General Medical Council

Trauma and Orthopaedic Surgery

Specialty Specific Guidance (SSG)

This guidance is to help doctors who are applying for entry onto the Specialist Register via the Portfolio pathway in Trauma and Orthopaedic Surgery. You will also need to read the Trauma and Orthopaedic Surgery CCT curriculum.

This document was last updated on 21/11/2023

Contents

Introduction

You can contact us and ask to speak to the GMC Specialist Applications team for advice before you apply. You are strongly advised to contact the JCST for guidance **before** you submit your application. The RCF has a resources page for Portfolio applications.

Framework of assessment

The requirements for Portfolio pathway is to demonstrate the knowledge, skills and experience (KSE) for specialist practice in the UK. The framework for assessing KSE will reflect the high-level learning outcomes (HLLOs) of the relevant specialty curriculum – in surgery these are the Capabilities in Practice (CiPs).

To be able to demonstrate you meet the CiPs* (HLLOs) required for specialist registration, you must be able to demonstrate that you are performing at the level of a specialist† i.e. successfully managing the unselected emergency take, clinics and ward care, operating lists and multi-disciplinary working, while also demonstrating that you hold the Generic Professional Capabilities (GPCs) required of all doctors.

There are five generic CiPs across all surgical specialties:

- Capability in Practice 1: Manages an Out-Patient Clinic
- Capability in Practice 2: Manages the Unselected Emergency Take
- Capability in Practice 3: Manages Ward Rounds and the ongoing care of In-Patients
- Capability in Practice 4: Manages an Operating List
- Capability in Practice 5: Manages Multi-Disciplinary working

A doctor applying must demonstrate they are capable of unsupervised practice in all the Generic CiPs (HLLOs) and GPCs.

A specialist in Trauma and Orthopaedic Surgery at the time of application will need to demonstrate that they have the:

- acquired the knowledge, clinical and technical skills in Trauma and orthopaedic surgery as defined by the syllabus
- acquired the knowledge and clinical skills to independently manage an unselected emergency Trauma and orthopaedic on-call take

* Some surgical specialties have specialty specific CiPs.
† A doctor on the GMC's specialist register.

Bear in mind you are not being assessed on your progress in acquiring the KSE, but that at the time of application you have the KSE to practise as a specialist. To ensure this you will need to provide current evidence of competency in all areas.

Currency of evidence across your portfolio

It is important that you are able to demonstrate that you are able to meet the CiPs at the time of entry to the specialist register. Up to date evidence of competency is key. Surgical practice changes regularly as new evidence emerges so it is important for patient safety that not only are your skills and experience current but you can demonstrate currency in the more generic skills that sit under the CiPs e.g., audit, research, teaching, communication skills. You will need to demonstrate currency of protocols and practice in light of most recent evidence. On this basis, evidence drawn from the last 6 years of clinical practice prior to submission (Whole Time Equivalent (WTE), does not need to be consecutive) will be considered.

Evidence of competency in the critical conditions (CBDs) and emergency index procedures (PBAs)

If you have had a break in practise in the last six calendar years 50% of your evidence of competency in the critical conditions (CBDs) and emergency index procedures (PBAs) should be drawn from the last 2 years clinical practise (WTE, does not need to be consecutive), as long as your last two years clinical practise (WTE, does not need to be consecutive) fall within the last five calendar years.

If you have been working less than full time your evidence of competency in the critical conditions (CBDs) and emergency index procedures (PBAs) should be weighted to your more recent years of practise.

The reason for this is that surgery is a craft speciality and it is important that you keep your skills up to date. Also, evidence of recent competency is important because surgical practice changes and develops quickly. Applicants need to provide assurance that they can deal with complications at the time of entry to the specialist register so the evidence will need to cover this.

Evidence of competency needs to be supported by evidence of involvement in presentations at Mortality and Morbidity Meetings and Clinical Governance to provide confidence that the applicant would be able to deal with an adverse event appropriately.

We advise that if you have been out of practice for 6 months or more directly prior to submission you may wish to defer your application until you have returned to practice. This will give you the opportunity to strengthen your application by gaining more skills and experience, as well as to

refresh your previously acquired skills. It will also allow you to demonstrate more recent competency in clinical skills. You are more likely to be successful if you can provide clinical evidence from current practice.

Structured reports

The structured reports are in a set format and the GMC will seek them. The reports are structured against the GPCs and CiPs. Robust reports will comment, give examples and list the evidence on which the comments are based.

Who should complete the reports?

Four reports from consultants who have observed your practice over the last two years of practice (WTE, does not need to be consecutive) prior to your application.

