ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

AMC PROGRESS REPORT 2014

COLLEGE DETAILS

Name: Royal Australasian College of Surgeons

Address: College of Surgeons' Gardens,
250-290 Spring Street,
East Melbourne, VIC 3002

Date of last AMC accreditation decision: 2011 by comprehensive report

Periodic reports since last AMC assessment: 2012, 2013

Re-accreditation due: 2017

This report due: September 2014

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STANDARD 1: CONTEXT IN WHICH THE EDUCATION AND TRAINING PROGRAM IS DELIVERED

1.1 Governance

1.1.1. The education provider's governance structures and its education and training, assessment and continuing professional development functions are defined.

1.1.2. The governance structures describe the composition and terms of reference for each committee, and allow all relevant groups to be represented in decision-making.

1.1.3. The education provider's internal structures give priority to its educational role relative to other activities.

Challenges and Changes

- In 2013 the College completed the renegotiation of training agreements with the 13 Specialty Societies and Associations. As a result of the renegotiations, the existing College Board of Plastic and Reconstructive Surgery was reorganized into separate Australian and New Zealand Boards of Plastic and Reconstructive Surgery, with responsibility for the regulation of the training program in each country. Both are College boards. A joint committee has been formed with representatives from each board which is responsible for determining the Surgical Education and Training Program curriculum applied by both boards.
- The existing Board of Orthopaedic Surgery was replaced with the New Zealand Board of Orthopaedic Surgery, responsible for the regulation of the SET program in that country. The College has delegated responsibility for the RACS Orthopaedic Surgery program in Australia to the Federal Training Committee of the Australian Orthopaedic Association. The new Service Agreement with the AOA commits the Federal Training Committee to regulating training in accordance with the SET policies of the College. The Chair of the FTC is a member of the College's Board of Surgical Education and Training.
- Each Board of Specialty Training has its own terms of reference.
- Other than those detailed above, there have been no other changes in the Governance structure of the College. A map depicting the relationship of all of the Education and Professional Development Committees to Council is available on the website.
- The terms of reference for each committee are also available on-line.

1.2 Program Management

1.2.1 The education provider has established a committee or committees with the responsibility, authority and capacity to direct the following key functions:

- *planning, implementing and reviewing the training program(s) and setting relevant policy and procedures*
- *setting and implementing policy and procedures relating to the assessment of overseas-trained specialists*
- *setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activities.*

1.2.2. The education provider's education and training activities are supported by appropriate resources including sufficient administrative and technical staff.

Challenges and Changes

- There has been no change in the committees responsible for management of the training program; the assessment of International Medical Graduates (IMGs); or Professional Development.

1.3 Educational Expertise and Exchange

1.3.1. The education provider uses educational expertise in the development, management and continuous improvement of its education, training, assessment and continuing professional development activities.

1.3.2. The education provider collaborates with other educational institutions and compares its curriculum, training program and assessment with that of other relevant programs

College - generic

- The College continues to employ staff with appropriate education qualification in key roles in relation to the development of education and training programs, assessment, and professional development.
- The College continues to be involved in a number of collaborative activities to enhance training and professional development.
    - The annual Tripartite meetings between RACS; the Royal Australasian College of Physicians (RACP); and the Royal College of Physicians and Surgeons of Canada (RCPSC) (2011-2014).
    - RACS staff are actively involved in a number of networks of staff representing specialist medical Colleges in Australia and New Zealand:
        - the Network of Medical College Educators (NMCE) which meets four times per year and reports to the Education Subcommittee of the Committee of Presidents of Medical Colleges (CPMC)
        - Medical Education e-Learning Network meets monthly by teleconference and reports to the NMCE
        - Continuing Professional Development Managers Network meet bi-annually, additional meetings can be held by teleconference if required.
        - the Network of College IMG Managers (NCIM) also meets bi-annually.
- The College continues to consult widely with external expert medical educators in relation to the development and introduction of new educational initiatives. For example:
    - the planning of the J-DOCS initiative has involved extensive consultation (see also Sections 3.5)
    - the development of the new Foundation Course for senior trainees and supervisors
    - the revision of the ASSET course to include on-line pre-course modules
- See also information below about consultations conducted by the Specialty Training Boards in reviewing and revising their education and training programs.
- In the past 12 months RACS Fellows and senior staff have presented papers at Surgical Education conferences in England, Australia, Sweden and Singapore.

Specialty specific

- As outlined throughout this report the specialty training boards consult with experts in medical /surgical education to advise them as they review and revise the many aspects of their training programs. These experts are drawn from overseas as well as within Australasia.

Recommendation 2:
Report to the AMC on the schedule of planned changes in its educational programs and the proposed time of implementation. Please include an update on changes to the assessment of generic and specialty specific basic sciences, and potential changes to the Fellowship examination.

Challenges and Changes

A. Curriculum Changes

College - generic

- The College and the Specialty Training Boards continue to address the planned changes to a 'competency based' Training Program. See the attached Table in Appendix 2. Progress towards the defined targets is on-track.

General Surgery

- As outlined in the 2013 report, the General Surgery Training Board introduced SEAM (Surgical Education and Assessment Modules) in 2014. SEAM is online module based learning replacing the SSE – (Specialty Specific Examination). Two modules were introduced in Term 1 – 2014 and

a further two will be introduced in Term 2 – 2014. The remaining four modules will be introduced in 2015.

Neurosurgery

- As outlined in the 2013 report, the SET Board of Neurosurgery and Neurosurgical Society of Australasia have made modifications to the SET program in Neurosurgery. As part of this process the program is now divided into three stages as follows:
- Basic Neurosurgical Training known as Level 1. It will be possible for the very competent trainee to complete Level 1 in one year, although the expectation is that most trainees will take two years, which is the maximum time allowed.
- Intermediate Neurosurgical Training known as Level 2. It will be possible to complete Level 2 in three years, with a maximum of four years allowed.
- Advanced Neurosurgical Training known as Level 3. We hope that most trainees will complete Level 3 in one year, with a maximum of three years allowed.
- This new program structure introduces flexibility so that the very competent trainee can complete the SET program in five years, although it is expected that the majority of trainees will still take six years which was the previous standard duration.
- New trainees in 2012 had the option of enrolling in the (then) current SET Program or the new SET Program. Existing trainees at that time remained enrolled in the (then) current SET Program structure. New trainees in 2013 were automatically enrolled in the new SET Program structure.
    - For information about changes to research requirements see Section 3.3, p.16
    - For information about changes to formative assessment processes see Section 5.1, p.21

Orthopaedic Surgery

- The training program is still largely time-based. Examples will be apparent with the revised training program to be implemented over the coming years.
- At this stage it is pre-emptive to report on developments that will be introduced or planned, however, the development of a competency-based training program is the focus, determining essential abilities of orthopaedic surgeons and aligning progression through the training program with trainees' achievement of defined goals.
- In February 2013, AOA surveyed a variety of stakeholders including members, trainees, Trainee Supervisors, Directors of Training and others to explore perspectives pertaining to training.
    - Results showed that respondents had lowest satisfaction with the teaching of 'non-technical skills', specifically practice management, research, teaching, health advocacy and communication skills. Highest rated aspects of training included trauma, arthroplasty, operating room time and opportunities to learn clinical procedures.
- The review, conducted by A/Professor Jason Frank from the Royal College of Physicians and Surgeons of Canada resulted in sixteen recommendations for change. The AOA Board approved recommendations for change in October 2013.
- Subsequently, a two stage, eight year implementation plan has been developed. Key areas that have been prioritised for development in the next four years include revision of AOA competencies, assessment, eLearning, Bone School and building capability of Trainee Supervisors and Directors.
    - A Curriculum Review Committee has been appointed and a larger curriculum review group is considering the essential abilities of an orthopaedic surgeon on their first day of independent specialist practice.
    - This work will culminate in a revised draft of AOA competencies toward the end of 2014, at which time it will be distributed to relevant stakeholders for feedback.
    - The structure, composition and duration of training will be subsequently considered.

Paediatric Surgery

- As reported in 2013, the Training Board for Paediatric Surgery changed the initial experience for their trainees.

  - From two years of training in surgery in general (adult general surgical specialties) before commencing their paediatric surgical rotations;
  - To SET1 trainees being placed in a tertiary paediatric surgical post where they are closely monitored by a supervisor appointed to supervise just them (one on one), prior to commencing their two years of surgery in general.

- the Training Board have found this change to be very effective because, as anticipated, it has enabled them to identify two trainees who will be able to progress faster than anticipated with their general surgery time being reduced by a year due to good reports and RPL, as well as one trainee who will require additional time in order to meet the requirements of SET1.

Plastic and Reconstructive Surgery

- In July 2014 the Australian Board of Plastic and Reconstructive Surgery (the Board) commenced a review of the syllabus, assessment tools and learning outcomes for the P&RS SET program. To inform the review process, a survey has been sent to trainees and Supervisors seeking feedback on aspects of the SET program in P&RS including:

  For trainees
  - Trainee Management Program (TMP) – ease of use
  - How often trainees refer to the P&RS clinical syllabi (Modules 1-8 and their respective sub-classifications) and if they do how valuable is it to their training?
  - How often trainees access the Plastic Surgery and Education Network (PSEN) and if they do how valuable is it to their training?

  For Supervisors
  - Trainee Management Program (TMP) – ease of use
  - PPA Assessments and trainees in difficulty
  - Length of time spent on P&RS education and training activities (for Supervisors)
  - How often trainees and Supervisors refer to the P&RS clinical syllabi (Modules 1-8 and their respective sub-classifications) and if they do how valuable is it to provision of training?

- The review process is expected to conclude in October this year with the outcomes and recommendations for any changes to the SET Program in P&RS to be presented to the Board at its meeting in October.
- If the Board agrees to changes in the SET Program in P&RS, these will be developed and implemented in consultation with key stakeholders with development commencing in 2015.
- For information about possible changes to formative assessment processes see Section 5.1, p.22

All other specialties

- No change

B. Changes to Examination processes

College - generic

- As indicated in 2012 and 2013: from 2014 medical graduates can choose to sit the Generic Surgical Sciences Examination (SSE) prior to being selected into SET.
  - Initially (February & May) only a small number of places were available for doctors who had applied for selection in 2013.
  - In October this year the first on-line examination will be taken by approximately 140 candidates.
  - In 2015 the on-line Generic SSE will be available to an increasing number of junior doctors. Information about these changes has already been published on the College website.
- See Sections 5.1, p.20 for information about the Fellowship Examination

Urology

- The Surgical Sciences Examination in Urology was introduced in 2014. This examination is undertaken by trainees in SET3 or SET4 but must be passed before the end of SET4. Trainees have 4 attempts in which to successfully pass this examination. The examination is offered twice a year.
- All SET Urology trainees have been provided with a comprehensive reading list to assist their exam preparation.

Vascular Surgery

- In parallel with revision and renewal of their curriculum modules, the Board of Vascular Surgery is revising the current speciality specific exam in vascular surgery and expect the new exam to be available in 2016.

All other specialties

- No change

Recommendation 4:
Report, as part of its College Activities Report, numbers of entrants into SET1 and SET2+ and the origin of these entrants (by PGY year, whether or not BST, IMG) by jurisdiction and specialty.

- See pp. 13-17 in the 2013 Activities Report available for public assess on the RACS website.

1.4 Interaction with the Health Sector

1.4.1. The education provider seeks to maintain constructive working relationships with relevant health departments and government, non-government and community agencies to promote the education, training and ongoing professional development of medical specialists.
1.4.2. The education provider works with healthcare institutions to enable clinicians employed by them to contribute to high quality teaching and supervision, and to foster peer review and professional development.

Recommendation 5:
Agree with jurisdictions on mechanisms to facilitate resolution of issues of concern, including workforce numbers. These could include (a) a high-level consultative forum, possibly along the lines outlined in this report, to meet at least twice a year, and (b) consultative arrangements at the jurisdictional level with the relevant Regional Committee (and representatives of the regional sub-committees of specialty boards) to identify appropriate posts for accreditation and to facilitate resolution of issues of concern including issues of workforce availability.

Challenges and Changes

As identified in the Health Workforce Australia consultations (2012-3) (in which RACS was well represented) and subsequent publications, the health workforce is a multifaceted issue including the:

a) numbers of surgeons in each specialty in relation to projected community requirements
b) geographic distribution of surgeons (in each specialty) in relation to demand
c) balance between 'generalists' and 'sub-specialists' within each specialty
d) time and expertise required to train each trainee

Each of these facets requires a variety of on-going responses and adaptations.

A. The numbers of surgeons in each specialty in relation to projected community requirements

- The situation in relation to the numbers of surgeons in the workforce in relation to projected community requirements has changed substantially since the Birrell Report published in 2003 which argued that, in most specialties, the surgeon-to-patient ratio was well short of the ideal

number. It has also changed significantly since the initial review and recommendations contained in the AMC 2007 Accreditation Report to RACS (specifically Recommendations 5 & 25).

- These changes are clearly evidenced in the data published in the Health Workforce Australia report Health Workforce 2025 Medical Specialties; Volume 3, published in November 2012. Whilst not analysing ever surgical specialty individually, data for each of the four specialties (General Surgery; Orthopaedic surgery; Otolaryngology Head and Neck Surgery; and Plastic and Reconstructive Surgery), (plus a category called 'other'), indicated that there is 'no perceived shortage in the workforce' in the projected time-frame.
- These changes are at least partly due to the planned strategy to expand the specialty training program incorporated into the introduction of SET. Since the inception of SET each surgical specialty has reviewed all of the existing training posts as well as any which have been put forward by a hospital for potential accreditation (see also Section 8.2, pp.34-6).
- This has led to an increased number of training posts, and therefore trainees and graduating Fellows, in every specialty (see Appendix 3, p.49).
- Three possibly unanticipated outcomes of the increase in training posts and subsequent increase in trainees and graduating Fellows are that:
    - In some instances accredited posts have proven to be unable to provide sufficient access to clinical training. These posts are constantly being reviewed and some are being disaccredited (see information from specialties in Section 8.2, pp.34-6).
    - In the 2013 College wide surveys both current trainees and Younger Fellows expressed concerns about decreased opportunities for operative experience (see Section 6.2, pp.26-8, and Appendices 8 & 9)
    - Graduating Fellows are expressing concern about the difficulty they are experiencing in gaining positions without undertaking further 'sub-specialty' training (see C. below, as well as Section 6.2, pp.27-8).
- The number of active RACS Fellows is now increasing faster than both the demand for surgeons (in most specialties) and the number of surgeons retiring. For example:
    - In 2013 there were more than 5700 active RACS Fellows, an increase of 3.3% compared to 2012.
    - Almost 240 new Fellows were admitted into the College in 2013.
    - Female Fellows made up 18% of the total number of new Fellows admitted in 2013.

B. The geographic distribution of surgeons (in each specialty) in relation to demand

- It is acknowledged that this is an on-going issue which has no simple solution across much of Australia and New Zealand. And whilst being involved in discussions with jurisdictions and hospitals about identified 'areas of need', and advocating for employment opportunities for Younger Fellows, the following are not issues that the College can address directly:
    - community populations that are insufficient to support some specialties, e.g. cardio-thoracic surgery, paediatric surgery and neurosurgery
    - community populations that are sufficient to support only the most common procedures in most specialties
    - hospital resources that are insufficient to support the purchase of increasingly expensive surgical equipment and/or the maintenance of surgical suites with the necessary ICU facilities
- Another difficulty in addressing distribution is that, despite the incentives being made available through the DoH Rural Health Workforce Strategy (RHWS) Incentive Programs, not all Fellows are willing to live and work away from the major centres (see Appendix 9).
- One way that the College addresses this on-going concern is through the very active Rural Surgery Section dedicated to serving the interests of surgeons who practise outside the metropolitan areas of Australia and New Zealand. Their activities include:
    - encouraging trainees to consider working in rural Australia through a 'Rural Coaching' scheme
    - running an annual conference for Provincial Surgeons of Australia (PSA), and
    - Interacting with the Australian College of Rural and Remote Medicine on issues relating to surgery and surgical procedures

- A 2013 initiative to support surgeons in rural and remote areas has been the partnership with the Australian College of Rural and Remote Medicine to produce and publish an on-line resource on Telehealth. This resource, which is available on-line for members:
    - will give surgeons the practical skills and theoretical knowledge necessary to use Telehealth in their practice
    - uses case studies to address a range of topics including: clinical practice, technical issues, and contextual issues
    - provides links to standards, guidelines and on-line resources
    - it also provides access to discussion groups on ethical issues and research in telehealth

C. The balance between 'generalists' and 'sub-specialists'

- In the 2013 College wide surveys 36.6% of Younger Fellows stated that they had experienced difficulty in finding a job once they had completed training (see Appendix 9). Most of the comments from these respondents stated that it was 'necessary' for them to do sub-specialty training in order to get a job. Their comments included statements such as:
    - No consultant positions available in metro and outer metro centres. Further training seems to be mandatory in this day and age
    - If you don't get on a post fellowship training programme or SR job then there are no jobs avail apart from locum jobs
    - If you don't do subspecialty training, options are limited

- "*Serving the community: Training Generalists and Extending Specialists"* was the topic for the 2013 Conjoint Medical Education Seminar, held in Sydney in March 2013. This one day seminar was sponsored by HWA and the Australian Government Department of Health and Aging.
    - For a copy of the program see Appendix 4, p.50.
    - The seminar was attended by over 100 representatives from all sections of the medical sector.

D. The time and expertise required to train each trainee

This facet is also complex and multi-dimensional because it relates to the capability of both the trainee and their supervisors, as well as access to appropriate training including teaching time and operative experience

- in relation to educational resources and expertise of supervisors see also the response to Recommendation 2 in Section 1.3, pp.4-6, and Section 8, pp.32-4
- in relation to teaching time and operative experience see also the response in Section 6.2, pp.27-28 and Appendices 8 & 9

- Whilst there has been success in reducing the training time of some trainees (based on competence assessment), in the 2013 College wide surveys only 45.5% of Supervisors agreed that current trainees have adequate exposure to a suitable number (and variety) of procedures during training.(See Section 6.2 for further information on this issue)..

