As the Erout report states, this has developed over a number of years but the current direction of travel continues to disadvantage trainees.

4.1 The NHS did previously provide the service base for an apprenticeship-style system, but now the experienced obtained is thin and needs supplementation with higher quality training. The increasing numbers of trainees currently in the system also dilutes training opportunities further.

4.2 A significant amount of central money is given to trusts for training (both salary costs and other budgets) and greater transparency and control of this money is required.

4.3 Until training targets are set and Trust performance measured against these targets then training will continue to be an after-thought. As the Darzi and Tooke reports have stated, the money must follow the trainee, and Trusts that no longer train will have to accept the increased costs of service provision.

4.4 There must be separation of the Deanery from the SHA, as their primary purpose is diametrically opposed. If Deans remain employed by the SHA, then they will be in conflict with the primary aim of their employer and therefore cannot independently act as a champion for training excellence.

- **Standards for delivery of surgical training**

- Is there a requirement for a more robust and explicit set of standards for surgical training?
- What form should these standards take?
- How could they be enforced?

5.0 While there is undoubtedly a role for standards in the future, currently there is a concern that while we concentrate on developing a robust and explicit set of standards the actual training delivered is essentially unchanged.

5.1 When standards are set in the future they should be both to ensure maintenance and improvement in training, and also to allow development of training targets against which the regulator can enforce financial penalties for the failing service.

5.2 Problem areas need to be identified quickly and training places removed promptly when problems are found. Continuing training in a failing post is risible, but too often happens.

5.3 Exactly who enforces this is less important than the fact they must have statutory authority, together with the “teeth” and willingness to effect change.

- **Time for surgical training**

- Is there enough time to deliver the training?
- Can the time frame be extended?
- What strategies could be employed to deliver training in the shortened time frame?

6.0 It is imperative that in the current training climate surgery as a speciality is allowed to opt-out of the EWTD, allowing trainees to work up to 65-hours per week as appropriate. This demand is driven by the representative surgical trainee bodies based on the views of their membership, and supported by the Surgical Royal Colleges and Speciality Associations.

6.1 Once this is achieved, training can be further optimised if the environment and working practices are altered to the benefit of training e.g. ward time as appropriate to the speciality, dedicated training lists, and clinics optimised for training rather than service.

6.2 With trainees primarily used as a service provider then there is never going to be sufficient time for adequate surgical training. As the Eraut report states, junior trainees spend an unnecessary amount of time on the wards and a balance must be achieved.

6.3 Novel strategies could be introduced such as utilizing a non-clinical training coordinator who marries experience and training needs to the potential training opportunities in a unit e.g. taking into account numbers based deficiencies in log books/competence etc.

6.4 Simulation, good quality regional training days and adequate 'study leave' funding for specialist courses are all important in delivering training in the allotted time.

6.5 Trainees should only be allocated to units that have been shown to provide adequate training. As not every unit provides good training (nor *can* all units provide it), ultimately and realistically this means that the number of training places needs to reduce to ensure that all training is of high quality.

6.6 The level of a CCT must be maintained and not diluted.

- **What is the purpose of surgical training**

- is every trainee on a CCT programme expected to achieve a consultant post?
- Is it necessary to review the future of the surgical workforce?

7.0 The purpose of surgical training in its broadest sense is to provide the surgical expertise which at the very least maintains the current level of surgical care and all that this entails (including continued tuition of the proceeding generation, service organisation and leadership and academic advancement of surgical care provision).

7.1 Every trainee enrolled on a programme ending in a CCT qualification should have a Consultant post at the end of training and after the CCT has been awarded.

7.2 With regards to reviewing the surgical workforce, an honest debate at Government and NHS employer level is required to discuss how they wish to provide surgical services in the future. Both patients and the profession are under the impression that this must continue to be Consultant based or led. If the Government or NHSE wish to alter this model then it must be debated with both the profession and public alike.