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Improving surgical training

Pilot training programme – independent evaluation

Evaluation report summary

SQW

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Evaluation summary

1. **Improving Surgical Training** (IST) is a pilot initiative designed to take forward the recommendations of a **Royal College of Surgeons** report, to support better training for surgeons. IST is based on a set of principles underpinning good training practices that have the support of all key stakeholders. It is a **multi-partner** project with implementation (in different ways) in England, Wales and Scotland; the Scottish experience is subject to different evaluation arrangements.

2. In England and Wales IST trainees commenced training in **2018** in general surgery; in **2019** the cohort in England included some vascular and urology trainee surgeons, with trauma and orthopaedics joining in **2020**. For the 2020 intake, sites working towards IST compliance hosted 92 IST trainees plus 28 core uncoupled IST posts.

The evaluation

3. **Health Education England (HEE) commissioned an independent evaluation of the IST pilots** across England in February 2019. SQW conducted this evaluation using evidence from document reviews, observations, surveys of trainees and trainers, case studies, and interviews with samples of IST trainees, core surgical trainees, trainers and stakeholders. Secondary data drawn anonymously from Annual Review of Competence Progression (ARCP) outcomes, the General Medical Council (GMC) annual trainee survey, preferencing data, work-based assessments and e-logbook data have been used.

4. The **structural challenges** facing any surgical training improvements are considerable, not least as responsibility for training is delegated across a very diffuse workforce. Trainees in general surgery and other IST specialties have been amongst the group most dissatisfied with their training in successive GMC surveys. These challenges have been **exacerbated by the effects of the Covid-19 pandemic**.

5. In conducting the evaluation, fundamental challenges have emerged. In England, the **IST pilot was designed more as a development programme than a pilot** experiment. Consequently, sites were offering IST posts that were not yet compliant with all the principles of IST. Other differences from a pilot programme emerged, associated with communication of IST goals and expectation management, resourcing for IST sites, stakeholder agreement and awareness, and the design of a compromise gateway for run through posts to ST3. Creating unequivocal evaluative assessments is therefore problematic. Nevertheless, the pilot has generated several lessons and examples of good practice that are transferrable between nations, sites and teams.

6. There was evidence from portfolio data regarding work-based assessments which indicated that **IST trainees, as a cohort, achieved higher standards than non-IST peers**. Similarly, logbook data demonstrated that across a selection of procedures, IST trainees progressed to a Performed procedure faster than their peers, and did more of them. The extent to which these were attributable to the quality of training available at a site, the supervisory experience, or the motivation and attitude of the candidate (and whether or not any of the above was affected by IST) is not possible to ascertain however. With regards to progression measured by all outcome categories recorded in the ARCP, IST trainees had similar rates of progression compared with their non-IST peers.

Transferrable learning

7. IST sites are generally those **with a reputation for good training, and typically attract motivated candidates**, committed trainers and offer a high-quality experience. Sites with less good training (IST or not) were not offered additional support to improve or sanctions when problems remained. This has the potential to create a two-tier system of training, with better performing sites having the advantage of attracting committed trainers and high calibre trainees.

8. Where IST sites implemented improvements, they benefitted both IST *and* their non-IST peers. The evidence indicates that IST therefore motivated practical improvements to rotas, supervision and placement design, but was predominantly in those sites committed to quality training.

9. **Simulation** was a requirement of IST but, unlike in Scotland, there was often a lack of investment in this area. Consequently, there were few significant changes evident arising from IST regarding simulation.

10. **Extended surgical teams** (ESTs) were part of many IST placements, although there remains debate regarding their costs versus utility, specifically for training improvements. Buy in to the EST model remains variable and can pose a barrier to its introduction. The ongoing HEE EST pilot is expected to provide insights regarding this, to be reported separately.

11. **Run through** was initially a core component of IST until uncoupled posts were introduced alongside in 2020. The rationale for run through was to provide stability for surgical teams, enhanced relationships, focussed training and more rapid progression, and it has proved popular with some trainees. The desire to include a gateway review point for run through postholders has proved problematic however. Some stakeholders also note that run through introduces rigidities into the system which reduces flexibility of workforce planning.

12. **Data availability** has been compromised by a lack of data sharing agreements between key partners. Data is also not routinely reported by equality, diversity and inclusion (EDI) characteristics.

Recommendations

13. The following recommendations are informed by study findings and conclusions, and are grouped into key themes.

Recommendations for governance and management

Recommendation 1. Maintain the Improving Surgical Care Assurance Board to continually improve surgical training, and involve employers in dialogue

ISCAB should be sustained with membership to reflect key stakeholder groups. Members of the Board should discuss with employers improvements to surgical training as part of an ongoing professional development dialogue. Training to meet the needs of the current and future workforce must be at the heart of service provision and resourcing discussions.