- Similar concerns were expressed by the Younger Fellows of whom only 41.1% felt that they were adequately prepared for independent consultant practice at the end of their training. (See Section 6.2 for further information on this issue)

- Readiness to commence training was another concern expressed by a very large proportion of supervisors in response to the question 'What are some of the negative aspects of the SET program compared to the previous training program' (see Appendix 9) (Note: almost 75% of respondents had been supervisors in either BST or AST prior to the commencement of SET)
    - As reported in 2013 (Section 3.5), the College has been working to improve the guidance and resources for aspiring surgeons. This has involved several kinds of consultation with stakeholders (see Section 3.5, pp17-18). The purpose behind publishing this information is to ensure that selected trainees are better equipped to commence training.
    - Several of the specialties are also addressing this issue (See Sections 1.3; 3.2 and 7.1)

E. On-going discussions and representations - 2013

- Sometimes, as indicated above, there have been meetings or activities in which one single issue has been addressed. However, the College has found that the on-going development of plans and processes to meet the comprehensive range of workforce issues is best tackled through continued interaction and representation in the appropriate organisations. As reported in 2012 and 2013, the College, the Specialty Training Boards and the Specialty Societies continue to interact with the Health Sector at all levels of government across two nations being National, Commonwealth, and State based. For example:

a) During 2013 senior Councillors as well as senior staff met with:
   - Prof. Chris Baggoley, CMO, Dept of Health, [Topics: surgical training; specialist training]
   - Prof. Chris Baggoley, CMO, and Simon Cotterall, Secretary International Strategies, Dept of Health, [Topic: National Surgical Quality Improvement Program (NSQIP); safe surgery and anaesthesia; WHO]
   - Hon. Peter Dutton MP, Shadow Minister for Health, Australian Federal Government
   - Etienne Scheepers, Executive Director, HWA, [Topics: Nurse Endoscopy]
   - Don Mackie, CMO, Global Health and Jane Chambers, representative NZ Ministry of Health, [Topics: Global health; safe surgery]
   - Dr Steve Hambleton, President AMA, [Topic: Safe working hours]

b) As part of his role as Dean of Education, Assoc. Prof. Stephen Tobin made visits to most Australian regions and had consultations with:
   - NSW Dept Health reps/HWPC; HETI; RACP; Medical Deans CEO;
   - Qld Dept Health reps/HWPC; Rural generalist Program (Toowoomba);
   - ACT Dept Health reps/HWPC/ Brian Ashman-surgeon; ANU Medical School Dean;
   - SA Dept Health reps/HWPC/Dr P Phillips-CMO; SA MET;
   - VIC Dept Health reps/HWPC;
     UniMelb Prof. of Med Education; Medical Education Planning Group (quarterly meetings)

c) The Dean also met with representative of ANZCA and RANZCOG to discuss the J-Doc proposal and presented papers at conferences such as ANZAHPE and the College ASC.

d) The Board of Regional Chairs (BoRC) and their regional committees have a very strong role in advocacy within each of the regions [see their Terms of Reference].

e) Discussions at forums of Surgical Leaders continue to focus on issues such as credentialing, the viability of surgical health care and workforce. (See Appendix 5 for details of the meeting in October 2013).

f) Where possible specialties continue to have JRs as members of their Training Board, in the selection processes and as participants in hospital accreditation (see individual specialty notes below).

Australia specific

- At the June 2013 Council meeting, A/Prof Owler spoke with Council. He was then NSW AMA President and also the surgeon representative on the Council of Federal AMA. He is also a member of the COAG Expert Panel on Emergency Department and Elective Surgery Performance.
- Senior surgeons serve as members on regional medical education committees such as HETI, SA MET, and Queensland Health.
- In Tasmania, Pauline Waites served as a Reviewer for the Faculty of Pain Medicine Training Unit Accreditation Committee; and James Roberts-Thomson is on the Tasmanian State Surgical Services Committee
- Senior surgeons also provide advice on a wide range of consultative committees and Ministerial Advisory committees (see Appendix 6 for examples from NSW and South Australia)

New Zealand specific

- Senior surgeons provide advice on a wide range of committees / advisory groups established by one of the NZ statutory groups (see Appendix 6 for examples)

- There are also a number of regular meeting between College Representatives and NZ statutory groups that have an input into NZ medical workforce matters:-

  a) Medical Council of New Zealand (sets requirements for prevocational training years; and for standards for vocational registration)
     - quarterly meetings through Council of Medical Colleges (CMC);
     - at minimum biennial meetings between MCNZ and its approved Vocational Education & Advisory Bodies (VEABs; and this College is one of those VEABs);
     - meetings set up specifically between NZ National Board representatives and College staff and MCNZ Council members and / or senior staff to discuss matters of common interest / concern (usually between 2 and 4 per year).

  b) Health Workforce New Zealand
     - HWNZ attends 1 or 2 CMC meetings each year to discuss workforce matters with all medical colleges;
     - meetings set up specifically between NZ National Board representatives and College staff with HWNZ Board members and / or senior staff to discuss matters of common interest / concern (usually between 1 and 2 per year)
     - meetings where HWNZ senior staff and staff of several medical colleges discuss links regarding data transfer and future plans (there have been two already in 2014 and will probably be at least one more in 2014)

Cardiothoracic Surgery

- Jurisdictional representatives are regularly invited to hospital accreditations for Cardiothoracic Surgery

General Surgery

- Once again JR's were invited to participate as inspectors on the Queensland Quinquennial Inspections held in June 2014.
- Jurisdictions have also been communicated with in relation to the changes to Selection and the SET Training program.
- The board has been communicating with the jurisdictions on the changes to the program and how this will improve training.

Orthopaedic Surgery

- Regular meetings occur between AOA Training Staff and NSW Health staff. At the March 2014 meeting Business Processes were agreed upon and have now been documented.
- A jurisdictional representative attends these meetings with NSW Health; he also attends AOA Federal Training Committee Meetings.
- As review and implementation plans are progressed updates will be provided to those parties AOA regularly has contact with including Departments of health, AMA, Private Health organisations, industry etc.
- AOA has active and regular involvement with a number of key stakeholders in regards to workforce and training issues. Stakeholders include Health Workforce Australia, Department of Immigration and Border Protection – Skills Australia, Australian Medical Association, Ministry of Health (NSW), and the Federal Department of Health and Minister for Health (Chief of Staff).

Paediatric Surgery

- Additional training posts at Coffs Harbour, Campbelltown and Hobart have been identified and filled (Hobart in 2015).

Urology

- The majority of interaction with external bodies is undertaken at a Society level by the USANZ President or members of the Board of Directors. This has involved high level consultation with a range of bodies to ensure urologists are maintaining expected standards.

- In some cases, assistance is provided by members of the USANZ to some jurisdictions (through RACS) where there have been queries made regarding credentialing for urological procedures.

All other specialties

- No change

1.5 Continuous Renewal

1.5.1. The education provider reviews and updates structures, functions and policies relating to education, training and continuing professional development to rectify deficiencies and to meet changing needs.

Challenges and Changes

- There have been no changes to College structures
- All policies are regularly reviewed and up-dated
- See also relevant sections of this report for information about changes to assessment and CPD processes

STANDARD 2: THE OUTCOMES OF THE TRAINING PROGRAM

2.1 Purpose of the Training Organisation

2.1.1. The purpose of the education provider includes setting and promoting high standards of medical practice, training, research, continuing professional development, and social and community responsibilities.

2.2.2. In defining its purpose, the education provider has consulted fellows and trainees and relevant groups of interest.

Challenges and Changes

- No change in the purpose of the training organisation.
- Because the first cohort of SET trainees completed their training in 2012 the College conducted three separate evaluation surveys in 2013.
    - These surveys were designed to collect information from supervisors; recently graduated Fellows (Younger Fellows); and current trainees - across each of the specialties.
    - See Section 1.4 C&D (pp.7-12); Section 6.2 (p 27) for information about recent consultations, and Appendix 9 for a summary of the results of these surveys.

2.2 Graduate Outcomes

2.2.1. The education provider has defined graduate outcomes for each training program including any sub-specialty programs. These outcomes are based on the nature of the discipline and the practitioners' role in the delivery of health care. The outcomes are related to community need.

2.2.2. The outcomes address the broad roles of practitioners in the discipline as well as technical and clinical expertise.

2.2.3. The education provider makes information on graduate outcomes publicly available.

2.2.4. Successful completion of the program of study must be certified by a diploma or other formal award.

Challenges and Changes

- Since publication in 2003, the RACS statement of graduate outcomes, the *Definition of Surgical Competence* has become the curriculum framework for all of the surgical specialties. Documents are available for public assess on the RACS website. These are the 'Nine RACS Competencies' and the Training Standards booklet.
- The number of trainees completing their Fellowship examination (by specialty; region and gender) is publically accessible on the RACS website. See pages 27; 31-34 in the 2013 Activities Report

Recommendation 7:
Recognising the different needs of the specialty groups, aim to increase the uniformity between presentation of the aims and goals of training for nine surgical specialties particularly on the website, taking account of feedback from the trainee and supervisor groups.

- *With the move to 'principles-based' system, increased divergence is likely. However the intent of the recommendation that the College oversee and moderate information presented on the training programs in the nine surgical specialties remains.*

- Across all of the surgical specialties the aims and goals of training are the same – to train surgeons as competent, independently practising specialists. The definition of competent is encompassed in the 'Nine RACS Competencies' and the required standard at graduation is further defined in the Training Standards booklet.
- The Partnering Agreements clearly define the documents (policies, regulations, and training requirements) that each specialty needs to be published on the public section of their websites.
- The Board of SET (BSET) is the forum where specialty training boards present any planned changes of process, e.g. in selection, assessment, or course structure, for discussion and

approval. (See the governance map link in Section 1.1 p.3 which shows BSET within the College governance structure)

- Each specialty training board develops their planned changes after consultation with their supervisors and trainees, as well as with their wider Fellowship and the jurisdictions.
- For examples see Sections 1.3, pp,5-7 and Section 5.1. pp.20-22

Recommendation 10:
Involve health consumers and patients in any future consultation about the goals and objectives of surgical training.

The College continues to take steps to address this expectation. These include:

- Following enquiries amongst all of the other specialist medical Colleges and consideration of the different approaches (lay committees; community representatives; consumer groups for specific health issues; …) the College has agreed to adopt the same approach as ANZCA and invite members of the public to be nominate as community representatives
- Education Board Exec agreed that, once the community representatives are established (within the next three months) they will be surveyed for their opinions of the training and professional development programs.

<u>Specialty training Boards</u>

- The Otolaryngology Head and Neck Training Board have accepted one person to join their board as a community representative

<u>All other specialties</u>

- No change

STANDARD 3: CURRICULUM CONTENT

3.1 Curriculum Framework

3.1.1. For each of its education and training programs, the education provider has a framework for the curriculum organised according to the overall graduate outcomes. The framework is publically available.

- Since publication in 2003, the RACS statement of graduate outcomes, the *Definition of Surgical Competence* has become the curriculum framework all of the surgical specialties. These are the 'Nine RACS Competencies' and the Trainings Standards booklet.
- These documents are available for public assess on the RACS website.

3.1 MCNZ The training program should demonstrate that the education provider has respect for cultural competence and identifies formal components of the training program that contribute to the cultural competence of trainees.

- The College has instituted a Cultural Competency Steering Committee
- A variety of on-line education modules relating to cultural competence have been developed and are available on-line on the College website for all Members. The modules aims to promote a multi-disciplinary approach for surgeons in rural and remote locations who care for Indigenous patients, and will also be of value to metropolitan based surgeons with Indigenous patients.
    - Unfortunately at the moment these are only in the Australian sphere because they have been funded by the Australian Government under the Rural Health Continuing Education (RHCE) scheme. These include the following projects:
        - Australian Indigenous Health and Cultural Learning Online Portal for medical specialists
        - Australian Indigenous Health and Cultural Learning Online Modules
        - Intercultural Competency for Medical Specialists

3.2 Curriculum Structure, Composition and Duration

3.2.1. For each component or stage, the curriculum specifies the educational objectives and outcomes, details the nature and range of clinical experience required to meet these objectives, and outlines the syllabus of knowledge, skills and professional qualities to be acquired.

3.2.2. Successful completion of the training program must be certified by a diploma or other formal award

Recommendation 11:
Present to the AMC its timetable for the planned move to competency-based training and report annually on its progress.

- See Appendix 2. 'Timetable for the planned move to competency-based training. This work is continuing according to plan
- See detailed response to Standard 1.3, Recommendation 2, on page 4-6. As indicated there, several of the specialty training boards are currently working towards revising / redeveloping different components of their training programs. The work continued throughout 2013 and 2014.

General Surgery

- The Board is currently working towards redeveloping the General Surgery training program. A new selection process which will include a Procedural Skills and Professional Capabilities Assessment. This is a document that identifies the skills candidates will be required to attain prior to applying to the program. This is in line with the RACS Essential Skills document.
    - Trainees will then commence on the program as a SET2.

- The changes will commence for selection in 2015 and the first group of trainees that will commence as a SET2 will be in 2016.
- See additional information published on the GSA and NZAGS websites. Also Section 8.2 p.35 in relation to the current review of SET1 training posts

Neurosurgery

- See information outlined in Section 1.3, p.5

Paediatric Surgery

- Competency based training is in effect now

3.3 Research in the Training Program

3.3.1. The training program includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, and encourages the trainee to participate in research.

3.3.2. The training program allows appropriate candidates to enter research training during specialist education and to receive appropriate credit towards completion of specialist training.

Challenges and Changes

College - generic

The College Research Working Party provided their report to BSET in October 1013. In that report the working party provided detailed results of the survey which they conducted.

- The perspective paper, published in the *ANZ J Surgery* (October; 2013) titled "Necessary research knowledge and skills for all surgeons: futile survey or fuel for debated " is the result of the survey undertaken on behalf of the working party.
- The Chair of the working party is currently on sabbatical. It will be reconvened when he returns in October or November this year.
- The plan then will be to obtain general agreement on:
  - Those components of research knowledge, skills and attitudes which should be included in the training of all surgeons.
  - The creation a draft module(s) for the training and assessment of these.
  - Consideration of this by the specialty groups.

Neurosurgery

- The previous program (still applicable to trainees who commenced prior to 2013) has a six year structure which includes one year of compulsory full-time research. The new SET program replaces the compulsory full-time research year with additional clinical training and a formal research requirement to be completed while undertaking clinical training.
- The proposal for the research requirement must be submitted and approved by the SET Board of Neurosurgery in the first six months of Intermediate Neurosurgical Training (Level 2) and the research requirement must be successfully completed prior to completing Intermediate Neurosurgical Training (Level 2).
- Trainees in the new SET program who wish to undertake a period of full-time research may still apply to the SET Board of Neurosurgery for interruption of training for that period (as is currently the case for trainees in the current SET Program who wish to spend more than one year in research).

All other specialties

- No change

3.4 Flexible Training

3.4.1. The program structure and training requirements recognise part-time, interrupted and other flexible forms of training.

3.4.2. There are opportunities for trainees to pursue studies of choice, consistent with training program outcomes, which are underpinned by policies on the recognition of prior learning. These policies recognise demonstrated competencies achieved in other relevant training programs both here and overseas, and give trainees appropriate credit towards the requirements of the training program.

Recommendation 14:
Report to the AMC on the impact of SET on the availability of flexible training opportunities

Challenges and Changes

- This is an issue on which work is continuing at both the College and specialty board levels
- The RACSTA 2013 trainee survey indicated that approximately 30% of trainees indicated an interest in flexible training. This finding is consistent with previous years. Of those who answered yes to this question, over 50% indicated that their preference would be for a shared position with a slightly lower proportion indicating that they would prefer an 0.5 EFT stand-alone position.
    - As both of these preferences would require additional funding, the College recognises that on-going negotiations will involve all levels of medical administration as well as any hospital that is willing to enable flexible training to happen
    - The job share model also creates additional complexity for the training boards in identify two trainees whose choices and training needs are compatible

<u>General Surgery</u>

- The General Surgery Board continues to support part-time training.
- The Board has recently also been able, through it's Regional subcommittees, to allocate trainees with an interest in rural surgery to Royal Darwin Hospital.

<u>Neurosurgery</u>

- The structure of the new SET program has been designed to enable greater flexibility (See Section 1.3, p.5)

<u>Paediatric Surgery</u>

- No approach has been made to the Board of Paediatric Surgery for flexible training
- The possibility for flexible training will be raised at each hospital accreditation

<u>All other specialties</u>

- No change

3.5 The Continuum of Learning

3.5.1. The education provider contributes to articulation between the specialist training program and prevocational and undergraduate stages of the medical training continuum.

Challenges and Changes

- In response to increasing pressure to provide information across the spectrum of education and training as well as to concerns expressed by supervisors, Younger Fellows and trainees in the 2013 SET evaluation surveys (see Section 6.2, pp27-8), the College is already putting the following strategies in place:
    - Consulting widely on the J-DOCS proposal to provide clearer guidance and more resources for interns and prevocational doctors who aspire to careers in surgery.

  - It is planned to provide some resources available for public access (such as the 'Essential Surgical Skills' booklet and the Training Standards booklet); others which will be available on payment of registration; plus courses and examination application and resources which will be available on payment of relevant fees.
  - During consultation with the various interest groups (see Section 1.4E, pp.10-12) it has become clear that the package of resources being developed will have wider application that surgery and could become a valuable package for preparation to a range of post-graduate medical training.

