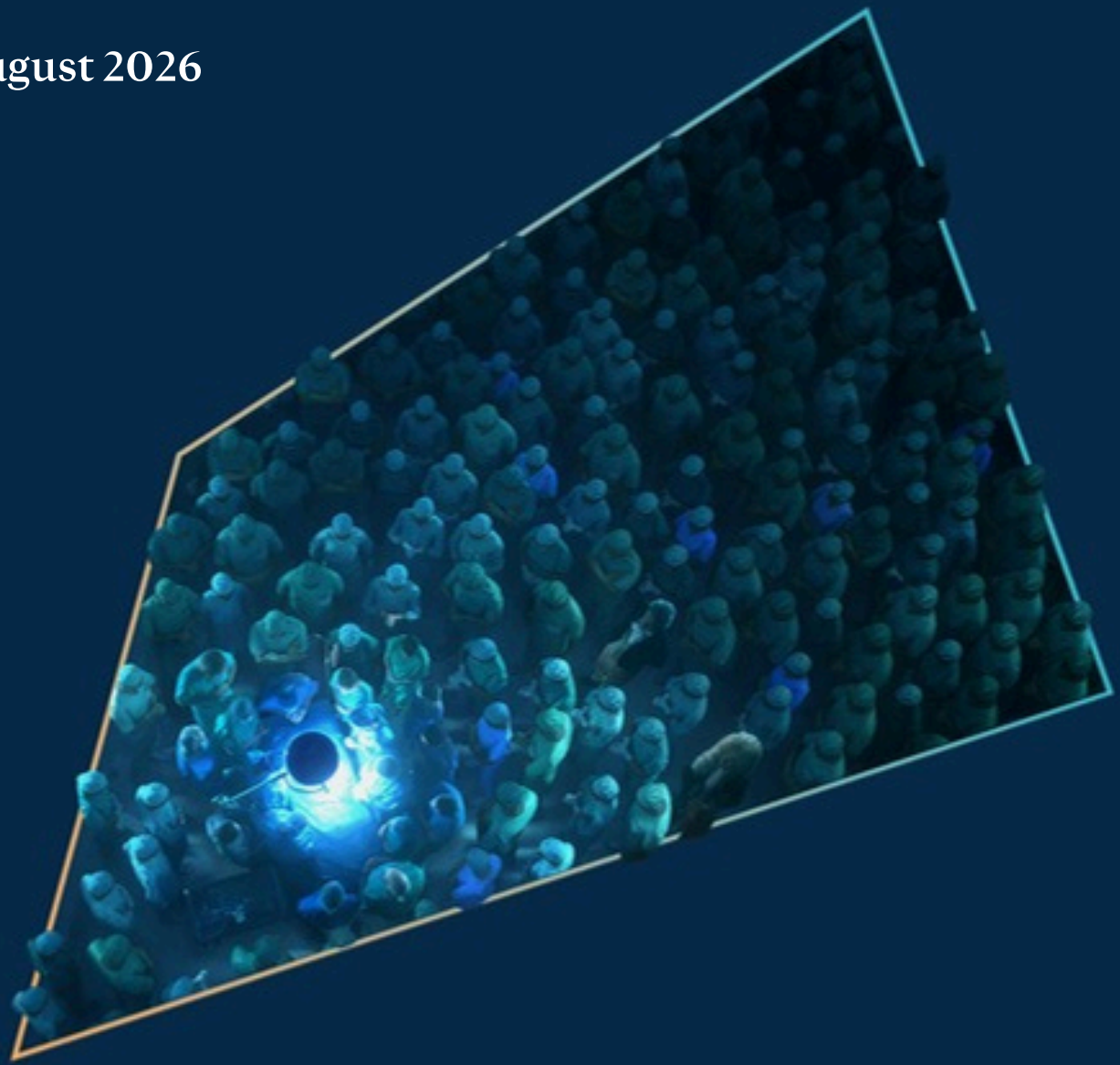
The ROYAL COLLEGE of SURGEONS of EDINBURGH

Locally Employed Doctor Best Practice Guidance and Implementation Checklist

August 2026



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1. Introduction

The landscape of surgical training in the United Kingdom has undergone a fundamental transformation, driven by systemic bottlenecks, shifting professional aspirations, and an increasing reliance on a flexible medical workforce.

