ACCREDITATION SUBMISSION 2016
AUSTRALIAN MEDICAL COUNCIL (AMC)

RACS
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

ACCREDITATION MARCH 2017

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8 December 2016

Professor Chris Baggoley AO
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Dear Professor Baggoley,

AMC accreditation 2017

The Royal Australasian College of Surgeons (RACS) welcomes the Australian Medical Council (AMC) accreditation team to review our activities in ensuring surgical standards across Australia and New Zealand.

RACS is built on quality improvement principles and enshrines that across all of our activities. We believe surgical standards are in an ongoing cycle of improvement. The community we treat demands nothing less than ongoing rigour in the review of ourselves and the organisations that oversee our training, education and ongoing professional development. As such, surgical standards will always need to be reviewed and raised. It is up to RACS and our Fellows to define this in the formal curriculum we teach and examine, and to demonstrate in the informal and hidden curricula in our ongoing behaviour and activities. We are very aware that we are all leaders and role models.

In 2016-17, RACS actively interacts with the community, with government and the many stakeholders within the health sector. We work collaboratively with the many surgical societies and associations that assist us in delivering our formal educational programs. We are always reviewing these programs and comparing them internationally. We aim to continue to identify better practice and incorporate it into our programs. In particular, RACS acknowledges the importance of training our Fellows to positively impact on cultural change across the health sector.

While all training and educational programs can be improved due to the complexity of relationships and interactions, RACS and the specialty societies and associations are very proud of the standard achieved. We believe we provide thoroughly competent surgeons to enter the workforce as independently practising specialist surgeons in all of our nine specialties.

Since we were last accredited by the AMC, RACS has not stood still. We continue to explore options and possibilities to ensure that the expectations from the proud history of surgery will live on within the continually updated expectations of the community of today.

RACS welcomes you and your accreditation team. We look forward to demonstrating our areas of excellence and identifying areas that require improvement into the future.

Yours sincerely

Mr Phil Truskett AM
President

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Acronyms

AIDA	Australian Indigenous Doctors' Association
AMC	Australian Medical Council
AOA	Australian Orthopaedic Association
AoN	Area of Need
ASC	Annual scientific congress
ASE	Academy of Surgical Educators
ASERNIP-s	Australian Safety and Efficacy Register of New Interventional Procedures - surgical
ASSET	Australian and New Zealand Surgical Skills Education and Training
BSET	Board of Surgical Education and Training
CCrISP®	Care of the Critically Ill Surgical Patient
CIC	Censor-in-chief
CLEAR	Critical Literature Evaluation and Research
CPD	continuing professional development
CPMC	Committee of Presidents of Medical Colleges
CV	curriculum vitae
EB	Education Board
EDSA	Executive Director of Surgical Affairs (Australia and New Zealand)
EMST	Early Management of Severe Trauma
FRACS	Fellow of the Royal Australasian College of Surgeons
HQSC	Health Quality & Safety Commission
HWNZ	Health Workforce New Zealand
IMG	international medical graduate
MCNZ	Medical Council of New Zealand
NOTSS	Non-Technical Skills for Surgeons
NSW	New South Wales
NZ	New Zealand
OHNS	Otolaryngology, head and neck surgery
OPBS	Orthopaedic Principles and Basic Science (Examination)
PDSB	Professional Development and Standards Board
PFETC	post-fellowship education and training
POMRC	Perioperative Mortality Review Committee
PRSSP	Plastic and Reconstructive Surgical Science and Principles (Examination)
PSEC	Prevocational and Skills and Education Centre
QLD	Queensland
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainee Association
SA	South Australia
SET	Surgical Education and Training
SSCE	Surgical Science and Clinical Examination
STP	Specialist Training Program
TIPS	Training In Professional Skills
VIC	Victoria
WA	Western Australia

Executive Summary

Executive summary

The Royal Australasian College of Surgeons (RACS) was formed in 1927 and, as the College of Surgeons of Australia and New Zealand, currently has a membership of 7373 active and retired Fellows, and 1177 trainees. It assesses around 100 international medical graduates each year.

In 1997, RACS was one of the first medical colleges to be accredited by the Medical Council of New Zealand and thereafter in 2001 by the Australian Medical Council (AMC). Since the first AMC visit, there have been ongoing enhancements and, in some cases, major changes within the delivery of surgical education and training conducted and assessed under the RACS governance structures.

Developing Surgical Education and Training (SET)

RACS has well-established processes to capture feedback and evolve our surgical training model with an emphasis on improved learning outcomes, competency-based assessments and community health. RACS will continue to adapt our educational approaches and methods to ensure our practices maintain relevance to the learner, the patient and the contemporary clinical environment:

Table 1 AMC review highlights

Pre-2007	AMC review highlights		
	2007	2011	2016

• Traditional, followed UK model
• Two-phase training:
  ▪ Basic surgical training
  ▪ Specialist surgical training
	• Instigation of Surgical Education and Training program (SET)
	• Planned entry directly into one of nine specialty pathways
	• Integrated nine RACS competencies based on CanMEDS
		• Ongoing evolution of the SET model
		• Governance fine-tuned to the RACS Education Board with dedicated surgical training boards for each discipline
		• More online education resources, including a new learning management system (LMS)
		• Development of Academy of Surgical Educators
			• SET now well matured
			• Establishment of the Digital College program has provided ease of access to educational resources through an online life-long learning portfolio
			• Building Respect, Improving Patient Safety campaign incorporates preventative discrimination, bullying and sexual harassment (DBSH) actions into all RACS training and continuing professional development (CPD) frameworks
			• Establishment of the JDocs Framework for junior doctors interested in a procedural career

As part of the 2007 AMC review, RACS described how we were responding to concerns about the length of training, the perceived challenges of moving from the basic surgical training to the later specialist phase and some perceptions of workforce adequacy within the RACS model. The 2011 AMC review noted the new SET program, where trainees move directly into their nominated pathway among one of the nine surgical specialties available. The model is now well accepted by RACS, specialty surgical societies, hospitals, departments of health, district training boards as well as trainees and Fellows, who contribute to the program as supervisors, examiners and surgical educators.

Building Respect, Improving Patient Safety

One of the key activities for RACS over the past two years has been an effort to address discrimination, bullying and sexual harassment within the practice of surgery. With the full support of the RACS Council, RACS fully accepts the responsibility that we must, as a profession, address issues associated with poor culture in the health sector.

Into 2017 and beyond, we remain committed to up-skilling our surgical educators through our Building Respect, Improving Patient Safety campaign, associated courses and educational material. RACS has invested heavily in the resources and processes required to establish a well-publicised, transparent and responsive complaints program. We are committed to working with hospitals, universities and other medical colleges to collaborate on discrimination, bullying and sexual harassment prevention and education initiatives.

Meeting the needs of junior doctors through JDocs

In moving to the single SET pathway, RACS has recognised a need to provide education, guidance and a portfolio of experience and competence for junior doctors seeking to explore a proceduralist career. In simple terms, there was a need to provide educational resources so junior doctors could make informed decisions prior to committing to a specialist pathway. The JDocs Framework provides a comprehensive curricula outline, and access to many educational resources and self-assessment tools. It has the broad support of prevocational educational groups across Australia. In New Zealand, the approach complements the Medical Council of New Zealand (MCNZ) Intern Training program and the requirements of the In-Practice recertification program for general scope registrants. The JDocs website was launched in February 2016 and more than 400 registered junior doctors are now using it to improve their skills and as a basis for considering their next career move.

Leading performance and professionalism, improving patient care

RACS advocates on issues relevant to surgical standards and access to surgical care. We have an ongoing commitment to many public health issues such as, alcohol-related harm, domestic violence, obesity and road trauma. We regularly raise relevant issues with government and work with other alliances to progress advocacy issues. In 2016, we have made over 55 submissions to government and statutory agencies on a range of matters.

RACS is particularly attuned to incorporating these standards into our continuing professional development program, which has a strong emphasis on professionalism and professional behaviour. The program encourages Fellows' participation in mortality audit programs where available.

Since the last AMC review in 2011, the continuing professional development compliance for the RACS CPD Program has risen to 100 per cent, which is consistent with the requirements of the RACS Code of Conduct. Non-compliance will lead to formal sanctions through the RACS Council and associated committees.

Supporting surgical educators

Since the 2011 AMC review, detailed analysis of training for educators has been undertaken and programs have been implemented to recognise the many Fellows who contribute to surgical education and training. The awards include:

- *Supervisor/Clinical Assessor of the Year*, which recognises an exceptional contribution toward supporting trainees or international medical graduates (IMGs) and will be awarded in each state/territory and New Zealand.
- *Professional Development Facilitator of the Year*, which recognises an exceptional contribution by a course facilitator teaching on professional development programming and will be awarded to one participant across Australasia.

The Academy of Surgical Educators is now more than 700 strong and promotes formal training of Fellows involved in the education and training of trainees. The academy actively engages international educational and standards bodies of excellence, as well as individuals, to enable ongoing benchmarking and exchange of ideas. Educational delivery remains the dominant method for RACS to raise awareness of professional and cultural expectations. Opportunities also exist to formally progress academic interest in surgical education into degree programs.

Since the 2011 AMC review, Fellows involved with education and training have been required to complete programs to ensure they have the skills to educate, as well as to build surgical teams founded upon respect and delivering improving patient care.

Supporting trainees, international medical graduates and Fellows

Since the last AMC review, RACS has placed greater focus and attention on support for members in distress, ranging from meaningful handling of concerns and complaints, to requests for more structured support and advice. Substantial resourcing has been directed towards these requirements. Importantly, RACS now has a more defined approach to focusing on the mental health and wellbeing of its Fellows, trainees and international medical graduates. In 2015, we launched the RACS Support Program, which provides confidential, arms-length counselling services, and we will continue with future initiatives to address concerns, such as healthcare provision through one's own general practitioner and better access to peer support.

Building diversity and inclusion

The Building Respect, Improving Patient Safety campaign has received significant external attention and this has provided impetus to other activities related to diversity and inclusion. A Diversity and Inclusion Plan is being incorporated across RACS and our training programs, which will improve multiple perspectives of diversity.

We have a well-established Indigenous Health Committee, which is focused on addressing concerns about the cultural and health outcomes of Māori and Aboriginal and Torres Strait Islander populations, but we acknowledge the time required for enduring impact. RACS Reconciliation Action Plan is being progressively implemented. Our global health activities continue to support capacity-development in the Asia and Pacific region.

Governance to provide leadership and oversight

RACS is well aware of the responsibilities of medical professionals and professional organisations. The calibre and training of Fellows involved in our governance is very high. Fellows on the RACS Council receive regular training in good governance, strategy and the role of the board through the Australian Institute of Company Directors. RACS is ISO accredited across the entire entity and is a member of the Australian Council for International Development (ACFID) and is compliant with its standards for international development.

RACS Council is responsible for identifying and managing risk, driving the strategic direction of RACS, overseeing its resources and ensuring compliance obligations are met. Through its robust and broad committee structure, RACS Council is able to deliver its objectives in surgical training, setting standards, advocating in health policy and engaging with government departments in Australia and New Zealand.

Leading change to improve the health sector

RACS takes very seriously its commitment to the broader health sector, as well as the educational sector. It is investing in research and evaluation capability to ensure this is done from the strongest evidence base. This is supported by the Foundation for Surgery, now stronger than ever, with a scholarships and grants program that committed $1.53 million in 2015 (up from $1.11 million in 2014). RACS is fully aware that it must work with multiple partners and collaborate extensively with other stakeholders to ensure improvements in these sectors.

RACS will continue to focus on driving change and continuous improvement to create the best environment for trainees to undertake surgical education and training, delivered by committed and trained educators. This will ensure we have highly competent and highly performing surgeons into the future.

In summary

In this 2016 review the AMC review team will see:

1. RACS does not stand still; we actively seek feedback and look to update our curriculum, education and training practices to improve community healthcare outcomes.
2. RACS is committed to taking informed and principled positions on issues of public health where we feel our unique input will assist decision makers.
3. RACS is fully committed to a range of initiatives that improve patient safety.

4. RACS seeks opportunities to collaborate with other organisations to make a positive difference to patient safety and health outcomes, including through our Building Respect, Improving Patient Safety campaign.
5. RACS invests time, resources and technology to continuously improve and address matters that present risks or obstacles to us achieving our mission.

We welcome this review by the AMC. Our team will consider and respond to any improvement opportunities you present.

RACS Mission:
The leading advocate for surgical standards, education and professionalism in Australia and New Zealand.

Section 1

The context of training and education

1. The context of training and education

1.1 Governance

Accreditation standard

1.1.1 The education provider's corporate governance structures are appropriate for the delivery of specialist medical programs, assessment of specialist international medical graduates and continuing professional development programs.

1.1.2 The education provider has structures and procedures for oversight of training and education functions, which are understood by those delivering these functions. The governance structures should encompass the provider's relationships with internal units and external training providers where relevant.

1.1.3 The education provider's governance structures set out the composition, terms of reference, delegations and reporting relationships of each entity that contributes to governance, and allow all relevant groups to be represented in decision-making.

1.1.4 The education provider's governance structures give appropriate priority to its educational role relative to other activities, and this role is defined in relation to its corporate governance.

1.1.5 The education provider collaborates with relevant groups on key issues relating to its purpose, training and education functions, and educational governance.

1.1.6 The education provider has developed and follows procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision-making.

Summary of RACS Response

1.1.1 RACS has substantial and well-established corporate governance structures appropriate for the delivery of specialist medical programs, assessment of specialist international medical graduates and continuing professional development programs as evidenced by its bi-national and international leadership in surgical and medical health.

1.1.2 RACS has structures and procedures for oversight of training and education functions, which are understood by those delivering these functions. The governance structures encompass the RACS' relationships (via alliances, collaborations and agreements) with internal units and external training providers.

1.1.3 RACS governance structures, composition, terms of reference, delegations and reporting relationships allow all relevant groups to be represented in decision-making. RACS is ISO-accredited.

1.1.4 RACS governance structures clearly articulate the priority for life-long learning, the determination of standards and ongoing education and review.

1.1.5 RACS collaborates with relevant groups, locally, nationally and internationally.

1.1.6 RACS has developed and follows procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision-making.

RACS background

RACS is responsible for the training, assessment, examination, qualification and continuing professional development of surgeons for standards of surgery in Australia and New Zealand. RACS has also contributed

substantially to the advancement of surgery in the Pacific and South-East Asia with leadership in postgraduate medical programs in Fiji, Timor Leste, Myanmar and Papua New Guinea. RACS is prominent in international forums, such as the World Health Organization, to profile the requirements for access to safe surgery.

RACS was established in 1927 with a clear vision to maintain standards in the practice of surgery. From the first meeting in Dunedin, New Zealand, with 165 founding Fellows, it blended the demands of experience and academic excellence to demonstrate the requirements of being a Fellow of RACS. As a bi-national College, it is now internationally recognised for the high standard of its trainees and as one of the main contributors to the high and safe standards of surgery practised in Australia and New Zealand. Regional representation is very important within the RACS structures. From the beginning, New Zealand Fellows, such as Sir Louis Barnett, have held prominent roles and have had significant influence on RACS and this influence is enshrined within the RACS Constitution. New Zealand and all states of Australia also are represented on the RACS Council.

RACS has one category of membership and that is of Fellow. RACS produces an Activities report each year, which is widely distributed. This details the breakdown of the distribution of Fellows, trainees and international medical graduates under assessment. Of the 7373 active and retired Fellows at the end of 2015, 5972 were resident in Australia, 951 in New Zealand and 450 overseas. RACS awards fellowship in nine surgical specialties: cardiothoracic surgery; general surgery; neurosurgery; orthopaedic surgery; otolaryngology head and neck surgery; paediatric surgery; plastic and reconstructive surgery; urology; and vascular surgery.

RACS places great importance on life-long learning and ensures that medical graduates interested in a procedural career have opportunities to attend RACS events. Universities and other medical colleges frequently share activities. RACS is a strong supporter of continuing professional development and the ongoing review of clinical practice throughout a surgeon's career. Within this broad educational program, the formal training program for trainees in the nine specialties comprises the RACS Surgical Education and Training (SET) program.

RACS is strategically placed in the role of advocate and advocates on behalf of the profession and in the interests of patient safety and the provision of quality surgical care. RACS has played a prominent role in initiatives related to road safety, cultural change, and the health outcomes for Aboriginal and Torres Strait Islander and Māori populations.

RACS graduates approximately 250 new Fellows each year and has the capacity to sustain its activities at the current level, and to train further surgeons, if the funding for training posts is available in hospitals. RACS has been strongly involved with many initiatives to increase the number of surgeons available in regional and rural areas, both from a training perspective and by providing ongoing educational opportunities. This has included government-funded programs, such as the multi-year Specialist Training Program (STP), and has assisted with improving e-learning opportunities and audit capacity.

Importantly, RACS has invested substantially in developing the skills of Fellows involved in the education and training of trainees, both through the Academy of Surgical Educators and by offering ongoing scholarships and educational innovation funds. The Foundation for Surgery provides ongoing and alternative funding for educational activities and core areas of surgical research, indigenous health and global health activities.

Governance

RACS is a company limited by guarantee under Australian corporations' law. In New Zealand it is registered with the New Zealand Companies Office as an overseas company. The RACS Council is the governing body and the councillors have fiduciary responsibility for the organisation. There are 16 Fellows elected from the membership at large; nine Fellows elected from the nine specialties (one from each specialty); three co-opted members, who include two expert community advisors and the RACS Trainee Associations (RACSTA) representative; and one co-opted representative, being the president of the Australian and New Zealand College of Anaesthetists (ANZCA). The Younger Fellows representative is an invited observer. Chairs of the NZ national board and regional committees are invited to attend council meetings on rotation. The full RACS Council meets three times a year to ensure the objectives of RACS as described in the RACS Constitution are met. The constitution was most recently updated in 2010 with a key change including the trainee representative on council. As the board of directors, the RACS Council sets and monitors the overall direction of the college through approval of the strategic and business plan, the annual budget and key

policy. An elected Council Executive of the five senior office bearers and three other council members meets monthly to monitor more closely the directions of RACS and ensure the objectives are achieved. The current membership of the RACS Council is described in the RACS Strategic Plan Business Plan 2017-2018.

The activities of RACS are broadly described under four portfolios: the delivery of the education and training program for trainees and assessment of international medical graduates; the ongoing maintenance of standards and support to Fellows throughout their professional careers; the ongoing nurturing of key relationships particularly through our advocacy role; and the careful stewardship of our resources.

The education requirements are met across the entire governance profile. RACS strongly supports an all-of-professional-life approach to learning and education. We train, educate and support our Fellows to be fully committed to all the nine RACS competencies: professionalism; medical expertise; scholarship and teaching; management and leadership; judgment and decision-making; technical expertise; health advocacy; communication; and collaboration and teamwork. This is demonstrated across all the areas of College endeavours.

Senior boards or committees oversee activities within the four portfolios. These are the Education Board (responsibility of the censor-in-chief), the Professional Development and Standards Board (responsibility of the chair of Professional Development and Standards Board or PDSB), the Governance and Advocacy Committee and Board of Regional Chairs (responsibility of the vice-president) and the Resources Committee and Risk Management and Audit Committee (responsibility of the treasurer). The current senior office holders are:

President	Mr Phil Truskett AM
Vice-president	Professor Spencer Beasley
Censor-in-chief	Mr John Batten
Chair, PDSB	Dr Cathy Ferguson
Treasurer	Associate Professor Julie Mundy

Other members of RACS Council and the NZ national board and regional committees as well as the leadership group of each specialty society, are detailed within the RACS Strategic Plan Business Plan 2017-2018. The abridged curriculum vitaes of councillors are available. These demonstrate an incredible commitment to the activities of RACS and the development of surgery across Australia and New Zealand. Interest in being a councillor remains very high, with more than 20 people competing for four fellowship-elected positions on council in 2016.

RACS has a highly engaged consultative committee process. More than 100 committees report to the RACS Council and are represented on the governance map in Figure 1. RACS Governance.

Figure 1. RACS Governance

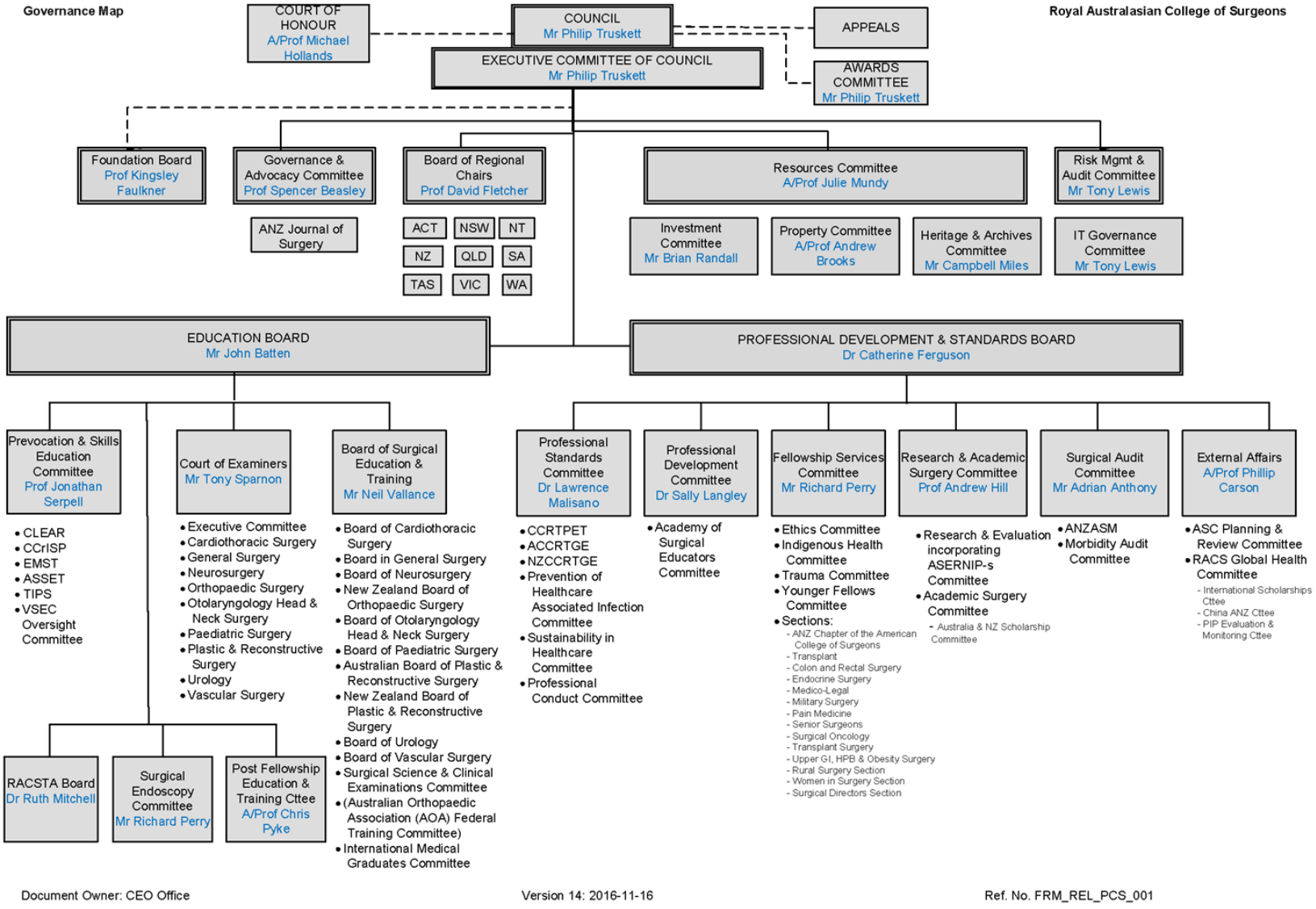


Figure 2 RACS Management Chart

Figure 3 Fellows of the College (FRACS) in formal positions on College staff

Terms of reference for all boards and committees are publicly available on the RACS website. The majority of committees are supported by management and staff. The alignment of more than 200 staff and their reporting lines largely mirrors the governance structure and this is shown within the RACS Strategic Plan Business Plan 2017-2018. The emphasis for all staff is to provide high-quality service to the Fellows, trainees and international medical graduates, particularly supporting the initiatives within the remit of their committee. This is emphasised by the structure of regional committees and national boards, which elect members from the Fellows of that region and represent RACS imperatives to their local governments. The NZ national board and regional committees also play a key role in the RACS communication strategy more broadly. The board and committee activities are a critical component of RACS educational and professional support and maintain close contact with other educational providers in the region. These activities are highlighted in the business planning process approved annually by the RACS Council.

RACS takes the training of Fellows in governance positions seriously and follows best practice governance methods for the induction and training of councillors. The induction of RACS councillors starts immediately after their election, which is six months before they formally join the RACS Council. All councillors are encouraged to join the Australian Institute of Company Directors (AICD) and RACS supports its councillors to complete the Australian Institute of Company Directors (AICD) Company Directors Course, which is compulsory within the first three years of appointment as a councillor. Formal induction occurs at the February council meeting prior to the transition to the role of councillor at the RACS annual general meeting. Refresher courses on governance issues are offered to the RACS Council each year and are incorporated into the council program. Formal media management training is provided with regular support from key staff. Documentation relating to corporate responsibility, the governance charter, media interactions and chairing committees are regularly updated and distributed.

There is a review of each council meeting and a self-appraisal of council's effectiveness is conducted by councillors and staff annually. The results are reported with recommendations for improvement. Trends are observed and areas for improvement addressed. The RACS Council is determined to maintain an approach of quality improvement for all RACS activities. This has been particularly demonstrated through the introduction of ISO-based systems across the RCS structure. RACS has been ISO-accredited since 2010. RACS is also an accredited non-government organisation (NGO) with the Department of Foreign Affairs and Trade (DFAT), registered by the Australian Charities and Not For Profit Commission, registered with

Charities Services in New Zealand and is a signatory to the Australian Council for International Development (ACFID) Code of Conduct. With the ISO standard 9001: 2015 there is also a strong emphasis on the understanding, profiling and management of risk. This is demonstrated through our Risk Framework, RACS documentation, ISO and Quality Manual and approach to reporting to council. The goals of the organisation and individual departments are reflected in the RACS Strategic Plan Business Plan 2017-2018; these are included in the goals for each staff member in annual performance appraisals.

All meetings are conducted to an agreed template and protocol, which includes a declaration of conflict of interest sought at the start of each meeting. The Conflict of Interest policy complies with the Commonwealth Corporations Act 2000. RACS routinely produces and distributes annual reports, financial compliance reports and an activities report. These are publicly available on the RACS website.

Management structure

RACS has more than 200 staff across head office and the regional offices. The four portfolios are operationalised through several divisions with the senior management staff positions and qualifications outlined in the Figure 2 RACS Management Chart. The qualifications of all senior managers are listed and they bring a strong interest in areas such as education, policy, advocacy, global health, as well as critical infrastructure areas of information technology and finance.

The RACS Chief Executive Officer, Associate Professor David Hillis, reports to the RACS Council on the progress and achievement of the goals set in the strategic and business plan.

In Figure 3 Fellows of the College (FRACS) in formal positions on College staff, RACS has 14 Fellows in formal positions. This includes four Fellows who are also advisors to the RACS Council:

- Dr John Quinn, FRACS, vascular surgeon, Qld; Executive Director Surgical Affairs – Australia.
- Mr Richard Lander, FRACS, orthopaedic surgeon, NZ; Executive Director Surgical Affairs – New Zealand.
- Associate Professor Stephen Tobin, FRACS, general surgeon, Vic; Dean of Education.
- Professor Guy Maddern, FRACS, general surgeon, SA; Surgical Director of Research and Evaluation.

Strategic review

RACS regularly updates its strategic plan and business plan. The strategic plan is updated on a four-year cycle and the business plan annually. The business plan is confirmed at the October RACS Council meeting along with the budget for the following year. (RACS operates on a January to December financial year).

The RACS risk profile changed substantially in 2015, leading to a refresh of the RACS Strategic Plan in 2016. The final document was approved for distribution at the October RACS Council meeting. Substantial issues addressed included the organisation-wide involvement with concerns around discrimination, bullying and sexual harassment and the development of the Building Respect, Improving Patient Safety Action Plan. The strategic plan also was refreshed to reflect the substantial progress made in the areas of advocacy, information technology support to develop a Digital College, and the direction to ensure that all policy positions and advocacy are based on a better evidence base through the more formal structuring of the Research and Evaluation department, incorporating Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIPS). This brought a change to the governance structure of RACS, with a councillor now formally responsible for research and academic surgery and another councillor responsible for surgical audit activities.

RACS is aware that other medical colleges have adopted governance structures that are smaller and more in line with a modern corporate board. This has been intermittently discussed and rejected because it would not allow fuller consultation across the breadth of the surgical profession, which is currently possible. It is agreed that the current model, whereby the full RACS Council has fiduciary responsibility and approves key strategies and decisions, while delegating month-to-month monitoring of RACS to the Executive Committee, is most appropriate.

The most recent changes in the RACS Constitution ensured that the voice of the trainees was more clearly heard with a designated position on the RACS Council.

1.2 Program management

Accreditation standard

1.2.1 The education provider has structures with the responsibility, authority and capacity to direct the following key functions:

Planning, implementing and evaluating the specialist medical program(s) and curriculum, and setting relevant policy and procedures.

Setting and implementing policy on continuing professional development and evaluating the effectiveness of continuing professional development activities.

Setting, implementing and evaluating policy and procedures relating to the assessment of specialist international medical graduates certifying successful completion of the training and education programs.

Summary of RACS Response

1.2.1 The Education Board of RACS oversees activities directly related to the education and training of surgical trainees across the nine specialties and the assessment of international medical graduates. Reporting to the Education Board are the Prevocational and Skills Education committee, the Court of Examiners, the Board of Surgical Education and Training with its sub-committee International Medical Graduates Committee, the Post Fellowship Education and Training Committee and the RACS Trainees Association.

The Professional Development and Standards Board oversees the Professional Standards Committee, the Professional Development Committee and the Academy of Surgical Educators.

The Education Board and Professional Development and Standards Board report directly to the RACS Council.

RACS oversees a complex training environment. Training, education and ongoing professional development in two countries, for nine specialties of differing size, administrative maturity and supported by 13 autonomous specialty societies and associations, each with their own requirements, demands flexibility and delegated responsibility. Key documents, such as the RACS Surgical Competence and Performance guide, which describes the nine competencies for RACS trainees and Fellows, and the RACS Code of Conduct, are critical reference documents across all areas. These are used to align the educational activities of RACS from the JDocs Framework, skills course delivery, professional development course availability to blue-printing of the fellowship examination.

Within the RACS structures, activities related to the formal training of surgeons mostly fall under the responsibility of the Education Board, with particular complexity relating to the nine specialties in which the programs are delivered. Ongoing professional standards, professional development across all the RACS competencies and, in particular, the development of surgeons involved with education and training, as well as international links with other educational bodies is overseen by the Professional Development and Standards Board.

Education Board

The **Education Board** (EB) is responsible for overseeing RACS' education policy, maintaining standards of surgical education, training and assessment standards and approving doctors eligible for admission to fellowship. The chair is the censor-in-chief, the most senior Fellow on the RACS Council responsible for educational issues. The censor-in-chief is supported by other councillors, who chair the committees that report to the Education Board. Together, they and the New Zealand censor form the Education Board Executive. The governance chart of council committees (Figure 1. RACS Governance) indicates the

reporting alignment. The terms of reference for all educational committees are provided. These committees are:

The **Prevocational and Skills Education Committee (PSEC)** is responsible for the ongoing development and uptake of the JDocs Framework by junior doctors and related stakeholders and the educational standards and criteria of relevant resources. PSEC also receives reports and provides strategic advice to the Victorian Skills Education Centre Melbourne Oversight Committee and also receives reports from five skills training committees:

- ASSET Committee (Australia and New Zealand Surgical Skills Education and Training).
- CCrISP® Committee (Care of the Critically Ill Surgical Patient).
- CLEAR Committee (Critical Literature Evaluation and Research).
- EMST Committee (Early Management of Severe Trauma).
- TIPS Committee (Training in Professional Skills).

The **Royal Australasian College of Surgeons Trainees' Association (RACSTA**). The role and function of this committee is considered in depth in Section 7.

The **Board of Surgical Education and Training (BSET)** is responsible for oversight of the surgical education and training. It comprises representation from all specialty training boards and key education stakeholders, and is responsible for policy development and approval. Policies are recommended to the RACS Education Board for review and approval.

It also has responsibility for the oversight of the assessment of international medical graduates (IMGs) seeking to practise as specialist surgeons in Australia and of New Zealand-based vocationally registered international medical graduates seeking RACS fellowship.

Specialty training boards

Delivery of the components of surgical education and training is contractually managed under formal agreements between RACS and the 13 specialty societies and associations in Australia and New Zealand. Specialty training boards report to BSET on these delegated responsibilities and activities as defined by the agreements.

Four of the training boards are bi-national (Australian and New Zealand) with no subsidiary regional boards/committees:

- Board of Cardiothoracic Surgery
- Board of Neurosurgery
- Board of Paediatric Surgery
- Board of Vascular Surgery

Three are bi-national (Australian and New Zealand) boards with regional subsidiary boards and committees:

- Board in General Surgery
- Board of Otolaryngology, Head and Neck Surgery
- Board of Urology

One has subsidiary regional boards and committees:

- Australian Board of Plastic and Reconstructive Surgery

There are two New Zealand boards, which have no regional boards/committees:

- New Zealand Board of Orthopaedic Surgery
- New Zealand Board of Plastic and Reconstructive Surgery

For orthopaedic training in Australia, RACS has delegated the powers of a RACS specialty training board to the Federal Training Committee of the Australian Orthopaedic Association (AOA).

All training boards (including the AOA Federal Training Committee) report to Board of Surgical Education and Training at meetings held in February, June and October.

RACS policies related to the activities of the training boards from selection to admission to fellowship are at a principle level. Each training board then defines regulations for its training program (including selection, management of trainees and accreditation of training posts), which comply with the overarching RACS

policies. The Education Board (or its Executive) verifies the specialty regulations, which are available on the RACS website:

- Cardiothoracic Surgery Regulations
- General Surgery Regulations
- Neurosurgery Regulations
- Orthopaedic Surgery Regulations
- Otolaryngology Head and Neck Surgery Regulations
- Paediatric Surgery Regulations
- Plastic and Reconstructive Surgery Regulations
- Urology Regulations
- Vascular Surgery Regulations

Activities such as curriculum development, e-learning development, monitoring and evaluation occur across the nine specialties depending on the critical mass and expertise of the specialty concerned, in collaboration with RACS departments, such as the Education Development and Research Department.

The **International Medical Graduate Committee** was formed in 2016 to assist with the support and assessment of international medical graduates. Specifically, the committee oversees the assessment of international medical graduates in Australia and, in particular, the support initiative undertaken by RACS. The assessment of international medical graduates is discussed in greater depth in Section 10.

The **Post Fellowship Education and Training Committee (PFETC)** conducts formal accreditation of post-fellowship courses and training programs for Fellows.

The **Court of Examiners** is responsible for conducting the summative fellowship examinations). The court is comprised of surgeons representing the nine specialties in which RACS conducts fellowship examinations. Individual surgeons are members of one of nine specialty courts that report to the Court of Examiners. The activities of the court are discussed in Section 5.

The **Professional Development and Standards Board (PDSB)** is the senior board with oversight of fellowship and standards. The PDSB has committees reporting to it in the areas of professional standards, professional development, academy of surgical educators, fellowship services, research and academic surgery, surgical audit and global health. Refer to Figure 1. RACS Governance. The activities of PDSB are discussed in depth in Section 9.

The board also has representation from all specialty societies and associations, which report on ongoing professional development activities.

Of particular relevance in the reporting committees are:

The **Professional Standards Committee** oversees the development of the RACS Continuing Professional Development (CPD) Program and monitors the compliance of all Fellows in achieving this. It also oversees the development of standards documents and position papers relevant to the practice of surgery in Australia and New Zealand.

The specialty societies and associations place particular emphasis on the technical expertise and medical expertise areas of the RACS competencies. RACS, through the **Professional Development Committee**, provides or accredits courses and activities against all nine competencies. This is described in the annual professional development booklet.

The **Academy of Surgical Educators** (ASE) fosters excellence in surgical education as a core component of ongoing professional development. RACS has placed particular emphasis on the recognition, support and training of surgeons in their role as educators. The ASE provides for the generic education needs of surgeon-teachers, trainers, supervisors, assessors and examiners in all surgically related areas. It collaborates with other colleges and universities, nationally and internationally. It provides special links through a number of in-house educational programs, to the mandatory Foundation Skills for Surgical Educators, and to graduate programs in surgical education with the University of Melbourne.

The development of the ASE and its involvement with international surgical education and postgraduate medical education has been important in ensuring that local and national needs in healthcare and health-related education are highlighted and incorporated into programs across RACS. In particular, the enrolment of surgeons in the master of surgical education has enabled educational research to be completed on many topics relevant to the delivery of the surgical education and training programs. Students enrolled in the

masters program are enthusiastic contributors to educational activity at university and College level, nationally and internationally.

1.3 Reconsideration, review and appeals processes

Accreditation standard

1.3.1 The education provider has reconsideration, review and appeals processes that provide for impartial review of decisions related to training and education functions. It makes information about these processes publicly available.

1.3.2 The education provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

Summary of RACS Response

1.3.1 As described within the RACS Action Plan for Building Respect, Improving Patient Safety, RACS has committed to substantially changing its approach to handling complaints. Now centralised with a more defined process, education and training reviews are still handled initially within the educational area. RACS has established policies and processes for reconsideration, review and appeals that provide for an impartial review of decisions. These are being augmented by external reviews as part of the complaints resolution activities. Information about these processes is publicly available.

1.3.2 RACS has an ongoing process for evaluating de-identified appeals and complaints to determine whether there is a systems problem. This will be augmented as part of the complaints resolution activities.

Complaints

Over the past two years, RACS has put considerable effort into reviewing and improving the systems for making complaints, requesting reconsideration or review, or making a formal appeal. Although RACS has had formal mechanisms in place for reconsideration of academic decisions for many years, there were significant concerns about the management of training problems or inappropriate behaviour within local workplaces. This is profiled in the Building Respect, Improving Patient Safety Action Plan and follows extensive work by the Expert Advisory Group (EAG) looking at discrimination, bullying and sexual harassment. A report produced by the EAG highlighted a lack of trust in College mechanisms, and the health sector more broadly, in handling complaints. Although RACS does not have line management or employment-based authority in hospitals, there is a substantial expectation that we are culturally responsible for the professional behaviour of Fellows and trainees in their educational and clinical activities.

Improved complaints handling is a major pillar of the Building Respect Improving Patient Safety program. RACS now has a substantially improved complaints resolution process, which gathers complaints from the widest spectrum, and many relate to educational activities or the educational environment that RACS oversees.

Implementation of the complaints resolution process, the more formal RACS investigatory processes and managing the ongoing interface into the academic progress of trainees is still active. The complexity of working with training boards, specialty societies (a key part of education delivery) and hospitals, health departments and district health boards (as employers) is being progressed under memoranda of understanding, which support the collaborative efforts of the program. An independent, external reviewer will regularly review RACS' actions.

Complaint metrics and progress on the program will be reported annually, and will be analysed to identify problems to be addressed.

The handling of all complaints is being progressively centralised with the appointment of a manager of complaints resolution in early 2016, and associated resourcing and infrastructure. All complaints are referred to the manager, Complaints Resolution, for registration, assessment, triage and assignment to the

appropriate RACS division for action. Information about registering complaints is available on the RACS website .

For further information refer to the complaints documents:

- Complaints policy
- Complaints Manual
- RACS Complaints User Guide
- RACS fact sheet: Unacceptable Behaviours

Formal reconsideration and review

RACS has implemented a process for reconsideration of decisions and appeals. The Appeals Mechanism Policy details the mechanism and grounds for appeal by any person or organisation adversely affected by a College decision that is inconsistent with College policy. This policy is publicly available on the RACS website. Unresolved, challenged appeals may follow an escalating process of consideration and judgments.

An appellant may approach any College board or committee to review a decision made by that board or committee. In the case of decisions relating to educational activities, this involves reconsideration by the Training Board or Examination Committee, review by a committee chaired by the censor-in-chief and including other members of the Education Board Executive. If the appellant wishes to appeal the ensuing, revised decision, they may request the executive director for surgical affairs (EDSA) to convene a hearing of the Appeals Committee. He or she will convene an Appeals Committee if there are grounds for an appeal.

Membership of the Appeals Committee is determined by the nature of the appeal and to avoid potential conflicts of interest. The Appeals Committee will either uphold or revoke the initial decision, and submit its decision to RACS Council with recommendations for issues requiring consideration. RACS monitors issues of concern and provides reports to the Education Board to ensure quality assurance of appeals processes.

For further information refer to appeals documents:

- Appeals Mechanism Policy
- CiC Review Committee Terms of Reference
- RACS Natural Justice position paper, in recognition of compliance issues

Training problems and disputes are handled by the training board in the first instance, but there is a mechanism to escalate an issue for review by the censor-in-chief if not satisfactorily resolved. This is discussed in more detail in Section 7.5.

Table 2 Appeals held within the last three years

Number of appeals	Subject	Outcome (upheld or dismissed)
1	International medical graduate clinical assessment - appeal against decisions of the Training Board of Plastic and Reconstructive Surgery	Upheld
1	International medical graduate specialist assessment validity period - appeal against extension for specialist assessment	Upheld
1	Fellowship examination - appeal against examination result assessment	Dismissed
1	Appeal against dismissal from the Surgical Education and Training Program of the Royal Australasian College of Surgeons	Upheld
1	Appeal against dismissal from the Surgical Education and Training Program of the Royal Australasian College of Surgeons	Dismissed

1.4 Educational expertise and exchange

Accreditation standard

1.4.1 The education provider uses educational expertise in the development, management and continuous improvement of its training and education functions.

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

Summary of RACS Response

1.4.1 RACS acknowledges the substantial educational expertise of its Fellows and their willingness to contribute to training and educational activities in the workplace, universities and medical colleges. This is augmented by the recruitment of Fellows into dedicated roles within RACS and also staff with specific educational and training expertise.

RACS acknowledges the ongoing contribution of our expert advisors in areas of education and actively engages with consultants, nationally and internationally as appropriate, to progress the ongoing development of educational material.

1.4.2 RACS collaborates both one on one and within alliances with other educational institutions to enable the ongoing progression of our educational activities.

There is substantial educational and surgical expertise within the RACS fellowship. Many surgeons have formal educational qualifications and other postgraduate academic qualifications. They form a critical component of the teaching and academic surgical departments in teaching hospitals around Australia and New Zealand. RACS draws on this expertise for the work-based delivery of its training programs. This cohort is well represented in RACS activities, such as in the delivery of courses, serving as examiners, developing educational material or serving the fellowship as members of RACS committees. RACS councillors and others involved in the governance of educational activities have strong involvement with the university sector and medical colleges, nationally and internationally. The Education Board has an expert community advisor with particular skills in assessment.

RACS deliberately augments this expertise by recruiting Fellows with specific expertise to key College roles, through the recruitment of dedicated medical educators, and ongoing engagement with external educational advisors and consultants. The academic qualifications of staff are broad but have a strong educational focus.

