JCST Quality Indicators for Surgical Training – Neurosurgery

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 Neurosurgery

Neurosurgery – All Trainees

QI 11	All Trainees in Neurosurgery should have the opportunity to be involved with the management of patients presenting as an emergency for at least one session each week (on average), under supervision and appropriate to their level of training.
QI 12	All Trainees in Neurosurgery should have the opportunity to attend at least one MDT meeting, each fortnight (on average).
QI 13	All Trainees in Neurosurgery should have the opportunity to participate in the daily handover of cases.

Neurosurgery Phase 1

QI 14	Trainees in Neurosurgery in Phase 1 should have the opportunity to develop clinical skills enabling them to assess and manage neurosurgical and neurological emergencies, urgent and elective cases.
QI 15	Trainees in Neurosurgery in Phase 1 should have the opportunity to develop practical competencies including ward, clinic and theatre based practical surgical skills.

Neurosurgery Phase 2

QI 16	Trainees in Neurosurgery in Phase 2 should have the opportunity to participate in the neurosurgical management of a range of high-dependency and intensive care patients as defined by the curriculum.
QI 17	Trainees in Neurosurgery in Phase 2 should have the opportunity to operate on a range of elective and emergency conditions as defined by the curriculum.
QI 18	Trainees in Neurosurgery in Phase 2 should have the opportunity to attend at least four consultant-led theatre sessions each week (on average), when not scheduled to be on night duties or off duty.
QI 19	Trainees in Neurosurgery in Phase 2 should have the opportunity to attend at least one consultant-supervised outpatient clinic each week (on average), when not scheduled to be on night duties or off duty. The Trainee should see a mix of new and follow-up patients.

Neurosurgery Phase 3

QI 20	Trainees in Neurosurgery in Phase 3 should have the opportunity to attend at least four consultant-led theatre sessions each week (on average), when not scheduled to be on night duties or off duty.
QI 21	Trainees in Neurosurgery in Phase 3 should have the opportunity to attend at least one consultant-supervised outpatient clinic each week (on average), when not scheduled to be on night duties or off duty. The Trainee should see a mix of new and follow-up patients.
QI 22	Trainees in Neurosurgery in Phase 3 should have the opportunity to undertake a range of operations in at least one area of special interest in accordance with the curriculum. The Training Programme Director or nominated deputy and the Trainee should discuss the planned placements during the final year of Phase 2 training.