General Medical Council

Trauma and Orthopaedic Surgery – August 2026 (version 3) curriculum update

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.

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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 the Portfolio pathway are 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

You 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 six years of clinical practice prior to submission (Whole Time Equivalent (WTE), does not need to be consecutive (e.g. a career break)) 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 two 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 specialty 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.

You may need to rotate to another hospital/unit if your primary place of work does not offer the breadth of experience required, to ensure that you can demonstrate the breadth of competencies required across the specialty.

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 six 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, 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 are 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 at Annex B gives further explanation of how your evidence will be cross-referenced against the CiPs and the descriptors.

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.

It is essential to organise your evidence in a way that is easily accessible and digestible for the evaluators. Please use tables where required (see Appendix A) to provide an index as a reference when required and signpost any key information where required. It can be very helpful to get advice on presentation from a colleague who has previously had a successful outcome.

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 relevant to each section, or the application may fail. There are instances where your evidence might also apply to other sections, and, for ease of reference, please provide an index to clearly map where the evidence can be found in your application.

On an occasion where you have a piece of evidence that is relevant to more than one area of your application, please 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.

Reflection

Where you provide reflection as part of your evidence, you should ensure that this directly relates to the primary evidence of the topics and instances you are reflecting on. AI-generated or generic reflections may not do this as they tend to be generic, rather than specific, personal examples. More weight will be given to your reflection where this includes specific topics/instances, your experiences, what you learned, and how this has been applied to your area of practice.

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.
	Please include a clear statement indicating which curriculum update version you are applying against – Version 2 August 2024, or Version 3 August 2026
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 six 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 needs 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.

- We can consider 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 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 they cannot replicate the random element of an exam.

PLEASE NOTE INFORMATION ON THE FOLLOWING EXAMS:

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. An applicant would need to submit additional evidence with their portfolio to make up for these gaps.

FRCS: Pre-ISB Examination

- The pre-ISB Examination versions of the Fellowship of the Royal College of Surgeons (FRCS) are not applicable. They show a very basic level of knowledge and are not specialty specific or current.

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 are 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, together with 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 you do not hold the JCIE or a comparable qualification, you can 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 your 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 on-call 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 infection in an adult or child
- Complications of inflammatory spinal conditions
- Metastatic spinal compression

- Acute painful hip in a child not including infection
- Physiological response to trauma
- Primary bone/joint infection in a 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 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 six 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 3x PBAs at level 4 in each specific operation group by two or more trainers.

For supracondylar fracture and operative management of a long bone fracture in a child application, an indicative number of 1x PBA at level 4 in a non-simulated setting is acceptable. 1x PBA may be assessed in simulation.

Elective	Indicative Number	Notes
Major joint arthroplasty	80	Total elbow, hip, knee, shoulder, ankle replacements
Osteotomy **Or:** Osteotomy (10 or more) + arthrodesis (10 or fewer) to make up a total of 20 cases.	20	Osteotomies can include: 1st metatarsal tibia, femur, hip, humerus, wrist, hand, paediatric, spinal. NOT allowed are: Akin, lesser toe and MT 2-5 Osteotomies. Fusions can include: Foot and ankle joint fusions, spine fusions, hand and wrist fusions. NOT allowed are: lesser toe PIPJ/DIPJ fusions (these can count towards k-wire indicative procedures).
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**
Fixation of a neck of femur fracture (DHS/proximal femoral nailing)		40
Hemiarthroplasty for Intracapsular Fracture Neck of Femur		40
Application of Limb External Fixator	10*	*Up to 2 can be completed on a saw bone.
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
Cercelage compression technique for fracture or	5	Patella, olecranon, ankle, wrist, hand

arthrodesis		
K wire fixation for fracture or arthrodesis	20	Wrist, hand, foot, paediatric
Children's displaced supracondylar Fracture	5 5	Displaced fracture treated by internal fixation or application of formal traction
Operative management of a long bone fracture in a child	5	

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 report 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.