The expertise required is determined by need, and is supplemented by external consultants if gaps are identified

A particular focus of RACS is to improve the educational expertise of all Fellows involved with surgical education and training and to progressively ensure that all trainees develop educational skills.

The Academy of Surgical Educators has a particular role in providing a ‘community of practice’ for surgical educators, but also availability of a range of accredited courses, links to formal university programs and international experts. The academy has an active membership of 705.

Specialty training boards also are supported in their educational functions. Most specialty training boards include representatives with a special interest in education. Specialty training boards engage external consultants for particular projects and/or access RACS’ educational expertise. An example is the Australian Orthopaedic Association engaging Dr Jason Frank, a Fellow of the Royal College of Physicians and Surgeons of Canada, to conduct a comprehensive review of its curriculum and engage with the development of the AOA21 educational program.

Educational collaboration

RACS interacts and collaborates with an extensive network of postgraduate medical colleges, universities, professional organisations in Australia and New Zealand. As well as maintaining historical links with surgical colleges in the UK and the US, RACS participates in international surgical meetings where all international surgical colleges discuss issues of surgical standards and education. This is repeated among the nine specialties of RACS; orthopaedic surgery, urology and general surgery, in particular, have very active international connections.

In Australia, all medical colleges interact through the Council of Presidents of Medical Colleges (CPMC). The networks for medical educators and those responsible for international medical graduate assessment are particularly strong and colleges work together on initiatives. In New Zealand, all medical colleges interact through the Council of Medical Colleges (CMC).

RACS awards scholarships and grants to examiners within the Court of Examiners to review examination processes internationally. RACS is closely involved with the ongoing review of the curriculum that supports our training courses. As an example, the Early Management of Severe Trauma (EMST) course is based on the international equivalent Advanced Trauma Life Support (ATLS™) from the US. Ongoing reviews have seen the curriculum move into a more e-based delivery model and this will continue over the next two years.

RACS was an initial partner in the development of the tri-nations educational forum and has maintained close ties with the other founding partners, the Royal Australasian College of Physicians and the Royal College of Physicians and Surgeons of Canada. The success of meetings in Australia and New Zealand has seen the alliance expand to include the Australian and New Zealand College of Anaesthetists and the Royal Australian and New Zealand College of Psychiatrists. This has enabled our Fellows to participate in interdisciplinary educational activities and has seen the development of educational initiatives, ranging from professionalism, to updating continuing professional development requirements, to the development of entrustable professional activities (EPAs). Reports from the meeting in March 2016 are available.

RACS educational activities in the area of professionalism are now being adapted to be appropriate for the International Society for Quality in Health Care (ISQua).

Collaboration is critical in all our educational endeavours and RACS draws on educational expertise from across the globe. It is important that there are mechanisms to appropriately engage and be able to incorporate educational improvements. RACS accredits courses from multiple areas; for example, RACS has a long-standing arrangement for recognition of courses offered by the University of Edinburgh. The development of our JDocs Framework has included active engagement with postgraduate medical councils in Australia and New Zealand, and internationally.

In developing the Building Respect, Improving Patient Safety program, RACS actively engaged with Professor Gerry Hickson from the Vanderbilt University Medical Centre (VUMC), including presentations by Professor Hickson at the RACS annual scientific congress and visits by RACS councillors and senior RACS staff to VUMC. These have been reported in RACS publications, such as Surgical News.

1.5 Educational resources

Accreditation standard

1.5.1 The education provider has the resources and management capacity to sustain and, where appropriate, deliver its training and education functions.

1.5.2 The education provider's training and education functions are supported by sufficient administrative and technical staff.

Summary of RACS Response

1.5.1 The Fellows who contribute to our educational and training endeavours are the most important educational resource for a medical college. RACS is focused on ensuring the ongoing support of this critical group, so skills are continually improved and educational resources are readily available, with a particular emphasis on progressively delivering this support online.

1.5.2 RACS training and education functions are supported by sufficient administrative and technical staff.

The most precious educational resource that RACS has available is the time of the Fellows, who contribute to the training and education of surgical trainees and the broader educational activities of RACS. This is predominantly contributed pro-bono by surgeons who are time-poor and are under increasing pressure from a health sector focused more on a 'service only' approach and less on education, research and academic support.

This imperative is fully recognised by the RACS Council and drives the ongoing strategic plan, the annual review of the RACS business plan and priorities for budgeting. The RACS business plan with identified priorities is funded through an annual budget cycle overseen by the RACS Council Executive and approved by the full council at its October meeting.

The delivery of the RACS educational programs is continuously reviewed to ensure the time contributed is used to maximum benefit and in the most streamlined manner. RACS resources are particularly focused on improving the skills of our Fellows in educational activities, and operating with respect within surgical teams and the broader health sector. This includes easy access to documents that state the standards required, and the expectations of our educational programs through curricula and assessment processes. It includes online resources through our comprehensive library and associated e-learning resources, and improved methods of obtaining evaluation, feedback and identification of areas for improvement at an individual and organisational level.

RACS continues to expand its management and educational resources to support education and training activities. The progression of the Digital College initiative was to achieve the ongoing online interaction with RACS and its educational activities. This included the implementation of ecommerce, online event registration and enrolment. Through the construction of electronic portfolios, junior doctors, trainees, Fellows and international medical graduates are able to track their own training and educational requirements and achievements. This includes multi-source feedback and online work-based assessments. Ongoing audit of surgical practice can be achieved through the Morbidity Audit and Logbook tool, and access to the mandatory Surgical Mortality Audit (where this is available) is through a dedicated portal. Library and other online resources have been enhanced across all specialties. Regular electronic communication highlights the tables of content of popular journals, and this is supported by library staff, who facilitate educational and research endeavours. The enhanced information technology department has been heavily involved in developing and supporting electronic exams delivery and marking. A dedicated help desk function provides ongoing support.

The RACS conference and events staff assist not only in arranging the RACS annual scientific congress (ASC), but also regional and national scientific meetings and, by arrangement, other educational meetings

delivered through the specialty societies. Expertise is highly developed to deliver time-efficient, high-quality educational events.

RACS has highlighted the importance of some initiatives with the development of the Academy of Surgical Educators within the Professional Development Department and, in 2015, RACS established the Pre-vocational and Online Education Department to support the JDocs program. The RACS Council highlighted the increased importance of research, audit and academic surgery by dedicating two councillors: the first with responsibility for research and academic surgery and the second with surgical audit. A formal position of surgical director of research and evaluation has been created and is an advisor to the RACS Council.

In implementing the Building Respect, Improving Patient Safety Action Plan, RACS has recruited a dedicated complaints resolution manager, an executive officer for RACS Trainees' Association (RACSTA), a principal medical educator to support the Foundation Skills for Surgical Educators course, and has enhanced the roles of general council, executive director for surgical affairs, clinical director of international medical graduate assessment and support, and dean of education to assist with ongoing educational reviews.

RACS funds this through a number of means, predominantly through trainee fees and Fellows' subscriptions. It acknowledges the support for some initiatives through Australian Government funding of the Specialist Training Program (STP).

Service agreements with specialty societies stipulate funding to ensure the provision of adequate resources so the specialty societies can support the educational requirements of their trainees. Trainee fees are reviewed annually to ascertain funding requirements for surgical education and training.

1.6 Interaction with the health sector

Accreditation standard

1.6.1 The education provider seeks to maintain effective relationships with health-related sectors of society and government, and relevant organisations and communities to promote the training, education and continuing professional development of medical specialists.

1.6.2 The education provider works with training sites to enable clinicians to contribute to high-quality teaching and supervision, and to foster professional development.

1.6.3 The education provider works with training sites and jurisdictions on matters of mutual interest.

1.6.4 The education provider has effective partnerships with relevant local communities, organisations and individuals in the indigenous health sector to support specialist training and education.

Summary of RACS Response

1.6.1 RACS has had long-standing relationships with hospitals and health departments, ministry and district health boards. The profile of work done on Building Respect, Improving Patient Safety has enhanced the previous focus on surgical education to more fully include surgical leadership and cultural change. RACS continues to advocate to health departments and the broader community about issues relating to health and surgical standards.

1.6.2 RACS works with training sites to enable clinicians to contribute to high-quality teaching and supervision, and to foster professional development. There is an increased emphasis on providing support for supervisors at each hospital to improve support for trainees, and also to provide for fuller training of those involved with surgical education and training.

1.6.3 RACS works with training sites and jurisdictions on matters of mutual interest.

1.6.4 RACS has strong relationships with the Australian Indigenous Doctors Association and Te Ohu Rata o Aotearoa, as well as other groups, to support specialist training and education.

RACS management and Fellows regularly engage with health departments, district health boards and ministries in their jurisdictions and at a Commonwealth level. As RACS is represented in New Zealand and each state of Australia, the local committee/board chair and regional manager regularly meet with health ministers, senior department staff, and opposition health representatives. In 2015, this involved 92 meetings and there have been 106 meetings this year to-date (October 2016). These meeting have a strong focus on advocacy for surgical services and also the requirements for surgical standards, education and training, and relevant public health issues. A summary of the meetings between national and regional committees and government agencies is available.

RACS has a strong advocacy focus, supported by a broad capability in standard creation, policy development and formal research and evaluation of policy areas. This is overseen by the Governance and Advocacy Committee of the RACS Council, with a strong interface to PDSB which is responsible for extensive policy development, and delivered through the many interactions of RACS, its Fellows and external stakeholders. In addition to our meetings with government and other stakeholders, responses to consultations and submissions are provided. Areas of focus for advocacy include sustainability of healthcare; indigenous health; trauma; alcohol-related harm; cessation of smoking; and discrimination, bullying and sexual harassment. This year to-date (October 2016) we have made 51 submissions to government, statutory agencies and external reviews. These are on the Advocacy section of the RACS website. RACS position papers are routinely submitted to influence the positions of major political parties wishing to form government. For example, concerns about driving speed limits were accepted by the incoming Northern Territory Government, and then enacted.

RACS also liaises with the Australian health department regarding the surgical workforce pipeline, audits of surgical mortality and clinical variation data. In New Zealand, this liaison is with Health Workforce New Zealand (HWNZ), Perioperative Mortality Review Committee (POMRC) and with Health Quality & Safety Commission (HQSC). RACS has worked for almost two years with the private health insurance industry, and Medicare, to provide reports to surgeons about key measures of performance relating to hospital admissions, complications and fee charges. It is planned that this will lead to comprehensive data analysis supporting patient safety and wellbeing. Refer to Surgical Variance Reports. This is overseen by the Sustainability Committee of RACS Council, which reports through Professional Standards to the Professional Development and Standards Board. RACS meets frequently with the Australian Health Practitioner Regulation Agency, the Medical Board of Australia and the Medical Council of New Zealand on a range of issues and responds to requests for data or information.

To increase effective interactions with individual hospitals, RACS has formed the Surgical Directors Section with a particular focus on the development of surgical leadership and the ability to influence organisations. RACS aims to ensure the senior surgeons within hospitals have the leadership skills and access to appropriate surgical resources, position papers and policy to ensure improvements are achieved in surgical services and the culture of the health sector. This development was particularly highlighted in the Building Respect, Improving Patient Safety Action Plan.

At the specific level of surgical education and training, the role of the surgical supervisor is critical to oversee specialty trainees and the provision of the appropriate resources in the hospital. The requirements for training in each specialty are detailed in the Accreditation of Hospital Posts guidelines. Training boards undertake five-yearly reviews of training posts on a rotating basis. At each of these reviews, emphasis is placed on supporting surgical educators and the interaction between clinical units and hospitals.

Of increasing importance is the feedback that surgical mortality audits can provide to the clinical governance areas of hospitals about mortality rates. Where possible, surgeons are involved with mortality audits and receive individual reports. Hospital-based reports, where this will not identify individual clinicians, and regional reports are available. A collaborative arrangement with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists means this now also covers obstetric and gynaecological procedures. In New Zealand, perioperative mortality data is looked at epidemiologically through POMRC research.

Building Respect, Improving Patient Safety

The Expert Advisory Group investigating the incidence of discrimination, bullying and sexual harassment surveyed all teaching hospitals across Australia and New Zealand and confirmed a high incidence of unprofessional behaviour. Following the launch of the Building Respect, Improving Patient Safety Action Plan, RACS has communicated frequently across the health sector about the initiatives being undertaken. A series of initiatives has been aimed at hospitals. To progress these, RACS has been particularly keen on a collaborative model and has met with health departments and district health boards and many hospitals across Australia and New Zealand. Formal agreements to collaborate to promote a work culture free from discrimination, bullying and sexual harassment have ensued. This has contributed to collaboration with hospitals to deliver training for supervisors and trainers and to support surgical professionalism on the platform of Building Respect, improving patient safety.

Several agreements are in place, with others yet to be signed or being discussed. Agreements or memoranda of understanding exist with:

1. Monash Health, Vic
2. St Vincent's Health, Australia
3. Metro South Health, Qld
4. Ramsay Health Care
5. Gold Coast Health, Qld
6. University of Otago Medical School, NZ
7. Queensland Health Department, Qld
8. NSW Health (statement of agreed principles – including with other colleges)
9. RANZCOG
10. Nelson-Marlborough District Health Board, NZ
11. NZ Private Surgical Hospitals Association
12. Royal Brisbane and Hospital

Community representation

RACS values community consultation and representation in its decision-making. Community advisors sit as full members of key RACS boards, with two community advisors on the RACS Council. Other advisors bring substantial additional skills and the opinion of the community to many of our committees. RACS has a policy and process for recruitment and approval of advisors.

RACS plans to 'refresh' the involvement of representatives from the community through an expression-of-interest process to be coordinated through the vice-president's office. A nominations committee will assist Specialty Training Boards and other committees to appoint suitable external co-opted members.

Indigenous health

RACS has developed a number of partnerships with organisations, individuals and the local community as part of its indigenous health plans. RACS has a longstanding relationship with the Australian Indigenous Doctors' Association (AIDA). As part of the RACS Reconciliation Action Plan 2016-2017, RACS has committed to maintain and enhance our partnership with AIDA and develop at least two new partnerships with organisations working in our sphere of influence.

RACS commitment to AIDA includes representation at their annual meetings; AIDA sits on RACS Indigenous Health Committee and sits on selection panels for scholarships relevant to Aboriginal and Torres Strait Islander candidates. RACS works closely with the local owners of the land on which our office stands in Melbourne. Wurundjeri elder Perry Wandin presided over RACS' commitment to develop a reconciliation action plan in 2015 and returned to assist with the launch of the plan in 2016 during National Reconciliation Week. RACS engages with local Aboriginal communities through our site offices and as part of our meetings and annual scientific congress. RACS has also partnered with Johnson and Johnson to work collaboratively to improve leadership, encourage more indigenous surgical trainees and their support though mentoring.

In New Zealand, RACS has a longstanding relationship with Te Ohu Rata o Aotearoa - Māori Medical Practitioners Association (Te ORA). RACS supports Te ORA's annual Hui-a-Tau and the 2016 Pacific Region Indigenous Doctors Congress hosted by Te ORA. Te ORA is represented on RACS Indigenous Health Committee as well as on selection panels for scholarships offered to Māori medical students or junior doctors. As part of RACS Māori Health Action Plan 2016-2018, RACS seeks to develop genuine partnerships with Māori organisations and Iwi (tribes). A Māori Health Steering Group, comprised primarily of Māori surgeons and Māori trainees, advises on activities required by the Māori Health Action Plan.

The RACS Indigenous Health Committee reports via Fellowship Services to the Professional Development and Standards Board. It oversees implementation of RACS' position statement and strategic commitments in indigenous health in Australia and New Zealand.

A major workshop day on indigenous medical workforce development is planned for the TriNations Alliance meeting in Melbourne in March 2017.

1.7 Continuous renewal

Accreditation standard

1.7.1 The education provider regularly reviews its structures and functions for, and resource allocation to, training and education functions to meet changing needs and evolving best practice.

Summary of RACS Response

1.7.1 RACS is an organisation based on the quality principles of continuous improvement. We reflect that in all of our ongoing activities, management reviews, risk assessment and audits. RACS is accredited within the ISO 9001 standard.

RACS is an organisation based on the quality principles of continuous improvement. The approach is described in the quality manual that details our quality management system. As such, RACS maintains a set standard and required protocol to address all work practices. RACS is accredited to the ISO 9001 standard and this requires ongoing monitoring and evaluation of key activities in a cycle of continuous improvement. This cycle includes governance and audit functions, formal review and updating of policies and procedures, and ongoing review of the risks confronting RACS and development of a risk register. This register quantifies risks as high, medium, or low risk, and includes risk mitigation strategies. These are regularly reviewed by Council.

The RACS Council approves the strategic plan, the yearly business plan and the annual budget. These are monitored monthly and reported routinely to the RACS Council or the Council Executive. RACS works in a heavily regulated environment. In addition to this regular reporting there are ongoing internal or external audits or review of all the RACS activities.

Audit plans are approved through the Risk Management and Audit Committee based on ongoing reviews of RACS activities and updating of the risk register.

The structure of RACS continues to be dynamic, reflecting this ongoing assessment. The past five years has seen substantial enhancement of the advocacy and policy generation capability; significant investment in information technology to move towards a Digital College with particular impact in the educational areas; profiling of risk assessment and risk management across the entire College; understanding of the impact of unprofessional behaviour and the influence of RACS in changing culture; the requirement for compulsory continuing professional development for fellowship of RACS; the impact of the sustainability of healthcare and the importance of a formal research and evaluation capability within RACS.

All these areas impact our educational activities. RACS, as a body, clarifies the standards required for the practice of surgery in Australia and New Zealand and documents these through position papers, policy, curricula and educational material. These are widely disseminated across the fellowship and are taught formally and informally through RACS educational programs.

Community evaluation of surgical standards is ongoing and is communicated directly by the community, through the media and by governments and departments of health. This ongoing evaluation demands ongoing review of what is expected within our standards of surgical competence and performance.

Strengths

RACS has substantial expertise and experience, with Fellows and staff engaging in government and health sector negotiation and collaboration, reflected through regional, national and commonwealth interactions.

RACS delivers surgical education and training in a devolved model, working closely with the 13 specialty societies and associations.

RACS encourages diversity and inclusion to address gaps in the profession, such as low numbers of women in surgery. The JDocs Framework provides those interested in careers in procedural medicine with a means to identify, progressively develop, and record the skills they require to enter specialty training. RACS advocacy activities address concerns about maintaining environments for surgical practice that are conducive to surgeons contributing to the health of the community.

RACS has improved resources for advocacy and communication. Staff skilled in policy, government relations, communications and digital media work closely with RACS' regional offices to influence policy development. RACS' focus is to ensure health outcomes for patients, that communities benefit, that health systems in Australia and New Zealand are improved, and that the interests of Fellows, trainees and international medical graduates are promoted.

RACS has advanced a comprehensive information technology program to embrace the concept of a digital College. The digital College has transformed the way the public, Fellows, trainees and international medical graduates interact with RACS. The improvements now enable more transactions to be carried out online, and RACS systems to function on mobile platforms and devices. A challenge is for RACS to stay ahead of user expectations and to continue to embrace technological advances to improve the efficiency and effectiveness of staff, Fellows, trainees, and international medical graduates.

The past three years have seen RACS focus on issues related to professionalism, ranging from relationships with industry and fees charged, to surgeons' behaviour and cultural change. RACS is actively responding to these issues.

RACS and specialty societies' governance and management methods continue to evolve, leading to greater certainty in methods used by committees to address and resolve issues. The underlying approach to governance, however, has remained consistent since the inception of the surgical education and training program, 10 years ago.

A major strength of the RACS programs is the commitment of Fellows who contribute their time to educational activities. Contributing to RACS and specialty society initiatives, providing expert advice on training courses, and serving as examiners, supervisors or committee members, are some of the ways surgeons become involved in improving standards and providing educational activities and opportunities.

RACS has promptly accepted the challenge of leading cultural change in the practice of surgery and in the healthcare sector. Although developing as a collaborative model with committed partners, there is a substantial cost to the contributions that RACS is making to address the issues identified in the Expert Advisory Group report. Meeting the expectations that now exist creates pressures on individual Fellows and on RACS.

The capacity of RACS and the range of resources available for development and delivery of training is a strength. Additional work to enhance the reach of programs, with partners such as hospitals (for example, through accreditation of courses), is required.

RACS is actively engaged with universities, medical student groups and with AIDA and Te ORA.

Challenges

RACS must balance the provision of support, and guidance that focuses on principles and key requirements, while rapidly delivering the detail and processes required of educational and standards organisations in 2016.

There are ongoing challenges within the delegated model as not all changes are reliably communicated. Service agreements do not guarantee full collaboration to enable global review and prioritisation for program development.

The Building Respect, Improving Patient Safety Action Plan has mandatory requirements to address cultural concerns, to provide essential education and to establish a comprehensive, centralised complaints process.

These are being implemented, but require carriage through all RACS committees, particularly the Board of Surgical Education and Training and individual training boards. RACS' diversity plan, Aboriginal and Torres Strait Islander and Māori health action plans, and mental health initiatives are not universally embraced, requiring complex change-management approaches.

The digital College concept has been broadly welcomed by Fellows, and efforts to ensure continuing benefit are ongoing. RACS has developed substantial resources and expertise in this area, however, pressure to update and improve the infrastructure and function, while providing strict data security and privacy protection, is considerable, and has increased the costs of delivering RACS' education activities. The trajectory for change in information technology is steep and commitment to providing these services requires substantial resources.

A challenge for RACS – as it is with many membership-based organisations – is to continue to define the standards expected by the community in ways that are meaningful to surgery and surgeons, to develop educational programs that can deliver appropriate content, and to provide cause for reflection and change in behaviour. The uptake and monitoring of this is critical. A further challenge is to communicate the standards to a broad membership, across all regions of Australia and New Zealand, in a short period of time, and to ensure that surgeons are the best possible role models. This support and communication with our members, particularly our educators, is one of RACS' most important, ongoing activities.

It is challenging to instigate change in a complex health sector. Improving experiences and infrastructure for all trainees, identifying opportunities for training in regional and rural areas and continuing to improve cultural awareness is paramount.

The development of the RACS Building Respect, Improving Patient Safety Action Plan and the need to collaborate broadly has increased RACS' interactions with the health sector and will continue to do so for many years. This has resulted in an enhanced focus on discrimination, bullying and sexual harassment issues, with RACS taking the lead in this area. With time it is expected that the health sector, and hospitals in particular, will take up the challenge of improving the culture and building on the work of RACS; as this cannot be done alone. Partnerships are essential for success.

Plans

Collaboration and partnerships underpin RACS' approach to delivering its education and training program. It is in this context that 'train the trainer' models are being implemented in hospitals, health networks and district health boards that have progressed memoranda of understanding, as part of mandatory training for those involved with surgical training.

Through greater engagement with hospitals, it is envisaged that over time, educational programs accredited by RACS can be delivered locally by these organisations. This will complement the courses being directly delivered by RACS. A challenge will be to ensure that the quality of the education resources are not compromised by a devolved model.

RACS will continue to seek and build collaborations with hospitals, through Memoranda of Understanding to develop and deliver relevant, high quality training to JDocs, trainees, international medical graduates and Fellows.

RACS will continue to build collaborations with stakeholders including universities and hospitals both nationally and internationally so high quality educational resources are available for our Fellows, trainees and international medical graduates.

RACS must ensure that Fellows are supported and have access to educational activities to develop skills required to undertake their roles.

Further engagement with government via the regional offices, and regional chairs, is vital to appropriately influence the delivery of health services that align with the RACS mission. The Surgical Directors Section is aimed at nurturing surgical 'champions' who can engage with hospital organisations and government. Development of leadership capability and improved quality assurance mechanisms in this group is a high priority.

Improving indigenous health and indigenous representation in surgery remains a key challenge. The recent push to alleviate ear disease in Australian indigenous communities is an example of current efforts to work with government to progress the agenda and strive for desperately needed improvements for indigenous Australians.

Section 2

The outcomes of specialist training and education

2. The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard

2.1.1 The education provider has defined its educational purpose, which includes setting and promoting high standards of training, education, assessment, professional and medical practice, and continuing professional development, within the context of its community responsibilities.

2.1.2 The education provider's purpose addresses Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand and their health.

2.1.3 In defining its educational purpose, the education provider has consulted internal and external stakeholders.

Summary of RACS Response

2.1.1 The RACS Constitution clearly articulates the purpose and objectives of RACS in relation to surgical practice, training, research and continuing professional development and its acknowledgement of its social and community responsibilities. The scope of surgical practice is clearly articulated and is continually evolving.

2.1.2 RACS addresses the health of Aboriginal and Torres Strait Islander peoples of Australia and Māori of New Zealand through the implementation of the RACS Reconciliation Action Plan, the Aboriginal and Torres Strait Islander Health Action Plan 2014-2016 and Māori Health Action Plan 2016-2018.

2.1.2 To define its educational purpose, RACS has consulted internally with the fellowship and staff on the revision its Strategic Plan 2014-2018 and via a fellowship survey. The Expert Advisory Group conducted extensive external consultation, which also has informed the future direction of this purpose.

The RACS Constitution sets out the reasons for and purpose of RACS. It defines the objectives to effect this purpose, lists the powers vested in the corporate entity to achieve those objectives, and guides all the activities of RACS, including training, examinations, assessment, and professional development. The RACS vision, as stated in the RACS Strategic Plan Business Plan 2017-2018, is to be "the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand".

The standards for surgeons are most clearly explained within the RACS Code of Conduct (updated 2016) and the RACS Surgical Competence and Performance guide (2011). This has been further detailed in Becoming a competent surgeon: Training standards for the nine RACS competencies.

The RACS Building Respect, Improving Patient Safety Action Plan complements these significant documents and provides direction in three key areas – culture and leadership, surgical education and management of complaints. The plan followed work undertaken by the Expert Advisory Group into bullying, discrimination and sexual harassment. The action plan is patient-centred as it is acknowledged that "every patient has the right to expect that their healthcare is not compromised by bullying, discrimination and sexual harassment in the practice of surgery"[1]. The link between patient safety and a safe and professional environment is well documented. Consequently RACS is engaged in a significant change-management process, and has implemented a number of projects and initiatives as part of the action plan. A public webpage, About Respect, provides comprehensive information on all aspects of the initiative.

[1] Expert Advisory Group on bullying discrimination and sexual harassment, Report to RACS, September 2015, EAG Statement p1

The RACS fellowship survey evaluates Fellows' opinions, levels of engagement and pro bono activities and provides feedback on how RACS is delivering on its strategy and purpose.

The role of the surgeon

The RACS Surgical Education and Training Program produces independent surgeons who have specialty knowledge and skills, as well as broad medical professional expertise. They have capacity to evaluate patients and their health issues from several perspectives, providing safe surgical care for the benefit of the community. Surgical practice requires a unique range of clinical knowledge and skills, and surgeons in Australia and New Zealand work in clinical environments ranging from remote rural environments to large metropolitan teaching hospitals in public and private practice, and the armed services.

The nine RACS competencies, referencing the CanMEDS Framework, are the standards that permeate all RACS training and education activities. Surgeons deliver patient care as part of a team in a patient-centred approach. This philosophy is emphasised through powerful statements from surgeons that underpin the RACS Building Respect, Improving Patient Safety communications strategy. The full range of posters and information on the communication strategy is available on the RACS website.

RACS' purpose is visible through its fellowship. RACS graduates are leaders in clinical healthcare, surgical research and throughout the healthcare sector. Fellows engage with national and international stakeholders on a range of health initiatives and advocate for surgical standards through engagement with senior government, statutory and regulatory bodies and other key stakeholders. RACS graduates are recognised educators in the broader health and higher education sectors.

Some aspects of professionalism are less visible, being generally the result of mentoring and role modelling. An outcome of surgical education and training is a surgeon who is highly committed to giving back to the professional community in the public interest. The value of the pro bono contribution to develop, to educate and to sustain RACS standards cannot be underestimated. RACS is fortunate to have sustained pro bono contribution across all levels of the organisation, from the education and training of trainees to engagement at an international level. RACS is a leader in the advocacy for universal access to safe and affordable surgery and anaesthesia in all communities through its global health initiatives, which are particularly successful in the Pacific region. The risk of losing this pro bono contribution is acknowledged in the RACS risk register and RACS continues to reward and recognise the contribution of Fellows.

RACS believes it has a vital role to play in addressing health disadvantage among Aboriginal, Torres Strait Islander and Māori communities. RACS' purpose addresses Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand, and their health, through specific health action plans for Aboriginal and Torres Strait Islander and Māori peoples. These plans aim to ensure the championing of high-quality surgical education and training for indigenous people and support for Fellows' involvement in indigenous health education, research and practice. The health plans also guide the establishment and maintenance of strong external relationships, which enhance RACS advocacy and ensure the most effective use of resources. The plans are publicly available, clearly articulated and integrated at all levels of RACS strategic and business planning.

Consultation with stakeholders

RACS communicates with its internal and external stakeholders about its purpose and role via regular publications. *Surgical News* is published monthly, and members receive a weekly e-newsletter, *Fax Mentis*. Regular state, territory and New Zealand newsletters are also sent to fellows, trainees and IMGs.

RACS has an open and transparent approach and the comprehensive website contains detailed information about RACS, including its history, structure, training program, educational opportunities for Fellows and trainees, information for international medical graduates, continuing professional development, and opportunities for research. RACS publishes an extensive list of publications, reports, plans, position papers and policies to inform and educate the public and advise of RACS activities and areas of engagement. External and internal stakeholders can contact RACS via a generic email address.

Ongoing consultation between RACS and the specialty societies and associations occurs in multiple ways, through individual, office-bearer, or organisational links. Surgical leaders forums have been held for many years, with changing formats. Currently held before the RACS Council meeting in October, the forums provide opportunities for consultation and dialogue with the presidents of the specialty societies and board

chairs. The forum discusses and debates issues such as training, advocacy, and legislative and regulatory issues, which impact on the direction of surgery and its purpose.

RACS has a strong and proactive traditional and social media program. In 2016, RACS distributed approximately 70 media releases, generating around 3000 media mentions across Australian and New Zealand. RACS uses its social media platforms to target and engage its stakeholders, and promote its media and advocacy messages. The RACS Facebook page has more than 5000 likes and its Twitter account has over 3500 followers. Both platforms are showing significant growth and are generating significant levels of traction and engagement from the community, health sector and the profession.

RACS is focused on eliminating bullying, discrimination and sexual harassment to improve the culture of surgery and this will be an ongoing challenge in 2017 and beyond.

2.2 Program outcomes

Accreditation standard

2.2.1 The education provider develops and maintains a set of program outcomes for each of its specialist medical programs, including any sub-specialty programs, which take account of community needs, and medical and health practice. The provider relates its training and education functions to the needs of the communities it serves.

2.2.2 The program outcomes are based on the role of the specialty and/or field of specialty practice and the role of the specialist in the delivery of healthcare.

Summary of RACS Response

2.2.1 The nine RACS competencies adapted from CanMEDS, articulate the requirements of being a competent and safe surgeon. All curricula address these nine competencies and RACS publishes resources to provide a practical guide on how the competencies relate to performance.

The program outcomes are articulated in the curricula of the nine specialty programs and are reviewed and updated in response to the changes in surgical practice, and the healthcare needs of the community. The clinical knowledge and skills required are determined by the specialty boards and reflect the contemporary practice of the discipline.

2.2.2 The outcomes of the nine surgical training programs align to the role of the specialist surgeon in the community and to the skills, attributes and knowledge required to deliver patient care specific to the requirements of the patient.

The RACS Surgical Education and Training (SET) Program is RACS' primary activity for training new surgeons. The desired outcome is to produce the competent, independent specialist surgeons necessary to provide communities and health systems with the highest standard of safe, ethical and comprehensive care.

The nine RACS competencies define the attributes of a surgeon and each is of equal value. These competencies are articulated in the RACS Surgical Competence and Performance guide and the RACS Code of Conduct.

Each specialty program defines the clinical skills and knowledge required for the practice of surgery in a specific discipline, and these are defined in each program's curriculum. Newly certified Fellows of RACS are able to practise across the generality of their specialty, can provide emergency care when required, and display competent performance across the nine competencies. Many new Fellows undertake further post-fellowship training or experience within an acknowledged sub-specialty, or a recognised field within the specialty. Some extra training may be completed overseas. This may be combined with experience gained as a junior Fellow in a hospital unit or department, or a multi-surgeon practice.

Most surgeons evolve a scope-of-practice over the first five years post-fellowship: this relates to their training and location and style of practice. There is subtlety in this, as new graduate Fellow numbers are growing the surgical workforce at a rate slightly greater than population growth. Relationships with senior colleagues, including mentoring, support this vital early-career development.

Surgery works in an environment of rapidly evolving science and technology, and the specialty boards respond to these influences. The curriculum-review process ensures surgical training keeps pace with innovation and community needs. The general surgery training program is implementing changes to its curriculum in response to consultation and feedback from stakeholders. The Australian Orthopaedic Association has commissioned a review of its curriculum against international standards and is undertaking extensive revision, planned over several years.

The specialty training programs prepare new Fellows to undertake the range of care and procedures offered by a surgeon of that specialty. Surgeons, their specialty societies, associations and RACS continuously engage and collaborate to ensure RACS is meeting the needs of the community.

The definition of a specialist surgeon will continue be reviewed as patient needs, the workforce and workplaces change. The purpose will remain constant, but the way it is implemented will require regular review, strategic planning and agile training.

2.3 Graduate outcomes

Accreditation standard

2.3.1 The education provider has defined graduate outcomes for each of its specialist medical programs, including any sub-specialty programs. These outcomes are based on the field of specialty practice and the specialists' role in the delivery of healthcare and describe the attributes and competencies required by the specialist in this role. The education provider makes information on graduate outcomes publicly available.

Summary of RACS Response

2.3.1 RACS defines its graduate outcomes based on the needs of the community and determined by available data. Information on graduate outcomes is published on the RACS website, and in publications that showcase the diverse work of surgeons.

RACS can determine that its education program is achieving its desired graduate outcomes through data that explains the activities of the training program. The annual RACS activities report records and reports data on the outcomes of each specialty program, including the number of new trainees, number of new Fellows and examination results.

Separate international medical graduate data for Australia and New Zealand provides an overview of the numbers seeking fellowship or vocational assessment, in addition to the number of international medical graduates working in areas of need. Data on participation in continuing professional development confirms RACS Fellows understand that their specialist training and education is always evolving, and requires ongoing commitment to continuous improvement to maintain the relevance of their skills. An extensive program of skills courses, conferences and events demonstrates RACS' commitment to education. RACS' work in global health is quantified in the number of clinics offered and number of scholarships and education grants awarded.

The RACS activities report has been produced since 2003 so data trends can be tracked and monitored for indications of failing outcomes, or deviations from the purpose expressed in the strategy and all activities reports (2003-2015) are available from the RACS website. The 2016 Activities Report will be available in February 2017.

Surgical News highlights the achievements, roles and activities undertaken by surgeons and trainees through engaging articles that explain the role of the surgeon in the community. Surgical News is publicly available on the RACS website and is broadly distributed in hardcopy.

Strengths

RACS' development and implementation of standards for surgical education and training, and for professional surgical practice, is a real strength. Consistent standards cover all facets of surgical practice, applying equally to trainees, new surgeons and senior surgeons. The many roles of the surgeon are mapped to the nine RACS competencies. The workplace roles of the surgeon as well-defined.

Each specialty is well-defined, with clear program outcomes and is able to develop its SET program within a framework of principle-based policies.

Challenges

The professional behaviours of surgeons, and their skills as educators, have been under scrutiny since early 2015. These issues are being addressed in the Building Respect, Improving Patient Safety Action Plan.

In some specialties, most new surgeons prefer to practise in major cities. Smaller towns rarely attract local graduates, but rely on international medical graduate surgeons, most of whom are on pathways to fellowship.

Some new graduates have expressed lack of confidence ('competent but not confident') and seek post fellowship experiences, subspecialty training, or both.

Plans

The Building Respect, Improving Patient Safety Action Plan is being implemented to address challenges faced by RACS, including issues of professionalism, and suboptimal supervisor and trainer skills.

The recently revised Code of Conduct defines the roles and behaviours of surgeons; RACS is working to give the Code suitable prominence.

RACS has discussed excessive fees with the Fellowship and has facilitated ways for patients or others to lodge complaints. RACS has clearly stated that there is no connection between the cost of a surgeons' service and superior care.

RACS encourages specialty training boards to identify and implement non-urban training networks.

Section 3

The specialist medical training and education framework

3. The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard

3.1.1 For each of its specialist medical programs, the education provider has a framework for the curriculum organised according to the defined program and graduate outcomes. The framework is publicly available.

Summary of RACS Response

3.1.1 The RACS Surgical and Education Training Program (SET) has a defined structure based on progression related to the attainment of competencies required of a new Fellow. The program is defined in terms of time (rotations and length of training) and by the attainment of increasing levels of competency. This is determined by progressive assessment.

Overview

RACS introduced the RACS Surgical Education and Training Program (SET) following extensive consultation with the surgical specialties, hospitals and government agencies. From 2007, medical doctors could enter directly into specialist surgical training as early as postgraduate year three (PGY3). Typically, in recent years, selection has occurred in postgraduate year four or five (PGY4 or 5), meaning commencement at postgraduate year five or six (PGY5-6).

The RACS curriculum framework maintains a focus on excellence in technical skills and medical knowledge, with major emphasis on the non-technical professional attributes required to equip surgeons for service in diverse health settings. The RACS framework is delivered by designated supervisors and trainers from each specialty. Supervisors and trainers meet College standards for education and training, in the workplace, and in all academic learning environments.

Curriculum development is based on the nine RACS competencies and focuses on outcomes, where trainees demonstrate proficiency in technical and non-technical competencies appropriate for the stage of training, and for the clinical activities the trainee has undertaken. Work-based is an integral part of the SET program.

The RACS Continuing Professional Development (CPD) Program also uses this framework of competencies and outcomes. This means it is possible to map the curriculum from junior doctor to experienced independent consultant throughout a surgical career. Operationally, the framework incorporates principles of adult learning, flexible learning and lifelong learning. RACS recognises that Fellows also need to demonstrate their competencies through work performance, particularly when they are involved in teaching trainees or assessing international medical graduates.

Key enablers in the RACS education framework include College events and workshops, conferences, courses, online resources, support through regional offices, training rotations that expose trainees to geographic and cultural diversity, development of technology to facilitate self-learning and self-assessment, and opportunities for mentors and supportive peers.

JDocs Framework

Introduced in 2014, the JDocs Framework demonstrates the RACS approach to the educational framework.

RACS developed the JDocs Framework to guide and support prevocational doctors interested in surgery or another procedural career and to ensure those selected into the SET program were better prepared for the registrar role. In developing the framework, RACS engaged with multiple stakeholders, including senior medical students, young doctor focus groups, hospitals and training networks, health department officials and specialist medical colleges.

The JDocs Framework is aligned to the nine RACS competencies and describes the tasks, skills and behaviours expected of junior doctors during the early prevocational years. This will assist doctors in their development towards a career in surgery as well as supporting those who follow other proceduralist careers. Pivotal to the JDocs Framework are key clinical tasks, which can be used to support feedback and assessment of junior doctors in the workplace. Guidelines for the key clinical tasks have been developed to aid supervisors to provide junior doctors with performance feedback. This initiative was developed in close collaboration with health practitioners and clinical educators to support junior doctors and their supervisors to engage in self-directed learning, regardless of their medical specialty. The resources are open access but for those doctors who wish to register with RACS, additional resources are provided including an electronic logbook (Morbidity Audit and Logbook Tool or MALT), a Portfolio and examination preparation resources.

The JDocs website provides a comprehensive overview of the curriculum, learning resources and opportunities for assessment.

Stages in the surgical career

The SET program has a defined structure combining aspects of time (rotations and duration of training) and competence (the progressive attainment of competence). Generally each year of surgical training is comprised of six to twelve month clinical rotations (with three-month rotations for some specialties in the first year of training). The surgical specialties differ slightly in structure and the time required to achieve independent practice, as shown in Table 3 Stages in the surgical career pathway.

Table 3 Stages in the surgical career pathway

		SET Program										
	PGY 1- 4/5	1	2	3	4	5	6	7	8	9	10	11
JDocs												
Cardiothoracic surgery		Expected duration of clinical training						Maximum time available to complete all requirements				
General surgery commencing pre-2017		Expected duration of clinical training					Maximum time available to complete all requirements					
General surgery commencing from 2017		Expected duration of clinical training				Maximum time available to complete all requirements						
Neurosurgery		Basic training 1-2 years		Intermediate training 3-4 years				Advanced training 1-3 years				
Orthopaedic surgery Australia		Intro 1 year	Core 3 years			Transition 1 year	Maximum time available to complete all requirements					
Orthopaedic surgery NZ		Expected duration of clinical training					Maximum time available to complete all requirements					
Otolaryngology head and neck surgery		Expected duration of clinical training					Maximum time available to complete all requirements					
Paediatric surgery		SET 1	Early SET		Mid SET		Senior SET		Maximum time available to complete all requirements			
Plastic and reconstructive surgery Australia		Expected duration of clinical training					Maximum time available to complete all requirements					
Plastic and reconstructive surgery NZ		Expected duration of clinical training					Maximum time available to complete all requirements					
Urology commencing pre-2016		Expected duration of clinical training						Maximum time available to complete all requirements				
Urology commencing from 2016		Expected duration of clinical training					Maximum time available to complete all requirements					
Vascular surgery		Expected duration of clinical training					Maximum time available to complete all requirements					

Several specialties now emphasise expected standards of performance at particular stages, a move away from the definition of training by numbers of years. For example, neurosurgery and otolaryngology head and neck surgery are introducing minimum and maximum periods of time in which competencies at each level must be achieved. General surgery has reduced the specified duration of training from five to four years and expects the competence of entry-level trainees will be evidenced by procedure-based assessments and other basic skills because the competence of entry level trainees will be at a higher level. The structure and framework for each specialty can be found in the specialty regulations.

An overview of the curriculum for each specialty is available in the RACS Guide to SET.

3.2 Curriculum content and alignment

Accreditation standard

3.2.1 The curriculum content aligns with all of the specialist medical program and graduate outcomes.

3.2.2 The curriculum includes the scientific foundations of the specialty to develop skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge.

3.2.3 The curriculum builds on communication, clinical, diagnostic, management and procedural skills to enable safe patient care.

3.2.4 The curriculum prepares specialists to protect and advance the health and wellbeing of individuals through patient-centred and goal-orientated care. This practice advances the wellbeing of communities and populations, and demonstrates recognition of the shared role of the patient/carer in clinical decision-making.

3.2.5 The curriculum prepares specialists for their ongoing roles as professionals and leaders.

3.2.6 The curriculum prepares specialists to contribute to the effectiveness and efficiency of the healthcare system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective healthcare, across a range of health settings within the Australian and/or New Zealand health systems.

3.2.7 The curriculum prepares specialists for the role of teacher and supervisor of students, junior medical staff, trainees, and other health professionals.

3.2.8 The curriculum includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, so all trainees are research literate. The program encourages trainees to participate in research. Appropriate candidates can enter research training during specialist medical training and receive appropriate credit towards completion of specialist training.

3.2.9 The curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia and Māori health, history and cultures in New Zealand as relevant to the specialty(s).