- Free on-line advice is available for junior doctors about Surgery as a Career and the Generic Surgical Sciences Examination
- Resources available on subscription include:
  - Access to some e-learning resources such as 'Goal setting' and 'Self-assessment'
  - Access to the MCQ Practice Bank
- Resources available for fees include:
  - Opportunity to sit the generic SSE examination prior to selection (see Section 1.3 B, pp.6-7)
  - Courses such as ASSET; CLEAR; CCrISP; and TIPS
  - An e-logbook
  - Out of the box ASSET course (components)
  - The e-portfolio and out-of- the-box simulation courses addressing non-technical competencies are still under development
- Further consultation through a series of stakeholder meetings is continuing in each region

STANDARD 4: TEACHING AND LEARNING METHODS

4.1.1. The training is practice-based involving the trainees' personal participation in relevant aspects of the health services and, for clinical specialties, direct patient care.
4.1.2. The training program includes appropriately integrated practical and theoretical instruction.
4.1.3. The training process ensures an increasing degree of independent responsibility as skills, knowledge and experience grow.

Challenges and Changes

Whilst the bulk of training continues to be based in hospitals, an increasing number of face-to-face course and on-line learning resources are being developed by the College and the specialties.

- The planned Trainee version of the SAT SET course became part of a much larger which now, under the Title of 'SET ready' addressed a wide range of questions and concerns identified by trainees in the early stages of their training. It has been published on-line and is available to Members. Consideration is being given to making this resource available to junior doctors.
- See Section 3.1 (page 15) for on-line learning resources relating to cultural competence.
- The new one day 'Foundation Course' focusing on workplace assessment and feedback is currently being trialed. The course is targeted at senior trainees, trainers and supervisors.

<u>General Surgery</u>

- See Section 1.3 – SEAM (p.5)

<u>All other specialties</u>

- No change

STANDARD 5: ASSESSMENT

5.1 Assessment Approach

5.1.1. The assessment program, which includes both summative and formative assessments, reflects comprehensively the educational objectives of the training program.
5.1.2. The education provider uses a range of assessment formats that are appropriately aligned to the components of the training program.
5.1.3. The education provider has policies relating to disadvantage and special consideration in assessment, including making reasonable adjustments for trainees with a disability

Recommendation 15:
Seek congruence of assessment processes between the specialties except when differences can be justified for educational reasons.

Challenges and Changes

- See also Section 1.3, Recommendation 2, pp.6-7

College – generic

- The scheduled change to the generic Surgical Sciences Examination (SSE) to allow candidates to take this examination prior to being selected into the training program is well supported by all of the Specialty Training Boards. It also addresses one of the key concerns expressed by supervisors in the 2013 College wide survey.
- In-line with agreed changes of focus for the Fellowship Examination (FEX) (2011-2012) — that is to remove assessment of basic sciences from the FEX and to concentrate on applied clinical knowledge and decision making — specialty training boards have become more involved in their specialty SSE. This involvement includes:
  - ensuring that there is closer alignment between the curriculum modules and the SSE's
  - improved communication between the specialty training board and their FEX committee
- Whilst the focus of the FEX has been redefined to ensure that two of the nine competences (Medical Expertise and Judgement – Clinical Decision Making) are assessed at the highest standard, each specialty continues to assess this knowledge and skill through seven modalities (written papers, and clinical exams/vivas). Any proposed changes to a modality is submitted through the College FEX Committee and then to Education Board.
- All of the specialty SSE's are overseen by the College through a range of educational committees and boards. These include the Surgical Sciences and Clinical Examination Committee; BSET, and Education Board.
  - Thus whilst there are variations in the modality and timing of these examinations they all meet the College expectations for early and specialty appropriate assessment of the basic sciences
  - Some of the differences in timing are historic – pre-dating the introduction of SET, at a time when only two of the specialties (Paediatric Surgery and Orthopaedic Surgery) had SSE's
  - Other timing differences relate to the way in which the program is structured. For example:
    - Neurosurgery and Vascular Surgery have clear demarcation between stages of their training which define educationally appropriate points for requiring trainees to have completed specific components of their training – including SSE's

Specialty Specific SSE

Changes in specialty specific surgical sciences examinations are being introduced for a number of reasons.

- Changes in timing to:
  - Spread the workload on the trainees more evenly across the training program.
  - Provide increased opportunities to monitor progress
- Changes of content to:
  - Align the examination more specific to the requirements of the specialty – in terms of the structure of their program as well as the content of their modules

        - Therefore when a specialty training board revises their curriculum modules the content and/or timing of their SSE will change
    - ensure that basic sciences are assessed early in the program and not left to the Fellowship Examination

Recommendation 16:
~~*Research thoroughly the strengths, weaknesses, practicalities and generalisability of the Mini-Clinical Evaluation Exercise and Direct Observation of Procedural Skills as assessment tools in the local hospital setting and make public its findings.*~~ *The AMC notes that since the 2007 assessment, considerable literature has been written on these tools. The AMC considers that this recommendation is no longer appropriate. It asks that in future reports the College advise the AMC on it is using the available research findings in making decisions about the assessment tools it employs.*

Work-based assessment

- There continues to be a dearth of agreement in the results of research into the implementation and effectiveness of work-based assessment tools in surgery. However available evidence supports the use of these tools for formative assessment and feedback (not summative assessment).
- See Appendix 9 for information from the 2013 SET evaluation surveys on Supervisors' ideas about the usefulness of a range of work-based assessment tools
- In March 2014 the College published a booklet titled 'Work-based assessment: a practical guide' which has been produced as a collaborative project of the Tri-partite Alliance between the Royal College of Physicians and Surgeons of Canada; the Royal Australasian College of Physicians; and our College.
- As outlined in Section 1.3 (Recommendation 2, pp.5-6) the specialty training boards are at varying stages in their curriculum reviews and on-going development. In conducting their review they consult internationally to ascertain current trends in work-based assessment in their specialty.
- An initial set of Entrustable professional activities (EPAs) have been drafted and were trialled during the first half of 2014 by the Paediatric Surgery Training Board. The Chair of Paediatric Surgery presented a report to the June meeting of BSET (see below).
    - The College is currently considering the development of EPAs (or similar) as an assessment tool for junior Doctors (see Section 3.5, pp17-8)
    - See also information published on the GSA and NZAGS websites in relation to changes in selection criteria

Neurosurgery

- As outlined in the 2013 report, in 2013 the in-training assessment and workplace competency assessments for all trainees were replaced by new assessment tools, the Professional Performance Assessment Report to be submitted quarterly and the Neurosurgical Competency Assessment Report to be submitted six monthly.
- There are milestones which must be achieved in the Neurosurgical Competency Assessment Report prior to completion of Basic, Intermediate and Advanced Neurosurgical Training (see Section 1.3, p.5).
    - Trainees will be assessed as either 'competent' or 'not yet competent' for each area procedure and as such there is no unsatisfactory, just a failure to have attained competence at that time. Attainment of competence in the milestones must be reached during each level.

Orthopaedic Surgery

- Quarterly in-training assessment reports (QARs) are now submitted online and all mandatory workplace-based assessments will be available online mid-late 2014.
- The overall assessment strategy for orthopaedic surgery will be developed in conjunction with the curriculum review.

- An Assessment Working Party has been appointed and met in July for an introductory workshop with A/Professor Jason Frank.
- AOA is planning a review of assessment methods and tools after revised orthopaedic surgery competencies have been determined. This will occur early in 2015 and include pilots of potential workplace-based assessment tools. The implementation of the revised assessment strategy is planned for 2016-17.

Paediatric Surgery

- Assessments in SET1 continue to be refined and tightened to ensure that this year becomes key in identifying underperformance
- The Chair of the Paediatric Surgery Training Board made a presentation at BSET in June reporting on the trials that their supervisors had conducted using EPAs. He said that at this stage their training board would recommend using EPAs for first one or two years of SET only.
    - Positive aspects identified were:
        - Provides a guideline of behaviour for trainees, a reminder that even "small" work day tasks need to be conducted with professionalism – identifies how the College competencies are involved with even minor tasks. We learn for each trainee that we can trust them with small matters.
        - Gives robust parameters that can be used in a summative way to assess struggling trainees.
        - Most trainees that lack insight into their struggles do so in the arena of non-technical competencies. Robust assessment of this in their Early SET years may suffice to allow for re-direction of career.
    - Negative aspects identified were:
        - The thought of even 30 EPAs to deal with was daunting – if there are even more, will they cumulatively become a "FRACS"?
        - Will we need to do a number of WPAs to gauge that one EPA is to be marked satisfactory?
        - EPA may be harder to sell to VMO trainer due to time involved as compared to other WPA (and their known inertia at introduction).
        - Some EPAs will require wriggle room to cope with "local processes", a N/A box or two.

Plastic and Reconstructive Surgery

- A recent demonstration of the MALT system revealed a user friendly platform for submission and approval of logbooks. From an administration point of view, the reporting functions in the MALT system also appear to be user friendly and efficient in terms of the time required to generate reports. The MALT system is superior to the current TMP for submission, approval and reporting on logbooks.
    - A paper is being prepared by the P&RS National Education and Training Manager on the process and timeline for transitioning to MALT.
    - The report will also include recommendations for alternatives for submission of other assessments (i.e. DOPS, Mini CEX and PPAs) with a view to ceasing use of TMP altogether if viable alternatives are available. A key consideration in submission of assessments is to minimise the workload on Supervisors.

Vascular Surgery

- Based on feedback from their supervisors the Vascular Surgery Training Board has introduced a new mini-CEX form

All other specialties

No change in work-based assessment tools

Statistical data:

a) The number of Trainees completing their Fellowship examination (by specialty; region and gender) is publically accessible on the RACS website. See pages 26; 30-33 in the 2013 Activities Report

b) The number of Trainees completing the generic Surgical Sciences Examination; the Clinical Examination and the Specialty Specific Surgical Science Examinations are publically accessible on the RACS website. See pp. 26-29 in the 2013 Activities Report

c) Data from the 2014 May Fellowship Examination is in Appendix 7 (see also Section 5.3)

5.2 Feedback and Performance

5.2.1. The education provider has processes for early identification of trainees who are under performing and for determining programs of remedial work for them.
5.2.2. The training organisation facilitates regular feedback to trainees on performance to guide learning.
5.2.3. The training organisation provides feedback to supervisors of training on trainee performance, where appropriate

Recommendation 17:
Report in annual reports to the AMC on the procedures for identification and management of under-performing trainees.

Challenges and Changes

A. Underperforming Trainee

College - generic

- The College has developed a range of resources that are being used by supervisors to identify and assist trainees who are progressing through the training program more slowly than expected.
  - Those resources include:
    - The Training Standards booklet which is recommended to be used by both supervisors and trainees as a guide to identifying levels of progress
    - Courses such as SAT SET; KTOT; and TSIA
    - An on-line resource with detailed information about the process of identifying and managing underperforming trainees plus template proforma for documenting each step of the process (available on the College website for Members)
    - On-line resources for both trainees and supervisors on self-assessment and goal setting (available on the College website for Members)

General Surgery

- No change in the management of underperforming trainees as the process works well
- The Board has introduced an Exam Preparation Form which is used by trainees who do not pass the Fellowship Examination. The trainees are to complete the form either fortnightly or monthly and the Board Chair, IMG Rep, or Training Committee Chair reviews the submission and provides feedback and further instructions on preparation for the Examination

Orthopaedic Surgery

- The suite of policy documents regarding assessment, including trainees requiring additional support that were developed and implemented last year continue to be well received by Supervisors
- Additional training for Trainee Supervisors and Directors of Training addressing concerns with underperformance has been developed and will be implemented during 2014.
- A webinar titled ‘Helping Underperforming Trainees’ has been developed and has been delivered multiple times. A workshop on this topic will feature at the AOA ASM later in the year.

Plastic and Reconstructive Surgery

- The Australian Board of Plastic and Reconstructive Surgery are developing new Regulations to deal with the identification and management of underperforming trainees.
- A key aim of the new Regulation is to take the administrative workload away from Supervisors and put it back with the ASPS Education and Training Unit. (Note: this is in line with the process outlined in the College generic on-line resource)
    - It is envisaged that the new Regulations will be in place for the start of Term 2 September 2014

Urology

- Urology supervisors continue to have regular meetings with poorly performing trainees, documentation, remedial plans, monthly reviews, etc

Vascular Surgery

- If a trainee submits a borderline assessment, a face to face interview is conducted and a performance plan is implemented in line with the Vascular program regulations.

All other specialties

- No change

B. Feedback to Trainees

- No change

C. Feedback to Supervisors

- No change

5.3 Assessment Quality

5.3.1. The education provider considers the reliability and validity of assessment methods, the educational impact of the assessment on trainee learning, and the feasibility of the assessment items. It introduces new assessment methods where required.

Challenges and Changes

- As stated in the 2013 report there was a significant reduction in the pass-rate in the Fellowship Examination in some specialties in the May 2013 FEX sitting. This reduction was a matter of great concern and was investigated in a number of different parameters. Findings indicated that there were no specific contributing factor. Some of the points raised were:
    - Results from one specific FEX sitting is not necessarily an overall indication of training quality
    - Consideration needs to be given to factors such as :
        - The number of prior attempts
        - Trainee or IMG
        - Location and access to examination preparation workshops
        - Location and access to out-patients clinics
        - The number of candidates sitting can have a large impact on a percentage score
            - The smaller specialties frequently have less than 8 candidates
            - the number of candidates from each specialty varies widely between sittings e.g. in May 2013 there were 16 candidates from Vascular Surgery – this year there were 5
    - These factors have been found to have no consistent correlation with FEX performance in a specific sitting
    - The best overall indicator of training quality continues to be ‘eventual pass rate’. This is reported each year in the Annual Activities Reports
- In the light of the above findings the data in Appendix 7 is difficult to interpret beyond noting that:

- In each of the larger specialties the percentage of passing candidates is higher
- In this sitting, in the larger regions the proportion of pass/fail candidates varied between 61% and 79.5%

5.4 Assessment of Specialist Trained Overseas

5.4.1. The processes for assessing of specialists trained overseas are in accordance with the principles outlined by the AMC and the Committee of Presidents of Medical Colleges Joint Standing Committee on Overseas Trained Specialists (for Australia) or by the Medical Council of New Zealand (for New Zealand).

5.4 MCNZ The role of the education provider is to provide comprehensive advice and recommendations on the IMG's qualifications, training and experience and whether this is at the level of a NZ trained specialist, and to advise the MCNZ on the suitability of the proposed employment position and supervisor for the assessment period.

Challenges and Changes

College – Australia - generic

- The initial processes of assessing IMGs has changed to correspond with changes introduced by the AMC.
- Information about the process and forms are accessible on the College website

College – New Zealand - generic

In New Zealand, RACS has agreed under a Memorandum of Understanding with MCNZ to act as an agent of MCNZ, called a Vocational Education and Advisory Body (VEAB).

- The New Zealand Censor is a surgeon appointed by the NZ National Board, and together with a New Zealand specialty representative from the speciality training committee/board, provides preliminary advice (paper-based) to MCNZ as to an applicant's suitability for vocational registration.
- Those applicants who are deemed suitable for vocational registration are then interviewed by a panel consisting of the NZ Censor, the speciality representative and a representative from another specialty. At this interview the applicant's training, qualification and experience are assessed and then advice is provided to MCNZ.
- The IMG may be considered equivalent, nearly equivalent or not equivalent to a doctor who is registered in the same vocational scope of practice and holds the FRACS.
- Information describing the process is available from the MCNZ website.

Orthopaedic Surgery

- Policies were reviewed early in 2014 and feedback was submitted to BSET at the June meeting.

Monitoring of IMGs

College - generic

- No change

- The forms are accessible on the College website.

All other specialties

- No change

STANDARD 6: MONITORING AND EVALUATION

6.1 Ongoing Monitoring

6.1.1. The education provider regularly evaluates and reviews its training programs. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.

6.1.2. Supervisors and trainers contribute to monitoring and to program development. Their feedback is systematically sought, analysed and used as part of the monitoring process.

6.1.3. Trainees contribute to monitoring and to program development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training program to ensure that existing trainees are not unfairly disadvantaged by such changes.

Recommendation 22:
Introduce procedures to collect feedback on the training program from external stakeholders such as health administrators and health consumer groups.

Challenges and Changes

College - generic

- See Sections 1.4E, pp.9-11 for information about interaction with health administrators, and Section 2.2, pp.13-14 for information about interaction with health consumer groups
- All specialty training boards receive feedback from hospital administrators as an integral part of post inspections.

General Surgery

- Refer to Recommendation 5, p.11

All other specialties

- No change

Challenges and Changes

College - generic

- No change in the way in which the Trainee Association (RACSTA) end-of-term survey is conducted. This survey is designed to collect information from all trainees to evaluate their experiences and enable issues and concerns to be brought to the notice of relevant Boards (BSET; EB; Council) for discussion and consideration.
- The findings of the 2013 surveys were generally consistent with those of previous years. Issues that have been identified in previous reports include:
    - Bullying
        - Further research into this area, as well as the competencies of Professionalism and Leadership have shown that the issue of bullying is more effectively addressed as a workplace culture issue, rather than targeting individuals. Based on these findings College staff have developed a one-day workshop for senior practitioners. This 'Professionalism and Leadership Workshop' is scheduled to be presented in October 2014
    - Decreased access to outpatients
        - See response to the supplementary question on page 36
    - Access to part-time training
        - See response to 'Flexible training', Section 3.4, page 17

- Findings in relation to the extent to which trainees had sufficient operating experience are at variance with the results of the 2013 College wide surveys outlined in 6.2 below and in Appendix 9. See Appendix 8 for two Tables of results for the RACSTA survey in relation to this issue.

Orthopaedic Surgery

- AOA trainees are required to complete a trainee evaluation at the end of each term. The survey addresses training and supervision, workplace experiences, working hours and on-call requirements, Bone School and AOA administration and support.
- For Term 2, 2014 131 responses were received.
    - Examples of responses include nearly 80% of trainees were satisfied or very satisfied with Bone School lectures and tutorials, and
    - over 80% of trainees agreed or strongly agreed that Quarterly Assessment Reports (QAR) and Direct Observation of Procedural Skills (DOPS) assessments were a constructive experience.
- See also Section 1.3 for information about the consultation with a variety of stakeholders including members, trainees, Trainee Supervisors, Directors of Training and others in February 2013

All other specialties

- No change

6.2 Outcome Evaluation

6.2.1. The education provider maintains records on the outputs of its training program, is developing methods to measure outcomes of training and is collecting qualitative information on outcomes.