	Injections in any site do not count as part of the indicative numbers or in any of the totals. **Principles of counting cases:** Unbundling of cases i.e. splitting up standard operations into two or more parts in order to count multiple cases is forbidden. As a principle, one patient counts as one operation. **Exceptions include the following:** Bilateral cases may count as two operations. Two or more operations on the same patient in different anatomical sites may count as multiple operations e.g. wrist and ankle. Two large operations on one patient may count as two operations e.g. pelvic and femoral osteotomy for DDH.
How to present your evidence	**Please upload a single consolidation report as a separate upload, ensuring the type and dates of the report are clear. These need to be filtered to show the last six-year (WTE) assessment period, e.g.** • SAC indicative group report – Jan 2020 - Jan 2026 • Operation group report – Jan 2020 – Jan 2026 **Full logbooks should be uploaded per institution and named as follows:** Institution – time period covered: *e.g. Stepping Hill – Jan 2024-Jan 2026*

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 which appear to be completed retrospectively will hold no weight. Therefore, please ensure you indicate when the procedure took place and the date of the assessment. WBAs should ideally be signed off by the Assessor on the day the assessment took place. 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 - 3x 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 1x PBA level 4 in a non-simulated setting is acceptable. 1x PBA may be assessed in simulation. AND Critical conditions: • At least 1x 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: PBAs Include all PBAs you have completed and ensure each index procedure is covered. CBDs Include all CBDs you have completed and ensure each critical condition is covered. **You should provide an OVERALL table index for WBAs submitted – a suggested template for this in Annex A** **Your evidence will be verified by each hospital, so please group your WBAs into as few PDF files as possible by WBA type and institution (e.g. all index procedure PBAs from Stepping Hill in one PDF file).** **Please ensure your indexes clearly reference where in the document the respective PBAs/CBDs are located.** **Please refer to the ANNEXES at the end of this guidance for index tables to assist you in collating your evidence.** **Please avoid submitting anything other than the required Level 4 PBAs/CBDs for indicative numbers unless particularly relevant to your experience in a particular sub-specialty, and it is signposted as to why they have been included.** **DOPS are not usually accepted as valid evidence for Portfolio Pathway applications. DOPS are designed to facilitate developmental feedback, most commonly at core training level and are not intended to demonstrate independent specialist practice.**

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.
Evidence of competency in non-technical skills	NOTSS 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

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 four 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 four 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.

Publications – please upload copies of the full publication document, so the evaluators can review the full paper content, not just the first page or a link to the publication. The evaluators will not follow hyperlinks to online websites.

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 ideally including feedback • Timetables which clearly show your involvement in training and ideally including feedback • 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 3x different sessions rather than 3x students in the same session) You <u>could also</u> include: • Evidence of assessing others (3x pieces of evidence-e.g. WBAs at least 2x different forms e.g. a PBA and 2x 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

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 3x audit or quality/service improvement projects in the last six years (WTE). In at least one of these, the cycle should be completed. Evidence of audit could include: • An audit certificate or a copy of the programme where it was presented. **PLEASE NOTE:** Slides of an audit presentation alone are not proof that the audit was presented. • Audit reports; • Presentations of audit work. • Assessment of Audit (AoA) 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 – 2024-2026 – audit lead* Audits should also be listed in reverse chronological order in your CV.

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 training on health service management and leadership (only need 1x course and piece of reflection)

	Suggested evidence could include one of the following: ○ Leadership courses / modules / training /coaching. ○ 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 two years of clinical practice (WTE, does not need to be consecutive) – This could be evidence showing: ○ rota organisation ○ clinical lead, ○ audit lead, ○ committee chair ○ educational leadership role etc. If you are going to provide only one piece of evidence, then it needs to be recent and significant (i.e. more than just being rota coordinator). If there are several pieces in the six 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 primary and secondary evidence to demonstrate outcomes. Primary evidence can generally be supported (but not replaced) by secondary evidence. 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	
Appraisal	You should aim to provide evidence which demonstrates engagement with an appraisal process as well as its use in determining future learning objectives / development needs. **Suggested primary evidence:** • Two cycles of appraisal within the assessment period (ideally consecutive) – this should include your most recent appraisal at the time of submitting your application to the GMC. • Separate Personal Development Plans if not included in the above.