3.2.10 The curriculum develops an understanding of the relationship between culture and health. Specialists are expected to be aware of their own cultural values and beliefs, and to be able to interact with people in a manner appropriate to that person's culture.

Summary of RACS Response

3.2.1 The RACS Surgical Education and Training Program (SET) curriculum underpins the graduate and program outcomes; alignment is achieved using the nine RACS competencies as a framework, with each specialty determining the required technical skills and expertise for the relevant program.

3.2.2 The SET curriculum includes activities that help to form the foundation for ongoing skills in evidence-based practice; research is included as a requirement of training.

3.2.3 The curriculum builds on the skills required to enable safe patient care.

3.2.4 RACS prepares specialists to protect and advance the health and wellbeing of individuals through patient-centred and goal-orientated care.

3.2.5 RACS has developed many resources on the subject of leadership and management in surgical practice, some within the SET training program, some for continuing professional development and others for general purpose. Trainees are encouraged to participate in activities that develop leadership and management skills.

3.2.6 The curriculum covers aspects of professionalism and technical expertise that prepares trainees to contribute to the healthcare system by delivering safe and high-quality healthcare across a range of settings.

3.2.7 RACS curriculum prepares specialists for the role of teacher and supervisor of students, junior medical staff, trainees, and other health professionals.

3.2.8 RACS has developed a Critical Literature Evaluation and Research (CLEAR) course on research methodology, critical appraisal of literature, scientific data and evidence-based practice so all trainees are research literate. The RACS SET program encourages trainees to participate in and undertake accredited research during specialist surgical training, for which they receive appropriate credit towards completion of specialist training.

3.2.9 RACS has developed a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia, and Māori health, history and cultures in New Zealand, and has developed specific resources for trainees and Fellows.

3.2.10 RACS has developed resources to assist trainees and Fellows to understand their own cultural values and beliefs and to gain a better understanding of the relationship between culture and health.

The SET framework emphasises self-directed learning aligned to supervised clinical work. The formal elements of the curriculum framework are outcomes-focused as trainees demonstrate acquisition and performance of the nine RACS competencies. Standards of performance through SET, leading to progressive independence, are indicated in Becoming a competent and proficient surgeon: Training standards for the nine RACS competencies and the Surgical competence and performance Guide. Specialty content is reflected in clinical and operative activities and in the assessments undertaken of trainees.

RACS curriculum standards are designed to:

1. Provide clarity about the selection for doctors wanting to become surgeons in Australia and New Zealand. This includes junior (prevocational) doctors, medical practitioners trained in other specialties and international medical graduates.
2. Provide details of the professional attributes required of surgeons. These reflect policies on professional practice and behaviour in the workplace.
3. Provide details of standards of performance expected at the completion of each stage of training and alignment of these with work-based assessments and clinical responsibilities.
4. Ensure that curricula facilitate acquisition of technical and professional skills in continuous, life-long learning and reflective practice.

RACS has developed resources for all trainees and international medical graduates undergoing assessment. These include audits, formative and summative assessments and work-based assessment tools that support feedback in clinical settings. Fellows can record their career development in portfolios and use the Morbidity Audit and Logbook Tool (MALT) for audit purposes; they are required to participate in regional audits of surgical mortality.

Alignment of the curriculum to outcomes

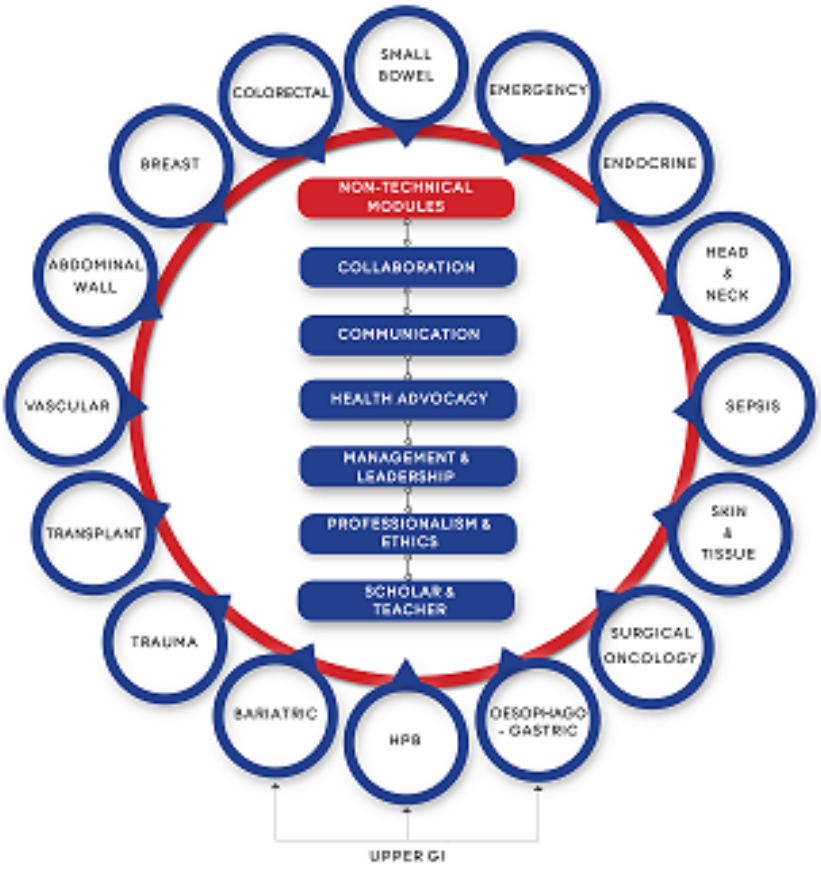
The program and graduate outcomes are described in detail in Section 2. The curriculum underpins these outcomes and alignment is achieved using the nine RACS competencies as the framework. Each specialty determines the required technical skills and expertise for the relevant program.

To ensure rounded professional training of surgeons, the curriculum and education resources are aligned to the nine RACS competencies. These were developed in 2006, and were adapted from the CanMEDS roles, published in 2005. They have generated broad discussion among Fellows and trainees, reinforcing the many

competencies required by a surgeon in practice as far more than a technical surgical expert. RACS also has introduced standards and strategies to ensure that SET learning, clinical requirements and assessments are similarly aligned. These core professional competencies are embedded in all components of SET.

As an example, Figure 4. Example of professional and technical competencies structure of the general surgery curriculum, illustrates the structure of the general surgery curriculum with the core competency modules and specific technical skills and knowledge modules

Figure 4. Example of professional and technical competencies structure of the general surgery curriculum



Scientific and technical competencies

The training boards determine the specialty-specific technical requirements to practice as generalists in the specialty, and all training boards follow this framework. Each defined surgical module or domain will contain the relevant core professional competencies as listed in the centre of the above diagram. Specialty-specific competencies are described in detail in each procedural module and other learning resources. Thus, each specialty curriculum lays a foundation for the scientific and technical knowledge required for practice in that specialty, along with the core professional competencies required of all surgeons.

The specialty curricula provide detailed information on content and how the curricula are structured for each specialty training program.

This competency framework makes it possible to map the aligned curriculum from JDocs through to continuing professional development as a practising surgical specialist. Consistent alignment throughout the RACS education spectrum is maintained through communication and collaboration between education committees, specialty societies, associations and hospitals.

The curriculum covers aspects of professionalism and technical expertise that prepares trainees to become surgeons and contribute to the healthcare system by delivering safe and high-quality healthcare across a range of settings. All specialties train for the generalist outcomes of the specialty, with formal post-fellowship training and/or experiential sub-specialisation occurring in the early years of practice as a surgeon, after completion of RACS fellowship. Surgical training typically occurs across several hospitals and networks, across several states if training in Australia and, for some specialties, a trainee may train in both Australia and New Zealand.

This exposes trainees to a wide variety of patients across different populations. Care is thus contextualised to a patient's needs, often within their own locality. Language, education and socio-economic status influence this and can be thoughtfully discussed by supervisors and trainers. RACS acknowledges that in a patient-centred approach, practice in a capital city tertiary referral hospital is not the same as practice in a major regional hospital, or practice in an outer-urban or provincial hospital. The shared nature of clinical decision-making needs to be adjusted depending on the patient, available resources and supports, and the urgency and/or severity of a patient's problem.

Scientific foundations and research

To establish a foundation in evidence-based practice, RACS strongly encourages research. All surgical trainees are required to undertake one or more research projects during SET. The research requirement may include (but is not limited to): presentation of a paper/poster display to a meeting for which abstracts are subject to review; publication in a refereed journal; a dissertation with a written review of a clinical problem together with a critical literature review; a period of full-time research; or a research higher degree at masters level or above. Trainees are encouraged to present research at the RACS annual scientific congress. Journal clubs help trainees maintain current scientific knowledge. The Critical Literature Evaluation and Research (CLEAR) course covers research methods in a combination of lectures and small-group teaching. It is mandatory for general surgery, neurosurgery, orthopaedic surgery New Zealand, paediatric surgery and urology SET trainees.

The master of surgical education course enables Fellows and trainees to conduct research in the field of surgical education. This has been particularly instructive in exposing participants to the value of mixed research methods, especially qualitative research.

Health advocacy

RACS has a dedicated advocacy webpage that regularly publishes position papers and statements on surgical healthcare and related issues to help inform Fellows, trainees and the wider community. RACS also conducts research into surgical health issues and technologies designed for surgical practice.

Surgical trainees work in multidisciplinary teams with a focus on patient-centred care and a well-informed patient will ask and seek advice. RACS' health advocacy work helps to build greater awareness and emphasis on the shared role of the patient or carer in clinical decisions. The clinical basis of SET, in which trainees combine supervised clinical practice with graduate learning, means that trainees work and train in the healthcare system. Components of clinical practice involve developing a working knowledge of this system.

Quality and safety in healthcare

RACS is strongly committed to quality and safety in healthcare. Since 2013, all applicants for surgical training must complete the Hand Hygiene Australia eLearning module, and from 2016 applicants must also complete the Operating with Respect eLearning module.

Specialty curricula contain specific references to quality and safety and are examined in some Fellowship examinations.

MALT is designed to enable audit and reflection of surgical practice. All surgical deaths are reviewed across Australia and New Zealand. Reviews are provided to individual surgeons; hospitals receive summaries via the clinical governance reports.

Leadership and management

Leadership and management is one of the nine RACS competencies, and aspects of it are taught in learning modules, skills courses and assessments. Trainees can develop leadership and management skills in practical ways, such as through involvement and engagement with the RACS Trainees' Association (RACSTA) or within their hospital, jurisdictional structures or medical associations (e.g. AMA Doctors in Training). However, the time constraints of training may prevent some trainees from seeking these opportunities. The formation of the Surgical Directors Section and the Leadership in Everyday Practice course (soon to be piloted) will assist in raising the profile of this competency and provide leadership role models.

The trainee as teacher and scholar

Trainees are encouraged to be educators in their own right, contributing as skills course instructors, as teachers of their juniors, and by engaging with junior doctors seeking a career in surgery through the JDocs Framework. Trainees can attend the Foundation Skills for Surgical Educators course and apply for membership of the Academy of Surgical Educators. Several are enrolled in the master of surgical education program. Trainees may present their work as teachers and supervisors at the surgical education stream for the RACS annual scientific congress.

Aboriginal and Torres Strait Islander and Māori health

The SET curriculum includes culture-specific modules to demonstrate the shared role of the patient and carer in clinical decision-making. RACS has developed these resources in collaboration with relevant indigenous communities and individuals who have participated in clinical scenarios. Aboriginal, Torres Strait Islander and Māori health and culture are primarily included as part of the health advocacy and communication competencies. Throughout surgical training, trainees are expected to:

- Provide care with compassion and respect for patient rights.
- Recognise that culture and beliefs affect patients and their expectations.
- Adapt patient care according to their concerns and expectations.
- Consistently deal with the challenges presented by different value systems.
- Adapt practices and care of patients from diverse backgrounds according to their culture and beliefs.

RACS has developed an Aboriginal and Torres Strait Islander History and Culture eLearning resource (log in required). RACS encourages New Zealand trainees to undertake training made available through the Ministry of Health for Māori health. Additionally, the Board of Otolaryngology Head and Neck Surgery is developing a curriculum module specific to Aboriginal and Torres Strait Islander and Māori health.

RACS encourages New Zealand trainees to complete the Ministry of Health's online module "Foundation Course in Cultural Competency" and to utilise the Medical Council of New Zealand's resources associated with best practice for Māori patients and their whanau.

Culture and health

RACS provides resources to assist trainees, Fellows and international medical graduates to recognise their own and others' cultural values and beliefs. RACS has developed a comprehensive Intercultural Competence for Medical Specialists eLearning resource (log in required). By describing the competencies as behaviours in practice, through the *Standards of Clinical Performance Guide* and *Becoming a Competent and Proficient Surgeon*, Fellows and trainees are encouraged to reflect on their values, and be aware of the importance of good professional practice.

Curriculum review

To ensure the curriculum reflects the evolving requirements of the community, is responsive to new and emerging technologies and surgical practices, and leads to the highest level of safe surgical practice, the SET curriculum framework is based on continuous renewal, informed by clinical and educational good practice. The SET program is developed, reviewed, approved, delivered and evaluated. Positive changes are incorporated throughout this cycle.

Formal feedback into curriculum development is provided through the RACS specialty training boards, which report to the Board of Surgical Training and the Education Board. The Professional Development and Standards Board also provides input. These boards include representatives from specialty curriculum development committees, examination boards and committees, supervisors and trainees. RACS has dedicated resources and staff with educational expertise (surgical and non-medical) to assist the committees and surgical specialties where required.

Boards and specialties are active in reviewing the curriculum. In response to changing needs and requirements, the Board in General Surgery undertook a strategic review of the program, including a review its curriculum and changes will be made over the next two years. The Australian Orthopaedic Association (AOA) undertook a significant review of the training program, which resulted in the AOA 21 Research Project and a subsequent plan for a revised curriculum.

3.3 Continuum of training, education and practice

Accreditation standard

3.3.1 There is evidence of purposeful curriculum design which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice, including continuing professional development.

3.3.2 The specialist medical program allows for recognition of prior learning and appropriate credit towards completion of the program.

Summary of RACS Response

3.3.1 RACS education and learning is based on purposeful curriculum design, which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice, including continuing professional development.

3.3.2 The RACS specialist surgical program allows for recognition of prior learning and appropriate credit towards completion of the program.

Horizontal and vertical alignment

A significant change since the last AMC accreditation report has been the development of the JDocs Framework. 'Vertical' integration of the curriculum begins with JDocs, which aligns with RACS' nine core competencies and uses key clinical tasks to articulate surgical skills early in trainees' careers and within the context of clinical practice. The need to support new surgical trainees by providing them with guidance to gain knowledge and skills that would readily integrate into surgical training was a significant driver in the development of JDocs.

SET was developed to encourage trainees to enrol directly in their preferred specialty, but within surgical training it is possible to move 'horizontally' from one specialty program to another, via the selection process. This does have drawbacks as transferring results in lost opportunity for the specialty who has trained the trainee for one to three years, and for doctors who were not selected during that period due to the number of posts available. It also may result in less than optimal numbers of surgeons graduating from the original specialty. The 2014 Review of the RACS SET Program (see figure 5.1) noted that 90 per cent of movement between specialties were from general surgery to other specialties. In 2015, 33 SET trainees applied for another speciality; of these, 14 were successful in transferring to another specialty training program.

Specialty training programs have processes to acknowledge prior learning in another discipline of surgery. A small number of Fellows undertake training in a second discipline.

Recognition of prior learning

RACS recognises that trainees have gained knowledge and skills through prior experiences. Where these are comparable to components of a College surgical education and training program in terms of learning outcomes, competency outcomes and standards, they may be assessed for recognition of prior learning (RPL) in accordance with specialty regulations. Where equivalence is established, specialty training boards may grant exemptions to relevant training components or activities. An exception to this occurs in paediatric surgery, which notes that prior learning is implicit in early demonstration of competence (see Paediatric Surgery Training Regulations 2.1.6).

The principles guiding assessment of applications for RPL or credit transfer are:

- Avoid unnecessary duplication of training and experiences that are equivalent to those delivered in the RACS program.
- Applications are considered after the applicant has been accepted into the SET program.
- Applications must be made at least three months prior to the start of the training year in which the component is scheduled to take place.
- Candidates will receive advice about the assessment process and will be notified in writing of the decision.

Further information can be found in the Recognition of Prior Learning Policy and the specialty regulations.

Table 4 Recognition of prior learning 2013-2016

Specialty	Year	No. of applicants	No. accepted	No. rejected
Cardiothoracic	2013	2		2
	2014	3	1	2
	2015	1		1
General surgery	2013	49	40	9
	2014	59	46	13
	2015	87	78	9
Neurosurgery	2014	1	1	
	2015	8	8	
	2016	12	11	1
Otolaryngology head and neck surgery	2014	2	1	1
	2015	0		
	2016	1	1	
Orthopaedic surgery Australia	2013-15	4	0	4
Orthopaedic surgery New Zealand	2013-15	1		1
Paediatric surgery	2013	0		
	2014	5	5	0
	2015	0		
Plastic and reconstructive surgery (Australia)	2014	0		
	2015	1	0	1
	2016	1	0	1
Plastic and reconstructive surgery (New Zealand)	2014-16	0		
Urology	2014	1	1	
Vascular	2014	2	2	0
	2015	1	1	0
	2016	0	0	0

Reference: Information provided by specialty training boards

3.4 Structure of the curriculum

Accreditation standard

3.4.1 The curriculum articulates what is expected of trainees at each stage of the specialist medical program.

3.4.2 The duration of the specialist medical program relates to the optimal time required to achieve the program and graduate outcomes. The duration is able to be altered in a flexible manner according to the trainee's ability to achieve those outcomes.

3.4.3 The specialist medical program allows for part-time, interrupted and other flexible forms of training.

3.4.4 The specialist medical program provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes.

Summary of RACS Response

3.4.1 The RACS specialty curricula articulate what is expected of trainees at each stage of the specialist medical program.

3.4.2 The duration of the RACS specialist surgical programs relates to the optimal time required to achieve the program and graduate outcomes. The duration may be altered in a flexible manner according to the trainee's performance related to those outcomes.

3.4.3 The RACS program allows for part-time, interrupted and other flexible forms of training.

3.4.4 The RACS program provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes

Stages of the program and duration

The RACS specialty curricula are developed with clear objectives for each stage of training. The curricula identify markers that demonstrate competence in the range of activities undertaken by SET trainees. They also identify assessment and examination tasks. Regulations specify barrier assessments to ensure trainees demonstrate required knowledge and skills before progressing to the next stage of training. Some specialties (for example, neurosurgery, otolaryngology, head and neck surgery, and orthopaedic surgery) specify minimum and maximum durations for stages of SET. There are differences in the duration of the program between specialities. The duration of each training program is determined by the training boards in consideration of the specialty skills required, and estimated time needed to achieve competence.

RACS is progressing these more flexible approaches to the duration of training and improved assessment by investigating entrustable professional activities (EPAs). Recent developments in this area are the key clinical tasks introduced in the JDocs Framework and the procedural skills and professional capabilities assessments used in selection to SET in general surgery. General surgery is piloting some EPAs in 2017.

SET training remains significantly time-framed and training in less than the usual time is rare. However, should a SET trainee come from another SET specialty, or have done significant other postgraduate medical training, then the SET program is able to allow for prior learning, especially with excellent performance at work.

Part-time and interrupted training

Trainees may apply for part-time or interrupted training (see the Trainee Registration and Variation Policy). Specialty boards may decide to grant applications for deferral, interruption or part-time training, in accordance with specialty regulations, taking into consideration the reasons for the request, the trainee's

progress to-date and logistical considerations. Table 5 Part-time and interrupted training 2014-2015 presents provision of part-time and interrupted training. 2014-2015.

Table 5 Part-time and interrupted training 2014-2015

Year	Application	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
2014	Part-time	0	6	0	0	0	0	0	0	0	6
	Interrupted	2	40	1	2	10	1	6	3	5	70
2015	Part-time	0	3	0	0	0	0	0	0	0	3
	Interrupted	3	36	2	0	6	1	3	2	4	58

Reference: RACS Activities Reports for 2014 and 2015

Elective study

Within the overall constraints of SET, the depth and breadth of each trainee's training is shaped by the focus of the clinical activities they experience in training posts. Specialty training boards consider trainee preferences when they allocate training posts. For example, orthopaedic surgery trainees in Australia can request specific rotations in order to focus on areas of interest, while urology trainees in the final year of training may select posts that offer a sub-specialty experience.

Comparison with other surgical training programs

RACS is the only provider of specialist surgical education and training in Australia and New Zealand, for the nine specialties in which RACS awards a diploma. It is challenging to make direct comparisons with other surgical training programs due to the structure of SET and the wide diversity of programs in other parts of the world.

RACS engages directly with many other colleges and is keen to stay abreast of contemporary surgical education and training. Locally, graduate programs in surgical education and the surgical education stream at the RACS annual scientific congress provide much information about surgical education. Involvement in the biennial International Conference on Surgical Education and Training places RACS at the centre of the international surgical education community.

Flexible training

Although RACS supports flexible training, it is challenging to implement this with employers in a clinical setting. In 2016, a working group investigated the barriers to – and possible models for – flexible training and this was discussed by the Board of Surgical Education and Training (BSET) at meetings in June and October. The Women in Surgery Committee and RACS Trainees' Association have advocated for greater profile of the issue and flexible training is now a standard item on the BSET agenda.

Strengths

A key strength of the curriculum framework is the extent to which the nine RACS competencies have been integrated across surgical practice and are well understood by surgeons. These competencies ensure that technical and non-technical competencies are acknowledged as equally important to professional practice. The nine competencies also clearly link the curriculum to workplace learning.

RACS has developed the JDocs Framework into a rich resource that provides much needed guidance for prevocational doctors who wish to enter specialty training programs. The JDocs framework is aligned with the nine RACS competencies, ensuring continuity of learning. The 'key clinical tasks' map to trainee roles, defining readiness for surgical or other training programs.

Challenges

The move to competency-based training in a time-based employment-and-training environment remains a challenge. Provision of 'early' and frequent assessment using a range of assessment tools, can be challenging. Additional challenges include ensuring that supervisors are appropriately trained in conducting assessments and providing feedback, and have sufficient time to assess trainees.

The model of devolved specialty training presents challenges in ensuring uniformly high-quality training and assessment across multiple programs. BSET provides a forum to share knowledge, discuss issues and collaborate.

Plans

Supervisors' skills will be improved by the recently mandated Foundation Skills for Surgical Educators (FSSE) course.

Specialties are moving to well-defined stages of training, thereby supporting a competency-based training approach.

Flexibility in geographic locations of training and in part-time training will benefit competency-based training. Where memoranda of understanding have been agreed, as part of the RACS Building Respect, Improving Patient Safety Action Plan, RACS will work with employers to promote flexible training.

RACS is keen for prevocational doctors to use the JDocs resource, and to ensure that those interested in surgical careers have access to the generic surgical science examination. Information about the JDocs Framework will continue to be promulgated to prevocational doctors, medical education officers, consultant specialists and senior registrars by RACS in 2017.

Section 4

Teaching and learning

4. Teaching and learning

4.1 Teaching and learning approach

Accreditation standard

4.1.1 The specialist medical program employs a range of teaching and learning approaches, mapped to the curriculum content to meet the program and graduate outcomes.

Summary of RACS Response

4.1.1 RACS provides a diverse range of educational material and uses multiple teaching and learning approaches for the training of surgeons. This approach ensures that the learning experience in the clinical environment will be complemented by the required knowledge and skills, and attributes so all components of the curriculum are available to trainees.

Overview

RACS has developed innovative models for teaching and learning, influenced by contemporary understanding of how adults learn and the increasing use of web technology. In addition to the Surgical Education and Training (SET) Program and resources specific to surgical education, RACS delivers education programs that contribute to medical education at prevocational and postgraduate levels. RACS collaborates and partners with national and international medical and surgical colleges and with universities in Australia, New Zealand and internationally.

Range of learning approaches

RACS trainees are employed by public and private hospitals in Australia and public hospitals in New Zealand. Clinical training in hospitals is highly contextual, being structured at hospital, rotational, regional, national and/or bi-national levels. Clinical learning activities are necessarily opportunistic, with teaching and supervision conducted by surgical specialists, cognisant of curriculum requirements, and in accordance with RACS' training-post accreditation requirements.

Consequently, the training program incorporates adult-learning theory and combines work-based experiential learning, independent self-directed learning, group activities and supplementary learning resources to satisfy stated curricular outcomes.

Teaching and learning methods include courses and workshops, simulation and, increasingly, eLearning. Although many learning activities are self-directed, peer-to-peer learning and trainee journal clubs or study groups are common. For example, the Board of Urology has partnered with trainees in endorsing an online journal club. The initiative includes a moderated webinar/live video forum (www.DiscussUrology.com) to discuss contemporary literature, and is indicative of how the delivery of education is changing.

Assessment is linked to the learning approach. Teaching and learning activities are aligned to the curricula and complemented by formative assessments. Together they support the trainee's career trajectory, enabling them to build and demonstrate their knowledge and skills. The education and training framework associates successful progression through the training program with increasing independence. Formative and summative assessments – ongoing work-based assessments, mid-term and end-of-term assessments, mandatory courses and examinations – identify trainees' individual strengths and areas required for improvement, and mark progression through the program.

4.2 Teaching and learning methods

Accreditation standard

4.2.1 The training is practice-based, involving the trainees' personal participation in appropriate aspects of health service, including supervised direct patient care, where relevant.

4.2.2 The specialist medical program includes appropriate adjuncts to learning in a clinical setting.

4.2.3 The specialist medical program encourages trainee learning through a range of teaching and learning methods including, but not limited to: self-directed learning; peer-to-peer learning; role modelling; and working with interdisciplinary and inter-professional teams.

4.2.4 The training and education process facilitates trainees' development of an increasing degree of independent responsibility as skills, knowledge and experience grow.

Summary of RACS Response

4.2.1 SET training is practice-based, and trainees are highly involved in the delivery of healthcare services and direct patient care appropriate to the level of supervision required.

4.2.2 SET includes a variety of adjuncts that facilitate and complement practice-based learning.

4.2.3 SET trainees are encouraged to be self-directed learners and to participate in a range of learning methods, including peer-peer and eLearning. The nature of the surgical role requires interdisciplinary and inter-professional teamwork. In addition to experiencing this in the clinical setting, inter-professional team work is taught through a range of courses and modelled by multidisciplinary course instructors.

4.2.4 The framework and structure of the SET program facilitates trainees' development of an increasing degree of independent responsibility as skills, knowledge and experience grow. Assessment, both formative and summative, supports attainment of increasing competency.

Practice-based learning

RACS' teaching and learning approach is premised on adult self-directed learning theory, with most teaching and learning occurring in practice-based healthcare settings throughout Australia and New Zealand. RACS education and training is evidence-based, developed by content experts, and is competency-focused with explicit outcomes.

Clinical experience is fundamental to the SET program. Clinical rotations, undertaken over several years, provide trainees with the breadth of experiences essential for acquiring all nine RACS competencies, in specialty-specific contexts.

Specialty training boards allocate trainees to rotations in surgical units that have been accredited as training posts. Allocation is based on each trainee's stage of training, their learning needs and, where possible, on their preferences regarding case mix and geographic location. During each rotation, clinical experiences include:

- Participation in ward rounds, handovers, multidisciplinary team meetings and outpatient clinics. The exception is NSW, which does not have the traditional outpatient clinics common in other regions.
- Participation in operating sessions where trainees develop technical skills and other competencies, such as teamwork and communication.
- On-call duties to assess and manage patients with acute surgical problems.
- Participation in clinical audit and morbidity and mortality meeting review processes.

Clinical settings provide opportunities for trainees to engage with, and be part of, inter-professional teams. These skills also are taught through skills courses. Multidisciplinary instructors also teach these skills courses, thus providing a model for interdisciplinary teamwork and engagement Trainees may be involved in Safer Australian Surgical Teamwork (SAST) courses, where inter-professional team training occurs in the hospital.

The RACS training program is designed to provide trainees with increased responsibility as their knowledge, skills, and experience grow. Supervisors and trainers are responsible for ensuring that each trainee receives the training and clinical experience that enables them to develop the necessary knowledge and skills to fulfil training requirements across the competencies.

Specialty training boards monitor each trainee's logbook to ensure they are gaining sufficient caseload and appropriate case-mix experiences. The training-post accreditation standards also are used to ensure there is appropriate case-mix, supervision, and that the physical environment fosters effective work-based learning. Hospitals are expected to support and demonstrate respectful culture.

Adjuncts to learning

Hospital-based learning alone is not sufficient to develop all the knowledge and skills necessary to practice as an independent surgeon. Therefore, RACS employs a variety of teaching and learning methods to ensure trainees receive well-rounded training and learning experiences.

RACS supplements training provided in clinical settings by offering mandatory skills courses and optional eLearning modules. The specialty training boards conduct specialty-specific educational activities, including tutorials, trainee days, clinical workshops and courses, and practice fellowship examinations.

Some learning activities are compulsory for all trainees, for example, EMST and CCrISP® skills courses; some are compulsory for particular specialties, for example, General Surgery Surgical Education and Assessment Modules (SEAM), Orthopaedic Surgery Bone School, Paediatric Surgery, CATS and DOGS; and some are optional, for example, SET Ready and Self-Assessment eLearning resources.

These resources supplement the knowledge and skills required to enable learning in a clinical setting.

To illustrate:

Directed online group studies (DOGS)

DOGS are designed to encourage discussion and understanding of management plans related to clinical paediatric surgical problems and are based on RACS curriculum modules. The answer will be in the style of a medium or short clinical exam question, either in the written paper or viva section of the fellowship exam. Marking takes into account the SET level of the candidate.

Critical appraisal task (CAT)

A CAT is a training tool designed to enable trainees to address a clinical question using the best available evidence. Trainees are expected to appraise the relevant literature and, based on this, to provide a concise rationale for their chosen management. These tasks equip the trainee to continually adjust management approaches during their career as a paediatric surgeon, as new information becomes available. CATs are designed to approximate the framework expected during written components of the fellowship examination.

The Care of the Critically Ill Surgical Patient (CCrISP®)

CCrISP® equips trainees to recognise a deteriorating patient, to implement a structured management plan, and includes practising 'calling in' the consultant and 'handover' to intensive care staff. This clinical knowledge, combined with a simulated learning environment, prepares trainees to take this responsibility in the clinical setting, where further experiential learning will take place.

The SET program supports independent, self-directed learning by all trainees. Each specialty program follows a curriculum and recommends reference books and supplementary resources relevant to their specialty. Trainees are responsible for undertaking independent study. Trainees also have access to the extensive RACS library. Many trainees form study groups where they can discuss specialty content and reflect on clinical experiences with their peers.

Trainees are encouraged to present peer-reviewed paper and posters, and regional offices and societies encourage and provide many opportunities for this to occur, for example at annual scientific conferences, trainees' days and at the RACS annual scientific congress.

Skills courses and simulation

The skills courses mandated by RACS address aspects of all nine RACS competencies, comprising technical and non-technical competencies. These courses provide participants with supportive learning environments and high learner-instructor ratios. Two courses are mandated by all specialties as being integral to the practice of surgery:

- Early Management of Severe Trauma (EMST).
- Care of the Critically Ill Surgical Patient (CCrISP®).

These two skills courses provide platforms for collaboration with surgical colleges in the UK and the US. The Advanced Trauma Life Support© (ATLS™) program developed by the American College of Surgeons is delivered in Australia and New Zealand as the Early Management of Severe Trauma (EMST) course. The Care of the Critically Ill Surgical Patient© similarly originated in the Royal College of Surgeons of England. As an equal partner, RACS collaborates with both colleges on curriculum development and international promulgation. RACS representatives hold significant positions with the ATLS™ Sub-Committee of the Committee on Trauma and have provided leadership in the Asia Pacific region (ATLS™ region 16). Collaboration among regional members helps support promulgation and address local requirements.

The remaining skills courses were developed by RACS and are mandated by some specialties, as outlined in the specialty curricula:

- Australia and New Zealand Surgical Skills Education and Training (ASSET).
- Critical Literature Evaluation and Research (CLEAR).
  Training in Professional Skills (TIPS).

All RACS courses except CLEAR have undergone curriculum review since 2011. Pre-course online modules and assessments have been introduced as prerequisites for the ASSET and TIPS courses. These modules are accessible to prevocational doctors who register with JDocs. The EMST program will trial an online version of the course in 2017. As well as the RACS skills courses, some specialties require their trainees to complete specialty-specific skills courses. These include:

- Orthopaedic surgery: Bone camp.
- Otolaryngology head and neck surgery: Functional Endoscopic Sinus Surgery (FESS), Head and Neck course, Temporal Bone course.
- Paediatric surgery: Advanced Paediatric Life Support, Emergency Management of Severe Burns course.
- Plastic and reconstructive surgery: Emergency Management of Severe Burns course.
- Vascular surgery: Trainee Skills.

All skills courses, eLearning and specialty educational activities can be mapped back to the curricula via the nine RACS competencies

RACS encourages and supports the integration of simulation into the SET program, and several specialties have introduced simulation into their requirements as relevant to specialty practice. The Board of Urology is reviewing how simulation may be better incorporated into the curricula. The RACS head office has a well-equipped skills laboratory, as do other states and New Zealand.

RACS' capability in developing eLearning resources has matured since the last AMC accreditation report. Flipped classroom and blended-learning resources, created by RACS, have been introduced into skills and professional development courses in recognition of the validity of this new approach to learning. The Operating with Respect online module is mandatory for trainees, supervisors and skills course faculty, and may be made available to other colleges. The RACS communication eLearning module has been widely used, receiving more than 3000 website interactions. RACS''s development of the Portfolio has improved the how learning resources are presented to trainees.

The specialty training boards are also embracing eLearning and offer a variety of resources to trainees via the specialty websites.

Increasing independence

In every specialty, the training program is designed to increase trainees' levels of responsibility as their knowledge, skills and experience grow. Progression towards proficiency in each of the nine RACS competencies is described in: Becoming a competent and proficient surgeon: Training standards for the nine RACS competencies.

Supervisors assess trainees' performance against standards expected for each stage of training; as. trainees' knowledge, skills and experience grow they are expected to manage increasingly complex clinical situations. Thus, trainees transition from novice stages, acting under direct, close supervision to become semi-independent clinicians who appropriately consult or request supervision and, by the conclusion of training, are competent to proficient independent surgeons. Work-based assessment: a practical guide: Building an assessment system around work, provides information to support supervisors to use workplace-based assessments appropriate to the level of training and the assessment required. In-training assessment reports and logbook summary reports capture information on the development of surgical and operative independence. At later stages of training, trainees are expected to take a greater proportion of cases as primary operator with less direct input from consultant supervisors, and to perform more complex procedures, usually with the supervising surgeon as assistant, providing supervision as required.

Other professional development opportunities

RACS accredits courses and activities from external education providers, which meet College educational standards and criteria. The standards and criteria act as benchmarks for high quality course design, delivery and review and contribute to the RACS course accreditation process. RACS may accredit activities such as tertiary courses, short courses, workshops, and online courses. In order to be accredited by RACS, educational activities must be aligned with one or more of the nine RACS competencies, and must meet the identified educational needs of the competencies they address. Trainees can access these for further professional self-development, widening the scope of teaching and learning available to them. Since 2013 when course accreditation was introduced, more than 30 courses have been accredited; the standards and criteria for the accreditation of courses and educational activities are available on the RACS website.

Participation in these educational courses and activities is not mandated by RACS or the specialties. Fees are set by the education provider and are paid by the trainee. Boards understand that mandating courses adds to the cost of training, so some specialties fund trainee participation in accredited or approved courses. For example, the Paediatric Board funds trainee participation in the Process Communication Course.

All components of the surgical training program are provided by RACS in partnership with the specialty societies and associations. RACS also partners with the University of Melbourne to deliver a master of surgical education program. Developed in 2011, the program is led by Professor Debra Nestel and is achieving its aim of creating a progressive cohort of leaders in surgical education, whose influence is already being seen.

Strengths

The training program is enhanced by the involvement of engaged and highly motivated Fellows, who fulfil a variety of roles, as clinical supervisors, trainers, leaders of tutorials and discussions, course instructors, mentors, and assessors. RACS recognises the importance of skilled supervisors and trainers in many ways, one example being the Academy of Surgical Educations Recognition Awards. The academy supports the professional development of surgical educators.

Trainees are becoming increasingly cognisant of their responsibilities as adult learners. As supervisors' teaching abilities improve, trainees and supervisors are able to work more confidently and efficiently towards this goal. Good surgical teams provide quality patient care and excellent surgical training at the same time.

RACS has proven capability in the development, implementation and sustainability of courses. RACS is able to regularly deliver high-quality courses, such as the skills courses and the Foundation Skills for Surgical Educators course. Some courses are available both face-to-face and online. RACS engages with many medical specialties though the multidisciplinary faculty and committee members who contribute to and enrich these programs.

Making the generic surgical science examination available before SET, and its requirement as a prerequisite for selection, have elevated the knowledge-base of those entering SET.

Specialties implement varied teaching and learning approaches to encapsulate specialty-specific requirements. Some examples are the SEAM modules developed by general surgery, the Directed Online Group Study (DOGS) utilised by paediatric surgery, and the webinar journal club utilised by urology.

Challenges

With both trainees and supervisors employed by hospitals, it can be challenging to manage the tensions between service delivery and access to training and education. The implementation of training through (supervised) service varies across hospitals in Australia and New Zealand. A balance must be found between meeting hospital service needs and the delivery of high-quality surgical education and training.

Concerns that surgical educators are supported by RACS, through the Academy of Surgical Educators, and are also well-linked to their specialty training boards are ongoing. Many hospitals implement a notional one-to two-hour allocation in supervisors' remuneration, however, the involvement of consultant surgeons in many aspects of the training program warrants all employing hospitals to recognise hospital-based supervision. Protected time is also required for supervisors and trainers to engage in their own professional development, supporting optimal performance of their education roles.

There is limited SET training in private hospitals despite there being suitable training posts for some specialties in the private sector. Some surgeons only work in the private sector (especially in Australia) and there are opportunities to involve these surgeons more with SET and other college activities.

Plans

As described in the RACS Building Respect, Improving Patient Safety Action Plan, specialty training boards will need to have excellent two-way communication with their supervisors, who in turn will set standards and follow up issues in their hospitals or units.

RACS' evaluations of SET and continued encouragement of related research are ongoing.

RACS will follow up the requirement for supervisors to complete mandatory training. Hospitals must demonstrate that respectful cultures are in place, and this is now a component of hospital post inspections.

Section 5

Assessment of learning

5. Assessment of learning

5.1 Assessment approach

Accreditation standard

5.1.1 The education provider has a program of assessment aligned to the outcomes and curriculum of the specialist medical program, which enables progressive judgments to be made about trainees' preparedness for specialist practice.

5.1.2 The education provider clearly documents its assessment and completion requirements. All documents explaining these requirements are accessible to all staff, supervisors and trainees.

5.1.3 The education provider has policies relating to special consideration in assessment.

Summary of RACS Response

5.1.1 The RACS Surgical Education and Training (SET) has a program of assessments that include work-based assessments to demonstrate level of competency, examination of technical and scientific knowledge at an early – mid stage of training and a final certification examination to further assess trainees' preparedness to practise as independent consultants. SET assessments are aligned with the curriculum and the level of training, and iteratively record the trainee's progression through the program.

5.1.2 Assessment and completion requirements are documented in policy, and in the specialty training regulations, and are available on the RACS website and on specialty websites.

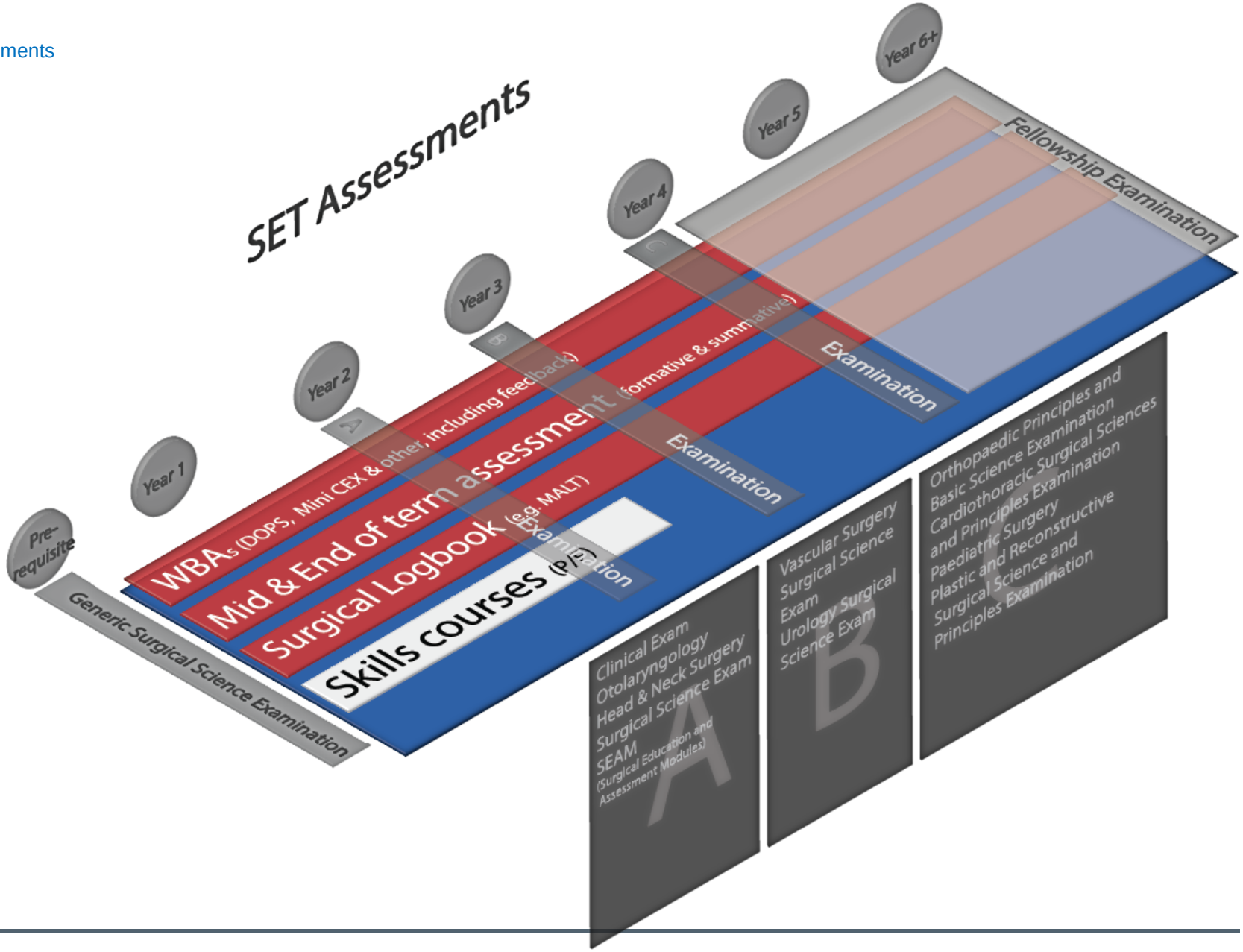
5.1.3 RACS has policies relating to special consideration in assessment, including reasonable adjustment for disability and consideration of religious observance.