Historically, progression from the Foundation Programme to Higher Surgical Training followed a linear trajectory, primarily mediated through the Core Surgical Training (CST) framework. However, the contemporary reality for many junior doctors is characterized by a "bottleneck" at the entry point to formal training, where the number of qualified applicants significantly exceeds the available National Training Numbers (NTNs).

This discrepancy has given rise to a substantial and growing cohort of Locally Employed Doctors (LEDs)—often holding titles such as Clinical Fellows, Trust Grade SHOs, or Junior Clinical Fellows—who provide essential surgical services while operating outside formal deanery-managed training structures.

For many doctors, the decision to opt for a locally employed role rather than a CST post is a strategic move to gain focused experience in a specific subspecialty, address personal geographical requirements, or enhance their portfolio in anticipation of a highly competitive ST3 recruitment cycle.

This "Alternative Pathway" to ST3 Higher Surgical Specialty national selection represents a pragmatic professional response to these structural constraints. Nonetheless, despite their critical role in maintaining the resilience of elective and emergency surgical services, LEDs have historically faced inconsistent access to structured mentorship, validated theatre time, and formal educational oversight.

This Best Practice Guidance and Implementation Checklist is designed to address this inequity collaboratively. Rather than imposing rigid, contractually binding mandates, this framework establishes a voluntary standard of professional support modelled on successful workforce initiatives. By adopting these recommendations, surgical departments can foster a supportive training environment that aligns with the educational governance of the Royal College of Surgeons of Edinburgh (RCSEd).

This guidance is built on the principle that clinical service delivery and high-quality training are mutually reinforcing; by actively supporting the development of their LED workforce, hospital departments can attract higher-calibre candidates, improve clinical safety, and reduce reliance on short-term locum staffing.[1]

2. Aligning LED Practice with the CREHST and ISCP Syllabi

The secondary goal of this guidance is to provide LEDs with the practical opportunities required to successfully navigate the technical and administrative requirements of the ST3 application process.

The CREHST Form as a Gateway

The Certificate of Readiness to Enter Higher Surgical Training (CREHST) is the mandatory evidence of equivalence for ST3 applicants who have not completed a recognized UK CST program. It is a rigorous, high-stakes document, and any omissions or formatting errors can lead to immediate longlisting rejection.

Surgical departments should ideally be structured to facilitate the requirements of the CREHST form, noting the following key clinical and administrative parameters:

- The Three-Month Rule: Consultants can only sign off on competencies if they have worked with the applicant for a minimum of 3 months. Stable, long-term local posts are therefore vastly superior to transient locum work for career progression.
- Distributive Sign-Off: If a single supervisor feels unable to sign off the totality of the CREHST competencies, departments should facilitate a collaborative sign-off, where multiple consultants initial the specific sections that they have personally supervised.
- GMC Standard Verification: All contributing consultants must complete their own separate declaration sections fully and legibly.

Outcome-Based Curriculum and ISCP Integration

Since 2021, UK core surgical training has operated under an outcome-based curriculum, mediated through the Intercollegiate Surgical Curriculum Programme (ISCP). Progression is measured against Capabilities in Practice (CiPs) and the Multiple Consultant Report (MCR), which assesses whether a candidate is performing at the level of a Day-1 registrar.

