Trauma and orthopaedic curriculum update

Cronan Kerin and Deepa Bose on behalf of the Curriculum Writing Group

Cronan Kerin is a Consultant Knee and Trauma Surgeon in the Liverpool University Hospital Teaching Hospital Major Trauma Centre. He is the current Chair of the Specialist Advisory Committee for T&O.

Deepa Bose is a Consultant in Orthopaedic Trauma and Limb Reconstruction at the Queen Elizabeth Hospital Birmingham. She is Chair of the Specialist Advisory Committee for T&O, BOA Honorary Secretary, BOA Vice President Elect (from mid-September 2026) and is the Past Chair of World Orthopaedic Concern UK. Deepa has been on the Emergency Response Team of UK-Med, a first response team for international disaster relief, since 2012 and regularly participates in humanitarian projects in Guyana, Gaza and Ukraine.

The 2026 curriculum update will come into effect at the beginning of August this year. This builds on the excellent work of those involved in the previous iterations. Trauma and Orthopaedics (T&O) was the first surgical speciality to have its curriculum approved by the Postgraduate Medical Education and Training Board in September 2006. At the time, it was hailed as an exemplar for the other surgical specialities. Numerous people were involved in the production of this groundbreaking document. However, Tony Banks, Dame Clare Marx, David Rowley, Lester Sher and David Pitts all deserve particular mention.

This marks the culmination of a long and exhaustive process where the curriculum was reviewed by the Curriculum Writing Group. All the proposed changes were then discussed with multiple stakeholders, including patients, trainers and trainees. The Heads of School and Lead Deans were also consulted. Once this process was completed, the curriculum was then submitted to the GMC for their approval. As one would imagine, there were some queries raised before everything was approved. This whole process involved multiple hours of work by those within and outside of our speciality. The Joint Committee on Surgical Training (JCST) support from Chris Fowles (ISCP lead) and Maris Bussey (Head of ISCP) was particularly helpful in formulating responses to all of the queries raised.

Whilst our syllabus has largely remained the same for several years, the speciality is changing rapidly. The roles and responsibilities of a 'day one' consultant ten years ago are not necessarily the same today. Practices vary widely across the country, and even within regions, there are differences in practice between specialist and major trauma centres compared with district general hospitals. Given this situation, it remains challenging to formulate a syllabus that is essential for all of us, retaining the core principles of trauma management whilst allowing for the development of specialist practice.

"Whilst our syllabus has largely remained the same for several years, the speciality is changing rapidly. The roles and responsibilities of a 'day one' consultant ten years ago are not necessarily the same today."

The proposed changes for 2026 have been informed by representatives from all the subspecialties of T&O in the UK and the British Orthopaedic Trainees Association (BOTA). None of the changes are a major departure from the old syllabus. The proposed changes reflect the evolving practice in the speciality and are intended to align the syllabus with this. Similarly, it is not anticipated that they will affect the portfolio pathway significantly, apart from the new mandatory workplace-based assessments (WBAs).

For trainees, a separate transition plan has also been provided, but essentially, only trainees below the level of ST6 are expected to transition to the new curriculum. Derogations are also provided. This can be seen in Figure 1. For those applying for entry onto the Specialist Register via the Portfolio Pathway, the changes will come into immediate effect. A new version of the Speciality Specific Guidance is in the process of being ratified and will be available in the near future.

Details of the changes are given in the edited version of the curriculum, which can be found at www.iscp.ac.uk/media/1479/proforma-mapping-document-to-surgery.pdf. The changes are all freely available on the Intercollegiate Surgical Curriculum Programme (ISCP).

Summary of the changes in the new 2026 curriculum

Trauma and orthopaedic syllabus (Appendix 2)

Several of the knowledge levels for phase 1 and phase 2 have been changed to reflect the level expected from core (phase 1) and speciality (phase 2) trainees.

Non-technical skills for surgeons has been added to the syllabus. Evidence demonstrates that these have a significant impact on surgical performance and surgical outcomes. We consider these skills to be an essential part of becoming a surgeon. This is another example of T&O leading the way, as we are the first surgical speciality to include this in their curriculum. During the stakeholder discussions this was favourably received by all groups, especially our patients. The safe use of radiation in theatre has also been added, as this important topic has recently been brought to light, following the publication of some papers showing an increased incidence of breast cancer in female orthopaedic surgeons.

Certain topics have been combined to avoid repetition and to make them more holistic; for example, 'Pain and pain relief' and 'Behavioural dysfunction and somatisation' have been combined into 'Management of pain and pain-related behaviour'. This is a more respectful term and more in keeping with modern practice.

In the **Foot** and **Ankle** and **Trauma** sections, Weber B fractures has been changed to all ankle fractures. T&O consultants need to be able to manage all ankle fractures as part of a general unselected trauma take.

In the **Spine** section, several inconsistencies existed in that knowledge level 3 was required for some topics at phase 2, but these same topics were included in the Critical Conditions (Appendix 3) and required mandatory Case Based Discussion (CBDs) at level 4. These have been changed to reflect this. In addition, several procedures are no longer performed on the NHS and have therefore been removed. For other procedures, the knowledge level has been left the same, but the competence level has been reduced to reflect the fact that most trainees will not have access to or be expected to perform such specialised procedures.