Overview

The RACS Surgical Education and Training (SET) Program provides for iterative, formative and summative assessment of trainees against the nine RACS competencies. Diverse methods are used to assess trainees' knowledge and skills in technical and non-technical competencies. Summative examinations, the responsibility of RACS, are conducted in the early stages of training and near the end of training, and are supplemented by specialty-specific examinations and formative and summative work-based assessments. Trainee performance in mandatory courses is also assessed. Figure 5 SET assessments presents assessments through SET.

In accordance with the Assessment of Clinical Training policy, each surgical specialty uses assessments to guide learning and to assess trainees' performance to ensure it meets the designated standards at each stage of training. The regulations of each specialty training board state the number, type and frequency of assessments, also found in the Guide to SET on the RACS website.

Figure 5 SET assessments



Becoming a competent and proficient surgeon: Training Standards for the Nine RACS Competencies ('the training standards') sets out performance standards in all nine RACS competencies, which are expected of trainees as they progress through SET. This guide for supervisors, trainees and specialty training boards provides a framework and benchmarks around which assessment processes and tools can be designed to ensure close alignment between curricula and assessments.

RACS has extended this approach to the JDocs Framework, describing competency levels and relating these to acquisition of skills to perform key clinical tasks. These tasks are common clinical activities, similar to entrustable professional activities (EPAs), and are mapped to the requirements of becoming a trainee. In the future, they may be used to identify the readiness of well-performing, prevocational doctors for specialty training.

Governance

Assessment of trainees in the clinical workplace is the responsibility of the specialty training boards. Examinations and skills courses are governed by the RACS committees or boards (see Section 1). The RACS Examinations and Skills Training Departments are responsible for administering and managing these activities.

The Surgical Science and Clinical Examinations Committee (SSE and CE Committee) governs the early examinations, which are generally conducted within the first three years of commencing SET. The SSE and CE Committee comprised of representatives from the surgical specialties, anatomists, pathologists and physiologists. This committee has representation from all specialties and conducts the generic surgical science examination, the written component of the cardiothoracic surgical science and principles examination, the otolaryngology head and neck, urology and vascular specialty-specific surgical science examinations and the clinical examination. The committee reports to the Board of Surgical Education and Training (BSET). Through sub-committees, the SSE and CE Committee devises examination questions, sets examinations, trains examiners, examines candidates, sets and reviews standards and reviews candidates' results.

The Court of Examiners (the court), comprised of members of all specialty courts of examiners, is responsible for the conduct of the summative fellowship examinations in all specialties and of the viva component of the specialty-specific examinations in cardiothoracic surgery,, orthopaedic surgery, paediatric surgery and plastic and reconstructive surgery. The court reports directly to the Education Board. Through the specialty courts, the Court of Examiners blueprints specialty examinations to training programs, devises examination questions, sets examinations, trains examiners, examines candidates and reviews candidates' results. The full court of examiners ratifies candidates' results.

In 2014 RACS introduced scholarships to members of the Court of Examiners. The scholarships allow for an examiner to observe and report on international examination processes. The Fellowship examination scholarship policy describes the purpose of, and criteria for the scholarship. The scholarship reports are presented to the Court of Examiners, which considers recommendations provided in the report.

Policies

RACS has a comprehensive suite of examination policies publicly available on the RACS website, to define the prerequisites, criteria, types of assessment and conduct of examinations. Assessment protocols may be adjusted to accommodate the needs of a candidate where a disability may affect the candidate's ability to participate in the examination under normal conditions. Trainees also may apply for special consideration in cases where illness, bereavement or other serious matters beyond their control, have the potential to adversely affect the results. The committee chair or specialty court will review and determine adjustment to assessment protocols. Applications for special consideration are assessed by the committee or specialty court.

Emerging trends

Electronic delivery of examinations

The Digital College included moving from paper-based examinations to an electronic delivery platform. In 2015, electronic exam delivery was introduced for the generic surgical science examination; by the end of 2015 all early examinations were delivered using this model. In 2016 this delivery format was trialled for the fellowship examination. Also in 2016, tablet marking for the clinical examination was introduced to improve

the efficiency of scoring and accuracy of feedback to clinical examination candidates. Dedicated IT resources provide ongoing support for these functions.

Timing of early assessments

RACS has made several changes to the timing of the early examinations since the last Australian Medical Council accreditation report, to better align these assessments to the curriculum (see Table 6 Changes to early examinations). A further impetus for review of the early summative assessments was the 2014 SET Evaluation report, which established that significant numbers of trainees were dismissed from training for not passing the generic surgical science examination prior to SET 3 (the third year of training). Making the generic surgical science examination available outside the SET program has reduced the incidence of dismissal for not passing the exam. Trainees who have been dismissed may reapply for training in accordance with RACS' Former Trainees Seeking to Reapply to Surgery policy.

Table 6 Changes to early examinations

Specialty	Examination	Changes (2015-16)
Cardiothoracic surgery	Cardiothoracic specialty-specific surgical science examination	The cardiothoracic surgical science and principles examination was introduced 2015, comprising a written paper and an anatomy viva. Completion of written component is required to progress to the viva. Trainees must complete by SET 4. (Previously a multiple-choice question exam required by SET 2).
General surgery	General surgery specialty-specific surgical science examination	Replaced with the surgical education and assessment modules (SEAM), a modular, summative assessment delivered online. Responsibility of the Board in General Surgery.
Neurosurgery	Clinical examination Neurosurgery surgical science examination	Removed as a requirement of training; specific clinical skills required for selection eligibility. Replaced with a neuroanatomy examination as a requirement of selection; responsibility of the Neurosurgery Board.
doctors	Generic surgical science examination	Offered to prevocational doctors since 2015; a selection requirement from 2017.
Urology	Surgical science specialty-specific examination in urology	Completion requirement moved from within two years of commencement of training to SET 3.
Vascular	Surgical science specialty-specific examination in vascular	Completion requirement moved from within two years of commencement of training to SET 3.

Reviews of assessment undertaken 2014-2016

Over the past four years, RACS has reviewed the scheduling and timing of early examinations, has reviewed standard setting in the specialty-specific surgical science examinations, has reviewed clinical examination standard setting and examiner stringency and leniency, has reviewed fellowship examination marking protocols and has conducted a comprehensive review of the implementation of examinations and work-based assessments. These reviews have improved assessment practices.

Reviews of standard setting across exams

RACS collaborates with the Australian Centre for Educational Research (ACER) to ensure appropriate standard-setting methodologies for its examinations are used. RACS recognises that different examinations and cohorts may require different methods to set the pass, or 'cut' scores. Rasch scaling is used to set the pass standard for the generic surgical science examination. Since 2014, three surgical science specialty-specific examination committees have changed the standard-setting methods used to determine cut-scores in their specialty surgical science exams from the 'Bookmark' method to a modified 'Angoff' method. In 2015,

the RACS Clinical Examination Committee changed the standard-setting method in the clinical examination to improve confidence in the predictive validity of this examination. Evidence-based proposals for changing standard-setting measures are approved by relevant examination committees before implementation.

Examiner stringency and leniency

Internally, RACS monitors the clinical examination data for examiners who may systematically mark examinees too leniently or severely. This can compromise the reliability and validity of the examination because variation in scores may be due to variations in examiner stringency rather than the competence of the candidate sitting the exam. The monitoring and review process is comprehensive. After reviewing the data, the Clinical Committee provides feedback to an examiner if required.

Fellowship scoring

Following a workshop to review aspects of the fellowship examination in 2011, RACS collaborated with the Joint Committee on Intercollegiate Examinations (UK and Ireland), which led to changes in scoring and the introduction of examiner training.

The expanded close marking system (ECMS) replaced the close marking system (CMS) in 2012, following a trial of its effectiveness. This change has seen an improvement in the reliability and validity of the fellowship examination, and provides better information for the specialty courts of examiners to pass judgment on borderline exam candidates. It also allows RACS to assess examination quality through tests of inter-rater reliability. RACS has since modified the system to include consensus scoring by examiners. A discussion of the expanded close marking system is presented in the article Beasley et al. (2013) *Justification and implications of the introduction of an expanded Close Marking System for the Fellowship Examination*.

2016 assessment review

In 2016 RACS completed a comprehensive review of all assessments, including work-based assessments and examinations. This review is discussed further in Section 6.

Research into the implementation and performance of all SET assessments has shown that work-based assessment is not appropriately used in SET and that the relationship between daily, observed clinical work by trainees with feedback and the end-of-term summative assessments is poorly understood. This is consistent with the findings of the RACS Expert Advisory Group, which recommended improving the capability of all surgeons involved in surgical education. Development of standards for surgical supervisors and trainers, including education in effective assessment and feedback, is being addressed in the RACS Building Respect, Improving Patient Safety Action Plan.

5.2 Assessment methods

Accreditation standard

5.2.1 The assessment program contains a range of methods that are fit for purpose and include assessment of trainee performance in the workplace.

5.2.2 The education provider has a blueprint to guide assessment through each stage of the specialist medical program.

5.2.3 The education provider uses valid methods of standard setting for determining passing scores.

Summary of RACS Response

5.2.1 Assessment of the RACS Surgical Education and Training Program (SET) uses a range of appropriate methods and tools to assess trainee performance in the workplace.

5.2.2 Assessments are blueprinted against the learning outcomes of each specialty program curriculum, and assessments are relevant to the level of training being assessed.

5.2.3 RACS uses validated methods of standard setting for examination scores.

RACS recognises that summative examinations do not adequately assess the full range of competencies, particularly the non-technical skills. Some competencies and professional attributes are better assessed by direct supervision and observation of ongoing clinical behaviours.

Work-based assessments

Specialty boards typically use formative assessments to direct learning by identifying trainees' strengths and areas where further development is required. Descriptions of the main work-based assessments used by each specialty are provided in Table 7 Work-based assessments.

Table 7 Work-based assessments

Assessment tool	Description	Specialties
In-training-assessments	Assessment of trainees' performance against key performance indicators and standards of competence during clinical placements.	All specialties
Direct observation of procedural skills (DOPS)	DOPS is a method of assessing competence in performing diagnostic and interventionist procedures during routine surgical practice. The assessment involves an assessor observing the trainee perform a component of a surgical procedure. The assessor's evaluation is recorded on a structured checklist, which facilitates provision of feedback to the trainee.	Cardiothoracic surgery General surgery Orthopaedic surgery NZ Otolaryngology head and neck surgery Paediatric surgery Plastic surgery Urology Vascular surgery
Mini-clinical evaluation exercise (mini CEX)	The mini CEX is designed to assess skills essential to good clinical care and to facilitate feedback. The assessment involves an assessor observing the trainee interact with a patient in a normal clinical encounter. The assessor's evaluation is recorded on a structured checklist, which facilitates provision of feedback to the trainee immediately after the encounter.	General surgery Orthopaedic surgery Otolaryngology head and neck surgery Paediatric surgery Plastic surgery Urology Vascular surgery
Multi-source feedback (MSF)	MSF is a questionnaire-based assessment that includes self-evaluation and feedback on observable behaviours from colleagues (peers and referring physicians), co-workers (nurses, pharmacists, psychologists etc.) and patients. Some specialties use MSF when requested by a supervisor, typically in cases where trainees are underperforming.	Paediatric surgery On request: Orthopaedic surgery Otolaryngology head and neck surgery Plastic surgery Vascular surgery

Emerging trends in work-based assessment

The Board in General Surgery, following a review of its work-based assessments, is introducing entrustable professional activities (EPAs) as a pilot in 2017. Procedure-based assessments (PBAs) also are being considered and there is substantial literature emerging around these. Procedure-based assessments have been used by general surgery for selection and have been successful in assessing candidates' competence at entry level.

In-training assessment (ITA) - formative and summative workplace assessment

RACS has developed in-training assessments (ITAs) – also known as mid-term assessments and end-of-term assessments – that define clinical performance standards in the nine RACS competencies. Specialty

training boards incorporate specialty-specific skills and performance indicators in the ITAs. These regular assessments monitor and record the trainees' progress in the training program and are a focal point to indicate progress.

At mid-term and at the completion of each rotation, supervisors, in consultation with surgical trainers in the unit, complete detailed assessments of a trainee's performance, which is then formally discussed by the supervisor and the trainee. The supervisor assesses the trainee's performance against the expected performance for level of training.

ITAs have both formative and summative functions. Mid-term ITAs provide opportunities to guide subsequent learning activities and for early identification and interventions to support trainees in difficulty. End-of-term assessments provide opportunities to review a trainee's performance over an entire rotation and to identify goals for subsequent rotations. End-of-term assessments also have summative functions, as failure to meet identified standards can result in trainees being placed on structured remediation programs, such as a performance management plan or on probation. Ongoing poor performance may lead to dismissal.

Logbooks

All trainees are required to complete logbooks in which they record each procedure they undertake, their level of involvement in the procedure (for example, primary operator, assistant, etc.), and any outcomes. Logbooks ensure that trainees are completing the minimum number of procedures required for given stages of training. The Morbidity and Audit Logbook Tool (MALT) is an online logbook developed by RACS. It is available to all Fellows, trainees, and international medical graduates, and for prevocational doctors as a component of JDocs registration.

Skills courses

Trainees undertaking the mandatory skills courses (Early Management of Severe Trauma and Care of the Critically Ill Surgical Patient) are assessed using multiple-choice question exams and assessment of a mock patient in a simulated scenario. The Australia and New Zealand Surgical Skills Education and Training course (ASSET) is not assessed, however, participants are given direct observational feedback throughout the course. All these courses provide opportunities for coaching and mentoring by instructors. The specialty training boards have specific requirements for technical skills courses, which must be completed as components of specialty training.

Examinations

The SET program involves completion of several examinations as barrier requirements, falling broadly into three categories – early generic, specialty specific and the fellowship certification examination. The policies relating to the conduct of each examination are publicly available on the RACS website, and cover topics such as the format of the examinations, eligibility requirements, timing of the exams, marking and dissemination of results.

Generic surgical science examination (GSSE)

The generic surgical science examination (GSSE) is designed to assess knowledge in the surgical science of anatomy, pathology and physiology. Trainees previously completed the examination within the first two years of training. From 2014, this examination was made available to prevocational doctors – a major change since the inception of SET in 2007. From 2016, all specialty training boards introduced the successful completion of the generic surgical science examination as a mandatory requirement for selection.

Clinical examination (CE)

The clinical examination is a practical examination, testing candidates' clinical application of the basic sciences. The exam is an objective structured clinical examination format, comprising 16 five-minute stations. Candidates are assessed as they undertake four questions or activities of each of four station types:

- Physical examination.
- Communication.
- History taking.
- Procedure.

Until recently, trainees in all surgical specialties were required to successfully complete the clinical examination. From 2016, neurosurgery trainees are exempt from this examination.

Specialty-specific examinations (SSE)

Each specialty has developed specialty-specific examinations to assess trainees' knowledge of surgical sciences and principles specific to their specialty.

The exceptions are neurosurgery, which assesses neuroanatomy as a component of the selection process, and the Surgical Education and Assessment Module (SEAM) online module for general surgery trainees. SEAM is administered by the Training Board and General Surgeons Australia, and integrates assessment into the eLearning module, which is aligned to the early years of general surgery workplace practice. Trainees must achieve 80 per cent to pass the assessment.

The specialty-specific examinations are:

- Cardiothoracic surgical science and principles examination.
- Orthopaedic principles and basic science examination.
- Paediatric anatomy and embryology examination.
- Paediatric pathophysiology examination.
- Plastic and reconstructive surgical science and principles examination.
- Surgical science examination in otolaryngology head and neck surgery.
- Surgical science examination in urology.
- Surgical science examination in vascular surgery.

Standard setting for the early and specialty-specific examinations

Standard setting methods used for the examinations have been determined through review of published literature and best practice. RACS consults with the Australian Council for Educational Research and uses psychometric methods to monitor the quality of all multiple-choice examinations (Generic surgical science examination, Orthopaedic principles and basic science examination, Plastic and reconstructive surgical science and principles examination and the multiple-choice component of the Orthopaedic fellowship examination). The quality audits have led to better identification of poor questions, enabling the subject-matter experts (Fellows) to structure examinations with better quality questions and stems. This method also supports standard setting of the examination, as poorly performing questions may be deleted or adjusted. See Table 8 Examination and SEAM assessment standard setting methods, for methods of standard setting in use.

Table 8 Examination and SEAM assessment standard setting methods

Exam	Standard setting method
Generic surgical science examination	Rasch model scaling
Clinical examination	Borderline regression
Specialty-specific examinations (urology, otolaryngology head and neck surgery, vascular surgery)	Modified Angoff
Cardiothoracic surgical science and principles examination	Predetermined 75 per cent cut score
SEAM module multiple-choice questions	Predetermined 80 per cent cut score
Neurosurgery anatomy examination	Predetermined 70 per cent cut score
Orthopaedic principles and basic science surgery examination	Predetermined 70 per cent cut score
Paediatric anatomy examination	Specialty experts
Paediatric pathophysiology and embryology examination	Predetermined 65 per cent cut score
Plastic and reconstructive surgical science and principles examination	Predetermined 75 per cent cut score
Fellowship examination	Expanded close marking system; consensus scoring Specialty experts and predetermined pass mark outlined in marking policy clause 3.16 of Conduct of the Fellowship Examination policy.

RACS has developed procedures for:

- Standard setting for the clinical examination.
- Standard setting for the specialty-specific surgical science examinations.
- Standard setting reports and presentations.

Fellowship examination

The fellowship examination represents the final assessment of competence in the RACS surgical training program. For all specialties except vascular surgery, the fellowship examination comprises two written components and five clinical/viva components. Vascular surgery has one written and six clinical components.

It is primarily an assessment of professional judgment, clinical decision-making and medical expertise. Technical aspects of surgery are discussed. The required standard for this examination is competent performance equivalent to that of a consultant surgeon in his or her first year of independent clinical practice – working within a surgical team, but not under direct supervision.

Fellowship examiners assess higher levels of thinking, analysis and evaluation in accordance with the designated surgical competencies being tested and aligned to the specialty curriculum. For each specialty, the seven segments of the fellowship examination have marking guidelines determined by the relevant specialty court. Although the number of marking points may vary between segments, each segment is equally weighted.

Candidates undertake the written segments prior to the clinical/viva segments. Two examiners assess the candidate during each of the clinical/viva segments of the examination. The examiners mark independently and then reach a final score by consensus at the end of the segment. Every effort is made to ensure as many different examiners as possible assess each candidate across the examination.

The fellowship examination is blueprinted against specialty curricula. Each court conducts a two-to-three-day workshop in February to determine the blueprint for their examination and to discuss questions. An example blueprint, covering the first three components of the otolaryngology head and neck surgery fellowship examination, is provided in TTable 9 Sample blueprint for fellowship examination, to illustrate the mapping approach. Examples for all nine specialty blueprints are provided.

Table 9 Sample blueprint for fellowship examination

Syllabus	Written Paper 1		Written Paper 2		Clinical Scenarios	
	Competency	Bloom's Taxonomy	Competency	Bloom's Taxonomy	Competency	Bloom's Taxonomy
HEAD and NECK	Medical Expertise	B	Medical Expertise	C	Medical Expertise	C
	Judgment and decision-making		Judgment and decision-making		Judgment and decision-making	
	Communication		Management and leadership		Management and leadership	
RHINOLOGY	Medical Expertise	B	Medical Expertise	C	Medical Expertise	C
	Judgment and decision-making		Judgment and decision-making		Judgment and decision-making	
			Management and leadership		Management and leadership	
OTOLOGY	Medical Expertise	C	Medical Expertise	C	Medical Expertise	C
	Judgment and decision-making		Judgment and decision-making		Judgment and decision-making	
	Communication				Communication	
PAEDIATRICS	Medical Expertise	B		B	Medical Expertise	C
	Judgment and decision-making				Judgment and decision-making	
					Communication	
SCIENTIFIC FOUNDATIONS	Medical Expertise	C		B		C
	Management and leadership					
	Health advocacy					

To be eligible to examine, all fellowship examiners must complete a fellowship examiner training course and observe an examination prior to examining for the first time. The Examiner Training Manual outlines the process for examining, blueprinting and developing questions.

5.3 Performance feedback

Accreditation standard

5.3.1 The education provider facilitates regular and timely feedback to trainees on performance to guide learning.

5.3.2 The education provider informs its supervisors of the assessment performance of the trainees for whom they are responsible.

5.3.3 The education provider has processes for early identification of trainees who are not meeting the outcomes of the specialist medical program and implements appropriate measures in response.

5.3.4 The education provider has procedures to inform employers and, where appropriate, the regulators, where patient safety concerns arise in assessment.

Summary of RACS Response

5.3.1 RACS provides regular and timely feedback to trainees about their performance to guide learning across the program of assessments.

5.3.2 Trainees receive feedback reports about their examination performance to enable discussion with their supervisor. Where a candidate has failed the fellowship examination, the supervisor also receives the feedback report.

5.3.3 Processes for the early identification of trainees in difficulty or underperforming trainees include mid-term in-training assessment and work-based assessments. RACS provides resources to assist supervisors to identify and manage trainees in difficulty. Specialty training boards provide planning and remedial support for such trainees.

5.3.4 RACS has procedures to inform employers and, where appropriate, the regulators, where patient safety concerns arise during assessment.

Feedback mechanisms

In addition to the feedback supervisors and trainers give to trainees in clinical settings, feedback on examination performance is provided within the timeframes stipulated in the conduct of the examination policies.

For the early examinations and specialty-specific examinations, written feedback is provided to each failing candidate by the RACS Examinations Department and is used as a basis for discussion with their supervisor.

For the fellowship examination, the senior examiner's feedback report is provided to the candidate following an unsuccessful attempt. This feedback is used as a basis for discussion between trainees and their supervisors to assist with the review and planning of training and/or examination preparation for a subsequent attempt.

Following an unsuccessful second or subsequent fellowship examination attempt, candidates must meet with their specialty training board chair or nominee, and one other nominee from the training board, to consider options and preparations for a subsequent attempt.

If in addition to failing, a candidate has been identified as a poor performer, defined as a total score of 14 or less (that is, more than six below the pass standard of 21), he or she will be interviewed by the relevant training board to address concerns and implement a remedial plan. The Examinations Department will notify the specialty training board within two weeks of the Court of Examiners meeting to allow time for the meeting to be scheduled in a timely manner.

If the candidate is considered a risk to patient safety (not related to a defined score), notification will occur within two days. The board will consult with the candidate's supervisor, and may seek information from the

hospital. If the specialty training board considers there are concerns for patient safety, it will recommend to the chair of the Board of Surgical Education and Training that the candidate be reported to the Australian Health Practitioner Regulation Agency (APHRA) or the Medical Council of New Zealand.

These processes are detailed in the Fellowship Examination Eligibility and Examination Performance Review Policy and the following examples are provided:

- Fellowship Examination Feedback Report
- Generic Surgical Science Examination (GSSE) Feedback Report
- Clinical Examination Feedback Report
- Specialty Specific Surgical Science Examination Feedback Report

Skills course assessment and feedback

Participants in the mandatory skills courses, Early Management of Severe Trauma and Care of the Critically Ill Surgical Patient, are formally assessed with outcomes being 'pass' or 'fail'. If a participant fails either course, specific feedback is provided to the candidate, in person, at the completion of the course. The instructor also completes a Feedback to Surgical Supervisor form and submits it to the RACS Skills Training Department course program administrator, who sends the form and covering letter to the surgical supervisor. A copy of the letter and feedback form are sent to the relevant specialty board and the trainee or international medical graduate.

Identifying under-performance and trainees in difficulty

RACS training boards have policies and processes to identify and support trainees who experience difficulties during their training.

In-training assessments record detailed information about a trainee's competence and performance and are used to identify trainees whose performance is not satisfactory for their level of training. Such trainees may be placed on a performance management plan (description varies between specialties), or they may be placed on probation (typically for six months). The purpose of performance management plans and probationary training periods is to develop remediation strategies for trainees, and to closely monitor their progress. During this time, trainee performance is regularly reviewed, with constructive feedback and support provided by surgical supervisors.

RACS has developed the Keeping Trainees on Track (KTOT) course to help supervisors and trainers with the early detection of trainees in difficulty. The course is available face-to-face or as an eLearning module .The learning outcomes of the course are to:

- Recognise four different areas of trainee difficulties
- Recognise how to identify and support trainees in difficulty
- Identify effective principles of holding a difficult, but necessary, conversation
- Practise having a difficult conversation

RACS has an online resource "trainees in difficulty" which provides useful information for supervisors.

Probation

Probationary periods provide trainees with opportunities to improve their knowledge and skills in areas where their performance is unsatisfactory. Specialty training regulations stipulate the details of probation. Training boards formally notify trainees when probationary periods and probationary status have been applied. This correspondence also is sent to the surgical supervisor, and the employing institution may be informed. In general, this will include:

- Identification of areas of unsatisfactory performance.
- Confirmation of remedial action plans.
- Identification of the required standard/s of performance.
- Notification of the duration of the probationary period.
- The frequency of assessment reports.
- Possible implications if the required standard of performance is not achieved.

During the probationary period, surgical supervisors regularly review trainees' performance and trainees are given constructive feedback and support. Supervisors complete the required probationary forms, which trainees submit to their training boards.

Dismissal from surgical training

Reasons for dismissal

Training boards are obliged to ensure patient safety and maintain standards by identifying trainees who do not satisfy performance standards according to the Assessment of Clinical Training and Dismissal from Surgical Training policies. Trainees may be dismissed from SET for reasons including:

- Unsatisfactory performance during a probationary period.
- Three or more unsatisfactory assessment periods at any time during the SET program.
- Misconduct.
- Failure to complete training requirements within the specified timeframes.
- Failure to comply with written direction of RACS and the board.
- Failure to pay training-related fees by due deadlines.
- Failure to maintain general medical registration or general scope registration.
- Failure to achieve or maintain employment in accredited training posts.
- Other circumstances as approved by the board.

Process of dismissal

The Dismissal from training policy outlines the process, criteria and responsibilities for dismissal from the training program. Trainees are invited to meet with a training board subcommittee to consider their continued participation in the training program and to provide their perspective. Trainees may be accompanied by a support person.

The training board considers the sub-committee's recommendation and decides whether or not the trainee will be dismissed and, if dismissal is not recommended, whether any additional probationary periods or conditions will be applied. The trainee has the right to appeal the decision, in which case the Appeals Mechanism Policy is followed. Refer to Section 1.

The number of trainees dismissed from each specialty over the past three years is provided in Table 10 Number of trainees dismissed from training 2008-2016.

Table 10 Number of trainees dismissed from training 2008-2016

Specialty	Year	No. of dismissals	Reason
Cardiothoracic	2008-2014	6	*Time expired
	2016	2	*Time expired
General surgery	2008-2014	1	Misconduct
		4	Non-financial
		9	Maximum exam attempts
		66	*Time expired
		6	Unsatisfactory performance
		2	Death
Neurosurgery	2008-2014	3	*Time expired
		4	Unsatisfactory performance
	2015	1	Examination failure
	2016	1	Unsatisfactory performance
Otolaryngology head and neck surgery	2008-2013	2	*Time expired
		1	Death
	2014	1	*Time expired
	2015	2	*Time expired
Orthopaedic surgery Australia	2008-2014	1	Maximum exam attempts
		2	*Time expired
		4	Unsatisfactory performance
Orthopaedic surgery New Zealand	2014-2016	0	
Paediatric surgery	2008-2013	1	*Time expired
		1	Unsatisfactory performance
	2014	3	*Time expired
Plastic and reconstructive surgery (Australia)	2008-2013	1	Non-financial
		1	Maximum exam attempts
		2	*Time expired
	2014	1	*Time expired
	2015	1	Non-financial
		1	Unsatisfactory performance
		1	*Time expired
	2016	1	*Time expired
Plastic and reconstructive (New Zealand)	2013-2015	0	
Urology	2008-2014	3	*Time expired
		1	Unsatisfactory performance
	2015	1	Unsatisfactory performance
Vascular	2008-2013	1	Misconduct
		1	Maximum exam attempts
		5	*Time expired
	2014	0	
	2015	1	*Time expired
	2016	2	*Time expired

Reference: Review of the Royal Australasian College of Surgeons Surgical Education and Training (SET) program June 2015 and recent data provided by specialty training boards

Generally examinations must be completed within a stipulated time and the number of attempts allowed is limited (maximum exam attempts). Trainees usually have four opportunities to successfully complete an examination. Therefore, “time expired” refers to not passing the GSSE, specialty-specific examinations and/or clinical examination within two years of starting SET (usually SET1-SET2) but not having used the maximum permitted number of attempts.

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5.4 Assessment quality

Accreditation standard

5.4.1 The education provider regularly reviews the quality, consistency and fairness of assessment methods, their educational impact and their feasibility. The provider introduces new methods where required.

5.4.2 The education provider maintains comparability in the scope and application of the assessment practices and standards across its training sites.

Summary of RACS Response

5.4.1 RACS conducted a comprehensive review of RACS assessments in 2016. RACS introduced assessments of key clinical tasks for the JDocs Framework in 2015 and is considering extending this approach to the RACS Surgical Education and Training Program (SET).

5.4.2 RACS maintains comparability and consistency in the application of examination practices and standards through the centralised administration of examination processes. Mandatory skills courses include faculty training, which includes an assessment component. Comparability of the scope and application of work-based assessments is achieved through policy and processes for approval of specialty regulations.

Consistency of assessors and examiners

To promote consistency in work-based, clinical assessments, RACS has developed several resources for supervisors and trainers, which are recognised in the RACS Continuing Professional Development Program. Fellows completing the Supervisors and Trainers for SET (SATSET), Keeping Trainees on Track (KTOT) and the mandatory Foundation Skills for Surgical Educators courses learn methods, tools and skills to facilitate supervision, training and assessment in SET. Further details are included in Section 8.

Mandatory examiner training has been introduced to maintain assessment standards and consistency. All new examiners appointed to the Court of Examiners are required to complete a training course to ensure they understand the surgical competencies they are testing, performance standards, possible limitations of the assessment tools and assessor-performance requirements. Training provides examiners with a good understanding of the concepts of standards, standard setting, reliability and validity. An online examiner-training course for the clinical examination will be introduced in 2017. Further details about examiner training are contained in Section 8.

Similarly, skills course instructors attend a 2.5-day instructor training workshop and are provided with an instructor manual to ensure consistency in the assessment of course participants.

Monitoring pass rates

Examinations

RACS closely monitors fluctuations in pass rates and provides reports to the Board of Surgical Education and Training. RACS publishes fellowship examination pass rates in its annual activity report.

Generic surgical science examination and specialty surgical science examination

In 2015, 701 candidates (SET trainees and pre-vocational doctors) sat the generic surgical science examination (GSSE) with an overall pass rate of 67 per cent. The pass rate for first attempt is 70 per cent.

Performance in the Generic surgical science examination (GSSE) fluctuated slightly with a 9.2 per cent decrease in the pass rate compared to 2014.

The specialty-specific examinations have seen a significant increase in the pass rate between 2014 (59.44 per cent) and 2015 (83.41 per cent).

Clinical examination

In 2015, the pass rate for the clinical examination was 3 per cent higher than in 2014. The pass rate is consistently around 94 per cent.

Fellowship examination

In 2015, the overall pass rate for the fellowship examination was 78.8 per cent, a slight decrease of 0.7 per cent compared to 2014. The total numbers of those presenting has risen and the pass rate of SET trainees continues to vary between specialties. Compared to 2014, the annual pass rate has decreased for first attempts, but has increased for second attempts. General surgery (75 per cent), neurosurgery (80 per cent), plastic and reconstructive surgery (75 per cent), urology (73 per cent) and vascular surgery (75 per cent) reported the highest annual pass rate for a first attempt. See Table 11 Pass rates in the fellowship examination, per attempt 2008-2014 for pass rates per attempt at the fellowship examination.

Since 2011, the eventual fellowship examination pass rate for SET trainees has been constant, at 96-98 per cent.

Table 11 Pass rates in the fellowship examination, per attempt 2008-2014

Number of attempts	Pass	Fail	Total	Percentage
1	535	215	750	71.3
2	109	66	175	62.3
3	24	33	57	42.1
4	9	15	24	37.5
5	2	7	9	22.2
6	1	4	5	20
7	0	2	2	0

Reference: Review of the Royal Australasian College of Surgeons Surgical Education and Training (SET) program June 2015

Trainee withdrawals

Between 2008 and 2015, 161 trainees withdrew from surgical training. To gain a better understanding of why trainees leave surgery, RACS commissioned an external survey and invited former trainees to participate. From a total of 162 respondents, 49 per cent of former RACS trainees responded to the survey and of these, 22 completed a follow-up interview. Over half the respondents were women.

The survey found that, typically, decisions to leave could be grouped under three major themes: inflexibility in the training program; an unacceptable culture in which to learn; and surgery being the wrong career choice, including surgery as an unattractive lifestyle choice. See Table 12 Reasons for withdrawing from training 2008-2015.

RACS is responding to the findings through the RACS Building Respect, Improving Patient Safety Action Plan. RACS will continue to survey trainees who withdraw from training to identify trends and ways to support these trainees before they decide to withdraw. Further information on the survey is available in the report *A study exploring the reasons for and experiences of leaving surgical training (2016).*

Table 12 Reasons for withdrawing from training 2008-2015

Reasons for withdrawing
Change specialty
Personal reasons not related to surgical training
Pursue a non-medical career
Experienced bullying
Experienced sexual harassment
Experienced discrimination
Personal health and wellbeing
Burn out
Unsatisfactory performance
Experienced adverse patient outcome

References: A study exploring the reasons for and experiences of leaving surgical training (p 21-23) and *Review of the Royal Australasian College of Surgeons Surgical Education and Training (SET) program June 2015*

A breakdown of the number of withdrawals per specialty is presented in Table 13 Number of withdrawals by specialty 2005-2015

Table 13 Number of withdrawals by specialty 2005-2015

Total	CAR	GEN	NEU	ORT	OHN	PAE	PLA	URO	VAS
161	5	93	11	12	9	10	3	11	7

Reference: Review of the Royal Australasian College of Surgeons Surgical Education and Training (SET) program June 2015

Standardisation and consistency

Monitoring examiner performance

Clinical examination

An ongoing review to identify examiner-marking traits (leniency and stringency) was introduced in 2016 and reports are provided to the Clinical Examination Committee.

In 2013, a centralised clinical examination was introduced to address religious observance concerns (previously the exam was held on Saturdays only in various locations). Centralisation of the clinical examination has improved standardisation, the calibration of the examiner scoring and examination administration. Consequently, the centralisation of both clinical examinations (February and June) will be implemented in 2017 to improve inter-rater reliability. Examination sites will rotate between Sydney, Melbourne and Brisbane, with a New Zealand examination concurrently held in June.

Fellowship examination

In 2011, RACS introduced a tool called 'heat maps' for examiners conducting fellowship examinations. Heat maps enhance the expanded close marking system by providing a visual representation of each examiner's scoring, highlighting any anomalies between examiners, or in the scoring process.

To provide feedback on examiner performance, the fellowship observer role has been expanded to include external observers who are examiners from different specialties. Observers will provide structured feedback on the validity of examination content, alignment to the syllabus, examiner performance and the taxonomy level employed. It is anticipated that this evaluation and benchmarking will benefit examiner fairness and consistency, the criteria and responsibilities of observers is described in the Observers of Fellowship Examination Policy. Comparability of examinations delivered in different sites is maintained by pairing senior examiners with less experienced examiners. Post-examination reviews such as the heat map, which provide information about examiner performance, contribute to inter-rater reliability.

Monitoring question standardisation

The Australian Council for Education Research routinely provides feedback on examination question performance, validity and standard setting.

The specialty courts of examiners meet annually to 'blueprint' forthcoming fellowship examinations by determining the allocation of examination content with regard to the specialty training curriculum, the RACS competencies and the taxonomy. This process is based on the consensus of experts, knowledge of clinical settings and work-based requirements and is supported by the collective knowledge, experience, expertise and qualifications (including educational qualifications) of the fellowship. Longitudinal consistency is achieved by members of the court combined ongoing practical experience of setting examinations.

Psychometric review of clinical examination stations

Analysis of reliability and validity of clinical examination scores is an annual and active study. Results are reported to the Clinical Examination Committee for consideration of recommendations to improve station and item quality. A sample review is available.

Monitoring work-based assessment

In 2016, RACS conducted a comprehensive review of assessments to assess:

- Reliability
- Validity
- Quality of assessment scales
- Feasibility
- Quality of feedback
- Educational impact
- Standard setting

This is discussed in Section 6.

In summary, the research demonstrated that work-based assessment is not appropriately used in SET and that the relationship between daily observed clinical work by trainees with feedback and the end-of-term summative assessments is poorly understood.

Consequently, standards for surgical supervisors and trainers, including education in effective assessment and feedback, are being developed in line with the RACS Building Respect, Improving Patient Safety Action Plan.

A report on the recent TriNations meeting, involving representatives from the Royal College of Physicians and Surgeons of Canada, the Royal Australasian College of Physicians, the Australian and New Zealand College of Anaesthetists, the Royal Australian and New Zealand College of Psychiatrists and the Royal Australasian College of Surgeons, outlines the collaboration and research into best practice work-based assessment that is being undertaken.

Strengths

The JDocs framework provides structure for work-based assessment of prevocational doctors. It also provides resources for those wishing to interact with the portfolio system, and for those registering for the generic surgical science examination.

Specialties have aligned their online modules, specialty-specific examinations, and work-based assessments to SET years, or to stages of training. This ensures that trainees are being assessed against appropriate standards for their given stage of training.

RACS frequently and consistently reviews the implementation of examinations. Where appropriate, aspects of examinations are renewed to maintain the validity, reliability and feasibility of examination processes. New assessment and standard setting methods are regularly evaluated for their application to the SET program, leading to iterative improvements in assessment processes.

RACS implements a range of assessment activities, including online and computer-based methods. This ensures that not only medical knowledge and technical skills, but also non-technical competencies such as communication and teamwork are assessed.

Recognition of the importance of knowledgeable and trained work-based assessors and examiners has resulted in the development and implementation of a number of courses. Examiner training is mandatory for the fellowship examination, and a similar course is being developed for clinical examiners. The annual Fellowship Examiner Scholarship helps RACS to benchmark and maintain best practice.

Candidates are provided with timely performance feedback for all RACS examinations, and written feedback is provided to candidates who fail the fellowship examination. Work-based assessments provide trainees with feedback on their clinical performance.

Challenges

The Review of Assessments report (2016) has shown that work-based assessments have not been used optimally. Relationships between trainees' daily, observed, clinical performance, and provision of task-related feedback, and the mid- and end-of term assessments are poorly understood.

Progress of trainees considered 'borderline' can be poorly documented, and surgeons who supervise or train can find it difficult to assess such trainees, or to appropriately share information with other supervisors.

It is concerning that some candidates fail the fellowship examination multiple times. Reviews of the processes allowing such candidates to present for the examination, and of their performance in examination components, would provide individualised information to candidates and may lead to measures to appropriately support these and future candidates.

Scheduling examinations is constrained by many other activities and events in the training calendar.

Provision of consistent feedback and workplace-based assessment across all sites can be difficult to monitor and enact. Ensuring protected time so supervisors can devote sufficient time to conducting meaningful work-based assessments may increase the frequency and reliability of work-based assessments.

With change and iterative development of the curriculum, there is an ongoing challenge to ensure that clinical assessments continue to align with curriculum requirements.

Plans

RACS continues to enhance its work-based assessments and in-training assessments and is reviewing international and national research on the use of entrustable professional activities (EPAs) for performance-based assessments.

RACS is planning to evaluate the influence of JDocs and the attainment of the generic surgical science examination prior to SET. With the generic surgical science examination being undertaken by prevocational doctors, RACS will closely monitor examination performance and trends to identify any differences resulting from the changing cohort.

Section 6

Monitoring and evaluation

6. Monitoring and evaluation

6.1 Monitoring

Accreditation standard

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

6.1.2 Supervisors contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses supervisor feedback in the monitoring process.

6.1.3 Trainees contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses their confidential feedback on the quality of supervision, training and clinical experience in the monitoring process. Trainee feedback is specifically sought on proposed changes to the specialist medical program to ensure that existing trainees are not unfairly disadvantaged by such changes.

Summary of RACS Response

6.1.1 RACS and the specialty training boards have processes in place for regular monitoring of the program, including supervision, assessment and trainee progress. Curriculum review is ongoing.

6.1.2 Supervisors are best placed to monitor the program in context to the healthcare environment. Supervisors' feedback on monitoring and program development occurs within the governance structure, primarily through the specialty training boards.

6.1.3 Trainees are integral to the monitoring and program development processes though their representation on education boards. Confidential feedback is provided through the RACS Trainees' Association (RACSTA) survey and this data has been used to monitor the quality of training, the accredited training post, and the learning environment. Trainees are consulted on any proposed changes to the program to ensure existing trainees are not unfairly disadvantaged by such changes.

Course evaluations

All courses delivered by RACS include an evaluation component; evaluation reports are discussed during course committee meetings. Reviews of feedback regarding the compulsory skills courses have resulted in the introduction of new models of training, revised course content and research projects. For example, the Australia and New Zealand Surgical Skills Education and Training and the Training in professional skills courses have adopted 'flipped classroom' delivery models in which online modules precede face-to-face workshop components. This delivery model has advantages of consolidating basic knowledge and skills, enabling class time with trainers to be used for skill development and discussion; it is also often possible to reduce the duration of face-to-face time.

Course evaluations of the Early Management of Severe Trauma course have resulted in research being conducted into the use of live animal models compared to mannequin simulations. The outcomes of this research will impact future delivery of this course.

Post-examination surveys are conducted for all examinations and provide opportunities for feedback from trainees. Changes to protocols, or conduct of examinations, have been made as a result, and the process for announcing results of the fellowship examination has been improved. An electronic system is planned to further improve the process, giving trainees greater control over when and how they access the results.

Expert Advisory Group investigations 2015

In 2015 an extensive review was undertaken by the Expert Advisory Group (EAG) involving Fellows, trainees, international medical graduates and external stakeholders.

An issues paper was produced to provide background information to the EAG activities and as a briefing paper to support survey requests. The paper looked at the cause of problems and actions needed to prevent discrimination, bullying and sexual harassment. A prevalence survey (quantitative and qualitative) was conducted of all RACS Fellows, trainees and international medical graduates. Facilitated online discussions were conducted for Fellows, trainees and IMGs and an organisational survey of over 300 hospitals was completed.

These investigations resulted in development and implementation of the RACS Building Respect, Improving Patient Safety Action Plan.

Monitoring the program

RACS monitors components of the RACS Surgical Education and Training Program (SET), targeting key areas of interest or risk, such as course delivery, examinations, professionalism, attrition and trainee and Fellow satisfaction.

Feedback from stakeholders, including hospitals, supervisors and trainees, is regularly obtained through training post accreditation processes. RACSTA regularly monitors trainee satisfaction and concerns and provides de-identified data to RACS. RACS conducts a census of Fellows every two years, providing feedback on workforce data. The two-yearly RACS fellowship survey reports on a variety of topics. Ongoing projects funded by government, such as the Specialist Training Program (STP), require regular monitoring and reporting

The training boards monitor the progress of trainees and the quality of supervision on a regular basis, through the training processes. This is described in more detail in Sections 5 and 8.