At least two of your referees should have current

- significant involvement in training, and
- knowledge of assessment processes.(for example be a Clinical Supervisor, Assigned Educational Supervisor, Training Programme Director or equivalent role.

One of these reports should be from the head of your specialty department in which you are currently working (this may be the Clinical Director if they come from your specialty).

How your evidence demonstrates the CiPs.

Each CiP requires integration of areas of learning including knowledge, clinical skills, professional skills and technical skills. In addition, a specialist will need to have acquired the generic skills, behaviours and values shared by all doctors in order to perform this task safely and well.

For example, managing the unselected emergency take (CiP 2) requires the integration of knowledge, clinical and diagnostic skills and technical skills, as well as communication and interpersonal skills, time management skills and many other generic skills described in the GPCs in order to be delivered safely, professionally and effectively.

The table below gives further explanation on how your evidence will be cross-referenced against the CiPs and the descriptors.

<table>
<tr><td colspan="2">Capability in Practice 1: Manages an out-patient clinic

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 care for safely and appropriately</td></tr>
<tr><td>Example descriptors:
Assesses and prioritises GP and inter-departmental 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 it to the patient and carries out the plan
Carries out syllabus defined practical investigations or procedures within the out-patient 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</td><td>Takes co-morbidities 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</td></tr>
<tr><td colspan="2">Evidence relevant to this CiP:</td></tr>
</table>

· Knowledge
· Skills, experience, and competence
· CPD
· Research- research underpins the evidence base for management of each patient and provides evidence for patient management protocols. In addition, research underpins surgical interventions as part of best practice. Applicants continuing in research and having current experience is important as we need to be confident someone can continue to be able to apply the findings in current research directly to the care of patients to improve their experience and outcomes.
· Medical Education and training - evidence of an understanding of, and participation in, medical education. Teaching and training in the workplace is an essential component of any consultant's job and sits in all the CIPs. Teaching and training is standard in all teaching hospitals to support workforce development.
· Audit and quality improvement- Clinical governance underpins everything (all the CiPs). In addition, QI is important in delivery of out-patient care and the out- patient clinic is especially important in terms of collecting data for audit.
· Management and leadership
· Multidisciplinary working
· Communication with colleagues
· Communication with patients
· Partnerships with patients –shares decision making with patients
· Consent in line with national legislation or applies national legislation for patients who are not competent to give consent- often work with specialist nurses on consent and other groups for those that lack capacity –consent often takes place in the outpatient clinic
· Dealing with complaints
· Working within appropriate health and safety legislation
· Working within appropriate information governance
· Working within equality and diversity legislation

Capability in Practice 2: Manages the unselected emergency take

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, delivers resuscitative treatment and initial management, and ensures sepsis is recognised and treated in compliance with protocol	● Demonstrates effective communication with colleagues, patients and relatives ● Makes appropriate peri- and post-operative management plans in conjunction with anaesthetic colleagues

• 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, accounts for and manages co-morbidity in the context of the surgical presentation, referring for specialist advice when necessary • Selects patients for conservative and operative treatment plans as appropriate, explaining these to the patient, and carrying them out	• Delivers ongoing post-operative surgical care in ward and critical care settings, recognising and appropriately managing medical and surgical complications, and 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 • Gives and receives appropriate handover
As for CiP 1 above In addition: • On call rotas – these are important to allow assessment of the amount of emergency work you have undertaken both within normal hours and out of hours. You should include rota patterns for each post held over the last 6 years (WTE, doesn't need to be consecutive) • Specialty Trauma course (ATLS or course covering the same training)	
Capability in Practice 3: Manages ward rounds and in-patients Manages all hospital in-patients 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 multi-disciplinary 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	• 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

requests, interprets and discusses appropriate investigations to synthesise findings into an appropriate overall impression, management plan and diagnosis	specialist advice as required, and discusses plans with the patient and their family • Summarises important points at the end of the ward rounds 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
As for CiP 1 above	
Capability in Practice 4: Manages the Operating list 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, co-morbidities, 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 the 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 the patient • Carries out the operative procedures to the required level for the phase 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
As for CiP 1 above	
Capability in Practice 5: Manages multi-disciplinary working Manages 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 of a consultant surgeon in order that safe and appropriate multi-disciplinary decisions are made on all patients with conditions requiring care within the specialty.	
Example descriptors: • Appropriately selects patients who require discussion at the multi-disciplinary team • 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 multi-disciplinary team in reaching an agreed management decision, taking co-morbidities 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 the patient, GP and administrative staff as appropriate • Manages time to ensure the case list is discussed in the time available • Arranges follow up investigations when appropriate and knows indications for follow up
As for CiP 1 above In addition: • Documentation is important as part of MDT and onward delivery of care. • Research –in addition to the reasons given for competencies in research you cannot contribute to a patient MDT discussion if you are not familiar with the evidence base for management plans • Multidisciplinary/interdisciplinary working is vital to CiP 5	

Submitting your evidence

Do not submit original documents. You must provide your evidence electronically – it's important that you follow the structure in our user guide when doing so.