Multidisciplinary team working	You should provide evidence which demonstrates attendance and participation at formal MDT meetings as well as your skills in working with colleagues of other disciplines. **Suggested primary evidence:** • Formal MDT attendance lists to show attendance • Copies of patient referral to MDT forms • Involvement in MDT meetings by means of presentations (and / or minutes including involvement in discussions) and formal outcome letters / forms **Suggested secondary evidence:** • Examples of communication with all members of the multi-disciplinary team in reaching an agreed management decision or other examples of shared decision making with colleagues • A specific MSF or 360 from the members of an MDT you work with • Testimonial Letters from colleagues from other disciplines
Communication with colleagues	You should provide evidence which demonstrates clear and open communication with colleagues leading to agreed management decisions. **Suggested primary evidence:** • Formal referral letters to other clinicians that you personally have compiled and signed off • Individual handover sheets/discharge summaries that you have personally compiled and signed off • Mobile phone screenshots – complete audit trail of conversation to show shared decisions regarding care leading to a formal letter **Suggested secondary evidence:**

	• Letters requesting opinions (e.g. MDT outcome meeting letters to other participants seeking confirmation on the appropriate patient pathway of care) • Communication with colleagues about shared projects • Comments from your appraisal specifically referencing your ability to communicate with colleagues.
Communication with patients	You should provide evidence which demonstrates clear and open communication with patients ensuring information presented is clear and concise. **Suggested primary evidence:** • Direct letters to patients that you personally have compiled and signed off • Discharge letters that you personally have compiled and signed off **Suggested secondary evidence:** • Comments in other sections of your evidence demonstrating higher-order thinking when communicating with customers i.e. use of interpreters, selecting suitable environments etc. • Thank You cards/letters from patients
Partnerships with patients and obtaining consent	You should provide evidence which demonstrates your ability to form successful partnerships with patients and obtain consent as well as your knowledge of current UK legislation. **Suggested primary evidence:** • Courses relating to consent, e.g. GCP course with a module on consent • CEXs related to consent taking • Consent forms noting conversation with the patient on consent and signed by the patient • Preoperative and perioperative letters to the patient related to the risks and benefits of surgery

	Suggested secondary evidence: • Feedback from patients to you related to the consent process • Thank You cards/letters from patients • Comments from your appraisal specifically referencing your ability to obtain consent
Learning from complaints	You should provide evidence which demonstrates your commitment to learning from complaints and patient safety investigations as required in the General Professional Capabilities **Suggested primary evidence:** • Example of learning from a complaint and changes made to the practice as a result; this should include: • Outline of the complaint, either in the form of a redacted letter or email • Your response to the complaint • Reflective statement, including what changes have been implemented as a result to prevent re-occurrence **Suggested secondary evidence:** • Evidence of your complaint discussed in a governance meeting or other relevant meeting attended. • Feedback and/or letters about your handling of a complaint and the impact of changes made to your practice as a consequence. • Comments from your appraisal specifically referencing your learning from complaints. • Course related to learning from complaints. **In the rare instance where you have not been directly involved in a complaint,** you should provide the following: • In the absence of this being specifically mentioned by your appraiser, you should provide a letter from

	your clinical supervisor confirming that no personal complaints have been received and/or a reference to this in your appraisal. **AND** • You should provide recent primary evidence demonstrating a commitment to learn from patient safety investigations and complaints. This could be demonstrated by means of a Datix incident, or an incident that has happened to you, or a colleague or in the department, that has caused you to reflect on your practice and make changes. **OR** • Evidence of a complaint discussed in a governance meeting or other relevant meeting you have attended, along with a reflective statement on how you would have responded if the complaint had been about you, and any key learning points you would have applied to your practice. • Course related to learning from complaints.
Working within health and safety legislation	You should provide evidence of being able to work safely and understand relevant legislation and protocols. **Suggested primary evidence:** • A relevant Mandatory Trust course covering modules such as: 'Infection Control Clinical', 'Safeguarding Adults' and 'Safeguarding Children'. These should be recent courses - in the last two years. **OR** • In the absence of a mandatory record, relevant courses with course outline/modules (as above) related to infection control, and safeguarding adults and children. These should be recent courses in the last two years. **Suggested secondary evidence:**