Curriculum review is ongoing, as described in Section 3. The RACS Education, Development and Research Department monitors and reviews selection to SET annually. Results and recommendations regarding the effectiveness of the selection tools are reported to each specialty training board.

A summary of monitoring activities is presented in Table 14 Monitoring activities.

Table 14 Monitoring activities

Monitoring activity	Report date or frequency
Expert Advisory Group investigations	2015
Fellowship survey	Two yearly
In-training assessments	Two yearly
Participant evaluation of courses, and professional development activities	Ongoing, each course
Participant evaluations of examinations (post examination surveys)	Ongoing, each examination
Post accreditation	Five yearly, or if required
RACSTA end-of-rotation surveys	Bi-annually
Specialty selection reports	Annually
STP project evaluations	Ongoing
Survey of STP-funded training posts	Ongoing
Census: Workforce numbers and distribution	Two yearly

RACSTA end of rotation surveys

Since early 2011, the RACS Trainees' Association has conducted an anonymous survey each six months, providing a snapshot of issues in training. Survey reports are presented to the Board of Surgical Education and Training. Initially the response rate was 25 per cent but the most recent survey, conducted in mid-2016, had 42 per cent participation. Matters raised are those expected with a distributed training system, as well as matters overlapping with the Expert Advisory Group content. Bullying continues to be reported. The presence of a surgical Fellow in a unit, usually a recent graduate gaining experience, often leads to competition for operative cases. RACSTA is compiling five years' data from the end of rotation surveys and this will be available in early 2017.

Specialists Training Program (STP) project evaluation

Each STP-supported project includes an evaluation report of how the project has performed in general and against specific STP-funding criteria. Projects are not considered to be complete until evaluation reports have been submitted to the Training Projects Department and approved by the Education Management Team. Evaluation reports are provided to the Australian Department of Health as part of a six-monthly reporting cycle. The Department of Health and RACS discuss any aspects of reports that may require further explanation or consideration.

Survey of STP-funded training posts

RACS conducts anonymous end-of-rotation online surveys of trainees in STP-funded training positions for each six-month rotation. The results are collated and a summary report is provided to the Department of Health as part of a six-monthly reporting cycle. To date the response rate from the trainees has been very low – less than 20 per cent. An incentive prize draw campaign to encourage participation failed to increase the number of responses.

Workforce numbers and distribution

RACS is actively involved in monitoring surgical workforce data. In addition to the fellowship census, the Australian and New Zealand Surgical Workforce Projections to 2025 reports provide long-term national projection requirements of the surgical workforce. The reports serve as the basis of RACS' ongoing efforts to ensure adequate growth of the surgical workforce to meet future population demands. RACS' work provides further evidence of the urgent need for long-term planning to ensure national self-sufficiency of the surgical workforce.

The Health Workforce Australia National Training Plan Meeting Report (2011), published on the RACS website, summarises the workshop discussions in which RACS was invited to participate. The goal of the National Training Plan is to have self-sufficiency in the supply of medical personnel by 2025 within a global labour market.

Supervisor participation

Supervisors' contributions to monitoring and to program development occur within the governance structure, primarily through the specialty training boards. Supervisors provide first-hand knowledge of the training program and the training context. Representative supervisors, as board members, are well positioned to provide feedback for discussion. Supervisors in general surgery, orthopaedic surgery, otolaryngology head and neck surgery, plastic and reconstructive surgery and urology are members of regional sub-committees.

Supervisors also are directly consulted during the training post accreditation process, and are frequently asked to contribute to working parties and ad hoc committees assigned to program development.

Trainee participation

With the introduction of SET in 2007, the new RACS Trainees' Association was highly involved with the discussions and decisions that affected current trainees and those of the future. RACS continues to encourage, support and seek the opinion of trainees in all aspects relevant to their training. The RACSTA Board is a successful advocate for trainee issues and trainees have opportunities to contribute to their own training program in a number of ways.

Individual trainees may raise issues directly with their specialty training board or through trainee representatives. Each specialty training board includes at least one trainee representative as a full member, who advocates for trainees and contributes to the board's discussions. Trainees are invited to participate in the twice-yearly end of term RACSTA survey and the specialty boards also seek feedback from trainees through surveys.

As members of specialty training boards, trainee representatives are consulted and involved in discussion on proposed changes prior to recommendations being made to the Board of Surgical Education and Training. Trainee feedback is sought on any changes to the program. Such changes are discussed at the Board of Surgical Education and Training where the RACSTA representative advocates on behalf of trainees, particularly if proposed changes would be disadvantageous to current trainees.

The confidential feedback received from the RACSTA survey is de-identified and reported through the governance structures. This feedback has been used to identify issue of concern to trainees and with the five-year longitudinal data now available, more specific information on the quality of posts and hospital training environments may be available and reported without detriment to individual trainees.

The accreditation of posts also provide an opportunity for feedback from trainees and, in some specialties, trainees are members of the accreditation team. As an example, during the general surgery five-yearly inspections, each trainee is invited to feed back anonymously on any of their training rotations at any hospital from the previous five years. The inspection team is from interstate so trainees would not be known to the Fellows on the team. This is variably attended, but is confidential, and forms part of the written report for the post.

Trainee feedback to the Expert Advisory Group strongly influenced the development of the RACS Building Respect, Improving Patient Safety Action Plan.

6.2 Evaluation

Accreditation standards

6.2.1 The education provider develops standards against which its program and graduate outcomes are evaluated. These program and graduate outcomes incorporate the needs of both graduates and stakeholders and reflect community needs, and medical and health practice.

6.2.2 The education provider collects, maintains and analyses both qualitative and quantitative data on its program and graduate outcomes.

6.2.3 Stakeholders contribute to evaluation of program and graduate outcomes.

Summary of RACS Response

6.2.1 The recently revised RACS Code of Conduct defines professional standards for all Fellows. The nine RACS competencies identify the attributes of practice required as a surgeon.

6.2.2 RACS augments regular, ongoing monitoring across the range of activities with discrete evaluation projects. These monitoring activities use a range of task-appropriate methodologies, including surveys, interviews and longitudinal data. RACS annually reports on all activities.

6.2.3 Community representatives sit on major committees and the RACS Council, bringing the community viewpoint. Stakeholder feedback was brought into sharp focus for RACS with the Expert Advisory Group 2015 research and resulting report.

Standards

RACS has developed a suite of resources to define the professional standards and competence of surgeons and trainees. These resources, focusing on individuals' professionalism and conduct of clinical activities, are implemented to evaluate performance.

The recently revised RACS Code of Conduct defines professional standards for all Fellows. The updated code is based on longstanding ethical and professional principles, reflects community expectations, and incorporates RACS' definition of surgical performance. Fellows who breach the code may be subject to sanctions as per the Sanctions policy, approved in November 2015. The Surgical Competence and Performance Guide sets out observable behavioural markers; the Morbidity Audit and Logbook Tool (MALT) enables practitioners to electronically log procedures and report on case history for training or peer-reviewed surgical audit purposes; Becoming a Competent and Proficient Surgeon describes training stages and levels of performance expected within SET, and the JDocs Framework identifies performance standards for pre-vocational doctors.

The nine RACS competencies identify the attributes of practice required as a surgeon. The specialty training boards train trainees (thus surgeons) about contemporary best practice in the continuously evolving field. RACS appreciates that 'best practice' addresses community needs. Community representatives on major committees and the RACS Council provide opportunities for dialogue – they adjust the perspective, bringing the community viewpoint. The Paediatric Board has introduced a community representative and this will be required of all boards in 2017.

Evaluation

Evaluation processes exist for the range of RACS activities. Regular, ongoing monitoring of activities is augmented by discrete evaluation projects. A summary of evaluation activities (2013-2016) is presented in Table 15 Evaluation activities.

Table 15 Evaluation activities

Evaluation activity	Report date
ASC evaluation report	2016
Fellowship examination written hurdle requirements	2015
Leaving surgical training	2016
Predictive utility of selection tools	2016
RACS review of assessments	2016
Selection diversity: Gender bias in SET applicant outcomes	2016
SET evaluation – mixed methods	2013
SET evaluation – quantitative	2014

ASC evaluation report

Feedback from attendees of the RACS Annual Scientific Congress is sought and evaluated to improve educational content and conduct of the conference each year. The ASC is a valuable educational activity for Fellows, trainees and IMGs and attendance is approximately 2000.

Fellowship exam written hurdle requirements

Quantitative studies. Reported to Court of Examiners 2015

RACS conducted a review in 2015 of the fellowship examination in response to a recommendation to disallow trainees proceeding to the vivas if they did not pass the two written components. The evidence supported the status quo, that is, failure at the written component is not a barrier to proceeding to the vivas.

Leaving surgical training

Mixed methods study; survey and interview. Reported at BSET June 2016

The Leaving Surgical Training study was initiated in response to unacceptably high rates of trainees failing to complete SET. Women were disproportionally represented in the cohort leaving surgical training. Previous studies (see SET Evaluation, 2014) found that women are 2.5 times more likely to resign or withdraw than men. Individuals who had resigned and/or withdrawn from SET (2008-2015), were surveyed to explore their experiences of training and their reasons for leaving prior to completing SET. The report is being consolidated for publication.

Themes emerging from this study highlighted inflexibility in the training program, a culture of discrimination, bullying and sexual harassment and complexity of work or 'wrong' career choice. 'Inflexibility' related to timing, geographic location and sequence of training. Most specialties conduct national or bi-national training programs, potentially requiring trainees to move interstate. General surgery, orthopaedic surgery, otolaryngology, plastic and reconstructive surgery and urology conduct regionally-based training programs, while trainees in cardiothoracic surgery, neurosurgery, paediatric surgery and vascular surgery are required to move to gain relevant training experiences. Ex-trainees challenged the need to move for training, noting that acute work in their specialty was usually similar regardless of jurisdiction. Many surgical trainees also had partners with careers, or family requirements, doubtless affecting their willingness or ability to relocate for training.

Predictive validity of selection tools

Quantitative study 2016

This study involves a longitudinal seven-year review of training outcomes for SET trainees since 2007, focusing on the predictive utility of selection tools (curriculum vitae, referee reports and interviews) into SET. Training outcomes included examination performance, attrition and successful completion of training (Fellowship). Recommendations from the project include increasing the influence of selection tools that predict positive training outcomes. This report will be presented to the Board of Surgical Education and Training in early 2017.

Selection diversity: Gender bias in SET applicant outcomes

Quantitative study 2016

This study used a longitudinal seven-year review of selection into SET since 2007 to focus on the probability of selection following consecutive attempts across the specialties, average performance on the selection tools and any gender difference in performance or probability of selection. The review concluded that the gender of candidates does not influence the probability of selection. However, the review did find the CV may disadvantage female candidates when compared to the performance of CV scores by their male counterparts. This report will be presented to the Board of Surgical Education and Training in early 2017.

RACS Review of assessments

Mixed methods study. Reported to Education Board June 2016

This comprehensive report compared RACS' assessment processes with those of established best-practice and made recommendations for improvements to the current assessment program. The report covered both work-based assessments and examinations and the reliability and validity of these assessment tools. Data analysis was conducted using assessment scores and training outcomes for the past seven years. Trainee and supervisor attitudes to work-based assessments were also surveyed as part of the report.

Work-based assessments

The results showed that work-based assessment (WBA) tools are not being used optimally, and satisfaction with these tools is generally low. The reliability of WBAs is likely to be low across most specialties due to infrequent assessment with a limited number of assessors. More precise rating scales, with a focus on the achievement of entrustable professional activities (EPAs), may improve the reliability, validity and educational impact of the WBAs. Blueprinting of WBAs onto the curriculum is needed to ensure that WBA tools are relevant, valid and that each of the surgical competencies is being assessed. Summary of recommendations:

1. Review WBA tools and their implementation
2. Improve clinical relevance
3. Blueprint WBAs onto the curriculum
4. Use entrustability scales to improve reliability of WBA ratings
5. Train raters
6. Use multiple assessments and assessors
7. Provide meaningful, constructive feedback
8. Introduce multi-source feedback
9. Introduce assessment portfolios

Examinations

The generic surgical science examination was shown to be the most reliable of the early exams and this exam also demonstrates good predictive validity. The clinical examination shows poorer reliability and does not discriminate well between candidates of differing ability levels. It is recommended that standard-setting practices are reviewed for many of the specialty specific exams. Quality assurance is necessary to ensure that poorly performing components are identified and any issues with questions or marking guidelines are addressed. Summary of recommendations:

1. Blueprinting to be used in designing all exams
2. Improve the discrimination of the clinical examination

3. Ensure evidence-based standard setting methods are used for all exams, including specialty specific exams with predetermined cut-scores
4. Review marking guidelines for poorly performing fellowship components
5. Analyse reliability of all fellowship components
6. Consider alternatives instead of essay questions in the fellowship
7. Consider analysing fellowship examiner stringency

SET evaluation 2013

Mixed methods study; online survey. Reported at BSET February 2014.

Online surveys of supervisors, younger Fellows and SET trainees

This review of the SET program covered a range of topics, including specialty curricula, supervision, assessment, access to learning resources, quality of training, support, and competency levels at the completion of training. The surveys were completed by 227 trainees, 159 younger Fellows, and 191 supervisors.

Trainee responses indicated that almost all trainees had accessed their specialty's curriculum, and that these curricula were somewhat helpful. Trainees also reported having largely positive training experiences, with adequate access to procedures and high-quality supervision. Examinations were rated highly, however work-based assessments were not considered useful.

Feedback from younger Fellows was particularly valuable as they were able to provide feedback on the transition from the Basic Surgical Training program to the SET program, and on the extent to which the training program prepared them for independent consultant practice. Almost 75 per cent of younger Fellows indicated that they felt confident to perform the core procedures of their specialty upon completion of training.

Supervisors reported that they did not receive adequate support from jurisdictions for their time commitments, but also felt that the expectations of their training boards were realistic. The introduction of training standards was also found to be helpful in clarifying what is expected of trainees. Over half of the surveyed supervisors felt that trainees are not exposed to a suitable number of procedures during their training.

SET evaluation 2014

Quantitative study; data analysis. Reported at BSET October 2014.

This quantitative study investigated performance outcomes of SET, including selection, completion rates, and attrition due to failure to pass examinations. Data was analysed for 2144 trainees since the inception of SET (2008-2014). The study showed that most candidates' postgraduate year (PGY) at selection had increased from PGY2-4 early on to PGY4-6 in recent years. By 2014, typical (median) year of selection was either PGY4 or PGY5 depending on specialty. Commencement is one year later – often at PGY5 or PGY6. Selection in recent years has proportionally reflected the gender of applicants, being around 30 per cent women (2012-2016).

Success in the fellowship varied widely by specialty and by PGY status at commencement of SET. The data also showed that there was a cohort who commenced in early years (PGY3-4) who progressed quickly through training; women were better represented than men in this group, gaining fellowship swiftly.

The study was presented to the specialty training boards at the Board of Surgical Education and Training in October 2014, with responses still under discussion when the events of 2015 occurred. The major research and planning activities in 2015 (resulting from Expert Advisory Group report) meant that the SET evaluation report has not been specifically addressed, other than through the Leaving Surgical Training (2016) report.

Ongoing evaluations

In addition to unique studies, RACS collects, maintains and analyses quantitative data about the SET program, mostly notably through the annual RACS activities reports. These reports include numbers of new Fellows and international medical graduates achieving fellowship and examination performance data.

Surveys of the fellowship enable estimation of workforce numbers, including possible retirement plans. Numbers of trainees relate to numbers of posts, with completion dependent on satisfactory end-of-term reports and fellowship examination success.

RACS does not routinely seek information about the work performance of graduates. New Fellows, in common with all Fellows, are required to undertake continuing professional development, practice visits, multi-source feedback, workplace performance reviews, audit, and morbidity and mortality reviews.

Engagement with stakeholders

Stakeholder feedback was brought into sharp focus for RACS with the Expert Advisory Group 2015 research and resulting report. These clearly showed that graduate outcomes – as demonstrated in the workplace – were deficient in many of the non-technical competencies, resulting in a culture in which discrimination, bullying and sexual harassment were commonplace. It is anticipated that, combined with cultural change, the emphasis on complaints management in the RACS Building Respect, Improving Patient Safety Action Plan, will provide a valuable conduit for evaluation of professional performance. This feedback has already resulted in the development and implementation of significant educational resources. The surveys will be repeated in five years.

6.3 Feedback, reporting and action

Accreditation standard

6.3.1 The education provider reports the results of monitoring and evaluation through its governance and administrative structures.

6.3.2 The education provider makes evaluation results available to stakeholders with an interest in program and graduate outcomes, and considers their views in continuous renewal of its program(s).

6.3.3 The education provider manages concerns about, or risks to, the quality of any aspect of its training and education programs effectively and in a timely manner.

Summary of RACS Response

6.3.1 Reporting of monitoring and evaluation activities and discussion and approval of recommendations occurs through RACS' governance structures.

6.3.2 RACS typically makes evaluation results available to stakeholders through reports. Evaluation results from high profile projects are made more broadly available. Cyclical review and renewal of programs is informed by stakeholder representation on boards and committees.

6.3.3 RACS' addresses concerns about the quality of its training programs through its governance and administrative structures. Actions and resources are identified and prioritised and project management plans effected.

Reporting of monitoring and evaluation activities and discussion and approval of recommendations stemming from these activities occurs through RACS' governance structures, as detailed in Section 1. Reports are usually submitted to the initiating board or committee and also may be submitted to committees responsible for the activities under review, where these differ from the initiation committee. RACS' approach to disseminating evaluation information varies, depending on the activities being reported. Ongoing evaluations of predominantly internal activities, such as courses, are reported to RACS committees. The Expert Advisory Group evaluations, representing a major study of interest to government and the general public, were published broadly, including on the RACS website, in the media, in social media, and in academic journals. Research findings from projects such as the SET evaluations (2013, 2014) and Leaving Surgical Training report (2016) have been presented at national and international conferences such as the TriNations conference, the International Conference on Surgical Education and Training (ICOSET) 2015, the International Conference on Residency Education (ICRE) 2014 and ICRE 2016 and have been shared with other specialty medical colleges in educational fora.

Concerns about the quality of RACS' training and education programs are taken extremely seriously. RACS responded to the major concerns raised in the Expert Advisory Group report with a comprehensive framework of action predicated on three areas: culture change, education and complaint management. Timely action in all these areas was paramount. The media and poster campaign, revision of the RACS Code of Conduct, the Operating with Respect eLearning module and face-to-face workshop, the Foundation Skills for Surgical Educators course and a new complaints process are among the initiatives underway. RACS has also made counselling services, through Converge International, available to all trainees, Fellows, international medical graduates and staff.

Strategic and key operational risks to the training and education program are included in the RACS Risk Register.

Strengths

RACS has maintained accurate records and comprehensive data since the inception of SET and has the in-house research and analysis capability to provide robust data about surgical training and assessment. The governance structure provides opportunities for discussion and decision-making.

RACSTA surveys continue to be a valuable tool through which trainees can report issues and provide feedback on training posts and their experiences of SET.

The expert advisory group described many issues across all aspects of surgical training and practice, and the RACS Building Respect, Improving Patient Safety Action Plan highlights RACS' commitment to address these issues comprehensively and efficiently. As a high profile initiative with RACS stakeholders, monitoring, evaluation and reporting the outcomes of the action plan will be ongoing and widely distributed.

RACS has systems in place to seek and respond to feedback and has a track record of cyclical development of training and assessment activities and resources.

RACS undertook detailed research into the sustainability of learning in simulated environments, and continues to assess the efficacy of mobile and simulated learning environments.

Challenges

RACS has been subject to significant external commentary and appraisal, and the expert advisory group findings relating to the surgical culture, insufficient educator skills, poor provision of feedback, and the prevalence of discrimination, bullying and sexual harassment, constitute a major, critical evaluation of SET and the practice of surgery in Australia and New Zealand.

RACS' exposure to regular, formal stakeholder evaluation – from patients or hospital directors and surgical directors – is limited. It has therefore been challenging to gather and evaluate feedback that fairly represents the breadth of opinions regarding RACS activities.

Plans

RACS is committed to dealing with all the issues identified by the expert advisory group and will be monitoring and evaluating activities ensuing from the RACS Building Respect, Improving Patient Safety Action Plan. This is expected to provide more opportunities to evaluate quality of supervision and training posts and the prevalence of factors that may be detrimental to optimal learning environments and trainee wellbeing.

RACS is planning a research project in 2017 to investigate the preparedness for practice or the 'capability' of new surgeons, (equivalent to individual graduate outcomes).

The qualitative survey of Fellows, trainees and international medical graduates conducted in 2015 will be repeated in 2020. An annual survey of those leaving surgical training without completing the program will be introduced in 2017.

RACS intends to set up training post surveys to evaluate individual training posts. This will be informed by the National Medical Training Advisory Network and the Medical board of Australia approaches to their national surveys of trainees

Section 7

Trainees

7. Trainees

7.1 Admission policy and selection

Accreditation standard

7.1.1 The education provider has clear, documented selection policies and principles that can be implemented and sustained in practice. The policies and principles support merit-based selection, can be consistently applied, and prevent discrimination and bias.

7.1.2 The processes for selection into the specialist medical program:

Use the published criteria and weightings (if relevant) based on the education provider's selection principles.

- Are evaluated with respect to validity, reliability and feasibility.
- Are transparent, rigorous and fair.
- Are capable of standing up to external scrutiny.
- Include a process for formal review of decisions in relation to selection, which is outlined to candidates prior to the selection process.

7.1.3 The education provider supports increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees.

7.1.4 The education provider publishes the mandatory requirements of the specialist medical program, such as periods of rural training, and/or for rotation through a range of training sites so that trainees are aware of these requirements prior to selection. 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.

Summary of RACS Response

7.1.1 RACS has clear, documented principles-based selection policies that are articulated in the specialty selection regulations and implemented by specialty training boards. The policies and principles support merit-based selection, can be consistently applied and prevent discrimination and bias.

7.1.2 The processes for selection into the specialist medical program:

- Use published criteria and weightings based on RACS selection principles.
- Are evaluated with respect to validity, reliability and feasibility.
- Are transparent, rigorous and fair.
- Are capable of standing up to external scrutiny.
- Communicate the formal review of decisions in relation to selection via published policy.

7.1.3 RACS supports increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees and has introduced initiatives and policies to progress this objective.

7.1.4 RACS publishes the mandatory requirements of each specialist-training program so trainees are aware of these requirements prior to selection. There are clear criteria, and processes in place for seeking exemption from any requirements.

RACS monitors the consistent application of selection policies by each surgical specialty.

Overview

The RACS Surgical Education and Training (SET) program was introduced in 2007-08 to develop the principle of early selection of applicants into their preferred surgical specialty. Early entry into specialty training means the training boards are responsible for appropriate training at an earlier stage of doctors' development, including training in many of the generic, early-career competencies.

The anticipated results were not yet evident when RACS was last accredited in 2011. However, the 2014 SET evaluation found that trainees were being selected at a later PGY stage than anticipated.

Competition for entry into surgical training has not declined; annually, there are approximately four applications for each position available. Not surprisingly, recent analysis of entry-level trainees indicates most trainees are entering SET at a later postgraduate level. Selection at postgraduate year four or five (PGY4-5) is typical, meaning commencement at postgraduate year five or six (PGY5-6). Selection requirements contribute to this later level of entry.

RACS introduced the JDocs Framework to address a lack of formal training in the prevocational years and to prepare doctors for entry into surgical training. The framework explicitly links the generic knowledge, skills and attitudes required of junior doctors to early-career development in hospitals for those seeking a surgical or other procedural specialty. The framework, resources and assessments are designed to support and assist prevocational doctors to plan and progress their training in all areas of being a competent and safe doctor, appropriately skilled at the level required, and well prepared to commence surgical or medical vocational training. RACS will monitor and evaluate the outcomes of the JDocs Framework to determine its value to training boards in the selection process and to the prevocational sector in general.

Selecting candidates with the values, aptitude and attributes most likely to lead successful completion the training program, and with the professional attributes required to practice surgery, is a challenge. The specialty training boards continue to review the selection process and have introduced prerequisites, such as evidence of specific clinical skills using procedure based assessments (PBAs) and examination of specialty knowledge to assist. Completion of the generic surgical science examination is now a prerequisite for all specialty training boards

There are no perfect tools for selection into postgraduate medical programs. Links to performance in the prevocational years is supported by College work on authentic, work-based reference reporting. This also is part of the rationale for the JDocs Framework, and having key clinical tasks mapped to the entry level of surgical education and training assists in establishing readiness for roles and responsibilities expected of an entry-level trainee. In the future, this authentication of work-based competency may inform selection into training. RACS will be trialling key clinical tasks with junior doctors in 2017; the pilot will be conducted at the Gold Coast Hospital.

The Australian Medical Council (AMC), the Medical Council of New Zealand (MCNZ) accreditation requirements, the Brennan Report, and current surgical education literature and practice all inform RACS selection policy. To maximise objectivity and fairness, selection is merit-based, with candidates scored by multiple raters in a minimum of three selection tools. All programs use curriculum vitae (CV), structured referee reports and multi-station interviews.

The Selection to Surgical Education and Training Policy defines minimum requirements for selection, with each specialty program determining specific procedures in its selection regulations. Specialties may use selection tools differently, for example, by weighting the score allocated to each selection instrument in proportion to the others; individual scores achievable with each item; and protocols for implementing the instruments. Referee selection methods, interview methods, the nature, number and content of questions asked also are unique to each surgical specialty. Training is provided to those rating candidates in an interview.

The RACS Education, Development and Research Department monitors and reviews the selection process at the end of each selection round. The review addresses processes and tools used, and reports on selection outcomes by specialty, with recommendations to address any concerns. All specialties also review selection processes and tools. Some have a designated committee and/or staff member to undertake detailed analyses of selection tools; some use external experts to review selection tools and processes.

The regulations are assessed for compliance with the Selection to Surgical Education and Training Policy, with compliance confirmed by the Education Board.

Selection process

Doctors are eligible for selection into surgical education and training once they have completed their intern year. The minimum eligibility criteria are:

- Permanent residency or citizenship of Australia or New Zealand at the time of registration.
- General (unconditional) registration in Australia or general scope or restricted general scope registration in the relevant specialty in New Zealand.
- Successful completion of the RACS Hand Hygiene learning module, which is available on the Hand Hygiene Australia website. No other module is accepted. Hand Hygiene New Zealand uses the Australian learning module as its default program; NZ registrants must also complete the Hand Hygiene Australia learning module.
- Completion of the RACS Let's Operate with Respect eLearning module (from 2017).

All generic eligibility requirements must be satisfied at the time of registration. Applicants must consent to a full criminal history check, including the submission of relevant documentation on request.

Selection involves two stages. SET registration, conducted by RACS for all specialties, confirms the minimum eligibility requirement before application to selection. The application process then follows. As described in Table 16 Specialty selection administration, selection is administrated either by RACS or a specialty society. Specialty societies that manage selection on behalf of a training board have developed mechanisms and policies for complaints and appeals that align with the RACS appeals mechanism policy.

Table 16 Specialty selection administration

SET program	Administrative responsibility	RACS online application system	Specialty-specific application system
Cardiothoracic surgery (Australia and New Zealand)	RACS	●	
General surgery (Australia)	General Surgeons Australia		●
General surgery (New Zealand)	New Zealand Association of General Surgeons		●
Neurosurgery (Australia and New Zealand)	Neurosurgical Society of Australasia		●
Otolaryngology head and neck surgery (Australia)	RACS	●	
Otolaryngology head and neck surgery (New Zealand)	RACS	●	
Orthopaedic surgery (Australia)	Australian Orthopaedic Association		●
Orthopaedic surgery (New Zealand)	New Zealand Orthopaedic Association		●
Paediatric surgery	RACS	●	
Plastic and reconstructive surgery (Australia)	Australian Society of Plastic Surgeons		●
Plastic and reconstructive surgery (New Zealand)	RACS	●	
Urology (Australia and New Zealand)	Urological Society of Australia and New Zealand		●
Vascular surgery (Australia and New Zealand)	Australian and New Zealand Society of Vascular Surgeons		●

Measures to ensure a transparent and fair process include, where possible, the standardisation of application documentation, standardisation of referee reports via an online referee report, and the use of scoring guidelines to mark the application. In the event of discrepancies, a third person (usually the board chair) arbitrates on the final score. Interview questions are standardised and marked against the same criteria. The RACS appeals mechanism policy is available to applicants who believe selection policies and procedures have not been followed.

Hospitals (as an employing entity) are not directly involved in the selection process. All trainees are recommended by RACS and its specialty training boards for employment by hospitals with training posts. Hospitals assess each recommended trainee according to their own recruitment and employment processes and may deny employment. Denying employment to a trainee does not affect the status of the training post.

The number of new trainees selected in any year depends on the number of accredited training posts available (including new posts accredited) and the number of existing trainees leaving clinical training (due to graduation, interruptions etc.). Specialty administration communicates directly with applicants during the selection process. Selection outcomes are reported annually in RACS activities reports.

RACS supports activities to increase the number of Aboriginal and Torres Strait Island and Māori trainees. These include the Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative and, as part of the Māori Health Action Plan, a number of scholarships to support Māori junior doctors. For the past three years RACS has been awarding up to six scholarships for Aboriginal, Torres Strait Islander and Māori medical students and junior doctors to attend the RACS annual scientific congress. In June 2015, the Board of Surgical Education and Training approved the Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative. In New Zealand, the Māori Health Action Plan also identified the need to develop appropriate SET admission and selection criteria for applicants to demonstrate competence in Māori health issues.

In 2017, the Board of Otolaryngology Head and Neck Surgery (OHNS) will reserve up to 10 per cent of posts (one post in 2017) for Aboriginal and Torres Strait Islander SET applicants who meet the minimum standards for appointment as defined by the board. It is hoped other boards will follow the lead of the Board of OHNS in future selection rounds.

Publication of selection requirements

RACS has developed webpages to provide information on becoming a surgeon. These pages provide an overview of the pathway to a surgical career and other relevant information, and link to more detailed specialist surgical websites. Life as a surgeon can be demanding as well as rewarding and the Surgical Career Transitions Guide, an open-access resource, has been positively received.

There are links to each of the specialties on the JDocs Framework, as well as RACS website, which clearly describe the national and bi-national programs, the rotations and geographic locations, and the nature of training in and across each of the specialties.

- Cardiothoracic surgery
- General surgery (Australia)
- General surgery (New Zealand)
- Neurosurgery
- Orthopaedic surgery (Australia)
- Orthopaedic surgery (New Zealand)
- Otolaryngology head and neck surgery (Australia)
- Otolaryngology head and neck surgery (New Zealand)
- Paediatric surgery
- Plastic and reconstructive surgery (Australia)
- Plastic and reconstructive surgery (New Zealand)
- Urology
- Vascular surgery

Applications to SET for 2015 are presented in

Table 17 Number of trainees who entered in SET per specialty, in Australia and New Zealand (2013-15)

Table 17 Number of trainees who entered in SET per specialty, in Australia and New Zealand (2013-15)

		CAR	GEN	NEU	ORT	OHN	PAE	PLA	URO	VAS	Total
AUS	2013	5	105	6	35	19	6	12	16	13	217
	2014	7	60	9	58	13	4	12	0	8	171
	2015	7	83	11	51	9	5	17	24	8	215
NZ	2013	1	13	1	9	2	0	3	3	1	33
	2014	0	9	1	9	5	2	4	0	0	30
	2015	1	11	0	9	2	2	4	5	2	36

Reference : Activities reports 2013-2015

7.2 Trainee participation in training organisation governance

Accreditation standard

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 RACS Response

7.2.1 RACS has an active and engaged trainees' association and trainee representation is embedded by policy and practice in through the governance structures of RACS.

The standing and position of trainees in RACS has increased and consolidated over the past five years and trainees have established a place as contributors to their own training. RACS offers opportunities for engagement and involvement, which contribute to the development of these surgical leaders of the future, broadening their perspectives beyond training to the wider healthcare and educational environments. Trainee representation on the education boards and committees that govern the training programs are embedded by policy, practice and precedence established over several years.

RACS established the RACS Trainees' Association (RACSTA) in 2007 and all trainees in Australia and New Zealand become members upon entry to SET. The association plays a vital role in advocating for trainees through representation on external organisations, the activities of the RACSTA Board and as trainee representatives on RACS boards and committees.

The RACSTA Board is part of RACS structure and reports directly to the Education Board. The RACSTA chair is a full, voting member of the RACS Council and RACSTA representatives are members of several boards and committees. The RACSTA Board represents all specialties, regions, states and New Zealand. Members of the RACSTA Board are elected by the trainee body via regional networks, specialty training groups or by direct application. In 2015, a RACSTA executive officer was appointed to provide additional support to the RACSTA Board. RACS funds the board's activities and staff support.

The RACSTA Executive fulfils several functions relevant to RACS trainees, including working to improve surgical training, representing surgical trainees, protecting trainees' interests and providing an avenue for communication between trainees and RACS. Over the past five years, RACSTA's influence has permeated into many areas of College activity and RACSTA's opinion is sought on many issues.

In 2011, RACSTA introduced an end-of-term survey to seek feedback from trainees in a confidential and supportive manner. Following an initial uptake of 18 to 20 per cent, the most recent survey, conducted in the first half of 2016, drew a 42 per cent increase in the response rate, evidence of RACSTA's relevance to trainees and their confidence in the survey. De-identified survey results are reported to the Education Board, Board of Surgical Education and Training and the specialty training boards, and the findings are widely used to promote the needs and requirements of trainees. Issues covered in the survey have included safe hours, part-time and flexible training, discrimination, bullying and sexual harassment, the quality of training, barriers to obtaining adequate clinical experience and, more recently, the quality of supervisor feedback. A longitudinal analysis of the standardised data has been undertaken in 2016; this will provide useful information on the quality of training posts and other aspects of training. A report on the 2016 January-June survey is available.

The Australian Orthopaedic Association also has an active Trainee Association, which is governed by the Trainee Executive Committee. The president of the Trainee Association is a full voting member of the Australian Orthopaedic Association Board, which enables effective two-way communication between the association and the orthopaedic trainees.

Trainees' willingness to engage with surveys and consultation conducted by the Expert Advisory Group influenced the development of the RACS Building Respect, Improving Patient Safety Action Plan. Thus trainees have contributed to wider issues of professionalism and improvement to the culture of their learning environment.

7.3 Communication with trainees

Accreditation standard

7.3.1 The education provider has mechanisms to inform trainees in a timely manner about the activities of its decision-making structures, in addition to communication from the trainee organisation or trainee representatives.

7.3.2 The education provider provides clear and easily accessible information about the specialist medical program(s), 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.

Summary of RACS Response

7.3.1 RACS has developed policies and implemented mechanisms to ensure that trainees are informed in a timely manner about the activities of decision-making structures, in addition to communication from the RACS Trainees' Association (RACSTA), which represents trainee interests.

7.3.2 RACS provides clear and easily accessible information about the surgical education and training program (SET), costs and requirements, and any proposed changes.

7.3.3 Trainees have access to timely and correct information about their training status to facilitate their progress through training requirements.

RACS communicates with trainees on many levels, ranging from formal written notification of examination results or outcomes of committee decisions, the weekly e-newsletter *Fax Mentis* and monthly publication *Surgical News*, through to social media posts. Specialty training boards and societies use methods of communication to trainees of that specialty that complement the overall RACS approach. In the case of smaller specialties and in regional networks, communication also includes regular training days and workshops, meaning trainees become known to their supervisors and trainers.

Responsibility for what, when and how information is communicated is stipulated in RACS policy and specialty regulations. In broad terms, RACS is responsible for providing information to trainees on the overall surgical education and training program and policies, including selection, examinations, information on skills courses, and program costs. The training boards inform trainees about their status and progression, requirements of the program, and any program changes or issues affecting training.

The internet is a key communications channel for both RACS and the specialty societies, and it is critical to ensure information is kept accurate and up-to-date. Social media is increasing as a communications channel. A significant change for RACS since 2011 has been the use of Facebook, Twitter and YouTube. The specialty training boards also engage actively in these media; for example, Urology uses Twitter to support clinical tutorials and a journal club. Work is progressing on the announcement of fellowship results through the RACS website. This will enable the candidate to choose whether they receive results in person (often considered a stressful event) or in private, in real time.

RACSTA has a dedicated webpage on the RACS website and has recently introduced a RACSTA e-newsletter, which will be circulated by email to all trainees, complementing *Fax Mentis* and *Surgical News.* The specialty training boards also use email newsletters and society publications to communicate with trainees.

Trainees can confidentially communicate their concerns or seek assistance from RACSTA's generic email address. A RACSTA board member then contacts the trainee by phone, particularly if an issue requires action or intervention. RACSTA filters trainees' concerns and opinions through to RACS and the training boards via reporting mechanisms and representation at relevant meetings.

RACSTA has a good reputation among trainees and this strengthens the ability to canvas opinion and seek feedback in a two-way communication with trainees.

7.4 Trainee wellbeing

Accreditation standard

7.4.1 The education provider promotes strategies to enable a supportive learning environment.

7.4.2 The education provider collaborates with other stakeholders, especially employers, to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training. It publishes information on the services available.

Summary of RACS Response

7.4.1 RACS employs a variety of strategies to create positive cultural change that leads to a supportive learning environment free of discrimination, bullying and sexual harassment.

7.4.2 As posts are located within hospitals, there is an implicit collaboration with the employer to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training. RACS has implemented an independent counselling and support program through Converge International and a peer-support program via RACSTA.

RACS is committed providing a supportive learning environment for trainees and has introduced several initiatives to support trainee wellbeing. Published policies have not been sufficient to stop discrimination, bullying and sexual harassment and the Expert Advisory Group found these behaviours were prevalent in hospitals and medical schools. In response, RACS has begun a significant program of work to affect positive cultural change in the practice of surgery and the healthcare sector in general.

Evidence supports the importance of safe environments for learning to occur. RACS endeavours to foster safe learning environments where unprofessional behaviours are not accepted.

From external reports, such as the beyondblue review of mental health concerns, it was recognised that trainees needed tangible support, and prior to the Expert Advisory Group report in 2015, RACS launched a Surgeons Support Service for trainees struggling with workplace, emotional, and personal issues. The RACS Surgeons Support Program, provided by Converge International, is a professional and confidential counselling service to College Fellows, trainees and international medical graduates. The program provides a range of counselling, coaching and support services. Access is not limited to RACS-related issues and support can be sought for any personal or work-related matter. Converge International provides a collated, de-identified report to RACS Council, twice yearly. The service has been well received and, according to RACSTA, is valued and appreciated by trainees. As well as being promoted on the RACS website, trainees are provided with a wallet-sized card for easy access and contact.

The RACS Building Respect, Improving Patient Safety Action Plan articulates a number of measures to support trainees' wellbeing. Stress and resilience management is recommended as a component of the curriculum, and training has been developed on how to effectively deal with unprofessional behaviours. Importantly, hospitals are engaging with RACS as partners in Building Respect, Improving Patient Safety initiatives.

Managing an ill, injured or impaired trainee requires hospital, supervisor and board support. Each case should be managed individually and, once any medical issues are resolved, the trainee should be supported to return to work. The recent Building Respect, Improving Patient Safety Action Plan commits RACS to developing flexible (less than full-time) work options, which may help with return to work as well.

Training post accreditation standards include a provision that hospitals must provide evidence of a respectful culture, which enables a supportive learning environment for trainees, and this forms a basis for collaboration between the training board and the hospital.

Supervisors play a key role in identifying trainees who are experiencing personal or professional difficulties. As employees, supervisors can liaise with the hospital on behalf of the trainee, as an individual and as a representative of the training board. Some training boards, particularly in smaller specialties, know their trainees personally and are often best placed to notice changes that may indicate personal, professional or health-related issues, and to offer support.

RACSTA, via an executive member, may be the first contact for a SET trainee with personal and/or professional difficulties. RACSTA may assist directly, but also may direct the trainee to appropriate support, whether this is the RACS Support Program, hospital, supervisor, GP, or training board. All Fellows and trainees are encouraged to have and regularly consult a general practitioner.

7.5 Resolution of training problems and disputes

Accreditation standard

7.5.1 The education provider supports trainees in addressing problems with training supervision and requirements, and other professional issues. The education provider's processes are transparent and timely, and safe and confidential for trainees.

7.5.2 The education provider has clear impartial pathways for timely resolution of professional and/or training-related disputes between trainees and supervisors or trainees and the education provider.

Summary of RACS Response

7.5.1 Specialty training boards have documented processes of decision making, and mechanisms to enable trainees to seek a review of a decision. The 'Let's Operate with Respect' campaign is empowering trainees to raise concerns, and equipping boards with the skills to address issues in a safe environment.

7.5.2 The RACS complaints process has been revised and refocused and a dedicated complaints manager employed to ensure complaints are handled according to policy and within stipulated timeframes. The Appeals Mechanism policy is regularly reviewed to ensure that it is fit for purpose.

While RACS typically manages complaints about bullying and harassment, issues raised by trainees in relation to training supervision and requirements are generally managed in the first instance by specialty training boards. The regulations stipulate how each of the boards conducts the process, and there are RACS guidelines to assist boards in meeting natural justice requirements, Natural Justice – Guidelines for Decision Makers. These guidelines stipulate three principles of natural justice: notice of hearing, absence of bias and evidence.

If the problem is not resolved, the trainee can escalate the issue to the RACS appeals mechanism. In the first instance, the matter would be reviewed by the Censor-in-Chief's Review Committee, comprising the censor-in-chief and two members of the Education Board Executive. The Censor-in-Chief's Review Committee will examine decisions as the final step before an Appeals Committee hearing is convened, and has the power to review the correct application of College policy, and to request the decision maker to reconsider the merit of the final decision made.

All trainees may lodge a complaint or an appeal and these processes are detailed in Section 1.3.

Strengths

Selection to SET follows established principles, noting that there is no single perfect selection method. Within the SET policy framework, each specialty may adapt the selection tools and their 'weightings' to be implemented in ways that are most suitable for their needs.

Specialty selection regulations have recently been updated; RACS reviews the selection processes of all specialties annually.

RACSTA is well-resourced, is representative of the trainees, and provides forthright feedback to RACS, through representation on committees and boards, including RACS' Council. RACSTA surveys are gaining more traction with the trainee membership, with response rates increasing over time.

Trainee wellbeing is supported by ongoing discussion about trainees' and surgeons' mental health, and the RACS support program (through Converge International) for trainees, Fellows and international medical graduates. The Building Respect, Improving Patient Safety Action Plan addresses related issues, including stresses encountered in surgical careers, support and resilience.

RACS sustains an active presence on social media to assist communication with trainees.

Challenges

Differences between each specialty's selection criteria can make it difficult for prevocational doctors to map their career development to more than one or two surgical specialties. Additionally, specialty prerequisites for selection tend to have increased, resulting in candidates applying later to SET as they spend time gaining experiences to fulfil selection requirements.

To date, only one specialty has moved to support indigenous doctors who wish to train as surgeons. Otolaryngology head and neck surgery will invite indigenous doctors who meet minimum standards to interview, and will prioritise a training position in the 2017 selection process. Other specialties are yet to meet this challenge.

Addressing complaints about training posts, training issues, and educator standards also presents challenges. Trainees, as members of training boards have been successful in bringing trainee issues to the forefront of discussions about SET; however, individual trainees still perceive themselves to be vulnerable, as many hesitate to raise issues with boards if they believe this could impact negatively on their progress.