6.2.2. Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.

Recommendation 25:
Continue to collaborate with the jurisdictions to increase the output of well-trained surgeons.

Challenges and Changes

- See Section 1.4, Recommendation 5 (pp.7-11) in regards to on-going communication with health care administrators and the jurisdictions.
- See Appendices 5 & 6 for examples of interactions and collaborations between representatives of the College, jurisdictions, and the wider medical community.
- See Section 2.2, 'Graduate Outcomes' (pp.13-14)
- Quantitative date on the outputs of the training program are reported in the Activities Reports which are available for public assess on the RACS website.

Brief summary of any completed training program evaluations

College – generic

- As planned and outlined in 2013, the College conducted surveys of supervisors, trainees and recent graduates (Younger Fellows) evaluating SET.
- See Appendix 9 for additional data from the 2013 evaluation of SET

The following are examples of answers to qualitative questions

- In response to the invitation to make positive comments about SET compared to previous programs a very large number of respondents in each group wrote that the program(s):
    - are well defined; more structured; has clearer objectives; clearer guidelines and expectations; better organised;

  - is more comprehensive and more transparent;
  - has better assessment
  - enable clear tracking of trainees, better documentation of progress

- In response to the invitation to make negative comments about SET compared to previous programs there was both similarity and variation between the groups in their responses.
- The three main concerns of Supervisors were:
  - The lack of experience of new trainees; trainees lacking a broad base of experience; lack of exposure to the specialty; poorer basic knowledge; lack of general surgical exposure;
  - Problems caused by the early SSE – time taken during SET1 to study; dismissal in SET2 of trainees who fail;
  - Increased paperwork; increased workload from both paperwork and more junior doctors without appropriate support from hospitals /jurisdictions
- The three main concerns of Younger Fellows were:
  - Variability:- the high variability between rotations; the quality of training is so hospital dependent; experience/teaching is very hospital dependent
  - Limits to access to training:- too many trainees; too many people being trained reduces operative experience; training diluted because of safe hours and number of Fellows
  - Training and jobs:- Too much emphasis on service rather than teaching/learning; not enough jobs for graduates
- The three main concerns of Trainees were:
  - Variability:- access to formal teaching is highly variable; variability in teaching and supervision; variability in the amount of assistance and help provided; lack of standardisation of rotations; amount of teaching and supervision very variable
  - Limits to access to training:- too many fellows, not enough primary operator experience; dilution of caseload; access to operating is often limited due to an excess of fellows; lack of protected teaching time; lack of supervised teaching in many units
  - Training and jobs:- Too much emphasis on service; service provision prioritised over teaching; many positions are glorified service jobs; because of pressure on theatre time there is less opportunity to discuss

<u>Neurosurgery</u>

- The SET Board of Neurosurgery continues to evaluate its selection process on an annual basis

<u>Orthopaedic Surgery</u>

- Refer to Recommendation 5 Section 1.4, page 11

<u>Urology</u>

- Refer to Recommendation 5 Section 1.4, page 11

<u>All other specialties</u>

- No change

STANDARD 7: ISSUES RELATING TO TRAINEES

7.1 Admission Policy and Selection

7.1.1. A clear statement of principles underpins the selection process, including the principle of merit-based selection.

7.1.2. The processes for selection into the training program:

- *are based on the published criteria and the principles of the education provider concerned*
- *are evaluated with respect to validity, reliability and feasibility*
- *are transparent, rigorous and fair*
- *are capable of standing up to external scrutiny*
- *include a formal process for review of decisions in relation to selection, and information on this process is outlined to candidates prior to the selection process.*

7.1.3. The education provider documents and publishes its selection criteria. Its recommended weighting for various elements of the selection process, including previous experience in the discipline, is described. The marking system for the elements of the process is also described.

7.1.4. The education provider publishes its requirements for mandatory experience, such as periods of rural training, and/or for rotation through a range of training sites. The criteria and process for seeking exemption from such requirements are made clear.

7.1.5. The education provider monitors the consistent application of selection policies across training sites and/or regions.

Challenges and Changes

College - generic

- There has been no change in the generic selection policy

General Surgery

- General Surgery is currently transitioning from their previous selection process to a new process which will include a Procedural Skills and Professional Capabilities Assessment.
- See also information in Section 3.2, pp.15-16, Section 8.2, p.32, and published on the GSA and NZAGS websites

Orthopaedic Surgery

- A review in September 2013 of selection processes confirmed that changes to the 2013 selection process (2014 intake) had improved the process.
- Minor amendments have been made to 2014 selection regulations (2015 intake).
  - The weighting of the curriculum vitae (CV) has changed from 20% to 15% and the in depth referee reports from 40% to 45%. The rationale for this change is the IDR reports more effectively differentiate suitable from non-suitable applicants than the CV and therefore the weighting of the IDR reports has been increased slightly.

Urology

- Changes proposed to the SET Program in Urology (including revised eligibility criteria for the selection process to be undertaken in 2015) were outlined in submission for the AMC Report in 2013. The only additional modifications have been to provide further clarity on alternatives to the 'surgery in general' term and ICU requirement. These are outlined below:

A 'Surgery in General' Rotation may comprise:	
• General Surgery	• Transplant
• Acute Surgical Unit	• Trauma
• Breast and Endocrine	• UGI/HPB
• Colorectal	• Vascular Surgery
• General Surgery	• Paediatric Surgery
• Surgical Oncology	

A *urology rotation* may only be considered a 'surgery in general' rotation if *a different urology rotation* has been included to meet the 'urology rotation' requirement (i.e. the same rotation cannot be included to comply with two criteria).
In terms of the ICU requirement, the following rotations will also be accepted: • Trauma Unit • ICU • HDU • Cardiothoracic Unit • Vascular Unit • Critical Care Unit

All other specialties

- No change

Statistical data:

- Data from the selection processes as well as on Trainee progression is published in the Activities Reports which are available for public assess on the RACS website.

7.2 Trainee Participation in Training Organisation Governance

7.2.1. The education provider has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

Summary of interactions with Trainee Associations

- There has been no change in the activities of the College Trainee Association, RACSTA
- There has been no change in the relationship between RACSTA and the College

Significant issues raised

- See Section 6.1, pp. 26-7

7.3 Communication with Trainees

7.3.1. The education provider has mechanisms to inform trainees about the activities of its decision-making committees, in addition to communication by the trainee organisation or trainee representatives.
7.3.2. The education provider provides clear and easily accessible information about the training program, costs and requirements, and any proposed changes.
7.3.3. The education provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

Challenges and Changes

College - generic

- The College continues to communicate with all members (Trainees, Fellows, IMGs) through the weekly e-journal – Fax Mentis, and the monthly e-news of Council Highlights. The latter is also published on the College website
- Fees for all activities are available for public access on the College website
- The College is responsible for the administration of Stage 1 of the selection process and for advising the applicants whether they meet the generic eligibility criteria and can progress to Stage 2, of if they do not meet the generic eligibility criteria
- The College is responsible for advising trainees on their training status in relation to:

  - All examinations administered by the College (generic SSE; specialty specific scientific examinations; the Clinical Examination and Fellowship Examination)
  - All courses administered by the College that have been designated by a specialty as a training requirement (e.g. ASSET; EMST; CLEAR; CCrISP; TIPS)

- The specialty training boards are responsible for advising applicants if they have been successful in selection – or not
- The specialty training boards are responsible for advising trainees of their training status in relation to:
  - In-training assessment (mid-term and end of term)
  - Workplace-based assessment
  - Any seminars, examination preparation workshops, or courses offered by the specialty
  - Eligibility to sit the Fellowship Examination
- The College is responsible for advising about any changes in relation to the examinations administered by the College (see list above)
- The specialty training boards are responsible for providing advice to their trainees of any proposed changes in their training program.

Plastic and Reconstructive Surgery

- See Section 8.1, p.33 for the 2013 summary of P&RS trainee evaluations of their training posts

All other specialties

- No change

7.4 Resolution of Training Problems and Disputes

7.4.1. The education provider has processes to address confidentially problems with training supervision and requirements.
7.4.2. The education provider has clear impartial pathways for timely resolution of training related disputes between trainees and supervisors or trainees and the organisation.
7.4.3. The education provider has reconsideration, review and appeals processes that allow trainees to seek impartial review of training-related decisions, and makes its appeals policies publicly available.
7.4.4. The education provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

Challenges and Changes

- The College policies and process have not changed
- See Section 5.2, Recommendation 17, p.23 in relation to underperforming trainees
- The College **'**In-house Counsel' continues to be available to provide advice on any issue relating to underperformance, disputes, complaints and/or appeals.
- The Appeals mechanism policy is available for public access on the College website

STANDARD 8: IMPLEMENTING THE TRAINING PROGRAM – DELIVERY OF EDUCATIONAL RESOURCES

8.1 Supervisors, Assessors, Trainers and Mentors

8.1.1. The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the program of study and the responsibilities of the training provider to these practitioners. It communicates its goals and objectives for specialist medical education to these practitioners.

8.1.2. The education provider has processes for selecting supervisors who have demonstrated appropriate capability for this role. It facilitates the training and professional development of supervisors and trainers.

8.1.3. The education provider routinely evaluates supervisor and trainer effectiveness including feedback from trainees.

8.1.4. The education provider has processes for selecting assessors in written, oral and performance-based assessments who have demonstrated relevant capabilities.

8.1.5. The education provider has processes to evaluate the effectiveness of its assessors/examiners including feedback from trainees, and to assist them in their professional development in this role.

Recommendation 27:
Report in annual reports to the AMC on:

- *changes in the workload of supervisors after the introduction of SET*
- *the introduction of training for supervisors and trainers in the new work-based assessment methods*
- *progress in developing a process for trainee evaluation of their supervision.*

Challenges and changes

College - generic

- The policies outlining the process for the selection of Supervisors and assessors and requirements and responsibility for surgical Supervisors and Trainers have not changed. These policies are available on the College website for public access.
- The College continues to provide training for Supervisors, Trainers and assessors in the SAT SET, KTOT; CDM; and TSIA courses which are all free for members of the College.
- See the information in relation to changes in the workload of supervisors in Section 6.2, pp27-8, and Appendix 9
- See the information about Trainee evaluation in Section 6.1, pp. 26.

General Surgery

- The General Surgery Board is looking at holding a workshop for supervisors to discuss how to manage underperforming trainees and increase their understanding of due process and appeals.

Paediatric Surgery

- A new newsletter for Supervisors has been established. To date two have been sent out. They are likely to go out quarterly to address areas of concern or confusion.
- All current trainees are taught principles of SATSET/KTOT/Surgeons as Teachers on induction to facilitate their understanding of the processes of surgical training.
- The PCM course has been done by around 30% of current trainees.
- Trainees in NSW are invited to attend private rooms of surgeons for outpatient experience, but current workload in hospital usually precludes this (together with the jurisdictions reluctant to pay wages for this).

Neurosurgery

- The SET Board of Neurosurgery, with funding from the Neurosurgical Society of Australasia, hosted a supervisor's face to face workshop over two days in March 2014. This was an opportunity for supervisors to get together to discuss issues and developments within the SET Program in Neurosurgery and will become an annual event.
    a) This also allowed supervisors to discuss workload and have direct input into the development and practicality of assessment tools.

Orthopaedic Surgery

- Workshops for Trainee Supervisors and Directors of Training were conducted at the AOA ASM in October 2013.
- Regarding training for supervisors, a key focus area in the coming years will be building capability of Trainee Supervisors and Directors of Training. Workshops will be conducted annually at the AOA ASM and a 'train-the-trainer' approach utilised to disseminate training more widely.
- Regular webinars will also be delivered to regional groups.

Plastic and Reconstructive Surgery

- Refer to Standard 5.1, p.22 – re plans to introduce MALT for submission of logbooks and alternatives for submission of DOPS, Mini CEX and PPAs with a key consideration being to minimise the workload on Supervisors.
- Refer to Standard 5.2, p.23 – re the development of new regulations and processes for dealing with trainees in difficulty with the aim of taking the administrative workload away from Supervisors.
- Trainee evaluation of their supervision. The Plastic and Reconstructive Surgery training board:
    a) Asks each trainee to complete an evaluation of their training post at the end of each six month rotation.
    b) Requests feedback from trainees on their supervision during site accreditation visits.
- The summary of evaluation feedback from trainees for Terms 1 and 2, 2013 shows that an overwhelming majority of trainees rate their training post either 'Satisfactory' or 'Good' on all of the training experiences.
    - In the 'clinical training' categories the following percentage were rated as deficient
        - 5% access to outpatient
        - 11% access to special clinics
        - 6% access to ward rounds
        - 2% access to surgical meetings
        - 2% access to audit
        - 5% access to journal review
    - In the 'operative teaching' categories 2% rated their supervision deficient, whilst 0% rated their access to teaching as deficient
    - 5% rated their opportunity for research as deficient
    - In the 'clinical management' categories 5% rated their emergency operating experience as deficient, whilst 0% rated their patient management experience as deficient
    - No trainee rated their training post experience as deficient overall
- Information on the number of outpatient sessions per week that P&RS trainees attend is requested as part of the accreditation process for training sites. The site inspection team reviews the information provided and asks for clarification as required from the site undergoing accreditation.

Urology

- The Board of Urology has been particularly cognisant of the workload of supervisors. Efforts have been made to streamline assessment tools, documentation and reporting requirements. The Board plans to publish a guide for supervisors, including comprehensive tools and templates for managing poorly performing trainees.
- In the last 12 months, there has been a concerted effort to assess teaching, education and supervision occurring in a number of training posts based on trainee feedback. As a result a

number of posts have been required to make significant modifications to ensure trainees are adequately trained, educated and supervised.

Vascular Surgery

- The lack of access to outpatients in NSW is an issue for Vascular Surgery. However, because Vascular Surgery trainees rotate to other states throughout their training this does assist slightly with this issue.

All other specialties

- No change

Summary of activities to support supervisors, assessors, trainers and mentors

College - generic

- The College continues to provide a range of free training courses that are available for all Fellows (including Supervisors, Assessors, Trainers, and Mentors). Currently these include: SAT SET; KTOT; and NOTSS and the two new courses CDM and TSIA.
- The College also encourages Fellows and IMGs to attend the 'Process Communication Model' course
  - Information about all of these courses is available for public access on the website
- In the last 12 months the College Academy of Surgical Educators has provided forums as well as a series on on-line webinars and other educational resources
- As a result of a partnership agreement with the University of Melbourne the Master of Surgical Education. There are currently 46 RACS Fellows undertaking this course
- The College has approved courses offered on-line from the University of Edinburgh and the Royal College of Surgeons of Edinburgh, as well as the Royal College of Surgeons of England
- The College is also interested in accrediting similar courses offered by universities throughout Australasia

Specialty specific

- See above responses to Recommendation 27

8.2 Clinical and Other Educational Resources

8.2.1. The education provider has a process and criteria to select and recognise hospitals, sites and posts for training purposes. The accreditation standards of the training organisation are publicly available.

8.2.2. The education provider specifies the clinical and/or other practical experience, infrastructure and educational support required of an accredited hospital/training position in terms of the outcomes for the training program. It implements clear processes to assess the quality and appropriateness of the experience and support offered to determine if these requirements are met.

8.2.3. The education provider's accreditation requirements cover: orientation, clinical and/or other experience, appropriate supervision, structured educational programs, educational and infrastructure supports such as access to the internet, library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated time for teaching and training and opportunities for informal teaching and training in the work environment.

8.2.4. The education provider works with the health services to ensure that the capacity of the health care system is effectively used for service-based training, and that trainees can experience the breadth of the discipline. It uses an appropriate variety of clinical settings, patients and clinical problems for training purposes, while respecting service functions.

Challenges and changes

College - generic

- The College Hospital Accreditation requirements have not changed
- See information in response to Section 1.4, Recommendation 5, pages 7-11.

General Surgery

- Based on feedback from supervisors and trainees the General Surgery Board believes that trainees are entering the surgical training program without appropriate surgical experience and preparation.
- The Board also has concerns about the quality and depth of experiences offered in some of the training posts accredited for training SET1
- After consideration of both of these issues the Board has planned to make significant changes to both entry requirements and the accreditation of training posts for early training.
    - See information published on the GSA and NZAGS websites in relation to the current review of SET1 training posts.

Paediatric Surgery

- The newly accredited training post in Hobart has increased our capacity.
- However a general reduction in logbook numbers in many hospitals has caused concern, as reduced experience may result in loss of training posts in some hospitals in the near future.

Orthopaedic Surgery

- AOA accreditation standards have been developed from RACS original Standards and include orthopaedic specific criteria to familiarise hospitals and orthopaedic departments with the requirements necessary to participate as an AOA accredited training site. They were approved in 2013 for implementation in the 2014 accreditation process.
- The 2014 hospital accreditation inspections were held across two weeks from March 17th to 28th, 2014.
- 37 AOA inspectors across Australia attended the 27 hospital inspections. Sixteen of the inspections were held as quinquennial inspections within the state of Queensland, with 2 mini-inspections, 3 additional post inspections and 6 initial post applications held nationally.
- The recommendations of the accreditation inspectors were presented to the Federal Training Committee on 6th July 2014 for their final accreditation decision.

Orthopaedic Surgery – New Zealand

- The NZOA Education Committee has agreed to a small redistribution of trainee placements to ensure that there is a more equal distribution of trainees in the Auckland region. The number of posts has not changed however there will be a drop in trainees in some DHBS on a rotating basis.

Supplementary question:
How does the College ensure that trainees receive appropriate experience in ambulatory and consultative surgery in NSW in the absence of outpatient clinics?