To demonstrate equivalence, LEDs should be supported in aligning their practice with the core CST curriculum benchmarks:

Curriculum Requirement	Core Training (CST) Standard	LED Best Practice Benchmark
Logbook Volume	Minimum 120 cases per year.	120 cases with documented training supervision.
Work-Based Assessments (WBAs)	Min 3 CBDs, 3 CEXs, and 3 DOPS per 6-month post.	3 WBAs of each type per 6-month placement.
Educational Supervision	Assigned Educational Supervisor (AES).	Named AES to establish a Learning Agreement.
Multi-Source Feedback (MSF)	Minimum one MSF per year (12 responders).	Facilitated annual MSF cycle via local appraisal.
Audit / QIP	One completed audit/QIP cycle per year.	One closed-loop audit with verified design and execution.

3. Specialty-Specific Portfolio Strategy

While the CREHST form acts as an eligibility gatekeeper, the portfolio self-assessment determines an applicant's shortlisting ranking. Departments should aim to structure LED roles to help candidates target high-scoring domains in their desired specialty.

General Surgery ST3 Portfolio Alignment (2026 Criteria)

The 2026 General Surgery recruitment process highly values consistent, specialty-specific experience and validated operative volume.

- **Experience Scoring:** Maximum points (8 points) are awarded for spending 13 to 36 months in General Surgery post-foundation. To claim these points, candidates must spend at least 4 months in both unselected emergency and elective General Surgery.
- **Complementary Placements:** Spending at least 4 months each in 2 or more related specialties (e.g., T&O, Urology, Vascular, ITU, A&E) awards 4 points.
- **Operative Volume (Appendicectomies):** Completing 36 to 70 appendicectomies (laparoscopic and/or open) as STS, STU, P, or T awards the maximum of 10 points. Departments should support LEDs in accessing emergency lists to achieve this benchmark.
- **Logbook Verification:** Every single page of the submitted logbook (including cover sheets) must be individually verified with a legible consultant signature, printed name, and GMC number. Gaps or unverified pages will result in the application being downgraded to a minimum score.
- **Audit Standards:** Simple or highly generic audits (e.g. Trust-wide VTE compliance, simple operation note audits, or antibiotic prescribing compliance) are no longer accepted for ST3 points. Departments should steer LEDs toward high-value, closed-loop clinical audits with documented design, execution, and presentation stages.

Urology ST3 Portfolio Alignment (2026 Criteria)

- Urology selection places significant weight on technical procedural competence and academic leadership.

- **Procedure Validation via WBAs:** Candidates can score up to 20 points for demonstrated competence in index urological procedures: Scrotal procedures, Cystoscopy, Circumcision, and Stent insertion. Note: Logbook summaries alone are no longer accepted for these points; candidates must submit validated Work-Based Assessments (WBAs) showing Level 4 competence signed by a consultant.

- **Urology-Specific Audits:** To score full points (up to 4 points for closed-loop audits and 2 points for urology-focus), audits must be on a urological topic. Generic ward audits conducted on a urology ward do not count.

- **Teaching Leadership:** Scoring maximum points (4 points) in the teaching domain requires the candidate to be the principal organizer of a course lasting ≥ 4 hours or carrying the equivalent of 4 CPD points. It would be helpful if departments could help LEDs organize regional or local training courses to meet this standard.

Trauma & Orthopaedics (T&O) ST3 Portfolio Alignment (2026 Criteria)

T&O recruitment emphasizes structured preparation, specialty commitment, and clear portfolio organization.

- **Clinical Placements:** Requires a minimum of 24 months of surgical experience post-foundation, including at least 10 months in T&O.

- **Mandatory Courses:** Advanced Trauma Life Support (ATLS) or equivalent is a mandatory prerequisite at the time of interview.

- **Evidence Organization:** For 2026, a specific metric (2 points) has been introduced for the structural organization, labelling, and clarity of the submitted self-assessment evidence. LEDs are advised to seek feedback from their educational supervisors on the organization of their digital portfolio.