You will need to make sure your evidence meets our requirements, this includes:

- Anonymising (redacting) identifiable information
- Verifying your evidence to confirm its authenticity
- Authenticating overseas qualifications
- Translating any documents not in English

It is important that you read and follow our guidance. If your evidence does not meet these requirements, it may not be included in your application.

How much evidence to submit

As a general guide, most applications contain around **800-1000 pages of evidence**.

This guidance on documents to supply is not exhaustive and you may have alternative evidence. You do not necessarily have to supply every type of evidence listed, but you must submit sufficient evidence to address each of the required learning outcomes and the associated descriptors. If you do not have all the evidence listed here, we recommend that you delay applying until you are able to gather it.

It will help us to deal with your application more quickly if you make sure that you send us only evidence that is directly relevant.

You must ensure you follow our guidance on how to present and group your evidence in the online application

Organising your evidence

Your evidence will need to be organised to reflect the structure of the online application. You should submit your evidence electronically under the correct section of your online application.

You should also submit the evidence requested about your training, qualifications and employment history and your CV in the format set out in the GMC's CV guidance. You will also be asked to nominate referees to provide structured reports.

You should provide sufficient evidence in each section, or the application may fail. **If you have a piece of evidence that is relevant to more than one area, do not include multiple copies in your evidence.** Instead, include one copy and list it in your application under each relevant area, stating that the evidence is located elsewhere, and you would like to cross-reference it.

Where we ask in our guidance, please group your evidence together to keep the number of individual electronic uploads manageable. This will need to be done prior to uploading on the GMC application. There are many software solutions widely available that can be used for converting documents/excel sheets/PowerPoint presentations and images to PDFs and combining PDF documents.

Evidence of training, qualifications, and employment

Substantial primary evidence for any previous training towards a medical qualification should only be submitted if the training is directly relevant to your capabilities and dates from the past six years (WTE). Otherwise, certificates of completion are sufficient evidence of training.

	Evidence of employment in posts and duties (including training posts)
CV	You must provide an up to date copy of your CV, which includes all the details listed in the guidance on our website.
Employment letters	Evidence of employment is only needed if it is proof of your eligibility to make the application i.e proof of training posts.
On call rotas	These are important to allow assessment of the amount of emergency work you have undertaken both within normal hours and out of hours. You should include rota patterns for each post held over the last 6 years (WTE, doesn't need to be consecutive)

Evidence of training and qualifications	
Primary medical qualification (PMQ)	**If you hold full registration with us, you do not need to submit your PMQ** as we saw it when we assessed your application for registration. If you do not hold registration, you will need to have your PMQ independently verified before we can grant you full registration with a licence to practise. You can find out more about primary source verification on our website. You only need to get your PMQ verified by our provider. The rest of your evidence should be verified in line with our guidance.

Knowledge

What your evidence should show	You must demonstrate knowledge appropriate for specialist practice in the UK. The Joint Committee on Intercollegiate Examinations (JCIE) specialty examination- FRCS (T&O) demonstrates this. If you do not have this exam then you can submit alternative evidence but you will need to bear in mind that this need to be very strong. To demonstrate evidence of depth and breadth of knowledge you could provide a portfolio to demonstrate appropriate levels of knowledge in Trauma & Orthopaedics. To be able to show the knowledge that meets the CiPs there needs to be evidence of summative assessment of specialty knowledge. The scope and format of the exam is very important, as it should allow for the testing of a broad range of knowledge. Therefore, the methods of testing and the length of the exam/parts of the exam is very important. In addition, a test of knowledge/examination should test more than recall of knowledge. It should allow for • interpretation, • decision making, • professional communication skills (including shared decision making and explanation in a patient scenario, • application of knowledge and higher order thinking. Higher order thinking requires the ability to extrapolate from knowledge to solve a clinical problem. • therefore the test should provide confidence that knowledge can be applied through critical thinking. The following are examples of part of a portfolio to demonstrate knowledge – although it is unlikely that any one item would do this: • The Joint Surgical Colleges Fellowship Examination (JSCFE). This examination on its own does not show knowledge appropriate for specialist practice. The scope and format of the two exams are different. Part 1 of the JCIE and JSCFE are the same. In part 2 the oral examinations are the same, but the clinical examinations are

different- the cases are shorter, do not test the same extent of knowledge (including upper and lower limb) and they do not include encounters with patients or volunteers, therefore do not test for complex patient interaction. The following may help address this:

1. Range of CEXs for upper and lower limb cases (to demonstrate clinical examination and diagnostic skills)

2. Range of CBDs for upper and lower limb cases (to demonstrate diagnostic and decision-making skills)

3. Evidence of communication with patients through 360 degree feedback, patient letters, appraisals and structured references.