College – generic

- This issue has less impact on the smaller specialties which rotate their trainees around different regions during their training program
- As part of their on-going discussions with jurisdictional representatives from NSW (see Section 1.4 E pp.9-11) College representatives continue to advocate for improved access to ambulatory

and consultative surgery in that region. As a result of these, and other advocacy activities there has been some improvement, For example:

- A number of hospitals in NSW have re-introduced out-patients clinics
- The increase in training posts in private hospitals means that trainees can attend patient consultations in their supervisors rooms

Surgical specialties

- See above specialty responses in Section 8.2, and also Section 1.4E pp.9-11

Supplementary question:
Please provide an up-date on the progress of the attempts to charge jurisdictions for the accreditation of training posts.

- The College has decided not to pursue this further

Summary of Post accreditation activities

- See Appendix 10

STANDARD 9: CONTINUING PROFESSIONAL DEVELOPMENT

9.1 Continuing Professional Development Programs

9.1.1. The education provider's professional development programs are based on self-directed learning. The programs assist participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine as well as changing societal expectations.

9.1.2. The education provider determines the formal structure of the CPD program in consultation with stakeholders, taking account of the requirements of relevant authorities such as the Medical Board of Australia and the Medical Council of New Zealand.

9.1.3. The process and criteria for assessing and recognising CPD providers and/or the individual CPD activities are based on educational quality, the use of appropriate educational methods and resources, and take into consideration feedback from participants.

9.1.4. The education provider documents the recognised CPD activities of participants in a systematic and transparent way, and monitors participation.

9.1.5. The education provider has mechanisms to allow doctors who are not its fellows to access relevant continuing professional development and other educational opportunities.

9.1.6. The education provider has processes to counsel fellows who do not participate in ongoing professional development programs.

9.1 MCNZ- The following elements need to be defined:

- *The categories of practitioner and the number of practitioners undertaking their recertification program.*
- *Any categories of practitioner that are not enrolled in the recertification programs.*
- *Confirmation that the recertification program is available to practitioners registered within a vocational scope of practice who are not members*
- *Details of hours that members are required to spend on recertification activities and how that is comprised.*
- *Whether the education provider collects information about:*
  - *The numbers of and outcomes for practitioners who undertake regular practice reviews*
  - *Whether their practitioners have undertaken a credentialling process and if so whether there are checks in place to ensure those practitioners are doing CPD appropriate for their clinical responsibilities.*
- *How the education provider has respect for cultural competence and identifies formal components of the recertification program that contributes to the cultural competence of fellows and affiliates.*

Summary of significant developments introduced or planned

College – Generic

A. Adjustment to CPD program – Update

- The College has move to an annual cycle and is currently receiving CPD returns for the 2013 year. The 2013 program represents a significant transition from the historical triennial-based program. This included a revised list of practice types to better reflect a Fellows' practice as they transition through different phases of their career:
  - Operative practice in hospitals or day surgery units
  - Operative procedures in rooms only
  - Operative practice as a locum only
  - Clinical consulting practice only
  - Other practice type (research, administration, academic, teaching, assisting etc.)

- The categories Fellows participate in was also reduced to streamline and simplify the program without reducing the breath or type of activities a Fellow can claim for their CPD. These categories are:
  - Category 1: Surgical Audit

  - Category 2: Clinical Governance – Quality Improvement, Evaluation of Patient Care and Professional Advocacy
  - Category 3: Performance Review
  - Category 4: Maintenance of Knowledge and Skills

- The program requires the average operative surgeon to participate in at least 70 hours of CPD activity per annum in addition to undertaking a peer reviewed surgical audit and where applicable participate in the Australian and New Zealand Audit of Surgical Mortality (ANZASM). While the program does not mandate participation in specific activities, the framework is designed to encourage Fellows to participate in activities within their scope of practice.
- Participation in the performance review category suggests that Fellows are actively engaging in these types of activities. At this stage the College does not collect information on the number of Fellows who undertake regular practice reviews although anecdotal evidence suggests that this an activity of interest to Fellows but which may be obstructed by difficulty in freeing up time, costs associated with travel etc.
- The program changes have been well received by Fellows and to date the compliance percentage is tracking at a similar rate to previous years.
- The College also increased its verification rate from 3.5% to 7% for the 2013 CPD year. To date there has been a slight reduction in the number of Fellows who have provided documentation to support their CPD participation. This may be due to the verification requirements threshold being increased from a component of a Fellows CPD (i.e. category 3/4) to now being a total review of participation across all categories.
- In 2013 the College amended its Code of Conduct policy to incorporate failure to comply with CPD. A process for managing Fellows who persistently fail to comply with CPD is being developed and it is expected that this process will commence in 2015.
- Surgeons who are not a Fellow of the College are able to participate in the CPD program for an annual fee. This provides the surgeon with access to the CPD diary, library access, eLearning activities and other College publications.
- The College is actively engaged in discussions on revalidation, as evidenced by the recent collaboration with the Royal Australian College of Physicians (RACP) and the Royal College of Physicians and Surgeons of Canada (RCPSC) to host a revalidation seminar in March 2014. The seminar was well attended by many Colleges, industry representatives and key stakeholders who were encouraged to actively debate the central issues regarding revalidation for both the Australian and New Zealand regulatory environment. The College is also exploring an appropriate approach to revalidation including the role of the College and regulators, and how these changes will impact on our Fellows.

Accreditation of Educational Activities

- The College continues to approve continuing medical education activities and there has been no change to this process since the last report.
- The College is looking at integrating standards for approval of training courses for trainees with standards of approval of professional development activities for Fellows to create a streamlined and integrated approach to accreditation.

B. Suite of eLearning activities

- The College has developed a suite of eLearning activities tailored to the needs of Fellows, International Medical Graduates (IMG) and Trainees. Most recently these have included eLearning resources for the Code of Conduct, Clinical Decision Making, Keeping Trainees on Track and Intercultural Competency for Medical Specialists. The College is also undertaking further work in developing new eLearning modules throughout 2014 and refreshing long-standing modules such as the Surgical Supervisors and Trainers for Surgical Education and Training (SATSET).
- The College has been successful in obtaining funding from Australian Government under the Rural Health Continuing Education (RHCE) scheme for a variety of education modules relating to

cultural competence, but only in the Australian sphere. Most recently this has included the following projects:
  - Australian Indigenous Health and Cultural Learning Online Portal for medical specialists
  - Australian Indigenous Health and Cultural Learning Online Modules
  - Intercultural Competency for Medical Specialists

- The College has also been working with other members of the Committee of Presidents of Medical Colleges (CPMC) to develop a standard training and on-going education curriculum in Aboriginal and Torres Strait Islander health.
- To support communication skills, the College regularly runs 'Process Communication Model' (PCM) courses. A core objective of this course is to assist surgeons to 'communicate with patients in a way that suits their preferred style of communication'.

C. Development of an eMSF Tool and eLearning module

- The College is currently developing an online electronic Multi Source Feedback (eMSF) tool for use by Fellows, IMGs and Trainees. The tool complements the introduction of the performance review category and will enable participants to wholly complete their performance review online. To support this project, the College is developing an eLearning module that supports all participants in this process.

9.2 Retraining

9.2.1. The education provider has processes to respond to requests for retraining of its fellows.

- The College has a process of retraining and reskilling surgeons, with each term having a specific meaning:
  - Retraining applies to surgeons who previously possessed the skills in the areas where there are now deficiencies. These deficiencies may be technical or non-technical skills.
  - Reskilling requires the attainment of skills not previously possessed which may pertain to a new procedure or an alteration in devices used. This is particularly relevant to surgeons returning to practice after an absence, or those who have not kept up with surgical developments. This pertains mainly to technical skills and less commonly to non-technical areas.
- The policy is due for review in 2015.
- These areas are managed through the Offices of the Executive Directors for Surgical Affairs.

9.3 Remediation

9.3.1. The education provider has processes to respond to requests for remediation of its fellows who have been identified as underperforming in a particular area.

9.3 MCNZ The response to this standard should encompass details of:
- *A process for auditing whether individual practitioners are participating in the recertification program and whether they are meeting the requirements. This includes a system of dealing with those who are not complying.*
- *A process for reporting to the MCNZ, for the purposes of the MCNZ audit of recertification, those who are participating in the recertification program and whether they are complying or not.*
- *A system for identifying and managing compliance with recertification programs, and where appropriate to refer the doctor to the MCNZ.*
- *A system for informing the MCNZ if the provider becomes aware of performance / competence concerns on the part of the practitioner.*

- The College monitors compliance through its governance channels including the Professional Standards Committee, the Professional Development and Standards Board and the College Council.

- The College audits 7% of its Fellows, with this percentage based on a statistical analysis undertaken during the program review. In 2013 this increased verification rate was introduced and is currently being monitored.
- As noted in Section 9.1, the College amended its Code of Conduct policy to incorporate failure to comply with CPD. While there will be a measured response, Fellows who persistently fail to comply with their CPD requirements risk losing their Fellowship. It is anticipated that this process will commence in 2015.
- The College office in New Zealand is in regular contact with the MCNZ regarding the audit for recertification and there are processes in place to ensure non-compliance with CPD requirements is communicated for this purpose.
- The College values its responsibility in regards to remediation and the importance of addressing underperformance. The College has a process for re-skilling and re-training to assist those Fellows who are looking to re-enter the workforce or who require up skilling. The development of the eMSF tool also represents an important evolution in the College's support in this area. The tool provides a measurement of performance against the RACS competencies and can assist in identifying areas for improvement across technical and non-technical competencies.

Statistics and annual updates

Statistical data:

Data for CPD participation is published in the Activities Reports which are available for public assess on the RACS website.

Continuing Professional Development – Compliance

As of 28 May, 2014, for the 2013 CPD year:

- There were **5955** active Fellows with a requirement to participate in CPD for 2013
  - **4763** Fellows had a requirement to participate in the RACS CPD Program
  - **1192** reported participating in an alternative approved program
- Of the **4763** Fellows participating in the RACS program, **3951 (83%)** have returned their CPD data.

Professional Development Activities

- Currently in **2014** (to end of June) we have delivered 16 activities with 165 Fellows, 53 Non-Members, 10 IMGs and 7 Trainees for a total of 235 Participants. An additional 122 have participated in our online programs – 57 Clinical Decision Making, 44 Non Technical Skills for Surgeons (NOTSS), 18 Surgical Supervisors and Trainers for Surgical Education and Training (SAT SET) and 3 Surgical Education and Training – Selection Interviewer Training (SET SIT). To date for online and face to face courses, our numbers are 357 participants.
- In **2013**, 59 activities were delivered with 1096 attendees (748 Fellows, 74 Trainees, 29 IMGs and 245 non-members). An additional 186 participated in our online programs, making 1282 participants up to the end of 2013.

<u>New Zealand Specific – Orthopaedic Surgery</u>

- In 2011 the Practice Visit Programme (PvP) was unanimously voted to become a mandatory part of the orthopaedic CPD programme. Surgeons can expect to be visited or be a visitor on a rolling 5-7 year programme. The PvP has Protected Quality Assurance status. All visitors must see the visitee operating in theatre and the discussion must be open and transparent and conducted in a supportive atmosphere.
- As of April 2014 NZOA members are approximately 95% compliant with their CPD programme. NZOA is actively encouraging the non-compliant members to complete their requirements in a timely manner.

- *The categories of practitioner and the number of practitioners undertaking their recertification program.*
  - Operative 236
  - Non-operative including medico-legal 17
- *Any categories of practitioner that are not enrolled in the recertification programs.*
  - If they have a practicing certificate they are enrolled
- *Confirmation that the recertification program is available to practitioners registered within a vocational scope of practice who are not members*
  - If they have a practicing certificate they are enrolled
- *Details of hours that members are required to spend on recertification activities and how that is comprised.*
  - 70 hours
- *Whether the education provider collects information about the numbers of and outcomes for practitioners who undertake regular practice reviews*
  - Random audit of 10% of participants
- *Whether their practitioners have undertaken a credentialling process*
  - Yes

APPENDICES:

Appendix 1 List of Acronyms

AHPRA	Australian Health Practitioner Regulation Agency
ACF	Australian Curriculum Framework (Junior doctors)
AIHW	Australian Institute of Health and Welfare
AMC	Australian Medical Council
ANZASM	Australia and New Zealand Audit of Surgical Mortality
ANZAPS	Australian and New Zealand Association of Paediatric Surgeons
AOA	Australian Orthopaedic Association
AORA	Australian Orthopaedic Registrars Conference
ASC	Annual Scientific Congress (College)
ASM	Annual Scientific Meeting (Specialties)
BiGS	Board in General Surgery
BoPS	Board of Paediatric Surgery
BoRC	Board of Regional Chairs
BSET	Board of Surgical Education and Training
CAT & DOG	Paediatric Surgery Assessment tools CAT - Critical Appraisal Tasks: DOG - Directed Online Group Studies
CBD	Case-Based Discussion
CBT	Competency-based training
CCrISP	Care of the Critically Ill Surgical Patient (course)
CDM	Clinical Decision Making (course)
CE	Clinical Examination
CHFA	Consumers Health Forum of Australia
CLEAR	Critical Literature Evaluation and Research (course)
CPD	Continuing Professional Development
CPMC	Council of Presidents of Medical Colleges
CPMEC	Confederation of Postgraduate Medical Councils
CSSPE	Cardiothoracic Surgical Science and Principles Examination
CV	Curriculum Vitae
DHA	Department of Health and Aging
DHBs	District Health Boards
DOPS	Direct Observation of Procedures
EAU	European Association of Urology
EB	Education Board
ED	Emergency Department
ECMS	Expanded close marking system (Fellowship Examination)
EDRD	Education Development and Research Department
EMST	Early Management of Sever Trauma (course)
EPA	Entrustable Professional Activities
FEX	Fellowship Examination
FRACS	Fellow of the Royal Australasian College of Surgeons

GSA	General Surgeons Australia
HDU	High dependency unit
HETI	Health Education and Training Institute (NSW)
HWA	Health Workforce Australia
ICU	Intensive Care Unit
IMG	International Medical Graduate
ITA	In-Training Assessment
JRs	Jurisdictional representatives
KTOT	Keeping Trainees on Track (course)
MALT	Morbidity Audit and Logbook Tool
MBA	Medical Board of Australia
MCQ	Multi-choice Question
MCNZ	Medical Council of New Zealand
Mini-CEX	Mini-Clinical Examinations
MOPS	Maintenance of Professional Standards
MOSES	Management of Surgical Emergencies
MOU	Memorandum of Understanding
MOUSE	Measurement of Understanding of Surgical Expertise
MSF	Multi-Source Feedback – also know as 360^0
KTOT	Keeping Trainees on Track (course)
NCIM	Network of College IMG Managers
NMCE	Network of Medical College Educators
NOTSS	Non-technical Skills for Surgeons (course)
nSET	New 5 year training program in Urology
NZAGS	New Zealand Association of General Surgeons
NZOA	New Zealand Orthopaedic Association
NZMC	New Zealand Medical Council
PBA	Procedure Based Assessment
PCM	Process communication Model (course)
PD	Professional Development
P-MEX	Professionalism Assessment Form
PPA	Professional Performance Assessment
PSA	Provincial Surgeons of Australia
PRSSPE	Plastic and Reconstructive Surgical Science and Principles Examination
QA	Quality Assurance
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainees' Association
RCPSC	Royal College of Physicians and Surgeons of Canada
RCS	Royal College of Surgeons

SAG	Special Advisory Group
SA MET	South Australian Institute of Medical Education and Training
SAT SET	Supervisors and Trainers for SET (course)
SEAM	Surgical Education and Assessment Modules
SET	Surgical Education and Training
SSE	Surgical Sciences Examination
STP	Specialist Training Program
TIPS	Training in Professional Skills (course)
TSET	Trainee version of the SAT SET course (on-line course)
TSIA	Training Standards – Interpretation and Application (course)
USANZ	Urological Society of Australia and New Zealand
UTF	Urology Training forum
WPB	Workplace-based
YF	Younger Fellows
360^0	360 degree evaluation – also known as MSF

Surgical Specialties

CS /CAR	Cardiothoracic Surgery
GS /GEN	General Surgery
NS/NEU	Neurosurgery
OS/ORT	Orthopaedic Surgery
OHNS /OHN	Otolaryngology Head & Neck Surgery
PS/PEA	Paediatric Surgery
P&RS/PLA	Plastic & Reconstructive Surgery
U/ URO	Urology
VS/ VAS	Vascular Surgery

Appendix 2 Timetable for the planned move to competency-based training

The Royal Australasian College of Surgeons recognises competencies as a holistic combination of knowledge, skills and attitudes which, whilst the competencies are articulated as nine separate facets, together define the high standard of safe and comprehensive surgical care for the community expected of every surgical graduate.

RACS also recognises the difference between competence and performance. For this reason Trainee assessment will focus on specific time/specific skill assessment (such as DOPS; Mini-CEX; and examinations) plus longer term/wider perspective assessment in the workplace (such as log-books and in-training assessment).

However, RACS acknowledges that workplace-based 'competency' assessment poses major challenges in its implementation including the need for:

- well trained supervisors and trainers who will be undertaking these assessments
- trials on the implementation of workplace assessment tools
- on-going evaluation to ensure that appropriate training experiences are being provided
- discussion with the jurisdictions in order for surgeons to have the time required to undertake these assessments.

The move to competency-based training (CBT) is being implemented slowly and carefully with due attention to the progress being made internationally in the introduction of CBT, and the need to maintain the high standard of the current training program. To this end, the Training Standards booklet (TSIA): "*Becoming a competent and proficient surgeon: Training standard for the nine RACS Competencies*" has been designed to aid Supervisors and Trainees to map progression from selection and the beginning of training.

This resource is supported by additional on-line resources such as 'Goal Setting', 'Self Assessment', and 'Trainees in Difficulty' (all password protected).