4. Best Practice Guidance Standards (The 5 Pillars)

To foster a balanced, high-quality, and operationally feasible training environment, surgical departments should aim to align with the following five pillars of best practice.

Pillar 1: Clinical Training and Operative Experience

Access to operating theatres is one of the main cornerstones of surgical development. Strategic scheduling can expand training capacity for both formal trainees and LEDs.

- **Surgical List Access:** Departments should aim to schedule all surgical trainees (CST and LEDs) for a benchmark of at least two training-appropriate operating theatre sessions (half day) per week (pro-rata for less than full-time staff).[1]

- **Supervised Practice:** Consistently identify opportunities where the LED can act as the primary operator under direct supervisor scrubbed conditions (STS/STU), aligning with their ISCP learning goals.

- **Outpatient and Emergency Take Integration:** Integrate LEDs into outpatient clinics (targeting one session per week) and emergency take rotas to develop critical diagnostic decision-making and patient management skills.

Pillar 2: Academic Development and Portfolio Support

To rank highly in competitive national selection, LEDs require structured time and departmental mentorship to build their academic portfolio.

- **Job Plan Professional Activity:** Best practice recommends that full-time LED job plans include a minimum of one 4-hour session per week of Supporting Professional Activity (SPA). This session should be protected from clinical duties and dedicated to audit, research, teaching, and portfolio development.[1]

- **Mentored Quality Improvement:** Provide active consultant mentorship for clinical audits, steering LEDs away from generic audits and toward robust, closed-loop projects that demonstrate clinical impact.

- **Encouraging Non-Clinical Leadership:** Leadership opportunities—such as rota coordination, audit lead, or student teaching coordinator—should be made available to LEDs, which directly contributes to their portfolio leadership points.

Pillar 3: Educational Equity and Study Leave

Educational development relies on access to professional study leave and academic resources.

- **Study Leave Allocation:** LEDs on contracts of 6 months or longer should be able to take up to five days of study leave per 6 months and have access to reasonable study leave funding. [1]

- **Exam and Course Support:** Facilitate reasonable shift swaps and professional leave to support LEDs sitting mandatory examinations (e.g. MRCS) or attending curriculum-essential courses (e.g. ATLS, BSS).

PILLAR 4: Workplace Wellbeing and Professional Respect

A supportive, inclusive working culture is vital for patient safety, clinical performance, and staff retention.[1]

- **Comprehensive Induction:** Ensure all LEDs receive an effective departmental induction upon commencement, outlining how to access clinical supervisors, logbooks, and study leave policies.

- **Mentorship and Pastoral Care:** Offer LEDs access to a named mentor or "buddy" (distinct from their clinical supervisor) to provide professional guidance, career advice, and pastoral support.

- **Wellbeing and Fatigue Management:** Align scheduling and rest facilities with the principles of the BMA Fatigue and Facilities Charter to support safe working hours and reduce burnout.

Pillar 5: Transparency and Recruitment

Clear, honest recruitment practices benefit both the department and the applicant.

- **Transparent Job Descriptions:** Job advertisements for LED roles should explicitly outline the prospective training opportunities, expected SPA time, and availability of educational supervision.

5. The RCSEd LED Best Practice Checklist

This checklist is designed as a practical, collaborative audit tool to be completed annually by the Clinical Director (or Educational Lead) and the Locally Employed Doctor. It utilizes a RAG (Red-Amber-Green) rating system to identify areas of excellence and opportunities for development.

RAG Rating Definitions:

- **Green (G):** Fully implemented and consistently practiced.
- **Amber (A):** Partially implemented or actively planned.
- **Red (R):** Not yet implemented or unavailable.

Domain & Best Practice Indicator	RAG Rating (R/A/G)	Required Actions / Evidence of Compliance	Target Date	Responsible Lead
1. Educational Governance & Supervision				
A named Assigned Educational Supervisor (AES) is allocated within 2 weeks of starting.				
A formal Learning Agreement is completed and signed off on the ISCP portfolio.				
An annual medical appraisal is scheduled, incorporating personal development plans (PDP).				