- Other examinations including overseas qualifications, and versions of the FRCS issued by individual colleges that are not the JCIE exam. You will need to provide certification of success together with details of what the examination covers and to what level i.e. the scope and format of the exam. A certificate of success alone will not show that you currently have the appropriate level of knowledge. Decisions are made on a case-by-case basis.
- It is unlikely however that any qualification on its own, other than the JCIE exam will show knowledge appropriate for specialist practice.
- If you are considering supplementing a portfolio where you have a qualification which is not the JCIE/JSCFE with WBAs you need to bear in mind that they are considered to be a formative assessment, the purpose of which is to assess clinical skills rather than knowledge in a clinical situation. Furthermore, they are self-selected so cannot replicate the random element of an exam.
- Please note pre-ISB Examination versions of the Fellowship of the Royal College of Surgeons (FRCS) will not contribute to the portfolio. They show a very basic level of knowledge but not specialty specific or current.

Note about the European Board Examination - The European Board exams (FEBOT) are unlikely even in combination with other elements of a portfolio to show knowledge as described.

The scope and format is different in that generally they are shorter and therefore don't give the opportunity to display/test the same amount of knowledge.

They tend to test knowledge recall only and not

	• decision making, • professional communication skills (including shared decision making and explanation in a patient scenario), • application of knowledge and higher order thinking. Higher order thinking requires the ability to extrapolate from knowledge to solve a clinical problem. The gaps between the European Board exams and what is required for knowledge appropriate for specialist practice that meets with the CiPs are likely to be too large to be satisfied by other elements of the portfolio.
What evidence you should submit	FRCS (T&O) certificate. You should provide confirmation of this from the JCIE. Or A portfolio of knowledge, which shows comparable knowledge to the curriculum If you choose to provide a portfolio of knowledge then you will need to show how the individual elements of your portfolio combine to demonstrate knowledge appropriate for a specialist across the CiPs. If applicants do not hold the JCIE or a comparable qualification, they can aim to demonstrate the same level of knowledge by providing: A detailed, thorough and succinct cross-referencing mapping exercise, demonstrating how each and every JCIE competency (Part 1 and 2) has been covered in their own qualifications. The evaluators will then determine whether what has been provided is comprehensive enough to demonstrate the same level of knowledge as the JCIE. Applicants must be aware that as no other qualifications are considered directly comparable, this will be assessed on a case-by-case basis and will require the applicant to produce an extensive portfolio of evidence. If your portfolio includes other qualifications or tests of knowledge then you should supply the relevant syllabus / curricula, show what the qualification tests, and explain how it tests i.e. you need to provide details about the scope and format of the exam.

You will need to show how the individual elements of your portfolio combine to demonstrate knowledge appropriate for Specialist Practice in that specialty in the UK.

Skills and experience

Clinical experience

Applicants must be able to provide evidence of their ability to manage patients presenting with the full range of emergency and elective conditions in the generality of trauma and orthopaedic surgery.

At the time of entry to the specialist register applicants must demonstrate the surgical competencies in general trauma orthopaedic surgery and the principles of orthopaedics across the full breadth of the specialty and more specialist skills in two areas both elective and trauma. A specialist must provide evidence to demonstrate that they are currently emergency-safe for unselected emergency on-call take.

The evidence for this will include logbooks, consolidation sheets, WBAs and on call rotas. The oncall rotas are important to allow assessment of the amount of emergency work you have undertaken both within normal hours and out of hours. Include rota patterns for each post.

Critical conditions

The curriculum contains critical conditions. It is particularly important that you include CBDs or CEX for each critical condition.

The list of critical conditions covers a range of conditions where misdiagnosis or mismanagement can result in devastating consequences for life or limb. You should be able to provide evidence of performance at the appropriate level by completion of CBDs/CEXs in all the critical conditions to level 4. Because of the seriousness of these conditions, you need to show these competencies in a clinical setting and you must be able to provide current evidence.

The critical conditions are

- Compartment syndrome (any site)
- Neurovascular injuries (any site)
- Cauda equina syndrome
- Immediate assessment, care and referral of spinal trauma
- Spinal infections
- Complications of inflammatory spinal conditions
- Metastatic spinal compression

- The painful spine in the child
- Physiological response to trauma
- The painful hip in the child
- Necrotising fasciitis
- Diabetic foot
- Primary and secondary musculo-skeletal malignancy
- Major trauma resuscitation (CEX)

Index Procedures

You should bear in mind that Index procedures are of significant importance for patient safety and to demonstrate a safe breadth of practice.