Safe-hours guidelines and increased numbers of medical graduates have reduced typical working hours in PGY1-4 as well as during training. Less opportunity for clinical experiential learning will limit the influence of CBT in terms of shortened time of training programs such as the College's SET system. However, utilising CBT concepts and mapping progress (as described by TSIA documents), within the SET system should aid efficiency by identifying any issues across the RACS Nine Competencies early.

As indicated in the time-line on the following pages, the plan to introducing CBT is based on the recognised need to progress slowly, being informed at each stage by evaluation of our own processes as well as information from international developments:

- Introduction of competency-based assessment in the Fellowship Examination has already begun as the content is being aligned to the curricula. This will be a work in progress over several years and will be informed by experience as well as workplace-based assessment. Despite the publications available on the methodology to undertake this type of assessment, there is as yet no literature on its actual use in major examinations such as the Fellowship. For this reason it is not possible to give a specific timeline but reports to the AMC will cover the progress.
- Selection is being reviewed each year with clear recommendations made before the next round is undertaken.
- Curricula have been converted to a competency-based format and these will be continuously reviewed in the light of experience by each specialty and the published international literature.
- The increased use of simulation for training of technical skills is being carefully monitored

Importantly, on-going and meaningful consultation with the jurisdictions continues to be required to ensure that any potential effect on the current workforce system is recognised and managed. For example, when a Trainee fails to reach the required standard they need additional time and careful support from the supervisors. If they continue to underperform and are obliged to repeat a training period, this also entails additional resources. RACS and its specialties have experience in managing Trainees who may be underperforming however, the numbers may increase in this new system.

Proposed timeline for the progressive implementation of SET as a competency-based training program

Activity	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016+	Contingences and external factors
Research of international developments and world-best practice											
Involvement of specialty Boards, Examination Courts and committees in writing, reviewing, and revising materials											
Further definition of RACS competencies following an evaluation of modules and identifying where they did not adequately reflect progression through training											Continued development depends upon: ▪ Development of curriculum and validated assessment tools ▪ Training of Supervisors ▪ Validation research demonstrating that these process enhance/facilitate training
Definition and implementation of progressive Training Standards											▪ Validation of standards ▪ Training for Supervisors, Trainees & IMGs
Redefinition of specialty specific modules – technical expertise; medical expertise; judgement – clinical decision making											
Rewriting of generic modules — non-technical modules											Dependent on review of international research and trends
Aligning revised competencies with in-training assessment											
Development of specialty specific assessment matrix aligned with competencies											
Possible introduction of additional tools such as 360^0 to assess performance											
Aligning competencies with FEX											
Alignment of SSE and CE with appropriate competencies											
Revision of the generic SSE											
Introduction of revised generic SSE											The introduction of revised examinations and/ or examination processes will be phased to ensure that: ▪ no candidate is potentially disadvantaged and ▪ all candidates receive appropriate advanced notification of the changes
Development / review of speciality specific SSE											
Introduction of revised speciality specific SSE											
Evaluation of FEX to ascertain the extent to which elements of the examination are being addressed earlier in the program											
Trial of revised marking scheme for FEX											
Introduction of revised marking scheme for FEX											

Activity	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Contingences and external factors
Development of the policy and procedures for the Recognition of Prior Learning											
SAT SET program for supervisors – Phase 1											▪ The introduction of CBT is contingent upon having trainers and supervisors who are skilled in the assessment and evaluation of competencies. ▪ CBT requires increased supervisor/trainer time in the workplace ▪ Negotiation and collaboration with JRs is required to achieve recognition of designated time and/or paid supervision
Introduction of workplace-based assessment processes such as Mini-CEX; DOPS; CBD; PBA for Trainees This is ongoing as Trainees progress – introducing different assessment tools to all levels of training at appropriate intervals and frequency											
SAT SET program for supervisors – Phase 2 Keeping Trainees on Track (KTOT)											
Development of on-line resources for Supervisors and Trainees ▪ Trainees in Difficulty ▪ Sat SET for Trainees ▪ Training Standards – Interpretation and Application											
Development and introduction of additional courses (face-to-face and on-line for Supervisors, Trainees and IMGs addressing the non-technical competencies (NOTSS; TIPS; TSIA; CDM)											Continued development depends upon: ▪ Access to funding ▪ Availability of Trainers ▪ Validation research demonstrating that these experiences enhance/facilitate training and can transpose to the clinical setting
On-going evaluation of SET training program to ascertain effectiveness of training and identify: ▪ Additional competency training programs required ▪ Principles on which training time may be varied ▪ Where there may be scope for shortening training period											
The development of web based educational materials to support training and encompass non-technical competencies											
Negotiating and collaborating with Jurisdictions to manage the risk of any adverse impact on workforce requirements and effect on employment conditions e.g. salary scale determinations											Continued involvement of JRs in College committees
Evaluation of selection processes to ascertain alignment between selection attributes and training competencies											

Appendix 3 The number of trainees across the specialties 2007-2013

Data Source: RACS Activities reports 2007-2013	Number of trainees per year - Australia (NZ)		Number of active trainees per year - Australia (NZ & other)				
Specialty	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Cardiothoracic Surgery	30 (6)	26 (5)	37 (6)	31 (3)	32 (3)	30 (4)	37 (6)
General Surgery	304 (60)	375 (60)	380 (68)	371 (62)	408 (68)	359 (60)	444 (72)
Neurosurgery	47 (-)	46 (5)	47 (5)	49 (7)	52 (6)	48 (5)	57 (4)
Orthopaedic Surgery	178 (49)	192 (48)	215 (58)	208 (56)	214 (55)	191 (49)	225 (50)
Otolaryngology Head & Neck Surgery	67 (11)	80 (15)	82 (11)	80 (15)	75 (15)	66 (15)	71 (18)
Paediatric Surgery	14 (6)	16 (3)	23 (2)	21 (3)	21 (3)	19 (3)	28 (3)
Plastic & Reconstructive Surgery	59 (7)	72 (15)	69 (18)	76 (20)	82 (16)	66 (18)	78 (22)
Urology	68 (10)	95 (14)	101 (18)	101 (15)	112 (19)	100 (13)	114 (19)
Vascular Surgery	28 (6)	38 (4)	46 (6)	40 (9)	38 (5)	38 (4)	40 (8)
Total	950	1109	1192	1167	1224	1088	1296

Notes:

- Data from the 2007 and 2008 Activities Reports did not distinguish between ‘active trainees’ and those on different kinds of leave.
- The numbers of active trainees fluctuates between years for a variety of reasons e.g. withdrawal or dismissal from the program; trainees taking different kinds of approved leave (heath; maternity; study; research; personal); deferral of commencement; pending and subsequent pass of the Fellowship Examination.

Appendix 4 Program for the 2013 Conjoint Medical Education Seminar

Serving the Community: Training Generalists and Extending Specialists

	Program	Presenters
8:30 am	Welcome	Associate Professor Leslie Bolitho
Session 1	Facilitator: Professor Richard Doherty	
8:40 am	Keynote Address – What is a Generalist? Mapping the Problem/implications	Associate Professor Phil Carson Mr Andrew Connolly Dr Jason Frank
9:40 am	Questions and Answers	
10:00 am	Morning Rea	
Session 2	Facilitator: Professor Nicholas Talley	
10:20 am	How do we deliver safe, effective and timely specialty medical care to populations which are distributed widely and unevenly?	Dr Ruth Kearon Mrs Anne Kolbe
11:00 am	Questions and Answers	
11:20 am	Break	
Session 3	Facilitator: Dr Andrew Padmos	
11:30 am	What does the future hold?	Mr James Birch Dr Bryce Taylor
12:10 pm	Questions and Answers	
12:30 pm	Lunch	
Session 4	Facilitator: Dr Ken Harris	
1:15 pm	Education and career transitions What success should look like?	Professor Trish Davidson Dr Kevin Imrie Dr Marie-Louise Stokes
2:00 pm	Questions and Answers	
2:20 pm	Afternoon tea	
Session 5	Facilitator: Associate Professor Stephen Tobin	
2.:40 pm	Panel Discussion What would success in addressing 'Generalist' agenda look like? What needs to change to achieve success?	
3:50	Break	
Session 6	Facilitator: Dr Jennifer Alexander	
4:00 pm	Wrap Up	Professor Richard Smallwood
4:20	Closing Remarks	Associate Professor Michael Hollands
4.30 pm	Close	

Appendix 5 Surgical Leaders Forum (2013)

SURGICAL LEADERS FORUM

8.30AM – 12.30PM, THURSDAY 31 OCTOBER 2013

RACS TRAINING AREA, LEVEL 2

MELBOURNE

9.00 – 9.10 10 mins	**Introduction** Chair: A*/Prof Mike Hollands, RACS President*
9.10 – 9.30 20 mins	**Role of Specialty Elected Councillors** *Garry Wilson* (Results of survey of SECs) *John Fuller* (Societies' expectations) *Roger Paterson* (Personal experience – representing two Societies) *Michael Grigg* (Governance – historical and future)
9.30 – 10.20 50 mins	**Discussion/Q & A** Facilitator: *John Batten* Panel: *Robert Costa, David Theile, David Winkle, Tony Sparnon*
10.20 – 10.30 10 mins	**Conclusions/Outcomes** *Cathy Ferguson*
10.30 – 11.00 30 mins	Morning tea
11.00 – 11.20 20 mins	**Role of Specialty Training Board Chairs/Role of BSET** *Phil Truskett* (Vision for BSET) *Stephen Tobin* (Resource for the Societies) *Richard Bloom* (Specialty's perspective) *Richard Gallagher* (Specialty's perspective)
11.20 – 12.20 60 mins	**Discussion/Q & A** Facilitator *John Quinn* Panel *Rowan French, Peter Choong, John Curotta, Deborah Bailey*
12.20 – 12.30 10 mins	**Conclusions/Outcomes** *Simon Williams*
12.30 – 1.30pm 60 mins	Informal lunch

Appendix 6 Examples of Interactions with the Health Sector

NSW REGIONAL OFFICE

2014 College Representatives on External Organisations

EXTERNAL ORGANISATION	REPRESENTATIVE
Area of Need Advisory Committee	Mr Robert Costa
Collaborating Hospitals Audit of Surgical Mortality (CHASM)	Dr Mary Langcake
CEC – Blood Clinical and Scientific Advisory Committee (BCSAC)	Mr Vincent Lam
Clinical Surgical Training Council (CTSC)	A/Prof David Storey
GP Procedural Training Program Committee	Mr Gary Fermanis
Health Care Complaint Commission (HCCC)	Mr Robert Costa
Health Education and Training Institute (HETI)	A/Prof David Storey
Master of Clinical Medicine External Advisory Group	Prof Stephen Deane
NSW Medical Board	Mr Anthony A. Eyers
Nursing Issues	Mr Tim Musgrove
Private Health Facilities Advisory Committee	Mr Tim Musgrove
Standards Australia CS-100 Bicycles Committee	Prof Michael Besser
Surgical Services Taskforce Committee (SST)	Dr Mary Langcake
Workcover - Whole Person Impairment (WPI) Co-coordinating Committee	Dr Neil Berry

NEW ZEALAND

2014 College Representatives or nominees on committees / advisory groups

Organisation	Representative
National Information Clinical Leaders Group (set up by the IT Health Board, Ministry of Health)	Allan Panting
Orthopaedic Surgery Prioritisation Working Group (set up by National Health Board, Ministry of Health)	Allan Panting
General Surgery Prioritisation Working Group (set up by National Health Board, Ministry of Health)	Allan Panting
Cardiovascular Working Group (set up by National Health Committee, Ministry of Health)	Harsh Singh
Respiratory Working Group (set up by National Health Committee, Ministry of Health)	Peter Alison
PHARMAC Wound Care Advisory Group	John de Waal
New Zealand Resuscitation Council	Murray Cox

SA REGIONAL OFFICE

2014 College Representatives on External Organisations

EXTERNAL ORGANISATION	REPRESENTATIVE
AMA Craft Group	Dr David Walsh
SA Regional Trauma Committee	Mr Rob Atkinson
SA Health Committee of College Chairs	Dr Sonja Latzel
SA Health Surgical Services Taskforce	Dr Sonja Latzel
SA Medical Education and Training (SA MET)	
Sportsmed SA Management Committee	No individual chosen yet

Appendix 7 Data from the Fellowship Examination May 2014

A. Total numbers and % from each region

	ACT	NSW	NT	QLD	SA	VIC	WA	NZ	Total
Total	**2**	**67**	**3**	**34**	**14**	**39**	**18**	**31**	**208**
PASS	1	44	1	22	11	31	11	21	**142 68.2%**
FAIL	1	23	2	12	3	8	7	10	**66 31.7%**
% pass rate		**65.6%**	**33%**	**64.7%**	**78.5%**	**79.5%**	**61%**	**67.7%**	

B. Numbers and % across each specialty and region

Total		**ACT**	**NSW**	**NT**	**QLD**	**SA**	**VIC**	**WA**	**NZ**	**Total**
		2	**67**	**3**	**34**	**14**	**39**	**18**	**31**	**208**
CAR	**SAT**	**0**	**2**	**0**	**0**	**1**	**1**	**0**	**0**	**4**
	PASS	0	2 100%	0	0	1 100%	0	0	0	**3 75%**
	FAIL	0	0	0	0	0	1 100%	0	0	**1 25%**
GEN	**SAT**	**0**	**26**	**3**	**11**	**5**	**13**	**5**	**10**	**73**
	PASS	0	19 73%	1 33%	8 72.7%	4 80%	12 92.3%	4 80%	7 70%	**55 75.3%**
	FAIL	0	7 27%	2 66%	3 26.3%	1 20%	1 7.7%	1 20%	3 30%	**18 24.7%**
NEU	**SAT**	**0**	**3**	**0**	**1**	**1**	**6**	**0**	**1**	**12**
	PASS	0	3 100%	0	0	1 100%	5 83.3%	0	1 100%	**10 83.3%**
	FAIL	0	0	0	1 100%	0	1 16.7%	0	0	**2 16.7%**
ORT	**SAT**	**0**	**23**	**0**	**13**	**4**	**8**	**8**	**11**	**67**
	PASS	0	13 56.5%	0	8 61.5%	3 75%	7 87.5%	5 62.5%	6 54.5%	**42 62.7%**
	FAIL	0	10 43.5%	0	5 38.5%	1 25%	1 12.5%	3 37.5%	5 45.5%	**25 37.3%**
OTO	**SAT**	**1**	**7**	**0**	**3**	**2**	**4**	**1**	**4**	**22**
	PASS	0	2 28.6%	0	2 66.6%	1 50%	2 50%	0	3 75%	**10 45.5%**
	FAIL	1	5 71.4%	0	1 33.3%	1 50%	2 50%	1 100%	1 25%	**12 54.5%**
PAE	**SAT**	**0**	**1**	**0**	**1**	**0**	**1**	**1**	**0**	**4**
	FAIL	0	1	0	1	0	1	1	0	**4 100%**

PLA	**SAT**	**0**	**3**	**0**	**1**	**1**	**5**	**2**	**3**	**15**
	PASS	0	3 100%	0	0	1 100%	4 80%	1 50%	2 66.6%	**11** **73.3%**
	FAIL	0	0	0	1 100%	0	1 20%	1 50%	1 33.3%	**4** **26.7%**
URO	**SAT**	**0**	**1**	**0**	**3**	**0**	**0**	**1**	**1**	**6**
	PASS	0	1	0	3	0	0	1	1	**6** **100%**
VAS	**SAT**	**1**	**1**	**0**	**1**	**0**	**1**	**0**	**1**	**5**
	PASS	1	1	0	1	0	1	0	1	**5** **100%**

Appendix 8 Findings from 2013 RACSTA surveys

The following Tables indicate that the majority of trainees felt that their experience in both acute and elective theatres was 'about right'.