Recommendation 2. Implement a communication strategy to maintain and build on IST progress

Stakeholders broadly agreed that the early stages of the IST pilot involved planned communications and information. However, not all staff within surgical units were fully aware of what IST meant or involved. Any future developments to improve surgical training should embed a communications strategy to reach all those directly and indirectly affected. Introducing IST Champions (or similar) may help with disseminating messages at different levels across the workforce.

Recommendation 3. The evidence indicated that run through posts should only be offered where clear criteria are met:

- A proven and urgent need for this specialty (and end grade) in the workforce
- A personalised training programme (conforming with the curriculum and aligned with the context) is devised to accelerate trainee development.

Recommendations regarding the use and capture of evidence and data

Recommendation 4. The development of (and learning capture from) EST should continue.

Focus on consistency of job role descriptors, to ensure that postholder contributions as both service providers and learning facilitators are recognised. There is also a need to ensure that consultants appreciate the training and job roles of EST members, so that their contribution to service delivery and training can be maximised. Resourcing for ESTs should consider not just the costs of employing the posts, but also the time required to effectively develop postholders. Sharing learning emerging from the current EST pilot will likely prove key to this.

Recommendation 5. Monitoring trainee progress by EDI characteristic should routinely be reported

This is to ensure that any issues pertaining to inequalities of experience or outcome are identified so that positive action can be taken.

Recommendation 6. Design future pilots to generate evidence of effects

Pilot interventions for workforce development should be designed with discrete and clearly articulated objectives, to enable assessment of their effects.

Recommendation 7. Agree data sharing protocols based on informed consent to facilitate evaluation

GDPR necessitates informed consent for personal data to be shared. In future similar programmes where evaluation is anticipated, we recommend building requests for trainees to consent to evaluation research into existing recruitment or induction processes. Evidence of informed consent should be maintained and refreshed periodically.

Recommendations for resource allocation

Recommendation 8. 'Good' training sites should be allocated training roles

Sites that meet training quality criteria and consistently achieve good progression or examination results should be offered the number and type of specialty training places that they can accommodate. Sharing learning and good practice to inform practice in other settings is also recommended.

Recommendation 9. Poor training sites should be offered support to improve, with mechanisms in place for training posts to be removed

Sites that do not meet training quality criteria, and/or have consistently poor feedback from trainees, should be offered support and guidance to improve. If improvements are not forthcoming, we recommend training roles be withdrawn.

Recommendations for trainer/supervisor support

Recommendation 10. Different modes of trainer training should be offered

A blended offer of digital and face to face training to align with participant preferences and availability should be offered by either regional or national teams. We recommend considering whether to mandate aspects of trainer training, to support the adoption of key principles or ways of working.

Recommendation 11. Trainers should receive training CPD for PA allocation

Trainers should understand current curriculum requirements including use of the portfolio. CPD can include peer support and reflection, providing opportunities for trainers to share practical tips as well as space for reflection.

Recommendation 12. PA allocation should be linked to number of trainees

Trusts need to resource training in ways that are transparent and equitable. We recommend guidance regarding PA time be provided linked to trainee numbers, with feedback to explore the extent to which trainers can use allocated time.

Recommendations for delivery of training improvements

Recommendation 13. Training programmes should have one year placements with careful management of rotations

Placements of at least one year enable trainees to build relationships with supervisors, understand systems and manage their competence development.

Recommendation 14. Rotas should balance training time with service delivery

Service delivery should be recognised as an important element of learning in its own right, but it needs to be effectively managed to ensure space is reserved for on and off-site training, supervision, use of simulation resources and scheduled time in theatre. Local solutions for a 1 in 10 rota or the 60% training time equivalent need to be devised.

Recommendation 15. Continue to ensure that learning agreements are formulated early in a trainee's appointment

Learning agreements provide a useful way to record mutually agreed expectations from the outset. Emphasising the importance and benefits of these may prove useful in encouraging consistent development of agreements.

Recommendation 16. Trainers should proactively create training opportunities where gaps emerge in logbooks or curriculum requirements

In many cases trainees managed this process themselves by requesting theatre time, but this has not always been possible. We recommend emphasising the key role trainers can (and should) play in this going forward.

Recommendation 17. Trainees should have access to simulation facilities - and trainers should require that they are accessed

Simulation should be seen as an integral and essential part of the trainee experience. This requires effort to change the culture regarding simulation, as well as practical steps to enable access to high quality simulation resources.

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