Establishing flexible training positions is challenging.

Trainees access information through a variety of channels, are increasingly IT-savvy, and expect information to be available immediately. RACS must test and implement new communication methods to keep pace with the expected speed and mode of communications.

RACSTA is sustained by the willingness of trainees to add to their already crowded training workload, by volunteering to attend additional meetings, and to be available for trainees to contact. To date, trainee representatives have managed to combine their studies and their training activities, and have been diligent in managing their RACSTA workloads at critical points in their own training, such as when preparing for the Fellowship Examination.

Plans

The improved complaints process enables more thorough and efficient resolution of training related disputes and complaints.

Independent training post reviews are currently being piloted. These reviews evaluate and report on situations in which issues have been identified or where a trainee is on probation or is in difficulty. A RACS representative, a medical educator, and a Fellow-on-staff visit the hospital post and meet the trainee and others concerned. There is a similar IMG post inspection process.

Introducing greater flexibility to training presents challenges. Despite support from the Women in Surgery group, and discussion at BSET, solutions will require hospitals and networks to engage with the training boards, through local supervisors, to decide what can be achieved. This is underway.

Ensuring trainees feel safe and confident to raise concerns about the quality of their supervision was a focus of the expert advisory group report. The RACS Building Respect, Improving Patient Safety Action Plan is addressing these issues in several ways.

Section 8

Implementing the program – delivery of education and accreditation of training sites

8. Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standard

8.1.1 The education provider ensures that there is an effective system of clinical supervision to support trainees to achieve the program and graduate outcomes.

8.1.2 The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the specialist medical program and the responsibilities of the education provider to these practitioners. It communicates its program and graduate outcomes to these practitioners.

8.1.3 The education provider selects supervisors who have demonstrated appropriate capability for this role. It facilitates the training, support and professional development of supervisors.

8.1.4 The education provider routinely evaluates supervisor effectiveness including feedback from trainees.

8.1.5 The education provider selects assessors in written, oral and performance-based assessments who have demonstrated appropriate capabilities for this role. It provides training, support and professional development opportunities relevant to this educational role.

8.1.6 The education provider routinely evaluates the effectiveness of its assessors including feedback from trainees.

Summary of RACS Response

8.1.1 Trainees are supported by an effective system of clinical supervision through the role of the training supervisor, and by trainers in the workplace, overseen by a specialty training board or its regional sub-committee.

8.1.2 SET is delivered in hospitals; consequently, community practitioners do not contribute to the delivery of the program. Within the hospital, other medical disciplines and allied health practitioners are involved, providing knowledge and experiences for the trainee's development and holistic understanding of healthcare, under the oversight of their surgical supervisor.

8.1.3 Surgical supervisors are RACS Fellows who have demonstrated experience in administrative, clinical and teaching skills. Mandatory training is provided for supervisors, who are expected to undertake professional development activities relevant to the role.

8.1.4 There are channels to receive feedback on supervisor performance, however this is often not specific to an individual.

8.1.5 Assessors for the fellowship examinations are selected according to criteria and are provided with appropriate training. Clinical assessors are volunteers; formal training will be introduced in 2017.

8.1.6 Trainees have an opportunity to provide feedback on assessors via de-identified post-examination surveys. Other means of evaluating assessor performance are described in Section 5.

Supervisors of training

Specialist surgical education is largely conducted in clinical settings under the supervision of surgeons during the normal course of providing surgical healthcare to patients. This provides enormous potential for acquiring surgical and professional skills in collaborative, collegial, diverse, real-world clinical settings.

Exposure to other medical disciplines and allied health practitioners within the hospital provide the trainee with additional and important knowledge and experiences, providing a holistic understanding of health care and the importance of an inter-disciplinary approach in managing patients. As the representatives of RACS and its training boards in training hospitals, supervisors have an important role and must have a broad understanding and experience of RACS activities and the training regulations. They liaise between trainees and hospital authorities on matters related to training, as well as with the specialty training boards to whom they report in regard to trainee and training matters.

Supervisors are not permitted to alter the training program, and must adhere to the regulations of the specialty. The supervisor informs hospital management and operating theatre management about the status of registrars and their capacity to be responsible for independently opening theatres.

RACS has defined the basic principles of supervision, incorporating the eligibility criteria for, and the duties to be performed by, a supervisor. The detailed specification of a supervisor's duties is provided by each specialty training board through its training regulations; some specialties have developed positions descriptions and supervisor handbooks. Those regulations must incorporate the principles in the RACS Surgical Supervisors policy.

RACS does not set supervisor to trainee ratios, instead applying its accreditation criteria to assess whether an institution can support educationally the number of training posts it has applied for. Typically there are three or more surgeons in an accredited-surgical unit that has a SET trainee. The minimum supervision levels for accredited posts are prescribed in the regulations of the relevant specialty training board.

Appointment and tenure

An institution nominates supervisors at the time the training post is accredited. Supervisors must be RACS Fellows (some specialty training boards also require membership of the specialty society or association) and fulfil the training criteria set down in the Surgical Supervisors Policy. In special circumstances, a surgeon credentialed to work by a particular hospital, but who is not a Fellow of RACS, may be appointed as a supervisor. Each specialty training board determines the appointment process for their specialty.

Nominees must be employees of the institution, and some specialties specify a minimum equivalent full-time (EFT) commitment. Each specialty determines the term of appointment, which is generally three years, with supervisors eligible for reappointment. The maximum period that a specialty training board can allow a supervisor to serve is nine years. In extraordinary circumstances, the RACS censor-in-chief may approve an extension for a supervisor.

During their appointment, supervisors must demonstrate clinical, teaching and administrative skills and remain compliant with a RACS-approved continuing professional development program. When a supervisor's appointment is ending, due to retirement or time served, the relevant board will appoint a new supervisor from the unit that hosts the post.

Supervisor training

Supervisors are expected to undertake professional development activities relevant to the role. RACS has developed a webpage dedicated to continuing professional development activities for Fellows, and resources are available for those involved in education and training, listed below.

- Foundation Skills for Surgical Educators.
- Supervisors and Trainers for SET (SAT SET) course.
- Supervisors and Trainers for SET (SAT SET) eLearning module (alternative course).
- Clinical Assessors for International Medical Graduates (IMGs) eLearning module.
- Keeping Trainees on Track course.
- Keeping Trainees on Track eLearning module (alternative course).
- Surgical Teachers course.
- Standards of Performance (Trainee Standards in Assessment).
- SET Selection Interviewer Training (SET SIT) eLearning module.
- The Academy of Surgical Educators forum.
- The Academy Educator studio sessions.
- The Trainee in Difficulty online resource.

- Graduate programs in surgical education.
- CLEAR Course for consultants

Other than the SAT SET courses, most of these resources have been developed since the last Australian Medical Council accreditation report. The eLearning modules for SAT SET and Keeping Trainees on Track were revised in late 2014. These modules, with the Foundations Skills for Surgical Educators (FSSE), cover the essential knowledge and skills required for clinical supervision.

The RACS policy stipulates the mandatory and recommended training required of all supervisors and trainers. Some specialty training boards have additional requirements for their supervisors. The Australian Orthopaedic Association provides workshops for surgeons involved in training on topics such as: Trainee supervision – a planned approach; helping underperforming trainees; effective feedback; teaching in the clinical setting; and workplace-based assessment. In 2016, the chair of the Board of Cardiothoracic Surgery hosted a supervisors' meeting at the Australian and New Zealand Society of Cardiac and Thoracic Surgeons annual scientific meeting to give all surgical supervisors a comprehensive update on training-related issues. Other specialties conduct workshops and training days specifically for supervisors.

The RACS Building Respect, Improving Patient Safety Action Plan stipulates improved resources for supervisors in adult-learning methodology and feedback. Consequently, all supervisors and surgeons who teach and train SET trainees are now required to complete the FSSE or equivalent, and undertake advanced training in discrimination, bullying and sexual harassment. RACS will provide this training, and 80 FSSE courses are scheduled for 2017. An advanced training in discrimination, bullying and sexual harassment course has been piloted and will be available across Australia and New Zealand from April 2017.

Feedback on supervisor performance

Feedback from trainees is obtained via the RACS Trainees' Association and specialty board surveys (usually de-identified), the post reaccreditation process, and a complaints hotline (discrimination, bullying and sexual harassment and breaches of the RACS Code of Conduct). However, specific named feedback attributed to a trainee about surgeons within a post – that is, how the surgeons were as supervisors – does not occur. Trainees, and indeed recent trainees, remain reluctant to be named.

RACS recognises there is more work to be done to improve the quality of supervision, both in supporting supervisors and trainers to address difficult training issues, as well as identifying and remediating underperforming supervisors. The Expert Advisory Group specifically commented about deficits in surgeons' educator skills, and the link between this and less-than-perfect professional behaviours. A program to review unsatisfactory assessment periods using an expert medical educator and an independent Fellow is in the early stages of a pilot.

Supervision standards also are being developed, which will provide a baseline against which supervision can be assessed and appropriate remediation plans developed. This initiative stems from the RACS Building Respect, Improving Patient Safety Action Plan.

The project will:

- Establish RACS standards of performance for supervisors.
- Establish methods of assessing supervisors' performance.
- Confirm resources available to supervisors.
- Describe the roles and activities of the specialty training boards in their relations with supervisors and RACS.
- Describe remediation activities and resources for supervisors who have been identified as performing below required standards.

This is a key focus during 2017, with a review of supervisor performance process to be implemented for 2018.

Assessors

Assessors: the fellowship examination

Membership to the Court of Examiners is by application, seconded by a Fellow of RACS, in response to an annual advertisement in the RACS monthly publication *Surgical News*. New examiners are selected in consultation with members of the court and must be Fellows of RACS (FRACS) and compliant with a RACS-approved continuing professional development program. In selecting new examiners, the specialty court will consider an appropriate geographical and teaching hospital representation and suitable sub-specialty mix to ensure diversity and broad representation across the full membership of the court. Examiners usually serve for nine years, and their appointment is reviewed every second year.

Since the last Australian Medical Council accreditation report, a one-day training course has been developed for fellowship examiners. In 2016, this was made mandatory for all members of the court as a requirement to examining, and there is 100 per cent compliance. (Four examiners are yet to complete the course due to personal circumstances but will do so before examining in 2017.) Training ensures examiners have a clear understanding of the surgical competencies they are testing, their taxonomy, and the limitations of their assessment tools. Training provides examiners with a good understanding of the concepts of standards, standard setting, reliability and validity. Each new examiner receives an examiner manual and must complete pre-course tasks prior to the one-day training course.

Once appointed, all new examiners must attend the RACS fellowship examination as an observer before starting as an examiner to observe examiner performance and the examination process.

Assessors: the clinical examination

There is no application process for clinical examiners and any Fellow is eligible to assess the clinical examination. Prior to each examination, an expression of interest is circulated to identify Fellows who are interested and available to assess candidates. RACS is developing a clinical examiner training course, which will be available before the second sitting of the exam in June 2017. Mandatory examiner training will help to ensure quality and consistency of assessment.

Evaluation of assessors and feedback from trainees

For all examinations, a post-examination survey of the candidates is undertaken, which includes feedback on examiner performance. However this is not specific to individual examiners and the survey is voluntary. RACS uses a range of other methods to evaluate examiner performance and these are described in detail in Section 5.

Assisting trainees to find a mentor

Prior to the introduction of SET, RACS implemented a facilitated mentoring program in the Basic Surgical Training program and the Rural Training Scheme, with limited success. During 2015 and 2016, a Mentoring Working Party concluded that a facilitated program was not feasible for SET, with almost 1300 trainees. Instead, the working party recommended that resources be prepared to assist trainees to find a mentor. Information on the RACS mentoring webpage provides a guide, tools and templates to develop and support an effective relationship, which is rewarding for both a mentor and a mentee.

8.2 Training sites and posts

Accreditation standard

8.2.1 The education provider has a clear process and criteria to assess, accredit and monitor facilities and posts as training sites. The education provider:

- Applies its published accreditation criteria when assessing, accrediting and monitoring training sites.
- Makes publicly available the accreditation criteria and the accreditation procedures, and is transparent and consistent in applying the accreditation process.

8.2.2 The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and:

- Promote the health, welfare and interests of trainees.
- Ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner.
- Support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of healthcare to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand.
- Ensure trainees have access to educational resources, including the information communication technology applications, required to facilitate their learning in the clinical environment.

8.2.3 The education provider works with jurisdictions, as well as the private health system, to effectively use the capacity of the healthcare system for work-based training, and to give trainees experience of the breadth of the discipline.

8.2.4 The education provider actively engages with other education providers to support common accreditation approaches and sharing of relevant information.

Summary of RACS Response

8.2.1 RACS has published the Accreditation of Hospitals and Posts for Surgical Education and Training: Process and Criteria for Accreditation information booklet detailing the standards that a post needs to meet to be accredited for the RACS Surgical Education and Training (SET) program.

8.2.2 RACS has included a new standard for accreditation to ensure trainees undertake training in a setting that provides a safe working and educational environment. The standards also specify supervision arrangements and training infrastructure. The standards apply to and can be achieved by hospitals in urban, rural and remote locations. Trainees also gain exposure to the challenges of Aboriginal and Torres Strait Islander and Māori health, as most Aboriginal and Torres Strait Islander and Māori people live in urban areas and use the public healthcare systems where most training posts are located.

8.2.3 The accreditation standards apply to the public and private sectors, and RACS encourages any hospital that self-assesses as meeting those standards to apply for accreditation as a training post in the SET program. Through its regional committees in the Australian states and territories, and the New Zealand National Office, RACS has constructive dialogue with the relevant jurisdictions.

8.2.4 RACS is an active participant in the Council of Presidents of Medical Colleges (CPMC) and has bilateral arrangements with other colleges. The Australian and New Zealand College of

Anaesthetists (ANZCA) and RACS have a representative on each other's council to facilitate communication on high-level education issues, including accreditation.

Accreditation of posts

Overview

In 2006 RACS introduced standards for the accreditation of hospital posts, and published these as the Accreditation of Hospitals and Posts for Surgical Education and Training guide ('the accreditation guide'). RACS reviewed the accreditation guide in 2007 and again in 2016 to incorporate the RACS Building Respect, Improving Patient Safety Action Plan. The introduction of RACS standards has created consistency across learning environments, with flexibility to address specialty-specific requirements and standards.

In 2016, RACS introduced – as the new first standard of accreditation – a requirement for hospitals to demonstrate that they provide a respectful culture. RACS has engaged with hospitals, hospital networks and jurisdictions to ensure this standard will be met, and to work collaboratively in the delivery of relevant (mandatory) education to supervisors, trainers and senior leaders in the clinical setting. A number of formal agreements and memoranda of understanding have been signed.

The aim of the accreditation process is to accredit posts that meet the eight standards RACS believes will ensure they provide a suitable learning environment for surgical trainees to acquire the competencies needed to become fully fledged surgeons in a range of clinical contexts. The accreditation criteria are based around these eight core educational, clinical and governance standards.

The accreditation criteria, factors assessed and minimum and essential requirements are described in detail in the Accreditation of Hospitals and Posts for Surgical Education and Training booklet, to be published by February 2017.

Summary of the eight accreditation standards

The demonstration of a respectful culture standard is to ensure trainees have a safe working environment free from bullying, discrimination and sexual harassment. Education facilities and systems required and the quality of education, training and learning standards provide criteria to support trainees' access to educational resources and activities that will facilitate their learning in the clinical environment. The standard for surgical supervisors and staff sets out criteria, which will provide assessable supervision supported by the institution. The standard of support services for trainees provides minimum criteria expected of the institution to support the wellbeing and safety of trainees, including safe hours. In determining roster and work schedules, institutions in Australia must take into account the principles outlined in the Australian Medical Association National Code of Practice, Hours of Work, Shift Work, and Rostering for Hospital Doctors (8) and, in New Zealand, the principles outlined in the Multi Employer Collective Agreement (MECA).

Standards for clinical load and theatre sessions determine the minimum access to a range and volume of clinical and operative experiences, which will enable the trainee to acquire the competencies required of a surgeon. The equipment and clinical support service standard ensures there are the facilities and adequate equipment required to manage surgical cases in a particular specialty. Hospitals involved in surgical training must be fully accredited and have appropriate clinical governance, quality and safety structures in place to deliver and monitor safe surgical practice.

Applying for accreditation

Hospitals wishing to host an accredited training post for the SET program apply to the relevant specialty training board. Each board has published the process for accrediting a training post in that specialty, which is compliant with the RACS Training Post Accreditation and Administration Policy. To be accredited, the post

must meet each of the eight standards specified in the policy and detailed in the accreditation guide. There are a number of criteria supporting each standard. It is not necessary for each criterion to be satisfied by every post, and it is the role of the accreditation team to determine whether the post satisfies enough criteria to meet the specific standards. When applying for a post, it is the responsibility of the applicant hospital to provide information that demonstrates achievement of the eight standards. Information for hospitals about accreditation is available on the RACS website.

Training post assessment

RACS accredits individual posts within hospitals, and not the hospital as a whole. The usual process is for an accreditation team (sometimes also referred to as an inspection team and effectively a sub-committee of the specialty training board) to make a recommendation on the suitability of the post for training purposes.

The assessment team uses the written information submitted by the hospital and, during the inspection visit, meets with hospital administration, members of the unit and, where the post is an existing training post being reaccredited, current trainees.

The team assesses whether the post provides the experience necessary for a trainee, based on likely operative experience, the breadth of procedures undertaken in the unit, the equipment available to ensure the unit can perform the procedures indicated in its submission, the infrastructure available to support a trainee (library, study facilities, access to examination leave, etc.) and the level of supervision a trainee would receive.

At the conclusion of the assessment of documents and the inspection visit, the team makes a consensus decision on the recommendation to be made to the specialty training board. The team must be assured that the post meets all eight standards. The basic question considered is: “Would a trainee performing satisfactorily be able to complete the training program in the minimum expected time if undertaking all their rotations in posts of the same standard as the one being accredited?”

The report prepared by the accreditation team is made available to the hospital prior to finalisation. The hospital’s input is sought on any errors or omission of facts.

Assessment Team

The assessment team usually comprises two to three Fellows of the relevant specialty who are involved in training. It is not uncommon for the assessment team members to be from outside the jurisdiction in which the post under review is located. The Board in General Surgery has also included a trainee representative in the accreditation process.

Approval

The recommendation of the assessment team is presented to the specialty training board for approval. The board may accept the recommendation or substitute a decision of its own. However, if the board is satisfied that an accreditation report has been made in accordance with policy and procedure, it is obliged to accredit for training any post that meets the minimum standards.

The board decides the accreditation period, and whether there should be any further inspections during the accreditation period. While five years is the usual accreditation period, a board may accredit for a shorter period. It is not unusual for new posts to be given a shorter period of accreditation to fit in with future reaccreditation schedules (for example, some boards accredit on a state-by-state basis).

Once accredited, a trainee is recommended to the hospital to start in the next training year, following selection of new trainees. In exceptional circumstances, a new post accredited during the first rotation of the training year may be allocated a trainee for the second rotation.

Review and monitoring

Posts are routinely reviewed in the first half of the final year of the five-year accreditation period. During the accreditation period, specialty training boards reserve the right to reinspect posts where it identifies – through complaints, trainee surveys, trainee underperformance, etc. – that there may be a diminution of standards. Issues that may result in a post review are:

- Significant change in staff.
- Proven complaints of discrimination, bullying and sexual harassment.
- Changes of accreditation by another organisation that is a prerequisite for RACS accreditation.
- Change of service provision by the hospital.
- Employment of a Fellow impacting on the access of a RACS trainee to operative experience, and/or ability to undertake procedures as a primary operator.
- Reduced access to theatres.
- Changes in delivery of acute services.

The immediate withdrawal of accreditation remains a rare event for RACS, precipitated only by extreme deficiencies. The more usual process when deficiencies are identified is to provide hospital management with a timeframe for remediation prior to a final inspection.

Table 18 Australian posts inspected and accredited 01/01/2012 to 31/12/2016

Specialty	Post inspections	Posts accredited
Cardiothoracic Surgery	38	44
General Surgery	309	557
Neurosurgery	53	80
Otolaryngology Head and Neck Surgery	64	103
Orthopaedic Surgery	93	242
Paediatric Surgery	46	73
Plastic and Reconstructive Surgery	67	107
Urology	142	214
Vascular Surgery	34	36
Note: Figures may include multiple inspections of the same posts		

Table 19 New Zealand posts inspected and accredited 01/01/2012 to 31/12/2016

Specialty	Post inspections	Posts accredited
Cardiothoracic	8	8
General Surgery	44	98
Neurosurgery	8	14
Otolaryngology Head and Neck Surgery	17	25
Orthopaedic Surgery	21	57
Paediatric Surgery	4	7
Plastic and Reconstructive Surgery	7	12
Urology	16	19
Vascular Surgery	6	8
Note: Figures may include multiple inspections of the same posts		

Appeals and reconsiderations

Hospitals who are denied accreditation, or have an adverse finding requiring remedial action, can appeal the decision through the RACS appeals process. Refer to Section 1 for further information on appeals. Since the last Australian Medical Council accreditation, no accreditation decision has been challenged before the Appeals Committee.

Standard of training sites

RACS is satisfied that the posts it has accredited are providing the appropriate educational opportunities to prepare trainees for independent surgical practice. Posts remain predominantly located in the public sector, and RACS has encouraged private sector hospitals to seek accreditation. This initiative has had limited success due to the different expectations of patients in private practice. It is essential that trainees receive experience as the primary operator (under supervision). Such opportunities are much more limited in private hospitals, which do not operate a team structure.

RACS recognises there are benefits to accessing training in the private sector, which would expose trainees to procedures predominantly conducted in that sector. As a participant in the Australian Department of Health Specialist Training Program (STP), RACS accredits 73 posts funded by that program.

Rural training opportunities

Because there are more trainees in general surgery and orthopaedic surgery, these programs are organised on a regional basis, and this enables operating training posts in rural areas. It is possible within these programs to have more non-metropolitan training, however, other specialties are city-based due to the need for highly specialised equipment (for example, neurosurgery). The ability to accredit posts in rural areas depends somewhat on the organisation of specialist services by health jurisdictions: suitable units exist in middle-sized cities, but trainees rotating in from a metropolitan-based program usually fill the training positions.

Aboriginal and Torres Strait Islander health

According to the Australian Bureau of Statistics (2013), 60 per cent of the Aboriginal and Torres Strait Islander population of Australia live in major cities and inner regional areas. This means all trainees are exposed to the treatment of indigenous patients in the major teaching hospitals.

In addition, some boards have initiatives that address indigenous health in rural communities. Members of the Board of Otolaryngology Head and Neck Surgery, and its supervisors and trainees, undertake regular outreach clinics to provide essential healthcare in remote indigenous communities, including:

- Deadly Ears Program – Queensland.
- Kimberley Region Outreach Clinics – Western Australia.
- Yatala Outreach Clinic – South Australia.

Trainees are attached to these visits as part of their training. The Board of Otolaryngology Head and Neck Surgery is developing a specific Aboriginal and Torres Strait Island and Māori curriculum module to ensure the health needs of these groups are being met. A copy of the draft module is included.

Engagement with jurisdictions

Training posts are accredited by, but independent of, RACS. As posts are predominantly in public hospitals, they are controlled by the relevant state or territory jurisdiction. Reports are produced for each accreditation and reaccreditation, and are provided to hospital management.

RACS has collaborated with jurisdictions in the accreditation of posts in the past by including a jurisdictional representative in the accreditation team, with the full rights and duties exercised by surgeon-members of the team. Jurisdictional representatives also were invited to be members of the specialty training boards, the Board of Surgical Education and Training and the Education Board.

Since the last accreditation by the Australian Medical Council in 2011, the jurisdictions formally advised RACS they were withdrawing jurisdictional representative participation in board meetings and training-post accreditation. They continue to participate in the assessment of international medical graduates.

The exception to this is orthopaedics, where a jurisdictional representative continues to sit on the Australian Orthopaedic Association Federal Training Committee and is a full, voting member of the committee.

Sharing of information with other colleges

RACS does not share information from its accreditation process with other colleges, and does not collaborate with them on joint accreditations, or share findings about common criteria. No other college has requested information from RACS about accreditation. This may be because of the nature of the RACS accreditation, which is of posts, rather than hospitals, as training sites. The Australian and New Zealand College of Anaesthetists (ANZCA) and RACS provide representation on each other's councils to facilitate communication on high-level issues of education, and this includes strategic discussion on accreditation.

Privacy legislation also is a consideration when collecting information from external sources, and this restricts the ability to share and collaborate.

RACS has participated in workshops organised by the Council of Presidents of Medical Colleges and the Health Workforce Principals Committee regarding opportunities to promote collaboration with accreditation, which may reduce the call on pro bono contribution and the administrative burden on hospitals. However, considerable work will be required to ensure a consolidated process will provide colleges with the information they need to make accreditation decisions, which will not compromise patient safety or negatively impact trainees on a pathway to independent practice.

Strengths

Examiners and assessors of skills course participants are trained, supporting inter-rater reliability and maintenance of appropriate assessment and examination standards.

The Accreditation of Hospitals and Posts for SET clearly describes criteria around eight standards, the first of which concerns respectful and safe working and educational environments.

Challenges

Providing adequate resources and facilities within the constraints of hospital environments, and balancing training and development commitments in a volunteer workforce are major challenges associated with supervision of training. A constant constraint in the SET program is the provision of adequate paid, protected time to allow supervisors to fulfil their educational role. When competing with service provision, the lack of time devoted to education impacts on supervisors' ability to provide high-quality assessment and feedback, particularly for trainees experiencing difficulties.

RACS is aware of commentary around poor standards of clinical supervision. To date, neither specific selection criteria for supervisors, nor routine evaluation of supervisor effectiveness, has been carried out. Regular, attributed feedback from trainees has not been sought. There is a need to enhance the skills of trainers. Collaboration with jurisdictions to better integrate supervisor skill acquisition into the workplace will be crucial.

RACS is committed to promoting teaching as an honoured pro bono contribution to its membership. While the larger specialties have significant numbers of potential trainers, that is not the case with smaller specialties.

Plans

Training post surveys will be influenced by the work of the National Medical Training Advisory Network and the Medical board of Australia; RACS awaits outcomes of this 'whole-of-system' approach.

Through BSET and individually, training boards will be encouraged and supported to closely monitor their training posts, rather than relying on five-yearly post inspections.

Ongoing mandatory training of supervisors and trainers, coupled with supervision standards, will result in improved supervision, and become a strength for RACS

Section 9

Continuing professional development, further training and remediation

9. Continuing professional development, further training and remediation

9.1 Continuing professional development

Accreditation standard

9.1.1 The education provider publishes its requirements for the continuing professional development (CPD) of specialists practising in its specialty(s).

9.1.2 The education provider determines its requirements in consultation with stakeholders and designs its requirements to meet Medical Board of Australia and Medical Council of New Zealand requirements.

9.1.3 The education provider's CPD requirements define the required participation in activities that maintain, develop, update and enhance the knowledge, skills and performance required for safe and appropriate contemporary practice in the relevant specialty(s), including for cultural competence, professionalism and ethics.

9.1.4 The education provider requires participants to select CPD activities relevant to their learning needs, based on their current and intended scope of practice within the specialty(s). The education provider requires specialists to complete a cycle of planning and self-evaluation of learning goals and achievements.

9.1.5 The education provider provides a CPD program(s) and a range of educational activities that are available to all specialists in the specialty(s).

9.1.6 The education provider's criteria for assessing and crediting educational and scholarly activities for the purposes of its CPD program(s) are based on educational quality. The criteria for assessing and crediting practice-reflective elements are based on the governance, implementation and evaluation of these activities.

9.1.7 The education provider provides a system for participants to document their CPD activity. It gives guidance to participants on the records to be retained and the retention period.

9.1.8 The education provider monitors participation in its CPD program(s) and regularly audits CPD program participant records. It counsels participants who fail to meet CPD cycle requirements and takes appropriate action.

Summary of RACS Response

9.1.1. RACS publishes its requirements for the continuing professional development (CPD) of specialists practising in its specialty(s).

9.1.2 RACS determines its requirements in consultation with stakeholders and designs its program to meet Medical Board of Australia and Medical Council of New Zealand requirements.

9.1.3 The RACS CPD program requires participation in multimodal and inter-professional activities that maintain, develop, update and enhance a specialist's knowledge, skills and performance. Participants must undertake activities relevant to their specialty and across the nine surgical competencies, which incorporate cultural competence, professionalism and ethics.

9.1.4 RACS requires participants to select CPD activities relevant to their scope of practice and self-identified learning needs. RACS encourages participants to complete a cycle of planning and self-evaluation of learning goals and achievements.

9.1.5 The RACS CPD program and educational activities are available to all specialists in the specialty(s).

9.1.6 For the purpose of its CPD program, RACS assesses and recognises educational activities that are based on educational quality and an established curriculum.

9.1.7 RACS provides an online system for participants to document their CPD activity.

9.1.8 RACS monitors participation in its CPD program and undertakes a full annual audit of 7 per cent of records. RACS counsels participants who fail to meet CPD requirements and has a process to address non-compliance.

Overview

The Royal Australasian College of Surgeons (RACS) established its Continuing Professional Development (CPD) Program in 1994, the development of which has been informed by a need for internal accountability, responsiveness to government, community expectations and a commitment to lifelong learning to promote a culture of collaboration, peer review and reflective practice.

Table 20 Achievements and improvement opportunities

Achievements	Improvement opportunities
100 per cent compliance with the RACS CPD program since 2014	Encouraging engagement in reflective practice and self-evaluation activities
Development of a multi-source feedback assessment using the RACS surgical competencies	Strengthening participation in audit to support better management of outliers (individual who is outside normal range)
Development of processes for managing CPD non-compliance	Ensuring compliance across all programs recognised by RACS

Governance

The Professional Standards Committee (PSC) oversees the RACS CPD Program and meets up to four times a year. The committee reports to the RACS Professional Development and Standards Board (PDSB). Participation in the CPD program is monitored through monthly reports to the PDSB (or its executive) and the RACS Council (or its executive). The chairs of the Professional Standards Committee and Professional Development and Standards Board monitor the reminder process, with input from RACS' executive directors for surgical affairs in Australia and New Zealand.

Program requirements

RACS provides all Fellows with a revised CPD guide every three years and the program requirements are available on the RACS website. Updates about the program and how to complete the requirements are published regularly in RACS' monthly journal *Surgical News* and are outlined in reminders to participants when they are update and finalise their annual CPD records.

Participation and compliance

Participation

Participation in CPD is mandatory for all RACS Fellows. The RACS program also is available to any surgeon who holds a valid qualification and relevant medical registration in Australia or New Zealand. Participants can submit their CPD online through the RACS Portfolio or in paper form. The RACS Portfolio was developed in 2015 to streamline access to RACS services, including CPD records and compliance statements. RACS participants can access up to six years' worth of their CPD data. Information received via paper (including verification documents) is uploaded into the RACS Portfolio, with the paper form due to be phased out in 2018.

Compliance

RACS has worked on its policy and processes to improve its CPD compliance rate, which increased from 87.9 per cent in 2010 to 100 per cent in 2014 (see Workforce Data and Activities Reports). The 2015 CPD year is being finalised and is on track to reach 100 per cent compliance. Participants who fail to comply with the CPD program are managed using an escalating reminder process. If a participant does not respond, they are referred to the Professional Conduct Committee (PCC) for review and possible sanction, including loss of fellowship. Since 2013, three Fellows have had their fellowship removed for failing to meet CPD requirements. RACS notified the Australian Health Practitioner Regulation Agency about these terminations. RACS is exploring ways to improve the support offered to CPD participants who are not Fellows of RACS to ensure they are held to a comparable standard.

Participation in other programs

Approximately 1000 RACS Fellows participate in alternative CPD programs, which have been recognised and approved by RACS

Table 21 CPD participants

Participant by category	**No. of participants**
RACS CPD program	**5119**
Non Fellow RACS CPD program	**95**
External CPD programs:	**1271**
Australian Orthopaedic Association	797
New Zealand Orthopaedic Association	228
Royal Australian College of General Practitioners	13
Australasian College for Emergency Medicine	2
Royal Australian and New Zealand College of Ophthalmologists	227
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	1
Royal College of Physicians and Surgeons of Canada	3
Participants by region	**No. of participants**
RACS CPD participants based in Australia	5283
RACS CPD participants based in New Zealand	860
RACS CPD participants based overseas	342
Total number of participants	**6485**

RACS works closely with each organisation to ensure its program is sufficiently comparable and meets relevant standards. For the last completed CPD year (2014), the New Zealand Orthopaedic Association and Royal Australian and New Zealand College of Ophthalmologists reported 100 per cent compliance with their programs and RACS continues to work with the Australian Orthopaedic Association to improve the compliance of participants in its program. In accordance with Medical Board of Australia guidelines regarding dual fellowship, from 2017 RACS will no longer recognise the Australasian College for Emergency Medicine or the Royal Australian College of General Practitioners programs as comparable, and Fellows will be expected to comply with the RACS program.

Verification

Each year, seven per cent per cent of RACS participants are subject to a full audit of their CPD participation. RACS Fellows also may be referred for verification through a recommendation from the Professional

Conduct Committee or the executive directors of surgical affairs in Australia and New Zealand. Participants are ineligible to receive an annual statement of participation until verification is complete. RACS only approves alternative CPD programs that include annual verification.

A review of verification documents and CPD records shows that most participants complete activities relevant to their scope of practice, but that there is limited engagement in activities around planning and self-evaluation. In response, RACS now requires participants to undertake one reflective activity – such as practice visits, multi-source feedback or a learning plan – each year. In the long term it is anticipated that participants will use multi-source feedback results to inform their learning plan and subsequent educational activities.

Professional development and approval of education activities

RACS offers a comprehensive program of professional development activities across all surgical competencies at no cost or on a cost-recovery basis. These address generic, non-technical competencies of communication, collaboration and teamwork, judgment and decision-making, professionalism, health advocacy, management and leadership, and scholarship and teaching. Programs are provided in a range of learning modes to suit different learning preferences and demands, and include: workshops, forums, webinars, seminars, blended learning, residential workshops and online learning.

RACS offers activities that address cultural competence, professionalism and ethics. The Network for Indigenous Cultural and Health Education portal (NICHE portal) is available to all Australian specialists; work is continuing to develop a wide range of modules that aim to improve cultural understanding and awareness. To support leadership development and professional insight, in 2017 RACS is piloting a one-and-a-half-day workshop, Surgeons as Leaders in Everyday Practice, developed in consultation with the RACS Surgical Directors Section and experts in the field. RACS piloted a new bioethics initiative in late 2016, which was very successful, and RACS will continue to support this program on a bi-annual basis.

The Expert Advisory Group urged RACS to better support supervisors, to help strengthen their teaching skills and understanding of adult-education methods. As a result, the RACS Council has resourced the Foundation Skills for Surgical Educators (FSSE) course so that all surgical supervisors can complete it promptly. Completing the FSSE is now a requirement for all Fellows who have contact with surgical trainees. RACS is rolling out more than 80 courses in 2017, in collaboration with the regions, training boards, and hospitals.

All activities offered by RACS – and an increasing number delivered by external providers – are assessed for educational validity, appropriateness and relevancy before they are ‘CPD approved’. RACS approves approximately 350 activities each year, with attendance data automatically populated into a participant’s CPD record to minimise duplication and assist with verification. To ensure activities meet the required standards, RACS plans to begin a pilot audit of approved activities in 2017 and to require education providers to upload results from their evaluation.

Review and consultation

To ensure the RACS CPD program and the activities it approves are relevant and comply with existing standards, RACS participates in regular discussions and forums organised by the Medical Board of Australia and the Medical Council of New Zealand, as well as those organised by the Council of Presidents of Medical Colleges (CPMC) (Australia) and the Council of Medical Colleges (CMC) (New Zealand). A CPMC CPD Managers’ Network, which meets twice a year and is attended by other specialist medical colleges, allows information exchange and continuous learning.

Regular engagement with external forums supports the review of the RACS CPD framework, which occurs every three years. Following a review in 2012, RACS made substantial changes to its 2013 program, which was revised from a triennial to annual program to enable greater compliance monitoring and alignment with regulatory requirements. A robust process was developed to manage non-compliance (see Compliance, above), including a sanctions policy for those who persistently refuse to comply.

RACS reviewed the CPD program in 2016 and the extensive consultation process included:

- A day-long CPD planning day in February 2016 attended by relevant specialty, regional and section representatives.

- Ongoing consultation and reporting to relevant committees and boards within RACS.
- Formal communication with specialty societies and regions requesting feedback on a proposed framework.
- Face-to-face engagement and feedback from Fellows at the RACS annual scientific congress.
- Ongoing communication and updates via the monthly bulletin *Surgical News* and e-newsletter *Fax Mentis*.

Amendments to the CPD program, based on stakeholder feedback and regulatory changes, will include:

- All participants engaged in any form of clinical consultation, including non-operative practice, will be required to participate in the audit.
- Surgical audit and peer review will be strengthened, particularly as it relates to the management of outliers and meaningful participation in peer-review meetings to support quality improvement.
- The importance of self-reflection has been promoted through the addition of a Reflective Practice category (replacing Performance Review), with all participants required to undertake at least one activity a year, which may include developing a learning plan, undergoing a multi-source feedback assessment, clinical attachment to a peer, and undertaking education to improve cultural competency.
- Mandatory training and greater awareness of discrimination, bullying and sexual harassment have been incorporated in line with the RACS Building Respect, Improving Patient Safety Action Plan.

Work has begun to support implementation of the framework in 2017, including a RACS pilot of the multi-source feedback assessment and development of an online learning plan in the RACS Portfolio, linked to the nine surgical competencies. To support and promote reflective practice, throughout 2015-16 RACS has been working with the private-health sector to develop a suite of surgical variations reports. The reports analyse clinical and other indicators for common procedures within general, urology, ENT, vascular and orthopaedic surgery. The reports have been well received and the initiative has provided surgeons with a valuable opportunity to reflect on their practice.

A review of the RACS Surgical Audit Guide began in late 2016 with a focus on how to better promote active reflection on outcomes and manage surgical outliers (or individuals who fall outside the normal statistical range for a particular procedure) . This project is supported by ongoing development of the RACS Morbidity Audit Logbook Tool (MALT), which provides comparative reporting to support reflection on practice against accepted standards. RACS also is developing a standard on morbidity and mortality meetings based on international best practice, to ensure meetings result in meaningful outcomes, directed at improvement.

9.2 Further training of individual specialists

Accreditation standard

9.2.1 The education provider has processes to respond to requests for further training of individual specialists in its specialty(s).

Summary of RACS Response

9.2.1 RACS has developed policy and processes to respond to requests for further training of individual specialists in its specialty(s).

Requests for further training

RACS responds to inquiries about further training on request from hospitals, specialty societies and individual surgeons. Requests for further training of individual specialists may arise as part of the remediation process following a complaint or inquiry concerning the performance of a RACS Fellow (see 9.3). RACS considers re-training to apply primarily in circumstances where a surgeon has been identified to have technical skill deficiencies or where they are returning to work following a period of absence. The executive directors of surgical affairs in Australia or New Zealand, as appropriate, manage this. The process is outlined in the RACS Re-Skilling and Re-Entry Program Guidelines.

RACS also has established a mechanism for reviewing clinical standards, which is valuable for maintaining standards for individuals and surgical units. The reviews may identify activities and outcomes that are below acceptable levels and can recommend appropriate corrective measures to the surgeon and/or institution. The process is outlined in the RACS Clinical Standards Review policy.

Formal assessment of ongoing competence

RACS does not have a process for formal assessment of ongoing competence unless requested by a regulatory authority or a hospital/health service. When these requests are received, the executive director of surgical affairs conducts a formal independent peer-review process. RACS is working to increase the integration of the nine surgical competencies into the CPD program, in conjunction with a greater focus on ongoing peer assessment of Fellows against these competencies through participation in multi-source feedback or other comparable assessment tools. It is anticipated this will better support the identification and early remediation of surgeons who may require further training to ensure they meet the minimum competencies for their scope of practice.

9.3 Remediation

Accreditation standard

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

Summary of RACS Response

9.3.1 RACS has processes to respond to requests for remediation of surgeons where concerns have been raised about their performance.

Remediation is most often required for departure from acceptable practice in non-technical skills and behaviours. To ensure appropriate oversight and centralisation of requests for remediation, RACS has introduced an enhanced complaints management process. In the past 18 months, RACS has focused on establishing remediation processes that address discrimination, bullying and sexual harassment including:

- Development of an Unacceptable Behaviours Fact Sheet.
- Improved web presence.
- Launch of the RACS Surgeons Support Program.
- Development of eLearning and interactive workshops addressing discrimination, bullying and sexual harassment.
- Establishment of an enhanced formal process for lodging complaints.

Complaints management

Improved complaints handling is a major pillar of the RACS Building Respect, Improving Patient Safety Action Plan.

RACS has developed a new comprehensive complaints management system with dedicated expertise and centralised recording. New specialised resources (both psychological and legal) enable RACS to respond much more effectively. In January 2016, RACS appointed a dedicated 'manager complaints resolution' to implement and oversee the complaints management framework. Additional legal and administrative resources have been provided.

Clear governance and associated processes are being developed, complemented by a suite of documents including revised policy, unacceptable behaviours fact sheet, a complaints user guide explaining the who, what, where, and how of complaints, and a complaints management manual detailing complaint types, triage, and dispute resolution pathways. A complaints management database has been established to assist centralised recording and to protect the confidentiality of complaints. External review of complaints-handling protocol has been embedded in the complaints policy.

RACS is committed to rebuilding the trust of its members and the public and recognises that this takes genuine commitment, good processes and time.

RACS has committed to enhanced confidentiality, procedural fairness, timely lodgement, and collaboration with stakeholders. This can be seen in the work completed to date, the increasing number of complaint inquiries received and the resolution of longstanding complaints. A key component has been the continuing program of advocacy progressing memoranda of understanding with health agencies to improve the timely handling of complaints, and education of internal stakeholders to encourage people to call out unacceptable behaviours. Key policies and documentation include:

- CPD Guide
- CPD program website
- Approval of CPD Activities and Accreditation of Educational Resources

- Clinical Standards Review
- Complaints Policy
- Complaints User Guide
- Complaints Manual (internal document)
- Sanctions Policy 2015
- Clinical Standards Policy
- Surgical Competence and Performance: A Guide to the Assessment and Development of Surgeons.

Strengths

RACS has continued to provide sophisticated IT support to the CPD program, through development of the web-based portfolio system. Compliance with the CPD program, and as an extension, with the mortality audit, is at a very high level. Provision of professional development activities across all the RACS competencies is available nationally and internationally.

Challenges

The increasing expectations of government and community are being met through continuing refinement of the CPD program. RACS is promoting an enhanced approach to CPD in line with the recent revalidation consultation by the Medical Board of Australia and also in alignment with the Medical Council of New Zealand. Further developments in performance assessment utilising multi-source feedback will no doubt evolve, in tandem with requirements for learning plans and increased emphasis on reflection for learning and development. RACS will continue to build on these developments as well as improved attention to audit requirements and further work to identify outliers, utilising meaningful health outcome parameters. We look forward to working with the MBA and MCNZ on the best risk-based approach to identify poorly performing surgeons, as well as ensuring that adequate support and remediation are readily available.