2. Clinical & Operative Training				
Job plan reflects a benchmark of at least two training-appropriate operating lists per week.[1]				
LED has regular, documented access to outpatient diagnostic and management clinics.				
Timely consultant validation of logbook sheets and Work-Based Assessments (WBAs).				
Consultants facilitate the three-month exposure requirement for CREHST sign-off.				

3. Academic & Portfolio Support				
Job plan includes a minimum of one protected 4-hour SPA session per week.				
Active consultant mentorship is provided for a closed-loop clinical audit or QIP.				
Opportunities are provided to organize and deliver structured medical teaching.				
LED has access to departmental or trust leadership roles (e.g., rota coordinator).				

4. Leave, Funding & Wellbeing				
LED has access to study leave benchmarks equivalent to national guidelines (10 days/year).[1]				
Professional leave is supported for sitting mandatory postgraduate exams (MRCS).				
A comprehensive departmental induction is delivered upon employment.				
A named professional mentor or peer "buddy" is offered to the LED.				

5. Recruitment & Transparency				
Job description explicitly states available training opportunities and educational support.				
Department incorporates SAS/LED representatives in workforce and recruitment planning.				

7. Role of the RCSEd and Regional Networks

The Royal College of Surgeons of Edinburgh remains committed to supporting Locally Employed Doctors through dedicated educational, professional, and pastoral frameworks. The College has previously published a guidance document highlighting the key resources available to this group for their career development and advancement[2].

SupportEd & Mentorship

The RCSEd SupportEd initiative provides a comprehensive suite of resources designed to assist surgeons at all career stages.[1] This includes access to professional development webinars specifically targeting the alternative pathway, portfolio building, and interview preparation. Furthermore, the RCSEd Surgical Mentoring Scheme connects LEDs with experienced consultants across the UK, offering an independent source of career guidance and pastoral support.[1]

The SASL Committee

The RCSEd SASL Committee actively advocates for non-deanery doctors at national workforce policy levels. The committee focuses on developing specialty-specific educational courses, enhancing leadership opportunities (such as the Future Leaders Programme), and supporting senior LEDs on the Portfolio Pathway (formerly CESR) to achieve specialist registration.[1] Through these networks, the College provides a professional home that celebrates and supports the diverse career trajectories of the modern surgical workforce.

Works Cited

1. SAS development guidance | NHS Employers, 2025. Accessed 19 May 2026, https://www.nhsemployers.org/publications/sas-development-guidance

2. RCSEd Resources for SASLED Surgeons and Dentists Career Development, October 2024. Accessed 19 May 2026. https://www.rcsed.ac.uk/news-resources/rcsed-news/2024/october/rcsed-resources-for-sas-led-surgeons-and-dentists-career-development

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The Royal College of Surgeons of Edinburgh

Established in 1505, the Royal College of Surgeons of Edinburgh is the UK's oldest medical professional body. With over 34,000 members and fellows in over 100 countries, we exist to improve the quality of surgical care by setting surgical standards and delivering the best possible training, education and professional development activity worldwide. As the majority of our membership is based in the UK, we also work directly with NHS bodies, government and other policy makers to enhance their surgical services and address the multiple challenges the NHS faces.

Core Trainee Forum

The Core Trainee Forum (CTF) was established by core surgical trainees, with the mission to enhance surgical training for those at the beginning of their careers. Recognising a significant gap in support and resources for trainees at this stage, we understand the challenges many face in obtaining quality training while meeting the essential requirements for advancing to higher surgical training. We are passionate about supporting the surgical aspirations of core trainees across the UK and aim to bridge this gap by offering high-quality teaching resources and career-building opportunities. Our goal is to empower surgical trainees to excel during these crucial years and successfully secure a position in higher surgical training.

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