JCST

Quality Indicators for the Training Interface Group (TIG) fellowships – Head and Neck Surgical Oncology

Quality Indicator	
1.	Trainees in surgery should be allocated to approved posts commensurate with their level of training and appropriate to the educational opportunities available in that post (particular consideration should be given to the needs of less than fulltime trainees). Due consideration should be given to individual training requirements to minimise competition for educational opportunities.
2.	Trainees in surgery should have at least 2 hours of facilitated formal teaching each week (on average). (For example, locally provided teaching, regional meetings, annual specialty meetings, journal clubs and x-ray meetings).
3.	Trainees in surgery should have the opportunity and study time to complete and present one audit or quality improvement project in every twelve months. (The requirements for audit vary for each surgical specialty. Please refer to the designated specialty for details).
4.	Trainees 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 an equivalent to half a day per week to allow for this.
5.	Trainees in surgery should be able to access study leave with expenses or funding appropriate to their specialty and level of training.
6.	Trainees in surgery should have the opportunity to complete a minimum of 40 WBAs per year (not including those done in a simulated setting), with an appropriate degree of reflection and feedback, the mix of which will depend upon their specialty and level of training.
7.	Trainees in surgery must be assigned an educational supervisor and should have negotiated a learning agreement within six weeks of commencing each post.
8.	Trainees in surgery should have the opportunity to participate in all operative briefings with use of the WHO checklist or equivalent.
9.	Trainees in surgery should have the opportunity to receive simulation training where it supports curriculum delivery.

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10.	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).
11.	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.
12.	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).
13.	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.
14.	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: 40 Plastic Surgery operating sessions, 40 Oral & Maxillofacial Surgery (OMFS) operating sessions and 40 Otolaryngology (ENT) operating sessions. Combined lists with multiple specialties will count as a session undertaken with each participating specialty.