Plans

Continuing communication and data sharing with the Australian orthopaedic association (AOA) will ensure greater clarity for those surgeons enrolled in the AOA CPD program; it remains a key objective of RACS to work towards 100% compliance of surgeons doing the AOA program. We are well advanced on this path.

The work undertaken with private health insurers and government on clinical variation over the past two years is gaining traction and is expanding to include further agencies who have expressed interest. RACS Fellows have responded very favourably to this approach. The recognition of our leadership in this area by the Australian Federal Health Minister and the MBA, as well as many other agencies, is encouraged.

Section 10

Assessment of specialist international medical graduates

10. Assessment of specialist international medical graduates

10.1 Assessment framework

Accreditation standard

10.1.1 The education provider's process for assessment of specialist international medical graduates is designed to satisfy the guidelines of the Medical Board of Australia and the Medical Council of New Zealand.

10.1.2 The education provider bases its assessment of the comparability of specialist international medical graduates to an Australian or New Zealand trained specialist in the same field of practice on the specialist medical program outcomes.

10.1.3 The education provider documents and publishes the requirements and procedures for all phases of the assessment process, such as paper-based assessment, interview, supervision, examination and appeals.

Summary of RACS Response

10.1.1 The RACS process for assessment of specialist international medical graduates satisfies the guidelines of the Medical Board of Australia and the Medical Council of New Zealand.

10.1.2 The basis of assessment is the comparability of the specialist international medical graduate to an Australian and New Zealand trained specialist in the same field of practice at the level of a consultant in their first year of practice.

10.1.3 Details of all phases of assessment, which includes paper-based assessment, interview, supervision, examination and appeals are published and publicly available on the RACS website. Processes are documented in RACS procedures.

Overview

The assessment of comparability of international medical graduates with specialist surgical qualifications in their country of origin has posed significant challenges to RACS over some time. The standard for comparability is a graduate of the SET program in their first period of independent practice. Since the last AMC accreditation of RACS in 2011. The assessment process has changed both in response to government initiatives and because of improved practices.

RACS assesses international medical graduates (IMGs) in Australia in collaboration with the Australian Medical Council, which assesses and verifies the applicant's primary medical qualifications within one of the nine defined surgical specialties in which RACS trains. These defined specialties, their training curriculum and assessed competencies are fit for purpose for the Australian and New Zealand context in that specialty discipline.

Specialty training in surgery overseas does not always correspond to the ANZ context. This is particularly evident in European surgical training programs, but there are subtle differences in all programs including those in the United Kingdom and Canada. As an example, Germany trains in the specialty of Trauma, which in Australia and New Zealand is a subspecialty of a number of specialties, including orthopaedic surgery and general surgery. Even where specialties are broadly aligned to those of RACS, such as the United Kingdom, there is a wider, or narrower, scope of practice, different procedural and core competencies and different methods of assessment.

Every IMG applying for specialist surgical assessment therefore requires an individualized assessment of comparability to the Australasian Trained specialist in each discipline.

Since 2011, significant work has been undertaken to clarify how comparability is assessed in each of the nine specialties. This enables IMGs to self-assess their comparability while also providing guidance for assessors in performing their task.

RACS was concerned about feedback received from the RACS Expert Advisory Group, which indicated that a significant number of international medical graduates reported discrimination. The Expert Advisory Group had conducted a dedicated online discussion forum for international medical graduates. Persisting lower pass rates at the fellowship examination also remain of concern.

In response, RACS has undertaken a number of new initiatives. The role of clinical director IMG assessment and support was expanded from 0.2 to 0.5 equivalent full-time, and now offers support to international medical graduates. This includes a personal email sent to every international medical graduate under assessment inviting feedback and offering assistance with any issues, and multiple phone and email contacts in response to this. There has been greater interaction with IMG representatives on training boards on a range of issues. The clinical director IMG assessment attends Education Board and relevant RACS Council meetings. RACS will support greater inclusion by promoting the annual scientific congress, and College and regional committee activities, to international medical graduates.

A process for an independent review for an international medical graduate in difficulty has been trialled, involving a site visit from a senior surgeon and medical educator, with feedback provided to relevant parties.

RACS has established an International Medical Graduates Committee (IMGC). It will meet for the first time in February 2017. Its roles will include reviewing and developing international medical graduate assessment tools and overseeing assessment to ensure consistency between specialties. The committee will include representatives from all training boards, at least two international medical graduates who have completed the pathway, and a community representative. The IMGC will report to the RACS Board of Surgical Education of Training, and the chair will be a member of the RACS Education Board.

Preliminary work is underway on a medical educator review of international medical graduate assessment interviews, and feedback will be available before the first meeting of the IMGC in 2017.

RACS is improving orientation for international medical graduates by holding regular face-to-face induction workshops (three were held in 2016), and the development of eLearning resources, which include orientation to the Australian and New Zealand health systems and fellowship exam preparation.

There has been considerable investment in migrating international medical graduates' interactions with RACS into an electronic format. Online application began in 2015 and most international medical graduates now record their logbooks via the Morbidity Audit and Logbook Tool (MALT). Work to create online international medical graduate assessor reports is well advanced. International medical graduates will move to online continuing professional development in 2017.

RACS has developed a Specialist Training Program-funded pilot to develop posts for international medical graduates in major hospitals that prepare them for Area of Need positions and help them gain clinical experience in preparation for the RACS fellowship examination.

RACS continues to communicate with our stakeholders about assessment of international medical graduates, a recent example is attached.

Governance

The Board of Surgical Education and Training oversees the assessment of international medical graduates. It develops policies and receives relevant reports on IMG assessment and support. In Australia, the Medical Board for Australia recognises the recommendations of RACS for medical registration purposes.

A different process exists in New Zealand where the RACS NZ Censors Committee acts as a vocational educational and advisory body of the Medical Council of New Zealand (MCNZ). The MCNZ is not obliged to accept the recommendation of RACS, and international medical graduates undergoing assessment for vocational registration are not on a pathway to fellowship of RACS.

Vocationally registered specialists apply to RACS for Fellowship. A panel undertakes an assessment, utilising assessments including VEAB report to the MCNZ, workplace based assessments done for the MCNZ registration process, referee reports from Fellows that the applicant has worked with, logbooks and a 360 degree feedback report. The New Zealand, vocationally registered IMGs may be assessed as

substantially, partially or not comparable, and may be required to complete clinical assessment under supervision, and the Fellowship Examination.

The New Zealand Vocationally Registered Doctors Applying for Fellowship policy was implemented in 2015 and is the subject of ongoing review. It is possible for the vocationally registered IMG to be assessed by RACS as not meeting the standards for Fellowship. Such an assessment does not however affect that doctor's rights of practice as an independent specialist in New Zealand.

The Assessment framework

RACS policies and processes have been developed to ensure compliance with the Medical Board of Australia's Guide to the Specialist Pathway and the Medical Board of Australia's Good Practice Guidelines for the Specialist International Medical Graduate Assessment Process.

All RACS policies relating to international medical graduates are published on the RACS website. This includes the Specialist Assessment of International Medical Graduates in Australia Policy, which outlines the requirements and process for assessment, and a guide entitled Specialist Assessment of IMG Surgeons Information for International Medical Graduate Applicants. The guide explains the process in clear and simple language.

Assessment categories

Specialist international medical graduates are assessed against three criteria:

- Recency of specialist practice.
- Comparability of specialist training of the international medical graduate to that of an Australian and New Zealand (RACS) trained surgeon.
- Comparability of the fellowship certification examination completed by the international medical graduate to the RACS fellowship examination and/or the quantity, depth and scope of surgical practice in the specialty is of a sufficiently high standard such that the fellowship examination is not required.

The assessment outcome will be one of the following:

- **Not comparable** – the applicant is advised to apply for the RACS Surgical Education and Training (SET) Program to pursue independent practice in Australia.
- **Partially comparable** – the applicant will undergo a period of level three supervised clinical assessment and undertake the fellowship examination.
- **Substantially comparable** – the applicant will undergo a period of level four supervised clinical assessment and upon satisfactory completion will be eligible for fellowship.
- In certain circumstances, an international medical graduate may be assessed as substantially comparable in a defined scope of practice (that is, a scope of practice that is a subset of the broad specialty in which RACS awards fellowship). For further information refer to the RACS IMGs Assessed with a Defined Scope of Practice Policy.

The Level 3 and 4 supervision provided by RACS conforms to the standards set out by the Medical Board of Australia in its publication *Guidelines: Supervised Practice for International Medical Graduates*. Level 1 and 2 supervision is not provided by RACS. All supervisors also complete the AHPRA online accreditation for supervision.

RACS also assesses international medical graduates for Area of Need (AoN) positions. These are surgical posts that have been declared by the relevant jurisdiction as an "area of need" due to an absence of suitable Australian or New Zealand trained applicants. An Area of Need declaration allows the post to be made available to an international medical graduate. RACS has no formal role in the declaration of AoN positions, but has encouraged jurisdictions to work with RACS when trying to fill vacant positions.

RACS assesses whether a post is a suitable surgical post, and whether the applying international medical graduate is appropriately competent to fill the position. AoN assessments are done in addition to a specialist assessment. International medical graduates who accept a recommended pathway to fellowship, and who are in an approved AoN post, are eligible for fellowship. Refer to the Area of Need Assessment Policy.

10.2 Clinical assessment methods

Accreditation standard

10.2.1 The methods of assessment of specialist international medical graduates are fit for purpose.

10.2.2 The education provider has procedures to inform employers, and where appropriate the regulators, where patient-safety concerns arise in assessment.

Summary of RACS Response

10.2.1 RACS methods of assessment of specialist international medical graduates are successful in identifying comparable surgeons for the Australian and New Zealand workforce, and the clinical assessment process incorporates recognised workplace-based assessment tools.

10.2.2 RACS has procedures to inform employers, and where appropriate the regulators, where patient-safety concerns arise in assessment.

The RACS assessment process progresses in stages.

Paper-based assessment

The first stage comprises a paper-based assessment to assess recency of practice and comparability of training. If the international medical graduate is assessed as not comparable, they are advised to apply for the RACS Surgical Education and Training Program (SET) to pursue specialist registration in Australia.

If an international medical graduate is assessed from the documents as having prima facie undertaken comparable surgical training and has had recent surgical practice they will be invited to attend an interview, which will further explore their training and experience.

Nine specialty specific policies provide the basis for assessing comparability with international training programs, including fellowship certification examinations.

Interview and decision

To explore their training and experience, the international medical graduate interview includes a series of semi-structured questions to assess the international medical graduate's non-technical skills. The panel will make a final decision concerning comparability and determine the pathway to attain fellowship of RACS.

The applicant is advised of the panel's decision and recommendations for pathway to fellowship and has 20 working days to accept that decision. International medical graduates who are assessed as partially or substantially comparable, sign an agreement linked to policy to comply with the assessment recommendation.

More detailed information on the international medical graduate assessment process is found in the following policies:

- Assessment of the Clinical Practice of IMGs in Australia Policy.
- IMG Recency of Practice Policy.
- Specialist Assessment of International Medical Graduates in Australia Policy.
- IMG Assessment Post Accreditation Policy.

Following an assessment for specialist recognition, the outcome of the assessment and all requirements, such as peer review, supervised practice, assessment or formal examination and timelines, are stipulated in a RACS letter to the international medical graduate and attached to the Medical Board of Australia's Report 1. The letter to the IMG applicant is also attached to the report that is required by the MBA.

Appeals and reconsideration

International medical graduates may seek reconsideration of the decision by the originating interview assessment panel. If, following reconsideration, a new recommendation is approved by the Board of Surgical Education and Training, or it's Executive, that recommendation replaces the original decision. If a reconsideration upholds the original recommendation, the international medical graduate may request a formal hearing of the Appeals Committee. Further information about the RACS appeals process is found in Section 1.

Identifying underperformance

As part of the regular three-monthly performance review, the clinical supervisors and/or the specialty training board are responsible for identifying any issues of underperformance or safety. Underperformance will result in a meeting between the international medical graduate and the supervisor/specialty training board, leading to the development of a performance management plan. If a subsequent period of underperformance is identified a formal interview is held to reassess comparability.

In the event that serious concerns are raised concerning misconduct or patient safety, RACS has developed procedures to inform employers. These procedures are described in the Fellowship Examination Eligibility and Exam Performance Review and IMG Misconduct policies Refer to Section 5.3 for further information about the process and policy.

10.3 Assessment decision

Accreditation standard

10.3.1 The education provider makes an assessment decision in line with the requirements of the assessment pathway.

10.3.2 The education provider grants exemption or credit to specialist international medical graduates towards completion of requirements based on the specialist medical program outcomes.

10.3.3 The education provider clearly documents any additional requirements such as peer review, supervised practice, assessment or formal examination and timelines for completing them.

10.3.4 The education provider communicates the assessment outcomes to the applicant and the registration authority in a timely manner.

Summary of RACS Response

10.3.1 RACS assessment decisions are aligned to the requirements of the assessment pathway.

10.3.2 Exemption or credit can be granted to specialist international medical graduates towards completion of requirements. The standard is that of the consultant in their first year of practice.

10.3.3 RACS clearly documents additional requirements such as peer review, supervised practice, assessment or formal examination, including timelines for completion.

10.3.4 RACS communicates the assessment outcomes to the applicant and the registration authority in a timely manner.

Clinical supervision

International medical graduates who are assessed as partially or substantially comparable to an Australian or New Zealand trained surgeon are usually required to undertake workplace-based assessments in an approved clinical setting. This will include logbook review, mini clinical-evaluation exercise (mini CEX), direct observation of procedural skills (DOPS) and multi-source feedback (MSF). Supervision reports are collected every three months. An unsatisfactory assessment will be followed by a formal review and the development of a performance management plan. Subsequent unsatisfactory assessments will lead to a repeat interview to reassess the appropriateness of the recommended pathway to fellowship.

Fast-tracking and exemptions

During clinical supervision, it may be identified that an international medical graduate is performing better than expected or an exceptional level. Supervisors can recommend reduction in periods of supervision and/or waiving of other requirements, including the fellowship examination. The specialty board considers these recommendations.

Based on performance, specialty training boards overseeing the clinical assessment of an international medical graduate (or their nominated international medical graduate representative) can recommend further exemptions to the pathway to fellowship, such as a reduction in the assessment period, or exemption from the fellowship examination.

Resourcing international medical graduates

RACS is committed to a more inclusive approach as evidenced by implementation of the RACS Building Respect, Improving Patient Safety Action Plan, the Diversity Plan, proactive engagement of international medical graduates on College committees, and in other RACS activities.

International medical graduates have access to the RACS Continuing Professional Development Program and all RACS educational resources. This includes the library, RACS publications and audits. International medical graduates also have a dedicated webpage on the RACS website.

RACS' expectation that international medical graduates will engage in professional development and lifelong learning is reflected in the RACS Professional Development Opportunities for International Medical Graduates Policy.

Summative assessment

Fellowship examination

International medical graduates who are required to sit the fellowship examination are subject to the same approval and eligibility criteria as trainees. Approval to sit the fellowship examination is confirmed by the IMG Department in accordance with relevant policy. If an international medical graduate fails the fellowship examination, a feedback report is provided to their supervisor. Should the international medical graduate no longer be under supervision, the feedback report is sent to the training board chair. Refer to Section 5: Assessment for details of the fellowship examination for IMGs.

Generally, international medical graduate pass rates fall below those of trainees. A challenge for RACS is to achieve comparable pass rates for international medical graduates. Data is included in the annual RACS activities reports.

Data on the number of international medical graduate assessments and outcomes is published in annual RACS activities reports, which are available on the RACS website, and distributed to hospital jurisdictions and other stakeholders.

Table 22 IMG applications and outcomes for assessment via specialist and area of need pathways between 2010 and 2015

Pathway	Applied and outcomes	CAR	GEN	NEU	ORT	OHN	PAE	PLA	URO	VAS	Total
Area of Need	Incomplete 31/12/2010	0	1	0	2	1	0	0	0	0	4
	Applied for assessment	1	20	0	17	15	2	3	2	2	62
	Not comparable	0	0	0	0	0	0	1	0	0	1
	Partially comparable	0	6	0	12	6	0	0	2	1	27
	Substantially comparable	1	15	0	5	10	2	2	0	1	36
	In progress (2015 ~)	0	0	0	2	0	0	0	0	0	2
Specialty Assessment	Incomplete app. 31/12/2010	0	1	1	2	3	0	0	0	0	7
	Applied for assessment	19	106	9	65	23	10	17	12	13	274
	Not comparable	5	36	3	19	5	1	6	5	2	82
	Partially comparable	9	41	6	43	11	3	8	5	8	134
	Substantially comparable	5	29	0	3	9	5	2	0	1	54
	In progress (2015 ~)	0	1	1	2	1	1	1	2	2	11

10.4 Communication with specialist international medical graduate applicants

Accreditation standard

10.4.1 The education provider provides clear and easily accessible information about the assessment requirements and fees, and any proposed changes to them.

10.4.2 The education provider provides timely and correct information to specialist international medical graduates about their progress through the assessment process.

Summary of RACS Response

10.4.1 The assessment requirements and fees are easily accessible from the RACS international medical graduate webpage. Any proposed changes are published and shared with international medical graduates who are already on a pathway to fellowship.

10.4.2 RACS provides timely and correct information to specialist international medical graduates about their progress through the assessment process.

RACS provides clear and easily accessible information about the specialist assessment pathway on the RACS website under the international medical graduates (Section 10).

Information provided on the website includes:

- Overview
- Application information
- Assessment information
- Assessment fees
- Interview dates
- Clinical assessment requirements
- Fellowship examination
- Resources and tools
- Courses and workshops
- Contacts, forms, guidelines and policies
- RACS publications, such as *Fax Mentis*, *Surgical News*, *ANZ Journal of Surgery*.

Strengths

RACS assesses about 100 International Medical Graduates for comparability each year. This significant number allows appropriate resourcing to expedite the assessment process.

Following the expert advisory group report, the Surgical Director role was increased to ensure that greater support is provided to international medical graduates. This is particularly emphasised through the RACS regional office structure.

Challenges

Lower international medical graduate pass rates in the fellowship examination remain a challenge, especially for those who are on the fellowship pathway and working in an area of need (AoN) position. Ensuring that international medical graduates have a complete understanding of the structure of the fellowship examination, as well as study time and access to resources for examination preparation, remains a significant challenge. While exam preparation courses are available to international medical graduates, they are not always accessible, for example if the time required or distance to travel conflicts with service obligations. This can be a particular concern where an international medical graduate is in an area of need post. Online resources are expected to assist international medical graduates to prepare for examinations.

Dedicated international medical graduate posts in larger hospitals, which allow contact with SET trainees, would also assist.

Plans

The new IMG Committee will increase the focus on supporting and assessing international medical graduates. It is expected that this committee will investigate better assessment tools, as well as addressing persistent issues, such as inclusion. Ongoing actual and perceived discrimination against international medical graduates in the workplace also needs to be addressed. The RACS Building Respect, Improving Patient Safety Action Plan contains initiatives to address this.

Appendix

Appendix

No.	Reference	Section of the report
001W	RACS Website (www.surgeons.org)	
002	RACS code of conduct	Executive summary, 1.2, 2.2, 6.2, 8.1
003	Reconciliation action plan 2016-2017	Executive summary 1.6, 2.1
004	Constitution of the Royal Australasian College of Surgeons	1.1, 2.1
005W	JDocs Framework (website)	Executive Summary, 3.1, 5.1, 7.1
006	Activities Report 1/1/2015 – 31/12/2015	1.1, 2.3, 3.4, 6.2, 7.1, 9.1, 10.3
007	RACS Strategic Plan and Business Plan 2017-2018	1.1, 1.5, 1.7, 2.1
008	RACS Council (webpage)	1.1
009	ISO and Quality Manual	1.1
010	Conflict of Interest Policy	1.1
011W	Council Committees Terms of Reference (policies webpage)	1.1
012	Building Respect, Improving Patient Safety Action Plan	1.1, 2.1, 3.2, 5.1, 5.4, 6.1, 6.2, 7.2, 7.4, 7.5, 8.1, 8.2, 9.1, 10.3, 10.4
013	Letter to the Minister – summary of RACS and IMGs	10.3
014	Terms of reference for education committees	1.2
015	Terms of reference for specialty training boards	1.2
016	Specialty training regulations	1.2, 5.1, 5.3
017	Terms of reference for professional development committees	1.2
018	Complaints documents	1.3, 6.3, 9.3
019	Appeals documents	1.3, 5.3, 7.1, 7.5
020	Surgical News	1.4, 2.1, 2.3, 7.3, 8.1, 9.1, 10.4
021	Surgical variance reports (Medibank)	1.4, 9.1
022	Agreements with specialty societies	1.2
023	Community advisors	1.1, 1.6, 6.1
024	Annual Scientific Congress (ASC) evaluation survey	6.2
025W	Annual reports and statutory accounts (publications webpage)	1.1
026W	About Respect (website)	1.1, 9.3
027W	Surgical News (publications webpage)	2.3
028	Digital College business plan	5.1
029W	RACS global health advocacy (webpage)	3.2
030W	Indigenous health (webpage)	3.2
031	Guide to SET	3.1, 5.1
032	Becoming a competent and proficient surgeon: training standards for the nine RACS competencies	3.2, 4.2, 5.1
033	Surgical competence and performance guide	1.7, 2.2, 3.2, 6.2, 8.1
034	Specialty curricula	3.2
035W	Cultural Competence eLearning resource (requires login)	3.2
036W	Keep Trainees on Track course outline (webpage)	5.3
037W	Expert Advisory Group (webpage)	6.1
038W	Morbidity Audit and Logbook Tool (MALT)	6.2

No.	Reference	Section of the report
039	2014 Review of SET report	3.2, 6.2
040	Recognition of prior learning policy	3.2
041	Trainee registration and variation policy	3.2
042	Skills course outlines	4.2
043	Work-based assessment: a practical guide	4.2
044W	List of accredited courses (webpage)	4.2
045	Standards and criteria for accreditation	4.2
046	Assessment of clinical training policy	5.1, 5.3
047	Specialty blueprints for fellowship exam	5.1, 5.2
048	Examination policies	5.1, 5.2, 5.3, 5.4
049	Fellowship examination eligibility and performance review policy	5.3
050	Specialty selection regulations	5.1, 7.1, 7.5
051	Standard setting for examinations	5.2
052	Fellowship examiner training manual	5.2, 8.1
053	Fellowship exam feedback reports	5.3
054	Feedback to Surgical Supervisor form	5.3
055W	Selection requirements and SET Application (webpage)	7.1
056	Dismissal from surgical training policy	5.3
057	Skills course instructor manual	5.4
058	A study exploring the reasons for and experiences of leaving surgical training (2016)	5.4, 6.2
059	Fellowship Examination heat maps	5.4
060W	Operating with Respect eLearning module (log in required)	3.2, 4.2, 6.3, 7.1
061	Assessing examiner marking styles on the Clinical Exam	5.4
062	Review of assessments report	5.1, 5.4
063	TriNation alliance medical education seminar	5.4
064	Fellowship survey report	2.1, 6.1
065W	RACS Trainees Association (webpage)	7.3
066	RACSTA end of term survey report to BSET	6.1, 7.2
067	Surgical Workforce Projection to 2025	6.1
068	Health Workforce Australia ~ National Training Plan Consultation Workshops	6.1
069	Sanctions policy	6.2
070W	RACS Mentoring (webpage)	8.1
071	EAG report	6.2
072	Risk register	6.3
073W	RACS surgeons support program	9.3
074W	RACS CPD program requirements (webpage)	9.1
075W	NICHE Portal webpage	9.1
076	RACS natural justice – guidelines for decision-makers	7.5
077	Surgical supervisors policy	8.1
078	Resources for mentors and supervisors	8.1
079W	About Respect website	9.3

No.	Reference	Section of the report
080	Accreditation of hospitals and posts for surgical education and training: process and criteria for accreditation	1.6, 8.2
081	OHNS draft ATSI and Maori module	8.2
082W	Continuing Professional Development policies	9.3
083W	RACS IMG webpage	10.3
084W	Selection information for Cardiothoracic surgery	7.1
085	RACS re-skilling and re-entry program guidelines	9.2
086	RACS clinical standards review policy	9.2
087	PD clinical director IMG assessment and support	10.1
088W	Selection information for General surgery (Australia)	7.1
089	RACS CPD guide	9.3
090W	Selection information for General surgery (New Zealand)	7.1
091	New Zealand vocationally registered doctors applying for fellowship policy	10.1
092	RACS IMG policies	10.1, 10.2
093	Specialist Assessment of IMG Surgeons Information for International Medical Graduate Applicants	10.1
094	Comparable specialist surgical training and fellowship certification examinations	10.2
095	Professional Development opportunities for IMGs	10.3
096W	Selection information for Neurosurgery	7.1
097W	Selection information for Orthopaedic surgery (Australia)	7.1
098W	Selection information for Orthopaedic surgery (New Zealand)	7.1
099W	Selection information for Otolaryngology head and neck surgery (Australia)	7.1
100W	Selection information for Otolaryngology head and neck surgery (New Zealand)	7.1
101W	Selection information for Paediatric surgery	7.1
102W	Selection information for Plastic and reconstructive surgery (Australia)	7.1
103W	Selection information for Plastic and reconstructive surgery (New Zealand)	7.1
104W	Selection information for Urology	7.1
105W	Selection information for Vascular surgery	7.1

Summary of RACS webpages referenced in this report

Reference	Section of the report	Website location
JDocs	Executive summary 3.1, 5.1, 7.1	http://JDocs.surgeons.org/
RACS Council	1.1	http://www.surgeons.org/about/governance-committees/council/
Council Committees Terms of Reference	1.1	http://www.surgeons.org/about/governance-committees/committees/
Annual Reports and Statutory accounts	1.1	http://www.surgeons.org/policies-publications/publications/#ar
About Respect	2.1	http://www.surgeons.org/about-respect/
Surgical News	2.3	http://www.surgeons.org/policies-publications/publications/surgical-news/
Health advocacy	3.2	http://www.surgeons.org/for-the-public/racs-global-health/advocacy/
ATSI History and Culture eLearning resource	3.2	http://www.surgeons.org/member-services/interest-groups-sections/aboriginal-and-torres-strait-islander-health/
Cultural Competence eLearning resource (requires log in)	3.2	http://ruralspecialist.org.au/courses/indigenous-health-cultural-learning/
Keeping Trainees On Track course outline (F2F and online)	5.3	http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/keeping-trainees-on-track/
Expert Advisory Group	6.1	www.surgeons.org/.../what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/
Morbidity Audit and Logbook Tool (MALT)	6.2	http://www.surgeons.org/for-health-professionals/audits-and-surgical-research/morbidity-audit-and-logbook-tool/
Selection Requirements and SET Application	7.1	www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/
Specialty selection information	7.1	
Operating with respect eLearning module (log in required)		http://www.surgeons.org/news/operating-with-respect-%E2%80%93-e-learning-module-launched/
RACSTA webpage	7.3	http://www.surgeons.org/becoming-a-surgeon/surgical-education-training/racsta/
RACS mentoring webpage	8.1	http://www.surgeons.org/education-training/mentoring/
CPD program requirements	9.1	http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/
NICHE portal	9.1	http://nicheportal.org/
About Respect: Addressing bullying and harassment	9.3	http://www.surgeons.org/about-respect/
RACS surgeons support program	9.3	http://www.surgeons.org/member-services/college-resources/racs-support-program/
RACS IMG webpage	10.3	http://www.surgeons.org/becoming-a-surgeon/international-medical-graduates/
Selection information for Cardiothoracic surgery	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-cardiothoracic-surgery-australia-new-zealand/
Selection information for General surgery (Australia)	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-general-surgery-australia/
Selection information for General surgery (New Zealand)		http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-general-surgery-new-zealand/
Selection information for Neurosurgery	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-

Reference	Section of the report	Website location
		neurosurgery-australia-new-zealand/
Selection information for Orthopaedic surgery (Australia)	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-orthopaedic-surgery-australia/
Selection information for Orthopaedic surgery (New Zealand)	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-orthopaedic-surgery-new-zealand/
Selection information for Otolaryngology head and neck surgery (Australia)	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-otolaryngology-head-neck-surgery-australia/
Selection information for Otolaryngology head and neck surgery (New Zealand)	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-otolaryngology-head-and-neck-surgery-new-zealand/
Selection information for Paediatric surgery	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-paediatric-surgery/
Selection information for Plastic and reconstructive surgery (Australia)	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-plastic-and-reconstructive-surgery-australia/
Selection information for Plastic and reconstructive surgery (New Zealand)	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-plastic-and-reconstructive-surgery-new-zealand/
Selection information for Urology	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-urology/
Selection information for Vascular surgery	7.1	http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career/selection-requirements/selection-information-urology/

Specialty performance against AMC accreditation standards

Specialty responses summary of accreditation standards

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to each specialty is presented here

Cardiothoracic Surgery 7

Accreditation standard 1.2.1 7
Accreditation standard 1.4.1 7
Accreditation standard 1.4.2 7
Accreditation standards 1.6.2 and 1.6.3 8
Accreditation standard 1.6.4 8
Accreditation standards 2.1.2, 2.1.3 and 2.1.4 8
Accreditation standard 2.2.2 8
Accreditation standards 3.3.1 and 3.3.2 8
Accreditation standard 4.1.1 9
Accreditation standards 5.2.1 and 5.2.2 9
Accreditation standards 5.3.1 and 5.3.2 10
Accreditation standard 5.3.3 10
Accreditation standard 6.1.1 10
Accreditation standard 6.1.2 10
Accreditation standard 6.1.3 10
Accreditation standard 6.3.1 11
Accreditation standard 7.1.1 11
Accreditation standards 7.1.2 and 7.1.3 11
Accreditation standard 7.3.1 11
Accreditation standard 7.3.2 11
Accreditation standard 7.3.3 11
Accreditation standards 7.4.1 and 7.4.2 11
Accreditation standards 8.1.1, 8.1.3 8.1.4 12
Accreditation standard 8.2.1 12

General Surgery 14

Accreditation standard 1.2.1 14
Accreditation standard 1.3.1 14
Accreditation standard 1.4.1 14
Accreditation standard 1.4.2 15
Accreditation standards 1.5.1 and 1.5.2 15
Accreditation standard 1.7.1 15
Accreditation standard 2.1.3 15
Accreditation standard 2.2.2 15
Accreditation standard 3.1.1 16
Accreditation standard 3.2.8 17
Accreditation standard 3.3.2 17
Accreditation standard 3.4.3 and 3.4.4 17
Accreditation standard 4.1.1 17
Accreditation standard 4.2.3 18
Accreditation standard 5.2.3 19
Accreditation standard 5.3.2 19
Accreditation standard 5.3.3 19
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Accreditation standard 6.1.1 19
Accreditation standard 6.1.2 20
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Accreditation standard 6.2.1, 6.2.2 and 6.2.3 20
Accreditation standard 6.3.1, 6.3.2 and 6.3.3 20
Accreditation standard 7.1.2 21
Accreditation standard 7.1.3 21
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Accreditation standard 8.1.3 23
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Accreditation standard 10.3.1 25
Accreditation standard 10.3.2 25
Accreditation standard 10.4.2 25

Neurosurgery 27

Accreditation standard 1.2.1 27
Accreditation standard 1.3.1 27
Accreditation standard 1.4.1 28
Accreditation standard 1.4.2 28
Accreditation standard 1.5.1 28
Accreditation standard 1.5.2 28
Accreditation standards 1.6.2 and 1.6.3 29
Accreditation standard 1.6.4 29
Accreditation standard 1.7.1 29
Accreditation standard 2.1.3 29
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Accreditation standard 3.1.1 29
Accreditation standards 3.2.1, 3.2.2 and 3.2.3 30
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Accreditation standard 6.3.2 32
Accreditation standard 6.3.3 32
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Accreditation standard 7.3.1 33
Accreditation standard 7.3.3 33
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Accreditation standard 8.1.4 33
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Accreditation standard 1.2.1 35
Accreditation standard 1.3.1 36

Specialty responses summary of accreditation standards

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to each specialty is presented here

Accreditation standard 1.4.1 36
Accreditation standard 1.4.2 37
Accreditation standard 1.5.1 37
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Accreditation standard 2.1.3 39
Accreditation standard 2.2.2 39
Accreditation standard 2.3.1 39
Accreditation standard 3.1.1 40
Accreditation standard 3.2.1 40
Accreditation standard 3.2.3 40
Accreditation standard 3.3.1 40
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Accreditation standard 3.4.1 41
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Accreditation standard 3.4.3 41
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Accreditation standard 8.1.2 46
Accreditation standard 8.1.3 47
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Orthopaedic Surgery New Zealand 50

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Accreditation standard 1.4.2 51
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Accreditation standard 3.1.1 52
Accreditation standard 3.2.1 52
Accreditation standard 3.2.2 52
Accreditation standard 3.2.3 52
Accreditation standard 3.2.7 53
Accreditation standard 3.3.2 53
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CARDIOTHORACIC SURGERY

Specialty performance against AMC accreditation standards

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Cardiothoracic Surgery specialty-specific activities is presented here.

Standard 1 The context of training and education

1.2 Program management

Accreditation standard 1.2.1

Evaluation

The Board of Cardiothoracic Surgery undertook a review of their training program in 2016.

The main changes relate to the SET 1 training year. These are:

- The Trainee must pass the GSSE before applying for SET training
- The removal of the mandatory Cardiology, ICU and/or respiratory medicine SET 1 year and reverting to a formal Cardiothoracic year taken in posts that have been formally approved for SET training.
- The requirement to complete a two week continuous attachment to the catheterization laboratory as well as a two week continuous attachment to the Echo laboratory

Refer to Training Regulations Handbook (Effective from 2017 training year).

The Board of Cardiothoracic Surgery also reviewed all DOPS, MALT and Supervisor reports for the assessment of trainee competency. This is reviewed regularly.

1.4 Educational expertise and exchange

Accreditation standard 1.4.1

The Board of Cardiothoracic Surgery comprises various members including:

- The Board Chair
- Deputy Chair
- President of the Australian and New Zealand Society of Cardiac and Thoracic Surgeons. (ANZSCTS)
- 5 General Members who represent the States and territories of Australia and New Zealand
- Senior Examiner
- Education and Sciences Subcommittee Representative
- Specialty Elected Councilor
- Thoracic Representative
- Trainee Representative

Refer to Terms of Reference.

Accreditation standard 1.4.2

The Cardiothoracic exit exam and the assessment of trainees is very similar to that of the College of Surgeons United Kingdom. e.g. London and Edinburgh. Some of the “clinical scenarios” recently adopted in our exit exams are based on the FRCS exam.

1.6 Interaction with the health sector

Accreditation standards 1.6.2 and 1.6.3

All Hospital Heads of Unit and Surgical Supervisors are regularly kept informed of any requirements/changes/updates to SET training and any other matters of mutual interest via email and/or formal, written correspondence. Surgical Supervisors are also invited to attend meetings via teleconference.

This year (2016), the Board Chair will be hosting a Supervisors meeting at the ANZSCTS ASM to provide all Surgical Supervisors with a comprehensive update on training related issues.

Accreditation standard 1.6.4

The Board will be looking at Indigenous Health partnerships in the future as well as support training of indigenous surgeons.

Standard 2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standards 2.1.2, 2.1.3 and 2.1.4

Internal

Starting from this year, the Chair will meet with the Heads of Department of the accredited teaching hospital and Directors of Surgical Training at the annual ANZCTS meeting. The President of ANZCTS is a co-opted member of the Board.

External

The annual RACS and ANZCTS Scientific Meeting have invited overseas speakers as part of the teaching faculty. Most, if not all the approved teaching hospitals have an affiliation with their respective Medical Schools and Universities. The ANZCTS work closely with the Cardiac Society of Australia and New Zealand, Australia Heart Foundation, as well as the Australian Lung Foundation.

2.2 Program outcomes

Accreditation standard 2.2.2

The Cardiothoracic Surgery Curriculum is divided into 16 technical and 8 non-technical modules. Successful achievement of these modules is measured through work-based assessments at each year level, via the trainee's assigned training post.

Standard 3 The specialist medical training and education framework

3.3 Continuum of training, education and practice

Accreditation standards 3.3.1 and 3.3.2

Table 1 RPL requested data from as 2013 – June 2016:

YEAR	No. of trainees granted RPL	No. of trainees rejected RPL	Total No. applied
2013	2		2
2014	2	1	3
2015	1		1

Standard 4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1

Teaching is not only undertaken onsite during a Trainee's rotation, but is also undertaken throughout various mandatory education sessions per year.

These include:

The annual trainee workshop – This is a comprehensive three day annual workshop which is mandatory for all SET 2 – 6 trainees. It consists of didactic lectures, peer presentations and wet lab participation.

Advanced Trainees Wet Lab at the ANZCTS ASM – This is also a compulsory all day session which is held at the ANZSCTS ASM

Practice exams – Board members conduct practice exam sessions at various times throughout the year.

Standard 5 Assessment of learning

5.2 Assessment methods

Accreditation standards 5.2.1 and 5.2.2

The Board of Cardiothoracic Surgery uses the Trainee evaluation form to assess the performance of the trainee in the workplace.

The assessment of the trainee is discussed collectively at unit meetings and signed off by the Supervisor of Training.

The Trainee Evaluation covers:

Clinical Knowledge/Medical Expertise: Acquisition and Application

- Basic Science and clinical knowledge
- Case Presentations

Clinical Skills: Acquisition and Application of Clinical Information

- Verbal description of clinical assessment
- Written record of clinical assessment
- Demonstration of Clinical Competence in Diagnosis
- Post-operative care

Clinical Decision Making

- Clinical Judgement
- Use of investigations
- Clinical care

Technical Skills

- Operative Ability

Scholarship

- Teaching and Learning
- Research ability
- Publications

Medical Communication Skills

- Communication with patients
- Cooperation with staff
- Leadership and Management

Attitude

- Self-motivation
- Stress response
  Professionalism

Trainees are rated as one of the following:

- Unsatisfactory
- Needs Attention
- Satisfactory
- Well above average.

Notes to Surgical Supervisors on their responsibilities in managing trainees and on completing the trainee evaluation. The Forms are available.

5.3 Performance feedback

Accreditation standards 5.3.1 and 5.3.2

Trainee assessments are reviewed by the Board twice a year. This certifies satisfactory or otherwise progression. Formal correspondence advising trainees of their assessment outcome is sent to them with a copy also forwarded to their Supervisor of Training.

Accreditation standard 5.3.3

Two trainees have been dismissed from the SET program in 2016

Standard 6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.1

The Board of Cardiothoracic Surgery recently undertook a review of the SET 1 requirements The changes included the removal of the current mandatory Cardiology, ICU and/or respiratory medicine SET 1 year and reverting to a formal Cardiothoracic year taken in posts that have been formally approved for SET training. Trainees selected into SET1 from 2017, will be required to complete a two week continuous attachment to the catheterization laboratory as well as a two week continuous attachment to the Echo laboratory in their first year of SET training.

From 2017, all trainees will be assessed twice yearly. Refer to clause 3.7 and 4 of the regulations regarding specific requirements at each SET level. The updated regulations will apply to all SET Trainees from 2017 and are available on the Cardiothoracic webpage

The Trainee Evaluation form and all DOPS assessment forms have also been recently reviewed and updated to assist in a more thorough evaluation of trainee progress. Ongoing evaluation of the program will be a key component of Board at future meetings.

Accreditation standard 6.1.2

Surgical Supervisors are invited to participate in the development of the SET program by attending annual supervisors meeting(s) and are kept informed of all Board deliberations through regular email communications.

Accreditation standard 6.1.3

The trainee representative is a full voting member of the Board. The role of the trainee representative is to inform the Board (on behalf of the trainees) of any training issues that may require discussion and report back to the trainees any issues/changes that are relevant to their training. This method allows an open and transparent communication process

6.3 Feedback, reporting and action

Accreditation standard 6.3.1

The Board of Cardiothoracic Surgery provides regular updated reports to BSET Committee regarding the training status of all trainees and IMGs, Examination results, Surgical Supervisor's status and all Hospital Accreditation updates.

Standard 7 Trainees

7.1 admission policy and selection

Accreditation standard 7.1.1

The SET Selection Regulations are reviewed annually by the Board and any changes recommended, receive final approval at Education Board level.

In 2013 six (6)* trainees were appointed into the SET Program to commence in 2014
In 2014 seven (7)* trainees were appointed into the SET Program to commence in 2015
In 2015 eight (8)* trainees were appointed into the SET Program to commence in 2016.
*Includes deferred offers

Accreditation standards 7.1.2 and 7.1.3

The Board has not implemented this as this has not yet been mandated by the RACS.

This was, however, discussed at BSET in June 2016 and the Policy is yet to be finalised.

7.3 Communication with trainees

Accreditation standard 7.3.1

Formal updates are provided by the Board Chair, Executive Officer and/or Trainee Representative via formal correspondence, email communication, face to face discussions and at various Educational sessions

Accreditation standard 7.3.2

Any changes to Training Regulations are communicated to all Trainees via email by the Executive Officer

Accreditation standard 7.3.3

All training assessments are reviewed twice a year. All trainees are advised of their assessment and rotation outcome within 10 days of the Board's review. This is communicated via formal correspondence.

7.4 Trainee wellbeing

Accreditation standards 7.4.1 and 7.4.2

Surgical Supervisors are encouraged to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training and bring this to the Board's attention.

Trainees are also encouraged to bring any issues they may have to the Board in writing. The Board will review their case individually.

Standard 8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standards 8.1.1, 8.1.3 8.1.4

From 2017, the Board will implement a trainee feedback form to be completed by all trainees at each rotation (names de-identified) and compiled at the end of the year. The information derived from this, to provide the Board with supervisor and hospital post effectiveness.

8.2 Training site and posts

Accreditation standard 8.2.1

The Cardiothoracic Surgery Post Accreditation

Standard 9 Continuing professional development, further training and remediation

In accordance with RACS policies

Standard 10 Assessment of specialist international medical graduates

In accordance with RACS policies

Cardiothoracic Surgery supporting documentation available

No.	Document name	Relevant standards
CAR web	The Australian and New Zealand Society of Cardio and Thoratic Surgeons	
CAR web	Cardiothoracic Surgery Specialty Overview RACS website	
CAR web	Cardiothoracic Surgery selection information	7.1.1, 7.1.2, 7.1.4
CAR01	Cardiothoracic Surgery Selection Regulations 2017	7.1.1, 7.1.2, 7.1.4
CAR02	Cardiothoracic Surgery Training Regulations	1.2.1, 1.3.1, 3.3.1, 3.3.2, 3.4.3, 4.1.1, 4.2.2, 4.2.3, 5.1.1, 5.1.2, 5.1.3, 5.2.1, 5.2.2, 5.2.3, 5.3.3, 6.2.1, 6.3.3, 7.3.2, 7.4.1, 7.5.1, 7.5.2
CAR03	Board of Cardiothoracic Surgery Terms of Reference	
CAR04	Cardiothoracic Surgery Curriculum	2.2.2, 2.3.1 3.2.1 – 3.2.10, 3.4.1
CAR05	Cardiothoracic Surgery Trainee Evaluation Form	5.2.1
CAR06	Surgical DOPS: Saphenous Vein Harvest	5.2.1
CAR07	Surgical DOPS: Median Sternotomy	5.2.1
CAR08	Surgical DOPS: Harvesting of Radial Artery	5.2.1

No.	Document name	Relevant standards
CAR09	Surgical DOPS: Dissection of Internal Mammary Artery	5.2.1
CAR10	Surgical DOPS: Aortic Valve Replacement	5.2.1
CAR11	Surgical DOPS: Coronary Artery Bypass Grafting	5.2.1
CAR12	Surgical DOPS: Mitral Valve Surgery	5.2.1
CAR13	Surgical DOPS: Resterotomy	5.2.1
CAR14	Surgical DOPS: Thoracotomy	5.2.1
CAR15	Cardiothoracic Surgery Memorandum of Understanding	5.2.2
CAR16	Cardiothoracic Surgery Post Accreditation	4.1.1, 4.2.1, 4.2.3, 8.1.1, 8.1.2, 8.2.1, 8.2.2

GENERAL SURGERY

Specialty performance against AMC accreditation standards -

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to General Surgery specialty-specific activities is presented here.

