JCST Quality Indicators for Surgical Training – JCST Fellowships
Major Trauma

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 Major Trauma Fellowship

QI 11	Fellows in major trauma should attend the daily multidisciplinary major trauma meetings and be actively engaged in trauma themed multi-disciplinary quality improvement meetings, research and leadership opportunities.
QI 12	Fellows in major trauma should have scheduled training opportunities in the relevant parent specialties to assure coverage of the curriculum.
QI 13	Fellows in major trauma should have attended a trauma team leader / member course.
QI 14	Fellows in major trauma should have access to a damage control surgery course.
QI 15	Fellows in major trauma should have access to an appropriate volume of patients (the host Major Trauma Centre should be in the upper 50% of the Trauma Audit and Research Network (TARN) dataset for the Injury Severity Score (ISS) >15 patients per annum).
QI 16	Fellows in major trauma should have access to an appropriate volume of trauma surgical patients over the fellowship period (20 trauma laparotomies, five thoracotomies, and ten peripheral haemorrhage control procedures). These should be supplemented with simulation exercises.
QI 17	Fellows should work within a designated Major Trauma Centre with a structured trauma response and major trauma consultant delivered care on a major trauma ward.