JCST Quality Indicators for Surgical Training – JCST Fellowships
Head & Neck Surgical Oncology

There are 10 'generic' QIs for all surgical training and JCST fellowship placements that are followed by specialty-specific QIs.

If you have any feedback on the QIs please email qa@jcst.org.

Quality Indicators for Surgical Training

QI 1	Trainees/Fellows[1] in surgery should be allocated to approved posts commensurate with their phase of training and appropriate to the educational opportunities available in that post (particular consideration should be given to the needs of less than full-time trainees). Due consideration should be given to individual training requirements to minimise competition for educational opportunities.
QI 2	Trainees/Fellows[1] in surgery should have at least two hours of facilitated formal teaching each week (on average). For example, locally/regionally/nationally provided teaching, educational induction, simulation training, specialty meetings, journal clubs, x-ray meetings, MDT meetings.
QI 3	Trainees/Fellows[1] in surgery must have the opportunity and study time to complete and present audit, patient safety or quality improvement projects during each post, *such that trainees will have had the opportunity to have completed three such projects by certification*[2].
QI 4	Trainees/Fellows[1] in surgery should have easy access to educational facilities, including library and IT resources, for personal study, audit and research and their timetables should include protected time to allow for this.
QI 5	Trainees/Fellows[1] in surgery should be able to access study leave ("curriculum delivery") with expenses or funding appropriate to their specialty and personal progression through their phase of training.
QI 6	Trainees/Fellows[1] in surgery must be assigned an educational supervisor and should have negotiated a learning agreement within six weeks of commencing each post.
QI 7	Trainees/Fellows[1] in surgery must have the opportunity to complete the Workplace Based Assessments (WBAs) required by their current curriculum, with an appropriate degree of reflection and feedback. Specifically, the mandatory Workplace Based Assessments in critical conditions and index procedures defined by the current curriculum should be facilitated.
QI 8	Trainees/Fellows[1] in surgery should have the opportunity to participate in all operative briefings with use of the WHO checklist or equivalent.
QI 9	Trainees/Fellows[1] in surgery should have the opportunity to receive simulation training where it supports curriculum delivery.

QI 10	Trainees/Fellows[1] in surgery must have the opportunity to develop the full range of Capabilities in Practice (CiPs) and Generic Professional Capabilities (GPCs), as defined by the current curriculum. Timely midpoint and end of placement Multiple Consultant Reports (MCRs) should be led and performed by trainers, with feedback and discussion of outputs. The focus of the placement should reflect the areas for development identified at the midpoint MCR or previous end of placement MCR.

[1]JCST post-certification Fellows. Fellowship placements are based on an approved surgical curriculum template and use the same 'generic' quality indicators as used for specialty trainee placements.
[2] See JCST post-certification fellowship curriculum for research and audit requirements for JCST Fellows. A JCST post-certification fellowship placement should provide opportunity for research and audit.

Quality Indicators for Head & Neck Surgical Oncology Fellowship

QI 11	Fellows in head and neck surgery should attend one or more multidisciplinary head and neck cancer meetings each week. If appropriate to their future career aspirations, they should also have the opportunity to attend the local thyroid cancer multi-disciplinary meeting (MDM) or skin cancer MDM at least once per month (if that is held separately from the head and neck cancer MDM).
QI 12	Fellows in head and neck surgery should, on average, undertake 2 or more clinics each week (including the MDM), which should primarily be head and neck cancer clinics. The clinics should be consultant supervised and should have a mix of new and follow-up patients, including patients on the 2ww cancer pathway.
QI 13	Fellows in head and neck surgery should have appropriate facilities to allow them to assess patients at all times, including out of normal working hours (i.e. nasendoscope etc).
QI 14	Fellows in head and neck surgery should participate in at least 5 operating sessions per week relevant to the fellowship and should be the designated first surgeon (after the consultant) in a minimum of 3 sessions per week, all of which should have a case mix relevant to the head and neck fellowship. They should have the opportunity to operate, under supervision, on the range of conditions as defined by the curriculum for the head and neck interface fellowship, including the subspecialist areas.
QI 15	Fellows in head and neck surgery should receive direct surgical training from all three of the parent specialties. This means that, during the year, the fellow should attend as 'first surgeon' after the consultant a mix of operating sessions in keeping with their chosen advanced topics. Combined lists with multiple specialties will count as a session undertaken with each participating specialty.