Indicative numbers of index procedures are listed below. These numbers are the minimum we need to provide the assurance of patient safety. An applicant is only likely to have gained sufficient experience to be able to manage the range of pathology they encounter when these minimum numbers are met. Evidence is needed to show that they can manage these at the time of entry to the specialist register to show the standard of skills and experience of a specialist.

- Indicative number of total operations [P, T, S-TU, S-TS or A] - approximately 1800 in the last six years clinical practise (WTE, does not need to be consecutive).
- Indicative number of cases performed as first surgeon (P, T, S-TU, S-TS) = approximately 1260 in the last 6 years clinical practise (WTE, does not need to be consecutive).
- Indicative number of specific operation groups expected.

To demonstrate the outcomes of the CiPS, there should be documented evidence of performance at the level of a day-one consultant in the portfolio by means of 3 PBAs to level 4 in each specific operation group by two or more trainers.

For supracondylar fracture and external fixator application, an indicative number of 1 x PBA level 4 in a non-simulated setting is acceptable. One PBA may be assessed in simulation.

Elective	Indicative Number	Notes
Major joint arthroplasty	80	total elbow, hip, knee, shoulder, ankle replacements
Osteotomy	20	1st metatarsal, proximal tibia, distal femur,hip, humerus, wrist, hand, paediatric, spinal. NOT allowed are Akin, lesser toe and MT 2-5 osteotomies
Nerve compression	20	carpal tunnel, cubital tunnel, tarsal tunnel, spinal decompression, discectomy
Arthroscopy	50	knee, shoulder, ankle, hip, wrist, elbow
Emergency/trauma	**Indicative Number**	**Notes**
Compression Hip Screw for Intertrochanteric Fracture Neck of Femur	40	
Hemiarthroplasty for Intracapsular Fracture Neck of Femur	40	
Application of Limb External Fixator	5	
Tendon Repair for trauma	10	Any tendon for traumatic injury (includes Quadriceps and patella tendon)
Intramedullary nailing including elastic nailing for fracture or arthrodesis	30	femur shaft, long CMN for subtrochanteric fracture, tibia shaft, humerus, hindfoot nail
Plate fixation for fracture or arthrodesis	40	ankle, wrist, hand, femur, tibia, humerus, forearm, clavicle, arthrodesis e.g. wrist
Tension band wire for fracture or arthrodesis	5	patella, olecranon, ankle, wrist, hand
K wire fixation for fracture or arthrodesis	20	Wrist, hand, foot, paediatric
Children’s displaced supracondylar fracture	5	displaced fracture treated by internal fixation or application of formal traction

Logbooks and consolidated reports	
What evidence to provide	*Logbooks* You should provide full logbooks for the assessment period (see currency of evidence). The dates of these logbooks should correspond to the dates of the consolidation sheets above to show your operative experience is current and meets the curriculum requirements. Logbooks should be set out in the eLogbook format. If you do not provide logbooks in this format then it may not be possible to perform a proper evaluation of your skills and experience. *Consolidation reports* You should provide logbook consolidation reports for the same assessment period to correspond with your above submission of logbooks. You should provide: • an operative group report over the above period • SAC indicative procedures over the above period. All consolidation sheets need to be categorized by your involvement, e.g. assisting, performed, supervised with trainer scrubbed, etc. All evidence in this area must be anonymised for individual patient data.
How to present your evidence	Full logbooks should be uploaded per institution and named as follows: Institution – time period covered: *e.g. Stepping Hill – Jan 2016-Jan 2018*

	Please upload each consolidation report as a separate upload, ensuring the type and dates of the report are clear: e.g. SAC indicative group report – Jan 2014-Jan 2020

Workplace Based Assessments (WBAs)	
What your evidence should show	WBAs should be undertaken with different assessors in different settings on a variety of patients. WBAs completed retrospectively will hold no weight. It is very important that your WBAs are as meaningful as possible and therefore they should show evidence of feedback and guidance. They should include comments from your assessors and, where appropriate, demonstrate reflection by you. Block entries of 'satisfactory' are not acceptable. You should ensure you provide critical condition CBDs and emergency PBAs to correspond with your procedural experience in line with the currency of evidence position. The index procedures are common procedures in orthopaedic practice in the UK, and therefore a Specialist consultant in the UK can reasonably be expected to be proficient in these procedures.
What evidence to provide	• PBAs - 3 x Level 4 PBAs in each specific operation group listed above by two or more trainers except for supracondylar fracture and application of external fixator. • For supracondylar fracture and external fixator application, an indicative number of 1 x PBA level 4 in a non-simulated setting is acceptable. One PBA may be assessed in simulation. AND Critical conditions: • At least 1 CBD or CEX in each of the critical conditions to level 4
How to present your evidence	You should upload your evidence per institution and grouped as follows: <u>PBAs</u>