Table 1 Acute operative exposure and support

Response	Clearly not enough	Not quite enough	About right	A little too much	Clearly too much
My acute operating exposure was	10.36%	26.29%	**59.36%**	2.79%	1.20%
Acute operating support from the consultants was	3.60%	10.00%	**80.40%**	5.20%	0.80%
The support provided for my acute decision-making was	3.20%	6.80%	**85.20%**	3.20%	1.60%

Table 2 Experience in elective theatre

Response	Clearly not enough	Not quite enough	About right	A little too much	Clearly too much
The level of responsibility I was given in elective theatre was	6.48%	20.65%	**70.85%**	2.02%	0.00%
Learning opportunities in elective theatre were	7.69%	21.86%	**69.23%**	0.40%	0.81%
The level of responsibility I was given on the wards was	2.83%	6.48%	**84.62%**	5.26%	0.81%
Learning opportunities on the wards were	5.26%	22.67%	**71.26%**	0.81%	0.00%
My elective operating exposure was	5.67%	27.13%	**64.78%**	2.02%	0.40%

Appendix 9 Data from the 2013 evaluation of SET

Responses from Supervisors

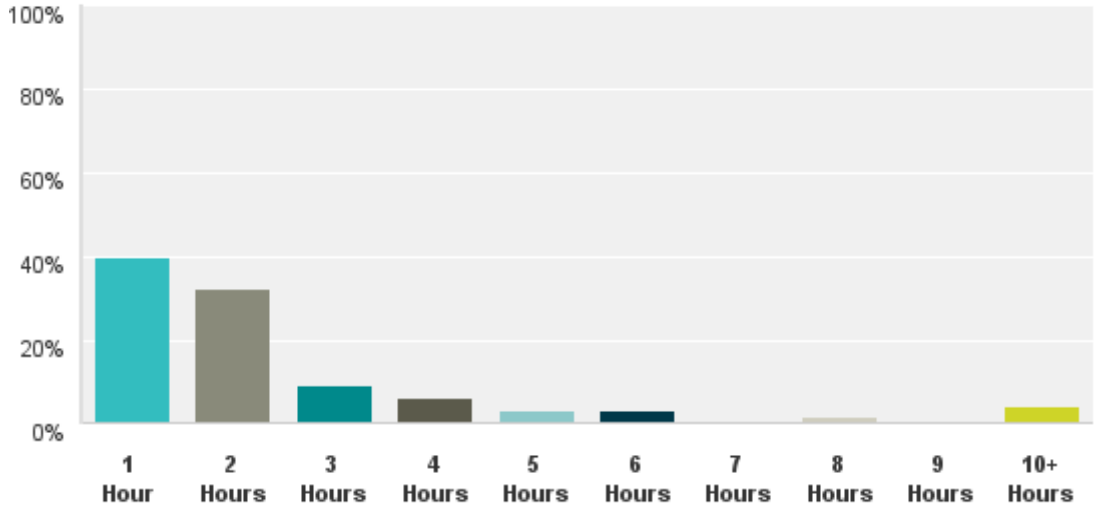
- Overall 191 supervisors completed the survey
- Respondents represented each of the surgical specialties and each of the regions

1) Appropriate PGY level for 1st year of training
   - Half (50%) of the 85.7% of respondents who indicated that there was an appropriate PGY level to commence training prefer PGY4; 40% indicated PGY3

2) Change of workload for trainers and supervisors since the introduction of SET
   - Two-thirds of respondents (67.15%) said that the workload had increased whilst 32.85% said that it had not increased

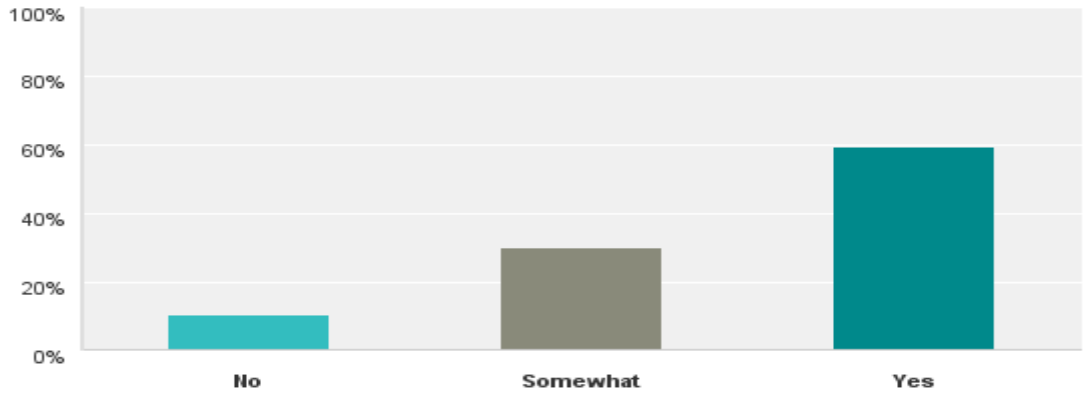
3) Time allocated to administration related to supervision

   Although the majority of supervisors indicated that they spent 1-2 hours per week on administration a small proportion said that they spent over 5 hours per week



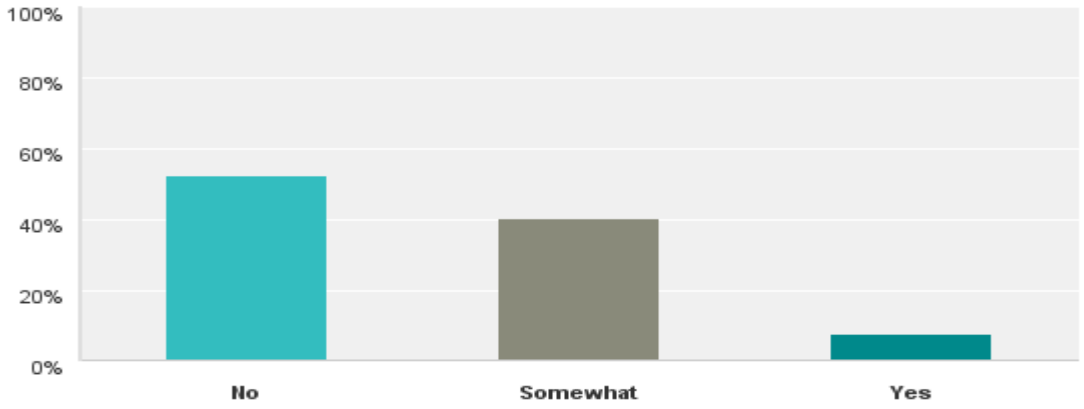
4) Appropriateness of the expectations of the training boards

   Whist the majority of supervisors indicated that their workload had increased, a similar proportion indicated that they thought the expectations of their training board were appropriate. Only a small proportion felt that they were not appropriate.



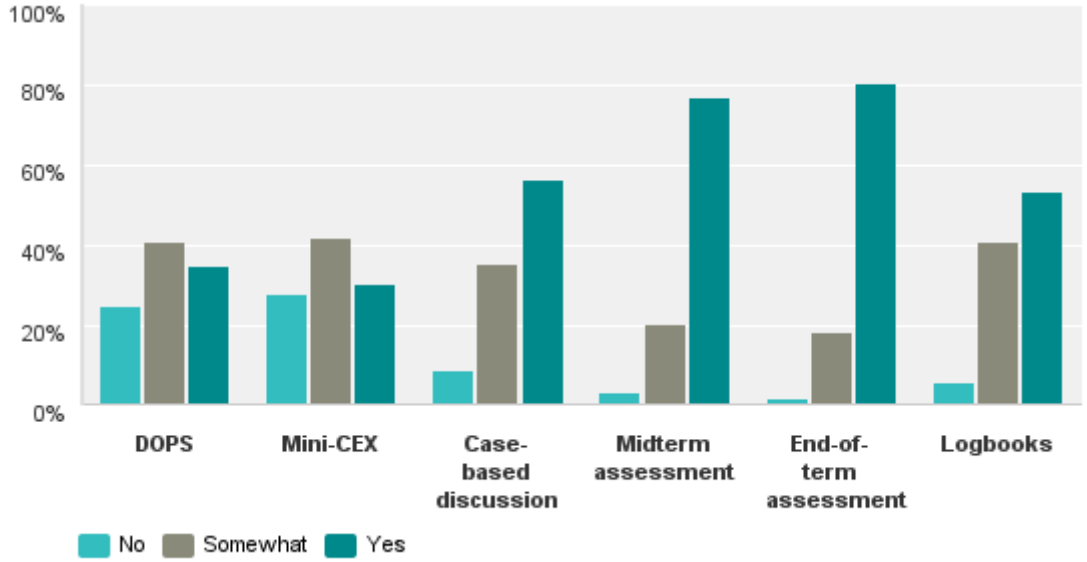
5) Support from jurisdictions for their time commitment

Supervisors were much less positive about the amount of support from jurisdictions for their time commitment. Note: this also correlates with concerns expressed by trainees



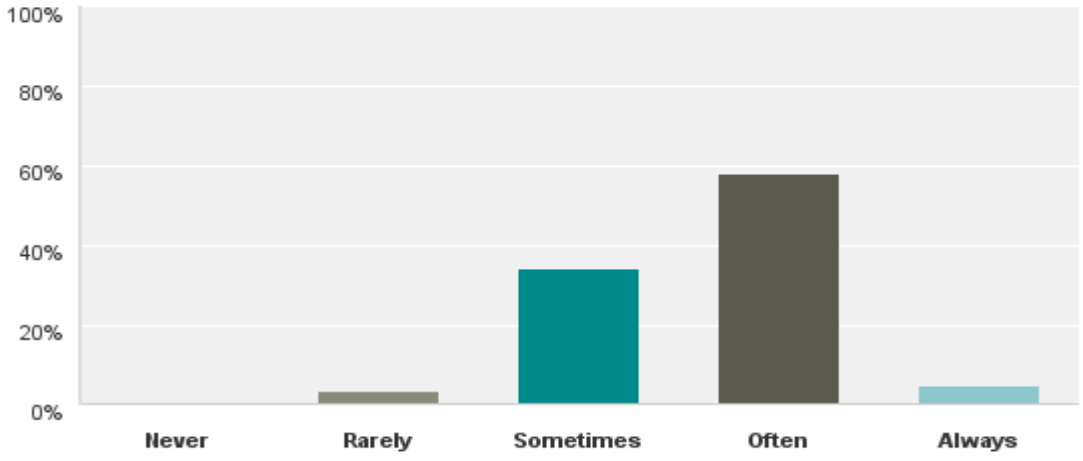
6) Usefulness of formative assessment in assessing trainee performance

Of the range of work-place based assessment tools the majority of supervisors indicated that they found DOP S and mini-CEX less useful that the other tools.



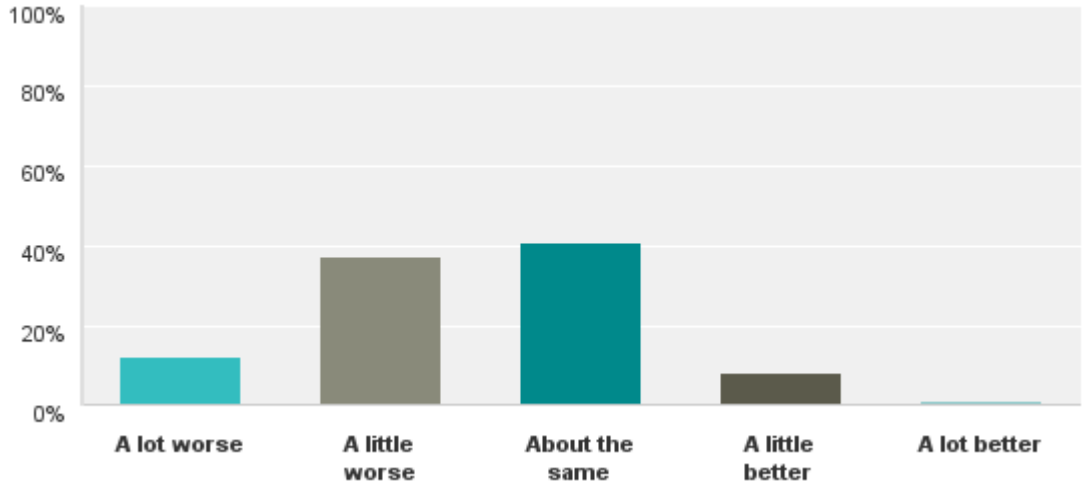
7) Suitability of the level of competency upon completion of training

See specific comments below



8) Comparison of level of knowledge and skill of senior SET trainees compared with AST

See specific comments below



- Supervisors concerns in relation to senior SET trainees levels of knowledge, skills and overall competence were attributed to a number of factors:
  - Trainees need more time - either before training (so they start at a higher level and can be involved in more complex cases from earlier in training) or more time in training.
  - If safe hours are to apply, then the training will need to be lengthened to achieve an adequate experience to work safely and independently at the end of training
  - There are probably too many rotations where the SET trainee acts as a resident while the Fellow (recent graduated undergoing sub-specialty training) does most of the operating
  - We continue to struggle to give them adequate exposure to very common procedures
  - Reduce the numbers of trainees at sites with multiple registrars or extend training
  - Due to pressure of lists and more complex surgery on list the trainees are getting less as primary operator

Responses from Younger Fellows

- Overall 159 Younger Fellows completed the survey
- Respondents represented each of the surgical specialties and each of the regions

1) Rural practice

- The majority of respondents (65.4%) reported that they were not currently involved in or considering rural practice. Of the others 25.8% said yes, whilst 8.8% were unsure.

2) Post-Fellowship training

- Almost three-quarters of respondents (74.5%) indicated that they are currently undertaking or planning to undertake post-fellowship training. Of the others 19.1% said no, and 6.4% were unsure.

3) Confident to perform core procedures on completion of training

- The majority of respondents (74.1%) indicated that they felt confident to perform the core procedures of their specialty upon completion of training. 20.2% said that they felt somewhat confident (and indicated that this depended on whether they were ‘private core procedures’ or the level of complication). Only 5.7% of respondents indicated that they did not feel confident.

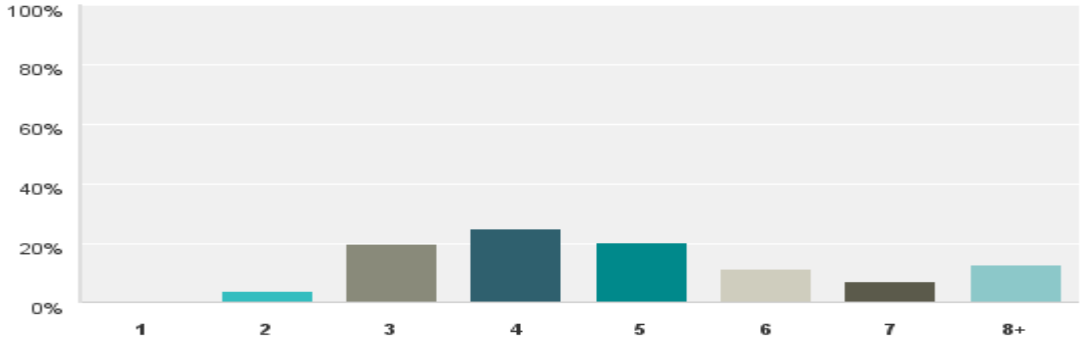
4) Difficulty in find a job on completion of training

- The majority of respondents (62.4%) did not experience any difficulties finding a job post-fellowship

Responses from Trainees

- Overall 227 Trainees completed the survey
- Respondents represented each of the SET levels, each of the surgical specialties, and each of the regions

1) PGY level when commencing SET training

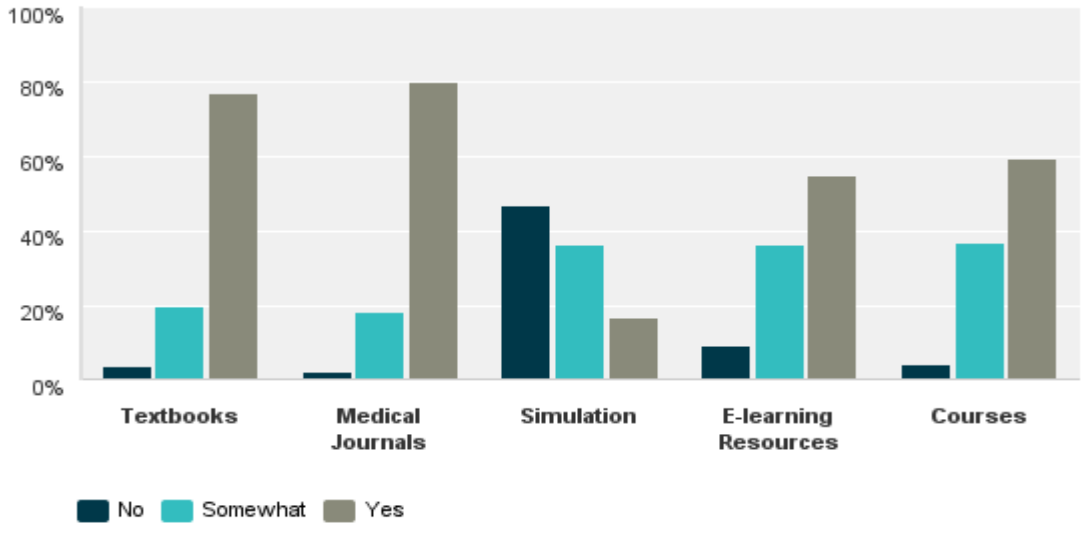


2) Experience during rotations

The following Table gives an indication of the variability of trainees experiences across several parameters (see p.27 for negative comments from Younger Fellows and trainees)

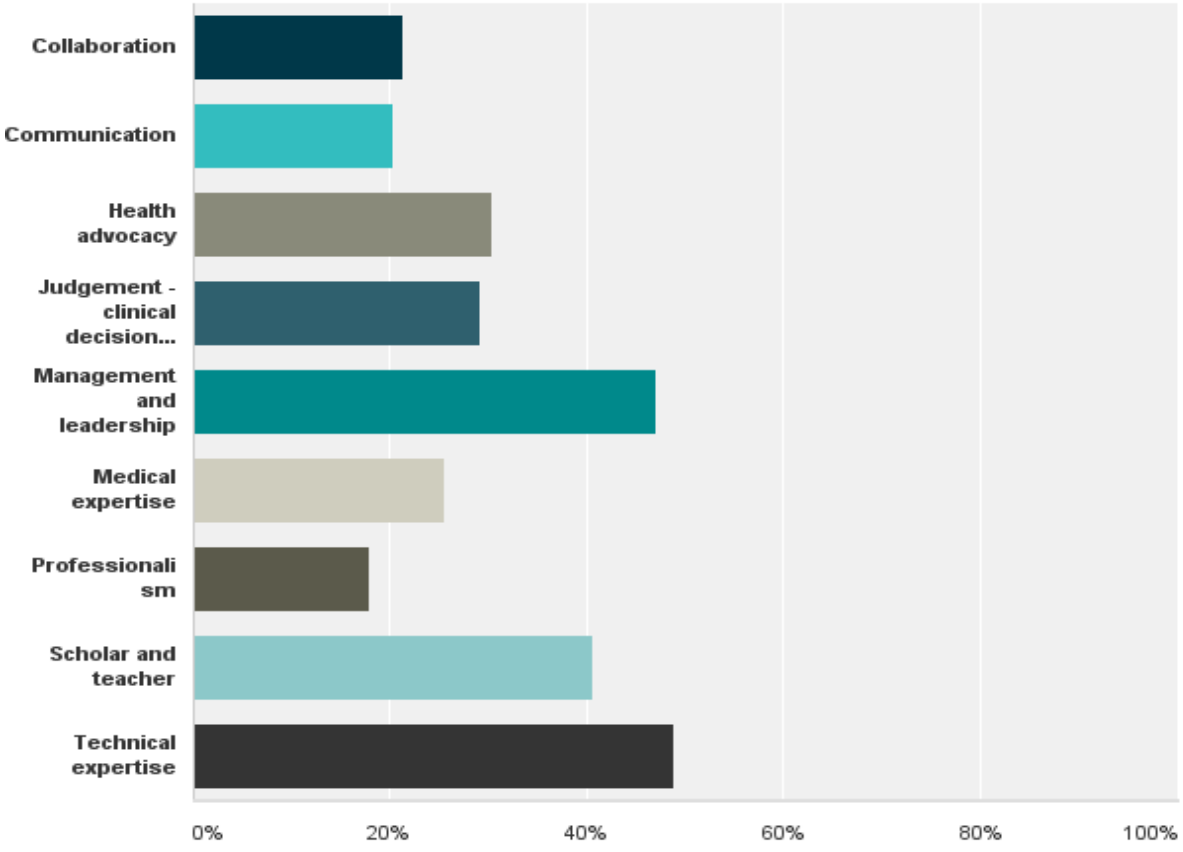
	In no rotations	In some rotations	In most rotations	In all rotations
I am given relief from work duties to participate in formal education programs	8.9%	**41.2%**	32.7%	17.3%
I receive adequate teaching and supervision for my level of experience	1.8%	28.3%	**52.7%**	17.3%
I receive appropriate feedback which is useful in guiding my ongoing performance	2.7%	29.7%	**46.5%**	21.2%
I have sufficient opportunity to acquire the range of skills appropriate to my level of training	3.5%	32.6%	**48.9%**	15.0%
Hospital placements have been suitable for my level of training	1.8%	21.6%	**54.2%**	22.5%
I have adequate access to relevant procedures for my level of training	1.8%	31.0%	**50.0%**	17.3%

3) Access to learning resources
Of the listed learning resources trainees indicated that they had least access to simulation



4) Which of the nine RACS competencies require more training and support

Whilst the trainees indicated that they would like more training in all of the nine competencies, Management and Leadership and Technical Expertise were the two given highest priority with Scholar and Teacher as the third. See Standard 4 p.19 for information about the new Foundation Course and Section 6.1 p. 26 for information about the Professionalism and Leadership Workshop.