	• Examples of working within H&S in practice: such as demonstrable participation in Mortality and Morbidity / Clinical Governance meetings which specifically reference H&S matters discussed at and outcomes • Section of your appraisal specifically referencing you working within appropriate health and safety legislation.
Working within information/data governance/GDPR legislation	**Suggested primary evidence:** • A relevant Mandatory Trust course. This should be recent - in the last two years. **OR** • In the absence of a mandatory record, relevant courses with course outline/modules related to both information governance and data protection legislation. These should be recent courses in the last two years. **Suggested secondary evidence:** • Examples of this in practice – e.g., redacting identifiable patient data from a paper, respecting patient anonymity when presenting M&M cases. • Comments from your appraisal specifically referencing you working within information/data governance/GPDR and legislation.
Working within equality, diversity and inclusion legislation	**Suggested primary evidence:** • A relevant Mandatory Trust course. This should be recent - in the last two years. **OR** • In the absence of a mandatory record, relevant EDI courses with course outline/modules. These should be recent courses in the last two years.

	Suggested secondary evidence: • Examples of working within EDI in practice - e.g. identifying the use of interpreters for patients where English is not the first language. • Comments from your appraisal specifically referencing you working within EDI.

Annex A – Indexes for WBAs

Example Index for Level 4 PBAs (index procedures)

This should be uploaded to your application with the description "Index for PBAs – Hospital name – date covered". Please consider the use of hyperlinks between your index and PBA uploads for ease of reference for the evaluators.

Index procedure (Grouped by Procedure)	**Assessor**	**Date of Procedure**	**Date of Assessment**	**Level**	**Page no(s).**
Osteotmy	Name of Trainer	12/04/2024	14/04/2024	4	Please indicate where and on which upload it is located. Insert hyperlink here.
Osteotomy	Ensure at least 2x different trainers for each procedure)				
Osteotomy					
Fixation of Neck of Femur Fracture					
Fixation of Neck of Femur Fracture					
Fixation of Neck of Femur Fracture					
Major Joint Arthroplasty					
Etc.					

Example Index for Level 4 CBDs/CEX (Critical Conditions)

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

Critical Condition	Title of CBD/CEX	Assessor	Date of Assessment	Level	Page no(s).
Diabetic Foot	Your specific case	Name of Trainer	12/04/2024	4	Please indicate where and on which upload it is located. Insert hyperlink here.
Cauda Equina Syndrome					
Necrotising fasciitis					
Etc.					

Example Index for Medical education and Training (similar can be used for Management and Leadership, Research, etc. Anything that helps clarify and organise your evidence is welcomed)

Event/Activity	Date (most recent first)	Evidence Type	Location
Training the Trainers Course BOA	12 September, 2025	Certificate and Reflection	Please indicate where and on which upload it is located. Cross-Reference as needed. Insert hyperlink here.
Lead Organiser of CT Teaching and Specific Hospital	August 2023-July 2024	Timetable, Lecture Slides and Feedback from Trainees	
OOT for Proximal Femoral Fixation	1st September 2023	OOT form completed by Trainer A.	
Etc.			

Annex B – CiPs and descriptors

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

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
- 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

Evidence relevant to this CiP:

· 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

<table>
<tr><td>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
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</td><td>Demonstrates effective communication with colleagues, patients and relatives
Makes appropriate peri- and post-operative management plans in conjunction with anaesthetic colleagues
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</td></tr>
<tr><td colspan="2">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)</td></tr>
<tr><td colspan="2">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</td></tr>
<tr><td>Example descriptors:
Identifies at the start of a ward round if there are acutely unwell patients who require immediate attention</td><td>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</td></tr>
</table>

• 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 requests, interprets and discusses appropriate investigations to synthesise findings into an appropriate overall impression, management plan and diagnosis	• Identifies and initially manages co-morbidity and medical complications, referring on to other specialties as appropriate • Contributes effectively to level 2 and level 3 care • Makes good use of time, ensuring all necessary assessments are made and discussions held, while continuing to make progress with the overall workload of the ward round • Identifies when further therapeutic manoeuvres are not in the patient's best interests, initiates palliative care, refers for specialist advice as required, and discusses plans with the patient and their family • Summarises important points at the end of the ward 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	• 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 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	• 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