	Grouped and named by institution and index procedure: *e.g. Stepping Hill – PBA Emergency laparotomy x 2* PBAs for non-index procedures can be grouped by institution: *e.g. Stepping Hill – PBAs other – 2017-2019* Include all PBAs you have completed and ensure each index procedure is covered. <u>CBDs</u> CBDs for should be grouped by institution and type to demonstrate: *e.g. Stepping Hill – CBDs x 7 – emergency general surgery* Include all CBDs you have completed and ensure each critical condition is covered. You should provide an index for WBAs submitted – a suggested template for this in Annex A

CPD/Conferences

CPD/Conferences	
Evidence of up to date competencies in Advanced Trauma Life Support	The Advanced Trauma Life Support® (ATLS®), European Trauma Course, Definitive Surgical Trauma Skills course or equivalent locally provided course(s) meeting the outcomes described.
CPD	All doctors practising in the UK are required by the GMC to engage in CPD, to demonstrate that they are keeping their knowledge and skills up to date. It is important that you can show that you engage in CPD. Surgical practice regularly changes as new evidence emerges so involvement in CPD is vital to demonstrate currency of protocols and practice in light of most recent evidence.
Specialist conferences	Evidence of having attended conferences and meetings. It is recommended that you attend national or international meetings during the 6 years (WTE – need not be consecutive but must show involvement recent to your application) prior to your application (e.g. annual meetings of specialty associations or major international equivalents).

Research

Research	
What your evidence should show	Applicants must provide evidence of having met the relevant requirements for research and scholarship as set out under GPC 9. Broadly, this includes capabilities in 4 areas: 1. The demonstration of evidence-based practice 2. Understanding how to critically appraise literature and conduct literature searches and reviews 3. Understanding and applying basic research principles 4. Understanding the basic principles of research governance and how to apply relevant ethical guidelines to research activities. At entry to the specialist register, for patient safety, we need to be assured that someone can continue to be able to apply the findings in current research directly to the care of patients to improve their experience and outcomes.
What evidence to provide	You should provide a portfolio of evidence to meet the descriptors. Suggested elements could include: ● A higher degree by research at level 7 or level 8 (level 11 or 12 in Scotland or equivalents in Europe and the rest of the world) awarded would fulfil the research criteria, provided there is clear evidence that primary research was the larger part of the degree assessment. To support this, if time has elapsed, evidence to show you continue to be able to apply the findings in current research directly to the care of patients to improve their experience and outcomes. A current piece of reflection would show this. Alternatively, you should provide a portfolio of evidence to meet the descriptors. Suggested elements could include: ● The demonstration of evidence-based practice could be shown by: ○ Publications ○ Poster or podium presentations at national or international meetings

- As presenter of full audit cycles at regional (regional means greater than one trust or board area), national or international meetings
- Confirmation of involvement in national data collection with reflection on personal outcomes

- Understanding how to critically appraise literature could be evidenced by:
  - A research degree
  - Regular evidence of journal club activity including outcomes and evidence of your role and participation
  - Publications where your role is clear and substantive
  - Evidence of understanding research methodology at Master's level evidenced by awarding of degree
- Understanding and applying basic research principles could be evidenced by:
  - high quality indexed publications where your role is substantive and clear
- Understanding the basic principles of research governance and how to apply relevant ethical guidelines to research activities can be shown by:
  - a GCP course in Research Governance and a current course in Research Methodologies
  - Authorship of papers where your contribution is substantive
  - Poster or podium presentations given at national or international meetings by you as presenter
  - Recruitment into a research ethics committee approved study or into a multi-centre observational study. Evidence should include the trial protocol, REC approval, patient information and evidence of consent for each included patient
  - Membership of a research collaborative with demonstrable published outputs

None of these suggestions are mandatory, but they are presented to give examples of evidence that may be submitted. You may have other evidence which you wish to submit as evidence of research and scholarship.

	It is suggested at least one piece of evidence is submitted for each of the 4 areas. Evidence should include assessment by peers (e.g. peer reviewed publications, presentation submitted subject to peer review with subsequent invitation for presentation). You should state which piece of evidence is for which area.