Appendix 10 List of hospital posts accredited / reaccredited in 2013

Hospital Name	Specialty	Region	Country	Valid From	Valid Til
Flinders Medical Centre	CAR	SA	AUSTRALIA	01/01/2014	31/12/2018
Royal Adelaide Hospital	CAR	SA	AUSTRALIA	01/01/2014	31/12/2018
Royal Perth Hospital	CAR	WA	AUSTRALIA	01/01/2014	31/12/2014
Sir Charles Gairdner Hospital	CAR	WA	AUSTRALIA	01/01/2014	31/12/2014
Alfred Hospital	CAR	VIC	AUSTRALIA	01/01/2014	31/12/2018
Epworth Private (Richmond) Hospital	CAR	NSW	AUSTRALIA	01/01/2014	31/12/2018
Royal Prince Alfred Hospital	CAR	NSW	AUSTRALIA	01/01/2011	31/12/2015
Christchurch Hospital	CAR	NZ	NEW ZEALAND	01/01/2014	31/12/2018
Royal North Shore	GEN	NSW	AUSTRALIA	2014	2018
Mona Vale	GEN	NSW	AUSTRALIA	2018	2018
St Vincent's Hospital (Sydney)	GEN	NSW	AUSTRALIA	2014	2018
Gosford Hospital	GEN	NSW	AUSTRALIA	2014	2018
Hawkesbury District Health Service Ltd	GEN	NSW	AUSTRALIA	2014	2018
Manly Hospital and Community Health Service	GEN	NSW	AUSTRALIA	2014	2018
Hornsbury Kuringai	GEN	NSW	AUSTRALIA	2014	2014
John Hunter	GEN	NSW	AUSTRALIA	2014	2018
Maitland	GEN	NSW	AUSTRALIA	2014	2014
Auburn	GEN	NSW	AUSTRALIA	2014	2018
Concord Repatriation General	GEN	NSW	AUSTRALIA	2014	2018
Royal Prince Alfred	GEN	NSW	AUSTRALIA	2014	2018
Bathurst Base Hospital	GEN	NSW	AUSTRALIA	2014	2014
Nepean Hospital	GEN	NSW	AUSTRALIA	2014	2018
Westmead Hospital	GEN	NSW	AUSTRALIA	2014	2018
Orange Base	GEN	NSW	AUSTRALIA	2014	2014
Wagga Wagga Base	GEN	NSW	AUSTRALIA	2014	2014
Canberra	GEN	NSW	AUSTRALIA	2014	2018
Goulburn Base	GEN	NSW	AUSTRALIA	2014	2014
Calvary Public/Private Hospital	GEN	NSW	AUSTRALIA	2014	2018
Canterbury Hospital and Community Health Service	GEN	NSW	AUSTRALIA	2014	2018
Liverpool Hospital	GEN	NSW	AUSTRALIA	2014	2014
St George Hospital	GEN	NSW	AUSTRALIA	2014	2018
Bega District	GEN	NSW	AUSTRALIA	2014	2018
Blacktown	GEN	NSW	AUSTRALIA	2014	2014
Mt Druitt	GEN	NSW	AUSTRALIA	2014	2018
Belmont District	GEN	NSW	AUSTRALIA	2014	2014
Coffs Harbour Health Campus	GEN	NSW	AUSTRALIA	2014	2018
St Vincent's Private Hospital (Lismore)	GEN	NSW	AUSTRALIA	2014	2018
Wyong	GEN	NSW	AUSTRALIA	2014	2018
Broken Hill Health Service	GEN	NSW	AUSTRALIA	2014	2014
Calvary Mater Newcastle	GEN	NSW	AUSTRALIA	2014	2018
Manning Base	GEN	NSW	AUSTRALIA	2014	2018
Port Macquarie	GEN	NSW	AUSTRALIA	2014	2014
Fairfield Health Service	GEN	NSW	AUSTRALIA	2014	2018
Shoalhaven District Memorial	GEN	NSW	AUSTRALIA	2014	2018
Tamworth Base	GEN	NSW	AUSTRALIA	2014	2018
Campbelltown	GEN	NSW	AUSTRALIA	2014	2018

Wollongong	GEN	NSW	AUSTRALIA	2014	2018
Dubbo Base	GEN	NSW	AUSTRALIA	2014	2018
North Shore Private	GEN	NSW	AUSTRALIA	2014	2014
Norwest Private	GEN	NSW	AUSTRALIA	2014	2018
Bankstown - Lidcombe	GEN	NSW	AUSTRALIA	2014	2018
Prince of Wales	GEN	NSW	AUSTRALIA	2014	2018
Sutherland Hospital	GEN	NSW	AUSTRALIA	2014	2018
Armidale	GEN	NSW	AUSTRALIA	2014	2018
Ryde Hospital	GEN	NSW	AUSTRALIA	2014	2018
Tweed Hospital	GEN	NSW	AUSTRALIA	2014	2018
Lismore Base	GEN	NSW	AUSTRALIA	2014	2018
Alfred Hospital	GEN	VIC	AUSTRALIA	2013	2015
Bentley	GEN	WA	AUSTRALIA	2013	2013
Fremantle	GEN	WA	AUSTRALIA	2014	2014
Royal Perth Hospital	GEN	WA	AUSTRALIA	2014	2014
Colac District	GEN	VIC	AUSTRALIA	2014	2014
Frimley Park (SW Thames) Hospital	GEN	SA	AUSTRALIA	2014	2017
Hurstville	GEN	NSW	AUSTRALIA	2014	2014
Mackay Base Hospital	GEN	QLD	AUSTRALIA	2014	2018
Cairns	GEN	QLD	AUSTRALIA	2014	2014
Royal Adelaide Hospital	GEN	SA	AUSTRALIA	2014	2014
Riverland Regional Hospital	GEN	SA	AUSTRALIA	2014	2014
Whyalla Hospital	GEN	SA	AUSTRALIA	2014	2014
Lyell McEwin	GEN	SA	AUSTRALIA	2014	2014
Port Lincoln	GEN	SA	AUSTRALIA	2014	2014
Royal Darwin Hospital	GEN	SA	AUSTRALIA	2014	2014
Northern Hospital	GEN	VIC	AUSTRALIA	2014	2014
Epworth Private (Richmond) Hospital	GEN	VIC	AUSTRALIA	2014	2015
Frankston Hospital	GEN	VIC	AUSTRALIA	2014	2015
Mildura Base	GEN	VIC	AUSTRALIA	2014	2015
Royal Melbourne Hospital	GEN	VIC	AUSTRALIA	2014	2015
Tasmanian Health (NW Mersey)	GEN	VIC	AUSTRALIA	2014	2015
Sir Charles Gairdner Hospital	GEN	WA	AUSTRALIA	2014	2014
Bunbury Hospital	GEN	WA	AUSTRALIA	2014	2014
Whangarei	GEN NZ	NZ	NEW ZEALAND	2014	2017
Dunedin	GEN NZ	NZ	NEW ZEALAND	2014	2017
Wellington	GEN NZ	NZ	NEW ZEALAND	2014	2014
Liverpool Hospital	NEU	NSW	AUSTRALIA	01/01/2014	31/12/2014
Monash Medical Centre	NEU	VIC	AUSTRALIA	01/01/2014	31/12/2018
Princess Alexandra	NEU	QLD	AUSTRALIA	01/01/2014	31/12/2018
Royal Hobart Hospital	NEU	TAS	AUSTRALIA	01/01/2014	31/12/2018
St Vincent's Public/Private (Melbourne)	NEU	VIC	AUSTRALIA	01/01/2014	31/12/2018
St Vincent's Public/Private (Sydney)	NEU	NSW	AUSTRALIA	01/01/2014	31/12/2014
St George Public/Private Hospital	NEU	NSW	AUSTRALIA	01/01/2014	31/12/2018
Flinders Medical Centre	NEU	SA	AUSTRALIA	01/01/2014	31/12/2014
Adelaide Women's and Children's Hospital	NEU	SA	AUSTRALIA	01/01/2014	31/12/2014
Monash Medical Centre	OHN	VIC	AUSTRALIA	01/01/2013	31/12/2017
Geelong Hospital	OHN	VIC	AUSTRALIA	01/01/2013	31/12/2017

Royal Perth Hospital	OHN	WA	AUSTRALIA	01/01/2013	31/12/2017
Royal Adelaide Hospital	OHN	SA	AUSTRALIA	01/01/2013	31/12/2017
Liverpool Hospital	OHN	NSW	AUSTRALIA	01/01/2013	31/12/2017
Westmead Hospital	OHN	NSW	AUSTRALIA	01/01/2013	31/12/2013
Royal Prince Alfred	OHN	NSW	AUSTRALIA	01/01/2014	31/12/2014
St George Hospital	OHN	NSW	AUSTRALIA	01/01/2014	31/12/2014
Royal Darwin Hospital	OHN	NT	AUSTRALIA	01/01/2014	31/12/2018
Logan Hospital	OHN	QLD	AUSTRALIA	01/01/2014	31/12/2018
Princess Alexandra	OHN	QLD	AUSTRALIA	01/01/2014	31/12/2018
Royal Children's Hospital (QLD)	OHN	QLD	AUSTRALIA	01/01/2014	31/12/2018
Adelaide Women's and Children's Hospital	OHN	SA	AUSTRALIA	01/01/2014	31/12/2014
Royal Children's Hospital (VIC)	OHN	VIC	AUSTRALIA	01/01/2014	31/12/2014
Royal Victorian Eye and Ear Hospital	OHN	VIC	AUSTRALIA	01/01/2014	31/12/2018
St Vincent's Hopistal (VIC)	OHN	VIC	AUSTRALIA	01/01/2014	31/12/2018
Dunedin	OHN NZ	NZ	NEW ZEALAND	01/01/2013	31/12/2013
North Shore and Watakarei	OHN NZ	NZ	NEW ZEALAND	01/01/2013	31/12/2017
Starship Children's Hospital	OHN NZ	NZ	NEW ZEALAND	01/01/2013	31/12/2017
Christchurch Hospital	OHN NZ	NZ	NEW ZEALAND	01/01/2014	31/12/2018
Christchurch Hospital	OHN NZ	NZ	NEW ZEALAND	01/01/2014	31/12/2018
Dunedin	OHN NZ	NZ	NEW ZEALAND	01/01/2014	31/12/2014
Palmerston North Hospital	OHN NZ	NZ	NEW ZEALAND	01/01/2014	31/12/2018
Whangarei	OHN NZ	NZ	NEW ZEALAND	01/01/2014	31/12/2018
Coffs Harbour Health Campus	ORT	NSW	AUSTRALIA	2014	2019
Dubbo Base	ORT	NSW	AUSTRALIA	2014	2019
Gosford Hospital	ORT	NSW	AUSTRALIA	2014	2019
Hawkesbury District Health Service Ltd	ORT	NSW	AUSTRALIA	2014	2016
Lismore Base	ORT	NSW	AUSTRALIA	2014	2019
Nepean Hospital	ORT	NSW	AUSTRALIA	2014	2019
Orange Base	ORT	NSW	AUSTRALIA	2014	2019
Port Macquarie	ORT	NSW	AUSTRALIA	2014	2019
Royal Newcastle/John Huner/Belmont	ORT	NSW	AUSTRALIA	2014	2019
Belmont District	ORT	NSW	AUSTRALIA	2014	2016
Sydney Children's Hospital	ORT	NSW	AUSTRALIA	2014	2019
Maitland Hospital	ORT	NSW	AUSTRALIA	2014	2019
Wagga Wagga Base Hospital	ORT	NSW	AUSTRALIA	2014	2019
Westmead Hospital	ORT	NSW	AUSTRALIA	2014	2019
Wollongong Hospital	ORT	NSW	AUSTRALIA	2014	2019
Wyong Hospital	ORT	NSW	AUSTRALIA	2014	2019
Canberra/Calvary Health Care ACT	ORT	NSW	AUSTRALIA	2014	2019
Royal Darwin Hospital	ORT	NT	AUSTRALIA	2014	2019
Royal Brisbane and Women's Hospital	ORT	QLD	AUSTRALIA	2014	2015
Logan Hospital	ORT	QLD	AUSTRALIA	2014	2015
Norwest Private Hospital	ORT	VIC	AUSTRALIA	2014	2017
Alfred Hospital	ORT	VIC	AUSTRALIA	2014	2018
Sir Charles Gardiner	ORT	WA	AUSTRALIA	2014	2016
Joondalup Health Campus	ORT	WA	AUSTRALIA	2014	2016
Shriners Hospital for Children	ORT	USA	AUSTRALIA	2014	2019

Mater Children's Hospital	PAE	QLD	AUSTRALIA	01/01/2014	31/12/2018
Royal Children's Hospital (Brisbane)	PAE	QLD	AUSTRALIA	01/01/2014	31/12/2018
Gold Coast Hospital	PAE	QLD	AUSTRALIA	01/01/2014	31/12/2018
Toowoomba	PAE	QLD	AUSTRALIA	01/01/2014	31/12/2018
Canberra Hospital	PAE	ACT	AUSTRALIA	01/01/2014	31/12/2018
Campbelltown	PAE	NSW	AUSTRALIA	01/01/2014	31/12/2018
Westmead Children's Hospital	PAE	NSW	AUSTRALIA	01/01/2014	31/12/2018
Sydney children's Hospital	PAE	NSW	AUSTRALIA	01/01/2014	31/12/2018
John Hunter Children's Hospital	PAE	NSW	AUSTRALIA	01/01/2014	31/12/2018
Canberra	URO	ACT	AUSTRALIA	01/01/2013	31/12/2013
North Shore/Middlemore	URO	VIC	AUSTRALIA	01/01/2013	31/12/2017
Hornsbury Kuringai	URO	NSW	AUSTRALIA	01/01/2013	31/12/2017
Bundaberg	URO	QLD	AUSTRALIA	01/01/2013	31/12/2017
Bega	URO	NSW	AUSTRALIA	01/01/2013	31/12/2017
Bankstown	URO	NSW	AUSTRALIA	01/01/2013	31/12/2013
Port Macquarie	URO	NSW	AUSTRALIA	01/01/2013	31/12/2017
Alfred Hospital	URO	VIC	AUSTRALIA	01/01/2014	31/12/2018
Frankston Hospital	URO	VIC	AUSTRALIA	01/01/2014	31/12/2014
Southern Health	URO	VIC	AUSTRALIA	01/01/2014	31/12/2014
Geelong Hospital	URO	VIC	AUSTRALIA	01/01/2014	31/12/2018
Nambour	URO	QLD	AUSTRALIA	01/01/2014	31/12/2018
Westmead	URO	NSW	AUSTRALIA	01/01/2014	31/12/2014
St George	URO	NSW	AUSTRALIA	01/01/2014	31/12/2014
Orange Base	URO	NSW	AUSTRALIA	01/01/2014	31/12/2018
Bankstown	URO	NSW	AUSTRALIA	01/01/2014	31/12/2018
The Northern Hospital	URO	VIC	AUSTRALIA	01/01/2014	31/12/2014
Peter MacCallum	URO	VIC	AUSTRALIA	01/01/2014	31/12/2014
Auckland	URO	NZ	NEW ZEALAND	01/01/2013	31/12/2013
Royal Prince Alfred Hospital	VAS	NSW	AUSTRALIA	01/01/2014	31/12/2018
Cambridge Hospital	VAS	UK	AUSTRALIA	01/01/2014	31/12/2018
John Radcliffe (Oxford) Hospital	VAS	UK	AUSTRALIA	01/01/2014	31/12/2018
Royal Edinburgh Hospital	VAS	UK	AUSTRALIA	01/01/2014	31/12/2018
Wollongong Hospital	VAS	NSW	AUSTRALIA	01/01/2014	31/12/2014
St George Hospital	VAS	NSW	AUSTRALIA	01/01/2014	31/12/2014
Royal Hobart Hospital	VAS	TAS	AUSTRALIA	01/01/2014	31/12/2014
Christchurch Hospital	VAS	NZ	NEW ZEALAND	01/01/2014	31/12/2015