In the **Paediatric** section, changes have been made to reflect the fact that some conditions present more frequently than others, so a different knowledge level would be expected in day-to-day practice at phase 2, for example cerebral palsy and developmental dysplasia of the hip (DDH) are commoner than other congenital/developmental abnormalities, so a higher knowledge level is required at phase 2 for these conditions. Regarding paediatric >>

	Requirement	Guidance
ST3	Use the new 2026 curriculum	Trainees entering specialty training must follow the new curriculum from the start of the specialty programme.
ST4 - 5		Trainees must follow the new curriculum as they move into a new training level.
ST6 - 8	Remain on previous curriculum	Trainees entering ST6 or above may remain on the previous curriculum.
Out of Programme (OOP)	Remain or Transfer	Trainees who have taken time out of Out of Programme may remain on the previous curriculum while at their previous training level but should follow the new curriculum when they move to a new level. *For example, a trainee returning from OOP to continue in ST4 in August 2026 may remain on the previous curriculum until they move to ST5.* However, if their next training level is in the final phase of training they may finish training on the previous curriculum.
Statutory leave (e.g. maternity/ paternity/ adoption leave)	Remain or Transfer	Trainees returning from statutory leave may remain on the previous curriculum while at their previous training level but should follow the new curriculum when they move to a new level. However, if their next training level is in the final phase of training they may finish training on the previous curriculum.
Less than full time (LTFT)	Remain or Transfer	Trainees who are LTFT may remain on the previous curriculum until they move to the next training level when they should follow the new curriculum. *For example, a 50% LTFT trainee after one year at ST4 (six months equivalent) by August 2026 may remain on the previous curriculum until August 2027 (12 months equivalent) and follow the new curriculum when they enter ST5.* However, if their next training level is in the final phase of training they may finish training on the previous curriculum.
Portfolio pathway applicants	Remain or Transfer	If applicants wish to apply under the previous curriculum they may do so for up to 12 months from release of the new curriculum.

Figure 1: The 2026 curriculum incorporates a new syllabus, which represents modern T&O practice. It is anticipated that the majority of trainees will transition to this curriculum, with exceptions as indicated.

procedures, competence levels have been changed to reflect modern practice.

In the **Upper Limb** sections, competence levels for some specialised procedures have been reduced because they are only performed in specialist centres, and trainees will not have equal exposure to them, or be expected to perform them in phase 2.

Critical conditions (Appendix 3)

Three of the critical conditions have been changed as follows:

- Spinal infections
- The painful spine in the child
- The painful hip in the child

Have been changed to:

- Spinal infections (adult or child)
- The acute painful hip in the child (not infection)
- Primary bone or joint infection in a child (septic arthritis or osteomyelitis)

The reason for this is that it was previously possible to fulfil these critical CBDs without seeing an infection. This change in wording ensures the original intention of the critical CBDs (to ensure competency when on-call for conditions, which will have life-changing consequences if not correctly treated) is restored. This oversight has been highlighted by Training Programme Directors (TPDs), Specialty Advisory Committee (SAC) Liaison Members and trainees, so we have rectified this. The proposal keeps the same number of CBDs as before.

Index procedures (Appendix 4)

One procedure has been added: fixation of long bone fractures in children. This is a different skill set compared to the fixation of adult fractures, but is a necessary skill when managing an unselected take. Intramedullary elastic nails are a common method of stabilising long bones in children, but plating is also used. Exposure to elastic nails, however, is not equitable amongst the training regions. For this reason, we are using 'fixation of long bone fractures in children (excluding K-wires)' as a generic term.

Application of limb external fixator requisite numbers have been increased from five to ten. This is because in modern practice, many complex fractures and open fractures are temporarily stabilised in peripheral trauma units with external fixation and are then transferred to major trauma centres for definitive treatment. This is therefore an essential trauma skill for consultants on an unselected take.

As the purpose of the indicative procedures is for the demonstration of competence of certain skill sets, the requirements around osteotomy surgery have been altered. It now allows for up to 10 fusions to be included in the indicative number of 20.

In terms of level 4 procedure-based assessments (PBAs) for the indicative procedures, the standards will largely remain the same. For all indicative procedures, 3 level 4 PBAs will be expected from a minimum of two GMC-registered trainers. The exception to this will be for supracondylar fracture and fixation of long bone fractures in children (excluding K-wires), an indicative number of 1 x PBA level 4 in a non-simulated setting is acceptable.

Due to the changes around osteotomies, the expectation is that at the end of training, or at the time of a Portfolio Pathway application, the Resident doctor would have **either** 3 x level 4 PBA for osteotomy or 1 x level 4 PBA for osteotomy + 1 x level 4 PBA for arthrodesis + 1 x level 4 PBA for osteotomy or arthrodesis.

Indicative numbers and level 4 PBAs achieved in simulated settings are acceptable; however, this must be with the prior agreement of the TPD and SAC Liaison Member for trainees. For those not in training, this would be with the prior agreement of their supervising consultant. This should only be for one case in each of the indicative procedure groups. There are two exceptions to this. Firstly, for supracondylar fracture and fixation of long bone fractures in children (excluding K-wires), where only one level 4 PBA is required, this should be performed in a non-simulated setting, but simulated cases would be allowed. The other is the application of an external fixator where, due to concerns raised by BOTA during the consultation exercise, we have a maximum of two index numbers in a simulated setting that are acceptable with the prior agreement as described.

Other changes to index procedures are minor. They concern bringing terminology up to date and aligned with modern practice. The total number of procedures (1,800) has also not been altered, nor has the requirement for 70% (1,260) of these to be first surgeon operations. ■