Medical education and training

Medical education and training	
What your evidence should show	Evidence of an understanding of, and participation in, medical education (see GPC 8- Capabilities in education and training) The GPCs require you to • carry out the roles and responsibilities of a clinical trainer • meet any regulatory or statutory requirements as a clinical trainer or educator. You must provide evidence of being trained in the training of others and present written structured feedback on their teaching. This is important and relates to all the CiPs. Particularly to • Team working. • Understanding training needs • sharing of clinical governance. It also provides feedback for communication skills by fellow health workers.

	You need to demonstrate: • participation in medical education – and feedback on this • understanding of educational theory underpinning adult learning, application to surgery, teaching methods, assessment principles). A course may be a way of doing this.
What evidence to provide	Evidence you <u>should</u> include: • 'Training the Trainers' course or equivalent. (An equivalent course to 'Training the Trainers' would be one covering educational theory underpinning adult learning, application to surgery, teaching methods, assessment principles). Provide the syllabus and details; This course should also cover undertaking assessments such as Work based assessments (WBAs) • Lecture slides to show your involvement in training; (Strong evidence would be slides aimed at a variety of learners e.g. Allied Health Professionals, students) • Evidence of participation in teaching and training for example • timetables which clearly show your involvement in training • Evidence from instances of ad hoc training (feedback from others, your own reflection) • A variety of written structured feedback from those taught(from at least 3 different sessions rather than 3 students in the same session You <u>could also</u> include: • Evidence of assessing others (3 pieces of evidence-e.g. WBAs at least 2 different forms e.g. a PBA and 2 CBDs) (this would be strong evidence) • an OoT; • Appraisal which confirms and details your role in teaching and training.

How to present your evidence	Please group and upload evidence by teaching activity with a clear description: *e.g. Stepping Hill – Foundation doctor training – Presentation, feedback and timetable – 2018*

Quality Improvement

Quality Improvement	
What your evidence should show	Evidence of an understanding of, and participation in, audit or quality/service improvement. See GPC 6 which requires you to • participate in and promote activity to improve the quality and safety of patient care and clinical outcomes. • design and implement quality improvement projects or interventions that improve clinical effectiveness, patient safety and patient experience
What evidence to provide	**The evidence of audit should make clear your role in the process.** Surgeons need to participate in audit continuously and this feeds into all the CiPs, QI, improving quality and safety of patient care and clinical outcomes.

	Applicants must provide evidence of completing or supervising 3 audit or quality/service improvement projects in the last 6 years (WTE). In at least one of these, the cycle should be completed. Evidence of audit could include: • Slides of an audit presentation are that prove that the audit was presented for example an audit certificate, or a copy of the programme where it was presented. • Audit reports; • Presentations of audit work. The evidence should show clearly your role in the audit.
How to present your evidence	Please group and upload evidence by audit activity with a clear description: *e.g. Stepping Hill – Audit and re-audit of General xxx clinic – 2016-2017 – audit lead* You should provide your audits in reverse chronological order Audits should also be listed in reverse chronological order in your CV. Audits should also be listed in reverse chronological order in your CV.

Management and Leadership

Management and Leadership	
What your evidence should show	Evidence of leadership and having taken part in a management related activity are essential as evidence of communication, partnership and team working. All of these are vital to patient safety. Involvement in the Clinical Governance delivery provides for better patient safety. Management and leadership - ○ an understanding of management structures and challenges of the health service in the training jurisdiction. ○ being aware of the legal responsibilities and be able to apply in practice any legislative requirements relevant to your jurisdiction of practice. ○ training in health service management and leadership ○ having taken part in a management related activity e.g. rota administration, trainee representative, membership of working party etc. or of having shadowed a management role within the trust.
What evidence to provide	An understanding of management structures and challenges of the health service in the training jurisdiction, including of being aware of the legal responsibilities and be able to apply in practice any legislative requirements relevant to your jurisdiction of practice. Suggested evidence could include: ○ A course on UK health service management. The course should provide you with an understanding of management structures and challenges of the NHS. You should provide evidence of the course content. ○ A reflection on the above (only need 1 course and piece of reflection)

	Training on health service management and leadership Suggested evidence could include one of the following: o Leadership courses / modules / training /coaching. o Reflection on the above piece of evidence Evidence of having taken part in management and leadership activities that shows your role with evidence of involvement in specific role within the last 2 years of clinical practice (WTE, does not need to be consecutive) – This could be evidence showing: o rota organisation o clinical lead, o audit lead, o committee chair o educational leadership role etc. If you are going to provide only one piece then it needs to be recent and significant (i.e. more than just being rota coordinator). If there are several pieces in the 6 years WTE then we can be more accepting of less significant or recent evidence. You should also provide reflection on management and leadership activities - see GMC Guidance. The Academy and COPMeD Reflective Practice Toolkit gives advice about reflection https://www.jcst.org/-/media/files/jcst/key-documents/reflective-practice--toolkit-aomrc-copmed.pdf.
How to present your evidence	Please group and upload evidence by activity with a clear description:

	e.g. UK NHS Management course and course programme with reflections July 2023

Additional evidence

The following application sections list suggested evidence to demonstrate outcomes. Some evidence may be used to demonstrate more than one outcome. If you are cross-referencing your evidence in this way, it will help your evaluators if you provide an explanatory statement/cover note in each section.	
Multidisciplinary working	Evidence could include • 6 examples of communication between you and colleagues across the multidisciplinary teams. This type of evidence could include referral letters, emails between colleagues • A specific MSF or 360 from the members of a MDT the applicant works with (one) in addition to the other MSF you have been asked to provide. • If MSF or 360 is not available you may provide specific feedback from colleagues on your communication across the multidisciplinary team. Minimum of 3 with feedback from 3 different disciplines • Involvement in MDT meetings -can be shown by your role at MDT meetings including presenting relevant case history (e.g. minutes from MDTs which include details of the discussions around patients and show your role clearly – it should show you presenting at these meetings); • Communication with all members of the multi-disciplinary team in reaching an agreed management decision • Shared decision making;

	• Robust structured reports • Appraisal (2x cycles of recent appraisal- one of which should be in the last year WTE) • General MSF (including from MDT and Patients)-at least 2 MSF or equivalent more than just the surgical team
Communication with colleagues	• Participation in MDT meetings –evidence of your participation and the role you played in at least 2 MDT meetings • Project work e.g. audit involving the multidisciplinary team • Referral letters between colleagues (2 letters to patients, 2 referrals to another consultants, 2 consent documents and 2 discharge summaries.) • Hand overs (2) • Robust Structured reports which comment on this • Appraisal (2x cycles of recent appraisal) one of which should be in the last year WTE) • MSF (including from MDT and Patients) - at least 2 MSF or equivalent
Communication with patients	• Letters demonstrating communication with patients, for example referral letters about patients ;(2 letters to patients, 2 referrals to another consultant, 2 consent documents and 2 discharge summaries.) • Feedback from patients (e.g. MSF) MSF (including from MDT and Patients)-at least 2 MSF or equivalent

	• Robust structured reports • Appraisal (2x cycles of recent appraisal) one of which should be in the last year (WTE) The Academy of Medical Royal Colleges (AoMRC) has provided guidance about writing to patients: Please_write_to_me_Guidance_010918.pdf (aomrc.org.uk)
Partnerships with patients and obtaining consent	• Courses relating to consent. (Most GCP courses have a module on consent) 1 course/module • Feedback from patients and colleagues relating to consent. 2 pieces which specifically mention consent- the 3 items below could provide this • robust Structured report which comments on this • Appraisal (2x cycles of recent appraisal) one of which should be in the last year (WTE) • MSF (including from MDT and Patients) - at least 2 MSF or equivalent
Dealing with complaints	• Evidence of complaints handling together with reflection. If you have not been involved in any complaints comments in relation to this should be clear in the below: • robust structured reports that refers to these, • May be covered in appraisal – the appraiser will need to refer to this directly

Working within appropriate health and safety legislation	• Relevant courses and reflection, could be covered by mandatory Trust courses (these courses are those such as Infection Control Clinical', 'Safeguarding Adults' and 'Safeguarding Children'. These should be recent on the last 2 years (WTE) • Participation in Mortality and Morbidity Meetings and Clinical Governance • robust structured report that refers directly to the courses and confirms they are current • May be covered in appraisal – the appraiser will need to refer to this directly **It is important that this evidence shows you are able to work safely in the NHS and understand the relevant legislation and protocols**
Evidence of working within equality and diversity legislation	• Relevant courses and reflection - this could be covered by mandatory Trust courses; Should have recently attended EDI courses/modules • robust structured report that refers to these • May be covered in appraisal – the appraiser will need to refer to this directly

Annex A – Index for WBAs

Example Index for PBAs index procedures

This should be uploaded to your application with the description “Index for PBAs – Hospital name – date covered”

Procedure	Assessor	Date of assessment	Outcome	Pg number

Example Index for CBDs/CEX

This should be uploaded to your application with the description “Index for CBDs – Hospital name – date covered”

Critical condition	Assessor	Date of assessment	Outcome	Pg number
Compartment syndrome (any site)				
Neurovascular injuries (any site)				
Cauda equina syndrome				
Immediate assessment, care and referral of spinal trauma				
Spinal infections				
Complications of inflammatory spinal conditions				
Metastatic spinal compression				
The painful spine in the child				
Necrotising faciitis				
Diabetic foot				
Primary and secondary Musculo-skeletal malignancy				
Major trauma resuscitation (CEX)				