Standard 1 The context of training and education

1.2 Program management

Accreditation standard 1.2.1

Evaluation

The Board in General Surgery undertook a review of the program through a Strategic Plan for 2015 – 2018. The major proposed changes relate to:

- Move to EPA's and PBAs for Assessment in an attempt to be more competency based and to highlight skills relates to General Surgery
- Redevelopment of logbook and move towards counting of experience rather than counting of procedures.
- Training and Induction for Supervisors
- Redevelopment of research component of training program
- Review of rotations required by each trainee

It is anticipated that the changes will occur over the next 12 – 24 months. Ongoing evaluation of the program will be a key component of any new areas implemented.

Curriculum

The Board reviews the General Surgery Curriculum every three years.

1.3 Educational expertise and exchange

Accreditation standard 1.3.1

The Regulations for General Surgery have an Appeal and Grievance section whereby a trainee can request a review of a decision made. The Board will review the request and determine if process was followed or otherwise. The Board has formed Review Panels to "remake" the decision in question. Membership of Review Panels is restricted to Fellows who have no prior knowledge of the original decision.

1.4 Educational expertise and exchange

Accreditation standard 1.4.1

The Board comprises of various members including:

- Training Committee Chairs
- Senior Examiner
- SSE Representative
- Rural Representative
- GSA and NZAGS representatives
- Rural Representative
- Trainee Representatives

During Curriculum Review and review of SEAM modules, Fellows with expertise in the various areas have been engaged to review the material.

With regards to SEAM Modules, Fellows have been engaged to Standard Set the MCQs.

Accreditation standard 1.4.2

The Assessment Working Party reviewed the EPA/PBA models used by other surgical institutions before recommending that these be introduced into general surgery.

1.5 Educational resources

Accreditation standards 1.5.1 and 1.5.2

Currently General Surgery training and education is administered through GSA (Australia) and NZAGS (New Zealand), with executive support for the Board provided by GSA and secretarial support jointly provided by GSA/NZAGS.

GSA has an annual process to review the resources, both budgetary and staff, provided to General Surgery. Organisational structure for GSA.

NZAGS employs a full time Training Manager who reports directly to a General Manager who also provided administration support to the Board. Budgets and resourcing for all training activities are reviewed annually.

1.7 Continuous renewal

Accreditation standard 1.7.1

The Board in General Surgery has a Project Management Committee whose purpose it is to review projects the Board has requested to be implemented and the impact on resources including budgetary and staff for both GSA and NZAGS.

Standard 2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard 2.1.3

The Board sought the view point of the following people during their initial investigations for input into the Strategic Plan:

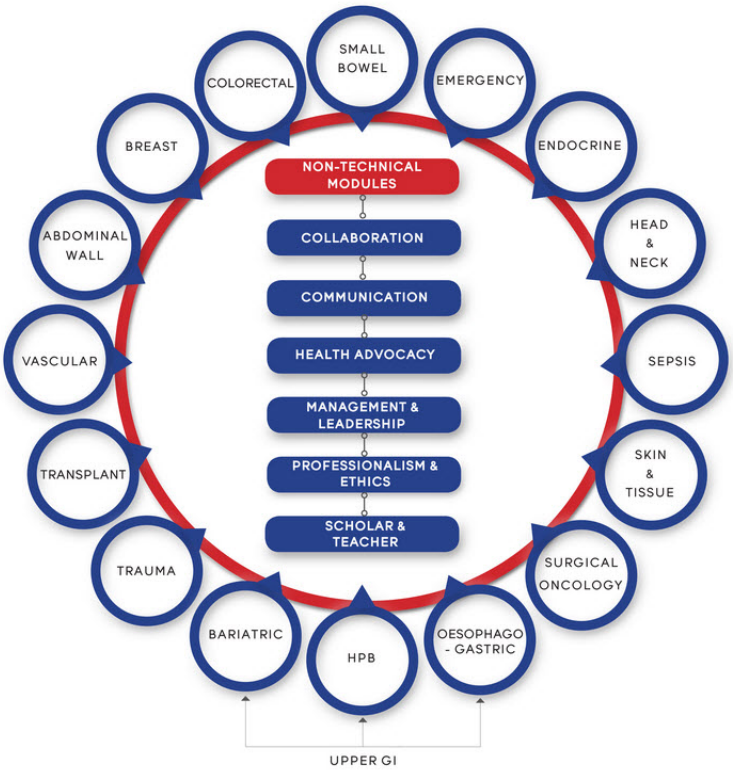
- Board in General Surgery members
- Hospital Surgical Supervisors
- NZAGS and GSA Presidents
- RACS Dean of Education
- RACS Chair of Board of Surgical Education and Training
- RACS Censor-in-Chief
- Australian and New Zealand Trainee Representatives

During the development of SEAM, external experts in the fields of Anatomy, Nutrition, Haematology, Critical Care and Palliative Care were engaged to develop the content and review MCQs.

2.2 Program outcomes

Accreditation standard 2.2.2

The Curriculum is divided into the following areas of General Surgery:



The General Surgery Hospital Regulations also provide criteria each accredited post is to deliver – this includes nights and on-call which are a major component of General Surgery

Standard 3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard 3.1.1

The General surgery curriculum stipulates the following for each technical area:

- Module Rationale and Objectives
- Anatomy, Physiology, Pathology
- Suggested Reading
- Learning Opportunities and Methods
- How module is assessed
- Medical Expertise
- Judgement/Clinical Decision Making – Clinical Assessment, Investigations and Principles of Management
- Technical Expertise – Operative Management: Knows and Does
- Operative Management - Knows: Trainees are required to be familiar with the indications, benefits and limitations of the procedure; trainees should be able to describe the relevant operative techniques involved in performing the procedure; trainees are encouraged to at least observe and preferably assist in these procedures.
- Operative Management - Does: In addition to the above, trainees must be competent at performing the procedure.

3.2 The content of the curriculum

Accreditation standard 3.2.8

Trainees are able to apply for RPL of Clinical Rotations in lieu of Research undertaken towards a higher degree over a period of two or more years. The Board may delay the decision however for up to one year to determine if the trainee is at the appropriate level of training. The Board reserves the right not to accredit research towards clinical training, if the applicable level of clinical competency is not evident at the point of re-entering clinical training after completing the research.

The Board is considering the participation of trainees in research collaboration initiatives to improve trainee access to larger and more significant research projects

3.3 Continuum of training, education and practice

Accreditation standard 3.3.2

The list of RPL's granted from 2013-2015 is available.

3.4 Structure of the curriculum

Accreditation standard 3.4.3 and 3.4.4

The list of Part-time requests and their outcome from 2010 is available.

Standard 4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1

Teaching is not only undertaken onsite during a Trainee's rotation, but also through Education sessions.

In Australia the following Educational sessions exist:

South Australian Long Course – weekly tutorials*

The Long Course Programme is a series of weekly tutorials for SET Trainees. Each week two (2) trainees are asked to present on a given topic and a General Surgeon will facilitate the tutorial. A pathology session and/or a radiology session are also held once a semester.

Queensland Core Course – fortnight tutorials*

The GSA Core Course is an annual program where typically SET 4's & 5's will present a clinical presentation on a particular given topic. These fortnightly sessions are held at the Royal Brisbane and Women's Hospital (Education Centre) and are video conferenced to most regional hospitals via link it. In attendance at each session are two expert panel to provide feedback as required. These panels are Fellows of the College and have kindly given up their personal time to attend. All presentations are webcast and uploaded to the GSA website for easy reference and are accessible to all including those linking in. Anatomy and Trial Exam sessions are also held throughout the year

Western Australian WARTS – Monthly tutorials*

Consists of a series of monthly tutorials for SET Trainees. The

sessions are facilitated by Fellows and guest speakers. The program includes the following:

- Peer Presentations in Interactive Group Format
- Specialist Lecture Presentation Sessions
- Expert Discussion Panels with Question Time
- Anatomy Lab Session
- Hospital Based Viva and Clinical Case Sessions

NSW-ACT – 5 full day tutorials per year*

The principle aim of the course is to provide a forum where trainee surgeons are given the opportunity to meet and interact with both their peers and Fellows of the College in a learning environment. The program does not aim to cover the entire syllabus nor should it be seen as replacing established clinical teaching programs at individual hospitals.

Trainee's are required to present on assigned topics. There will be a Chair Member to facilitate and consult on the presentation and faculty members at the panel desk to encourage discussion amongst the trainees. All presentations are webcast and uploaded to the GSA Website

Vic-Tas – Simulation Workshop

This delivers high quality advanced simulation workshops to complement regular training at no cost to our trainees.

Vic-Tas Trainees Weekend

This event offers key information to trainees to assist with progression in the Surgical Education Training program in General Surgery, particularly in the lead up to sitting the Fellowship Examination. The weekend consists of various modes of teaching including lectures, small group sessions and simulations training

SA Paper Day

This is an annual event that provides a platform for

General Surgery Trainees and Senior Registrars with an opportunity to present their accredited research in a peer reviewed group forum.

GSA Trainee's Days – full day lectures twice per year.

The Trainees Days focus on a particular section of the Curriculum and involve lectures and interactive sessions. Trainees are required to attend a minimum of four Trainee's Day throughout their training.

NSW Fellowship Exam Course, Vic-Tas Fellowship Exam Course and SA Fellowship Exam Course

The above are courses for trainees presenting for the Fellowship Examination during the year. The content consists of:

- Vivas in Operative Techniques, pathophysiology and anatomy
- Clinical Vivas
- Practice Exam Questions
- Trial Viva Examination

* Trainees are required to participate in Training Committee educational activities. Each Training Committee will set the minimum attendance rate that Trainees are required to meet per year.

In New Zealand the following Educational sessions exist:

NZAGS Trainee Days – twice per year.

This consists of didactic sessions for ½ day. Trainees in SETs 2-3 have ½ day of short cases for ½ day, SET4-5 trainees have ½ day mock fellowship exam viva cases.

4.2 Teaching and learning methods

Accreditation standard 4.2.3

The SEAM Modules are self-directed online modules that cover the following areas of General Surgery:

1. Acute Abdomen
2. Haematology
3. Anatomy
4. Operating Theatre
5. Nutrition
6. Peri-operative Care
7. Critical Care and Trauma

8. Post-Operative and Palliative Care
Each module consists of an eLearning Section followed by an Assessment comprising of 20 MCQs.

The modules are designed to teach and assess the knowledge required to function as a General Surgeon and to progress to SET4.

Standard 5 Assessment of learning

5.2 Assessment methods

Accreditation standard 5.2.3

The SEAM Modules are standard set routinely. A schedule has been developed whereby four modules are standard set each year. This means each module is standard set every two years.

5.3 Performance feedback

Accreditation standard 5.3.2

The Supervisor must 'sign off' the assessment form whether it is mid-term or end of term.

Accreditation standard 5.3.3

Australian Trainees

The number of trainees dismissed in the last three years is:

- Unsatisfactory Performance -1
- Not meeting requirements – 93 (SSE Generic, Specific and CE)
- Misconduct - 1

New Zealand Trainees

The number of trainees dismissed in the last three years is:

- Not meeting requirements – 3 (SSE Specific or CE)

5.4 Assessment quality

Accreditation standard 5.4.1

The Board has approved the move towards implementing EPAs and PBAs for assessment. The aim of this direction is to move towards ensuring competency across a range of General Surgery skills and behaviours. This was recommended as part of the General Surgery Strategic Plan Review. Summative assessments have also been reviewed as part of the Strategic Plan Review to ensure the process remains pertinent.

Data on withdrawals and pass rate are available in RACS Activities reports.

Standard 6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.1

Evaluation

The Board in General Surgery undertook a review of the program through a Strategic Plan for 2015 – 2018. The proposed major changes relate to:

- Move to EPA's and PBAs for Assessment in an attempt to be more competency based and to highlight skills relates to General Surgery
- Redevelopment of logbook and move towards counting of experience rather than counting of procedures.
- Training and Induction for Supervisors

- Redevelopment of research component of training program
- Review of rotations required by each trainee

It is anticipated that the changes will occur over the next 12 – 24 months. Ongoing evaluation of the program will be a key component of any new areas implemented.

Curriculum

The Board reviews the Curriculum every three years.

Accreditation standard 6.1.2

As part of the Strategic Plan all supervisors were contacted to provide their input into the areas that require improvement across various components of the training program.

Supervisors are also regularly kept up to date with changes to the regulations and the Board will seek the view point of supervisors when determining if a change to the program is required.

The New Zealand Training Committee routinely alerts supervisors to changes in regulations at its regular meetings.

The Board needs to do this because it needs to understand if the changes will impact the various training regions across Australia and New Zealand.

Accreditation standard 6.1.3

Trainee Representatives are a full voting member on all Training Committees across Australia and New Zealand.

The Board also has two Trainee Representatives – Australian and New Zealand.

The Australian Trainee Representatives also form part of the GSA Trainee Committee where issues pertaining to the program are discussed. The Australian Trainee Representative will then report back to the Board.

6.2 Evaluation

Accreditation standard 6.2.1, 6.2.2 and 6.2.3

This is currently in development. The Board is currently discussing an Evaluation Program.

During the Strategic Plan the following stakeholders were contacted:

- Board in General Surgery members
- Hospital Surgical Supervisors
- NZAGS and GSA Presidents
- RACS Dean of Education
- RACS Chair of Board of Surgical Education and Training
- RACS Censor-in-Chief
- Australian and New Zealand Trainee Reps

Copy of Strategic Plan attached.

6.3 Feedback, reporting and action

Accreditation standard 6.3.1, 6.3.2 and 6.3.3

The results of the Strategic Plan were distributed to various stakeholders including RACS, GS Trainees and Supervisors.

Standard 7 Trainees

7.1 admission policy and selection

Accreditation standard 7.1.2

The Australian Selection Process is reviewed annually by the GSA Education and Training Manager. Input is sought by the Australian Board members. Following this a report is provided to the Board with the suggested changes and reasons behind the changes. A statistically analysis of the scores across the three areas – CV, Referees and Interview – is also conducted by the GSA Education and Training Manager.

The NZAGS General and Trainee Managers review the Selection Process annually (including statistical analysis of the selection tools used), and the resultant report is considered by the New Zealand Training Committee for possible improvements to the process. All candidates are routinely surveyed after selection to identify any potential improvements in the selection process and this information is also considered by the New Zealand Training Committee.

Accreditation standard 7.1.3

New Zealand Process

The New Zealand RACS office has been working with Maori groups on how best to improve selection of Maori candidates. It is expected that a consultation process on how these initiatives may be incorporated in selection in the future will be discussed at the NZ National Board with all specialties.

Accreditation standard 7.1.5

Australian Process

This is undertaken during selection as followings

- CV - Each applications is scored by two people – a Board member and GSA Staff member. If there is disagreement the Board Chair acts as the third and deciding scorer
- Referee – Each section has defined criteria that referees can determine if they are applicable to the candidates they are completing the form for
- Interviews – Each questions has a set criteria answers that panel members rank the candidate against

In 2013 one hundred and one (101)* trainees were appointed into the SET Program to commence in 2014 commencing as SET1 and including deferred offers.

In 2014 fifty-four (54)* trainees were appointed into the SET Program to commence in 2015 including deferred offers commencing as SET1. Due to the removal of SET1 this was a half intake year.

In 2015 sixty-nine (69)* trainees were appointed into the SET Program to commence in 2016 at SET2 Level.

New Zealand Process and Data on Offers

NZAGS

This is undertaken during selection as followings

- CV - Each applications is scored by two NZ Training Chair members and this is checked by an NZAGS Staff member for national consistency of scoring. If there is disagreement of more than 1 point, the New Zealand Training Chair acts as the deciding scorer
- Referee – Each section has defined criteria that referees can determine if they are applicable to the candidates they are completing the form for
- Interviews – Each questions has a set criteria answers that panel members rank the candidate against

In 2013 thirteen (13) trainees were appointed into the SET Program to commence in 2014 including deferred offers.

In 2014 ten (10)* trainees were appointed into the SET Program to commence in 2015 including deferred offers. Due to the removal of SET1 this was a reduced intake year.

In 2015 eleven (11)* trainees were appointed into the SET Program to commence in 2016 at SET2 Level.

7.3 Communication with trainees

Accreditation standard 7.3.2

Australian Process

Specialist Trainee fee for SET Training is determined by GSA for Australian Trainees. The College is then responsible for advertising the fees on their website.

Changes to Regulations are communicated to all Trainees via email by GSA Staff. If a particular change is to affect only certain trainees, they formal letters are sent.

New Zealand Process

Specialist Trainee fee for SET Training is determined by NZAGS for New Zealand Trainees. The College is then responsible for advertising the fees on their website.

Changes to Regulations are communicated to all Trainees via email by NZAGS Staff.

Accreditation standard 7.3.3

Australian Process

Trainees have access to Trainee Management System (TMS). TMS details various aspects of their training including but not limited to:

- Trainee Status
- Current SET Level
- End and Max Dates
- Rotations including hospital allocation and assessment outcome at mid and end of term – past and current
- Logbook figures – per term and total across training
- All Requirements completed and those outstanding
- Probationary periods
- Clinical Training End date
- Maximum date to complete all requirements
- Supervisor for current term
- SEAM Modules

New Zealand Process

Trainees have access to SOLA which is an integrated Trainee management system and logbook. SOLA has a progress page for each trainee where trainees can view their progress against requirements. SOLA details all components of their training including:

- Trainee status (e.g. active or interrupted)
- Current SET Level
- Rotations - both current and completed (including Hospital, unit type and supervisor)
- All assessments with outcomes
- Current Logbook - view of logbook procedures for the current rotation
- All historical procedures completed since June 2013
- Total Logbook numbers by requirement i.e. majors, colonoscopy, endoscopy and total
- SEAM Modules –both completed and pending
- Other training requirements e.g. Trainee Days, Courses
- Clinical Training End date
- Maximum date to complete all requirements
- Research status
- Fellowship Exam status
- Key individual correspondence/documents including probationary terms

7.5 Resolution of training problems and disputes

Accreditation standard 7.5.1 and 7.5.2

The Board has clear regulations on obtaining Trainee Feedback on posts including supervision at the end of Term. Trainees are also requested to attend the inspection to provide feedback.

Standard 8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standard 8.1.2

The Board has developed a Position Description for Supervisors which details the responsibilities. The Regulations also detail the responsibility of the Supervisors and Trainers in terms of assessing trainees.

Accreditation standard 8.1.3

Through the Strategic Plan, the Board will be implementing an Induction Program for new supervisors.

For Australian Supervisors, GSA has also produced a manual which provides Guidelines to supervisors. This is available on the GSA website.

NZAGS has a manual for New Zealand supervisors which is sent to new supervisors on commencement and is available on the NZAGS website. Supervisors also have access to all trainee resources through a dedicated intranet. Additionally, New Zealand supervisors can view the training progress and logbooks of all the trainees under their supervision, and the assessments completed during the rotations they have supervised through SOLA.

Accreditation standard 8.1.4

This is undertaken through the Trainee Feedback Form at the end of each term. The process is outlined in the Hospital Accreditation and Feedback Regulations – a precis of which is described below.

The areas assessed in the Trainee Feedback are:

Registrar Workload

- Hours worked per fortnight
- Medical Staff on unit
- Outpatient Sessions
- Operating Sessions
- Consultant Ward Rounds
- On-call Requirements
- Night Roster
- Leave Arrangements

Education and Training

- Education sessions including Radiology, Pathology and Multidisciplinary meetings
- Ability to attend regional educational meetings
- Case related teaching experience
- Experience during teaching on ward rounds
- Operative responsibility and teaching
- On call supervision and training
- Journal club
- Practical and/or technical workshops

Professional Development

- Performance objectives

- Feedback and assessment
- Research support
- Learning initiatives
- Clinical audit
- Career advice
- Professionalism

Hospital Supervisors/Unit Supervisors/Hub Supervisors

- Introduction of supervisor, hub supervisor (if applicable) and Unit Co-ordinator (if applicable)
- Accessibility
- Role modelling
- Contact with trainees
- Interest in trainees and responsiveness to issues
- Organisation
- Delivery of educational program
- Motivational
- Seeks feedback

The data is de-identified and collated before being reviewed annually and at each quinquennial or re-inspection of training posts.

The GSA or NZAGS office will review the feedback in the first instance. If any malicious, defamatory or similar comments regarding consultants or other trainees are included, the staff will remove these comments from the report.

If significant or serious concerns about the educationally validity of a post are identified, the Board and/or Training Committee Chair will be notified.

The Board and/or Training Committee Chair will review the concerns and determine the most appropriate course of action which may include, but is not limited to:

- Discussion with the trainee if consent is provided by the trainee
- Discussion with the Hospital Supervisor
- Recommendation for a reinspection

If significant or serious concerns regarding the conduct of a consultant, trainee or IMG in the unit are identified, the RACS Complaints Resolution Manager will be notified and the Board will take advice

The Training Committee Chair will be provided with an annual (biannual in New Zealand) de-identified report. If there are areas of concern, the Chair will determine the appropriate course of action which may include, but is not limited to those listed in Section 10.3.5a-c.

8.2 Training site and posts

Accreditation standard 8.2.1

The Board adheres to the RACS Accreditation Standards however also includes General Surgery specific standards including:

General Surgery Trainers

Each unit must at a minimum have two General Surgery trainers. Failure to meet this criterion may deem the post disaccredited.

Impact of fellows on the unit

Units that employ fellows should not be at the detriment of the training of SET Trainees. Units with fellows, must at the time of application, specify the division of work between the fellow/s and trainee/s.

Unit Caseload and Case mix

Major general surgery procedures are those specified in the official General Surgery logbook (as per the General Surgery Training Regulations). Each training post must be able to provide a minimum of 100 major

cases per trainee per term. The trainee must be the primary operator rate as specified in the General Surgery Training Regulations.

Hospitals are provided with the opportunity to comment on the draft report. If the hospital provides comments or suggested changes, these will be reviewed by the Inspection Panel. Following which a response will be provided to the hospital either accepting the changes or providing a reason why the changes are not to be included. If significant changes are required or suggested, the report will be reviewed once again by the Board and/or Training Committee.

The Hospitals have the right to Appeal any decision through the RACS Appeals Mechanism

In terms of monitoring the posts, the Board has just introduced a Change in Circumstance Review. To ensure the integrity of a post and ensure that the conditions under which a post was provided accreditation continue and are adhered to, the Board and/or Training Committee will instigate a mid-accreditation review for posts that have been granted an accreditation period of five (5) years. Specifically the Board will request information on the following:

1. Number and EFT of General Surgery consultants on unit
2. Unit structure
3. Operative exposure
4. Endoscopy exposure
5. Outpatient exposure
6. Acute surgery exposure
7. Fellows on unit and division of responsibilities
8. Research opportunities
9. Hospital services
10. Trainee support & welfare

For Australian hospitals the regulations are available on the GSA website.

For New Zealand hospitals the regulations are available on the NZAGS website.

See attached spreadsheet for list of posts inspected for the last five years. Please note that due to the removal of SET1 posts I no longer have this data. However I have listed the hospitals where we did inspect. These are the posts that have a 0 in the column SET1 posts.

Standard 10 Assessment of specialist international medical graduates

10.3 Assessment decision

Accreditation standard 10.3.1

The IMG Representative assess the IMG based on the progress reports, mini-CEX, DOPS, Logbook, and MSF and if there are any special conditions to pathway

Accreditation standard 10.3.2

IMGs are able to request exceptional performance and either have their oversight or supervision reduced or exemption to sit the Fellowship Exam.

10.4 Communication with specialist international medical graduate applicants

Accreditation standard 10.4.2

The GSA IMG Co-ordinator informs the IMG of the term outcome via email.

General Surgery supporting documentation available

No	Document name	Relevant standards
GEN web	General Surgeons Australia	
GEN web	RACS links to General Surgery	
GEN01	Training regulations	1.2.1, 1.3.1, 3.3.1,3.3.2, 3.4.3, 4.1.1,4.2.2, 4.2.3, 5.1.1, 5.1.2, 5.1.3, 5.2.1,5.2.2, 5.2.3, 5.3.3, 6.2.1, 6.3.3, 7.3.2,7.4.1, 7.5.1, 7.5.2
GEN02	General Surgery Australia Organisational Chart	1.5.1
GEN03	General Surgery Strategic Plan 2015-2018	6.1.1, 6.1.2, 6.2.1,6.2.2,6.2.3,6.3.1.6.3.2,6.3.3 8.1.3
GEN04	General Surgery Curriculum Subject Outlines	2.2.2, 2.3.1 3.2.1 – 3.2.10, 3.4.1
GEN05	Recognition of Prior Learning Applications	3.3.2
GEN06	Pregnancy and training guidelines	3.4.2 – 3.4.3
GEN07	Australian Part-time training requests	3.4.2 – 3.4.4
GEN08	New Zealand Part-time training requests	3.4.2 – 3.4.4
GEN09	SEAM Overview	4.2.1 - 4.2.4
GEN10	General Surgery Selection regulations	7.1.1- 7.1.4
GEN11	Position description for supervisors	8.1.1 – 8.1.4
GEN12	Guide for New Zealand General Surgery Supervisors	8.1.1 – 8.1.4
GEN13	Guidelines to General Surgery supervisors	8.1.1 – 8.1.4
GEN14	Hospital accreditation and trainee feedback regulations	1.7.1, 4.2.1, 5.4.1, 7.2.1, 6.1.3, 6.2.3, 8.1.4
GEN web	Accredited hospitals	8.2.1
GEN web	International medical graduates	10.1 – 10.4.2
GEN15	Eligibility Report – Procedural Skills and Professional Capabilities	

NEUROSURGERY

Specialty performance against AMC accreditation standards -

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Neurosurgery specialty-specific activities is presented here.

Standard 1 The context of training and education

1.2 Program management

Accreditation standard 1.2.1

The Specialty Training Board consists of the following members:

- An elected Board Chair
- Nine elected members including at least one from New Zealand and no more than two from any individual state or territory of Australia
- An elected trainee representative
- The President of the NSA or nominee ex-officio
- The Senior Examiner in Neurosurgery ex-officio
- The RACS Specialty Elected Councillor for Neurosurgery ex-officio
- An appointed younger Fellows representative if there is no member satisfying the eligibility criteria appointed or elected by an alternate clause

The composition is designed to provide connection to both the RACS and the Neurosurgical Society (NSA) and to have a diverse representation.

Setting and implementing policy on continuing professional development and evaluating the effectiveness of continuing professional development activities does not form part of the Service Agreement and as such is not reported on.

Setting, implementing and evaluating policy and procedures relating to the assessment of specialist international medical graduates does not form part of the Service Agreement and as such is not reported on.

1.3 Educational expertise and exchange

Accreditation standard 1.3.1

The SET Regulations Handbook for Neurosurgery includes a review and special consideration process (Regulation 1.8).

The review and special consideration process may be used in the following circumstances:

- the trainee is applying to have a decision relating to their training reviewed; or
- the trainee is applying to have special circumstances considered relating to their training; or
- the trainee has been identified as potentially having an illness, injury or impairment which may impact on their ability to fully participate in training; or
- there are circumstances identified which may require a change in the trainees' training status or training requirements.

Applications from trainees must be addressed to the Board Chair and received within 14 days of the trainee being notified of the decision to be reviewed, or any time prior to the decision.

The review process is undertaken by an appointed review panel who make a decision on the basis of the evidence taking into account the quality and relevance of supporting documentation. This process is outlined in Regulation 1.8 and can include interviews with the applicant and others.

The appointed review panel has the authority to:

- Affirm the decision;

- Revoke the decision and provide an alternate decision; or
- Where there is no previous decision, make a decision.

The use of small review panels rather than the full Specialty Training Board has been a beneficial introduction. It is a more efficient and timely process. Trainee engagement has been high with 5 reviews commenced during 2016 at the time of preparing this report (August 2016). The review panel composition takes into account any perceived bias by not including those involved in previous reviews or who have supervised the trainee.

Where the decision being reviewed was made or previously reviewed under Regulation 1.8 or by a previous body established under previous regulations, it is not eligible for a subsequent review and the trainee will be referred to the RACS Appeals Policy.

The option to use the RACS Appeals Policy also remains open to trainees as an alternative or where they are dissatisfied with the outcome of a review or special consideration application conducted under Regulation 1.8.

The RACS Appeals Policy first step requires a review by the Specialty Training Board. In doing so, any member involved in the review panel is excluded from the Specialty Training Board review.

If the grounds for review include an allegation of discrimination, bullying or harassment (including sexual harassment) which may warrant a separate investigation, the allegation will be referred to the RACS for consideration in accordance with the RACS relevant policies.

1.4 Educational expertise and exchange

Accreditation standard 1.4.1

The Specialty Training Board has a diverse membership which includes neurosurgeons with formal qualifications in education and training. This experience is drawn on in the development and review of the training program. In addition, working parties are established to review particular components of the training program. When established those with relevant expertise and experience are selected.

Accreditation standard 1.4.2

The NSA has regular meetings with three other specialities (Urology, Plastics and Orthopaedics) to compare training program issues and developments. This has been a very beneficial exchange of ideas and experiences.

1.5 Educational resources

Accreditation standard 1.5.1

The NSA has a strong office support system for the Training Program. In addition, interest and involvement in the management and delivery of the education and training program is strong within the neurosurgical community.

The challenges facing the system are the increasing demands on pro-bono supervisors who are a critical component of the training system.

While time and compliance demands on supervisors are increasing there is a perception of decreasing support. A prevalent factor is increasing challenges to their assessment decisions. Specialty Training Board members can no longer provide advice to supervisors without then being excluded from performing components of their Board role on the grounds of perceived bias in future decisions. As such the supervisors feel increasingly unsupported at the time when they most need assistance.

Accreditation standard 1.5.2

The NSA now has five staff, three of which have dedicated functions supporting the Training Program. The staff qualifications include law, administration and business management. External educational expertise can be brought in on a contract basis as required.

1.6 Interaction with the health sector

Accreditation standards 1.6.2 and 1.6.3

The NSA holds surgical supervisor forums on an approximate annual basis to allow for issues and developments in surgical training to be discussed.

Accreditation standard 1.6.4

The Specialty Training Board does not have specific partnerships relating to indigenous health.

1.7 Continuous renewal

Accreditation standard 1.7.1

The NSA has established an Examinations Committee and a Training Post Committee.

Standard 2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard 2.1.3

The NSA also holds surgical supervisor forums on an approximate annual basis to allow for issues and developments in surgical training to be discussed. This has led to developments and modifications to the training program.

Trainees also attend twice yearly training seminars coordinated by the NSA. The Specialty Training Board Chair attends and the final session allows for trainee feedback and communication regarding developments.

The Trainee Representative on the Specialty Training Board also provides invaluable input into decisions and discussions from a trainee perspective.

2.2 Program outcomes

Accreditation standard 2.2.2, 2.3.1

The Statement of Competence has not changed significantly. The Neurosurgery Curriculum has learning outcomes for the three levels of training.

Standard 3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard 3.1.1

The SET Program in Neurosurgery is structured on a three level sequential curriculum to facilitate the cumulative acquisition of the experience, knowledge, skills and attributes aligned with the overall objective

The first level is Basic Neurosurgical Training focused on the basic neurosurgical foundational skills. This must be completed in a minimum of one training year and a maximum of two training years.

The second level is Intermediate Neurosurgical Training where the trainee involvement should be increasing in complexity. The trainee should be assuming more responsibility and building on the foundational experience, knowledge, skills and attributes towards the required level of competence. This must be completed in a minimum of three training years and a maximum of four training years.

The third level is Advanced Neurosurgical Training where the trainee should be functioning with full emergency competence, operating as primary surgeon in core neurosurgical procedures and acquiring the

foundation for subspecialist practice. This must be completed in a minimum of one training year and a maximum of three training years.

3.2 The content of the curriculum

Accreditation standards 3.2.1, 3.2.2 and 3.2.3

The Neurosurgery Curriculum outlines the syllabus.

3.3 Continuum of training, education and practice

Accreditation standard 3.3.1

The SET Program in Neurosurgery is structured on a three level sequential curriculum to facilitate the cumulative acquisition of the experience, knowledge, skills and attributes aligned with the overall objective. See 3.1.1 of this report. The Regulations also state what the training requirements are at each level in Regulation clause 2.4 to 2.6.

Accreditation standard 3.3.2

The SET Regulations Handbook clause, Section 8 outlines RPL requirements

3.4 Structure of the curriculum

Accreditation standard 3.4.2

Basic Neurosurgical Training (Level 1) must be completed in a minimum of one training year and a maximum of two training years. Intermediate Neurosurgical Training (Level 2) must be completed in a minimum of three training years from completion of Basic Neurosurgical Training and a maximum of four training years. Advanced Neurosurgical Training (Level 3) must be completed in a minimum of one training year from completion of Intermediate Neurosurgical Training and a maximum of three training years.

Accreditation standard 3.4.3

The SET Regulations Handbook clause 1.6 provides a process for deferment, Interruption and Part Time Training.

Accreditation standard 3.4.4

Elective studies are done as a post-graduate activity. The SET Program is focused on ensuring the trainees achieve the core competencies set out in the statement of competence.

Standard 4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1

The SET Regulations Handbook clause 2.4 to 2.6 for the range of requirements and assessment processes.

4.2 Teaching and learning methods

Accreditation standard 4.2.1

Each training unit has its own profile for patient case mixes, supervision, staffing levels, working requirements for trainees and equipment. The Board believes it is essential for trainees to be exposed to varied working environments during training. As such trainees rotate through a minimum of four training units.

Accreditation standard 4.2.3

The SET Regulations Handbook clause 2.4 to 2.6, outlines the range of requirements and assessment processes.

Accreditation standard 4.2.4

The SET Curriculum in Neurosurgery is structured on a three level sequential curriculum to facilitate the cumulative acquisition of the experience, knowledge, skills and attributes aligned with the overall objective.

Standard 5 Assessment of learning

5.1 Assessment approach

Accreditation standard 5.1.1, 5.1.2

The SET Regulations Handbook clause 2.4 to 2.6 outlines the range of requirements and assessment processes.

Accreditation standard 5.1.3

The SET Regulations Handbook clause 1.8 outlines the process for trainees to apply for special consideration relating to any aspect of their training.

5.2 Assessment methods

Accreditation standard 5.2.1

The SET Regulations Handbook clause 2.4 to 2.6 outlines the range of requirements and assessment processes.

Accreditation standard 5.2.2, 5.2.3

The SET Regulations Handbook clause 2.4 to 2.6 outlines the range of requirements and assessment processes.

5.3 Performance feedback

Accreditation standard 5.3.1

Completion of a Professional Performance Report must be undertaken quarterly during each year of training as part of the SET Program or more frequently where requested by the Board Chair or where the supervisor identifies unsatisfactory performance. This involves a meeting between the supervisor and the trainee.

Accreditation standard 5.3.2

At the start of each training year the trainee and the supervisor receive a letter which outlines their training requirements for the year and the due dates for all assessments.

Accreditation standard 5.3.3

The SET Regulations Handbook provides a detailed process for identifying trainees not meeting the outcomes. Section 3 of the Regulations specifically addresses issues such as progression between training levels, unsatisfactory assessments and performance, misconduct and dismissal proceedings

Accreditation standard 5.3.4

This is completed through the Surgical Supervisors.

5.4 Assessment quality

Accreditation standard 5.4.1

Trainees provide direct feedback on their training posts which includes education, training and supervision, at six monthly intervals. The NSA also holds Surgical Supervisor forums on an approximate annual basis to allow for issues and developments in surgical training to be discussed. This often includes discussion about the feasibility and success of assessment processes and has led to changes.

Standard 6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.1

The Handbook Regulations are reviewed on a frequent basis, including after each review initiated by a trainee. The curriculum is reviewed on a regular basis by the Board and appointed working parties.

Accreditation standard 6.1.2

The NSA also holds surgical supervisor forums on an approximate annual basis to allow for issues and developments in surgical training to be discussed. This often includes discussion about the feasibility and success of assessment processes and has led to changes.

Accreditation standard 6.1.3

Trainees provide direct feedback on their training posts which includes education, training and supervision, at six monthly intervals.

This feedback is considered by a Training Post Committee which includes two trainee representatives. Action is taken as a result of training unit confined issues and wider issues.

6.2 Evaluation

Accreditation standard 6.2.1, 6.2.2, 6.2.3

The SET Regulations Handbook outlines evaluation procedures

6.3 Feedback, reporting and action

Accreditation standard 6.3.2

Trainee position evaluations are kept confidential. However collated data over periods of time is made available. Trainees are provided with information on averages in examinations so that they can benchmark their own performance against that of their peers.

Accreditation standard 6.3.3

The SET Regulations Handbook clause 1.8 outlines the review process.

Standard 7 Trainees

7.1 Admission policy and selection

The SET Regulations Handbook outlines policy and selection procedures

7.2 Trainee participation in education provider governance

Accreditation standard 7.2.1

There is a trainee representative on the Specialty Training Board who has full participation and voting rights. In addition, the trainee representative sits on the Examinations Committee (which prepares the selection examination), the selection panel, the Training Post Committee which also includes another trainee, and some hospital post accreditation panels.

7.3 Communication with trainees

Accreditation standard 7.3.1

The trainees receive regular emails from the NSA office regarding any changes or requirements.

Accreditation standard 7.3.3

The trainees receive correspondence during the year if there are any changes or progress in their training and an annual letter outlining their individual requirements for the training year.

7.4 Trainee wellbeing

Accreditation standard 7.4.1

The SET Regulations Handbook clause 1.8 outlines review proceses

7.5 Resolution of training problems and disputes

Accreditation standards 7.5.1 and 7.5.2

The SET Regulations Handbook clause 1.8 outlines review proceses

Trainees complete training position evaluations on a six monthly basis which are confidential. This allows trainees to provide confidential information regarding the supervision and training experiences.

Standard 8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standards 8.1.1 and 8.1.3

The Training Post Accreditation Regulations outlines supervision requirements.

Accreditation standard 8.1.4

Trainees provide direct feedback on their training posts which includes education, training and supervision, at six monthly intervals.

Includes two trainee representatives. Action is taken as a result of training unit confined issues and wider issues.

8.2 Training site and posts

Accreditation standards 8.2.1 and 8.2.4

8 The Training Post Accreditation Regulations outlines accreditation requirements

Standard 9 Continuing professional development, further training and remediation

In accordance with RACS policies

Standard 10 Assessment of specialist international medical graduates

In accordance with RACS policies

Neurosurgery supporting documentation available

No.	Document name	Relevant standards
NEU web	Neurosurgical Society of Australia	
NEU web	Neurosurgery RACS website	
NEU web	RACS specialty society links to neurosurgery	
NEU web	SET selection RACS website	
NEU01	Service Agreement	1.2.1
NEU02	Neurosurgery SET Regulations Handbook	1.2.1, 1.3.1, 3.3.1, 3.3.2, 3.4.3, 4.1.1, 4.2.2, 4.2.3, 5.1.1, 5.1.2, 5.1.3, 5.2.1, 5.2.2, 5.2.3, 5.3.3, 6.2.1, 6.3.3, 7.3.2, 7.4.1, 7.5.1, 7.5.2
NEU03	Neurosurgery Training Post Accreditation Regulations	1.6.2, 5.4.2, 6.2.1, 8.1.1, 8.1.2, 8.1.3, 8.1.5, 8.2.1, 8.2.2
NEU04	Selection Regulations 2018	7.1.1, 7.1.2, 7.1.4
NEU05	Board Terms of Reference	1.2.1, 1.4.1, 1.7.1, 7.2.1
NEU06	Examinations Committee Terms of Reference	1.7.1, 5.1.1, 7.2.1
NEU07	Training Post Allocations and Evaluations (Committee Terms of Reference)	1.7.1, 4.2.1, 5.4.1, 7.2.1, 6.1.3, 6.2.3, 8.1.4
NEU08	Neurosurgery Curriculum	2.2.2, 3.2.1 – 3.2.10, 3.4.1
NEU09	Neurosurgery Statement of Competence	2.2.2
NEU10	Professional performance report	5.3.1 – 5.3.4
NEU11	Neurosurgery Training Post Evaluation Survey	1.6.2, 5.4.1, 6.1.3, 6.2.3, 6.3.2, 8.1.4

ORTHOPAEDIC SURGERY AUSTRALIA

Specialty performance against AMC accreditation standards –

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Orthopaedic Surgery Australia specialty-specific activities is presented here.

1 The context of training and education

1.2 Program management

Accreditation standard 1.2.1

AOA is led by a Board of Directors. The AOA Board has a number of standing committees.

The AOA Federal Training Committee (FTC) is a sub-committee of the AOA Board of Directors whose aim is: to deliver a world class Surgical Education and Training Program in Orthopaedics, which facilitates the development of competent orthopaedic surgeons and optimises patient care.

The objectives of the FTC are:

- To develop, deliver and review a comprehensive SET Syllabus and Curriculum, including appropriate assessment
- To develop, implement and review education and training policy
- To develop, implement and review training site accreditation guidelines and processes
- To develop, implement and review SET Selection Regulations and processes
- To monitor trainee progression through the training program, including the management of any performance issues
- To provide advice on the assessment of Overseas Trained Specialists (International Medical Graduates) for practice in Australia
- To assess, and monitor supervision and oversight of, Overseas Trained Specialists during their preparation for practice in Australia
- To support AOA members involved in training
- To promote efficient, transparent, effective and fair processes
- To provide guidance on interpretation of education and training policy and processes
- To report to the AOA Board of Directors on matters of education and training

The FTC has a number of subcommittees and working groups, with defined scopes of operation. The FTC's membership incorporates regional representatives, the Dean of Education, a Jurisdictional Representative and the President of the Trainee's Association. Additional expertise is provided via the AOA Education & Training staff, and targeted consultant services.

Preliminary scoping for a review of FTC governance has recently commenced with a view to establishing permanent subcommittees with some delegation of authority to perform duties with regard to the day-to-day operations of a defined area of work. The formation of active sub-committees would enable FTC to provide high-level guidance for the running of the training program, while making time available for education strategy. Possible sub-committees of FTC could be curriculum, assessment, selection, accreditation and IMG management.

The Chair of the FTC represents AOA on the RACS Board of Surgical Education and Training (BSET).

The AOA Continuing Professional Development (CPD) Committee is a sub-committee of the AOA Board of Directors whose aim is: To ensure the provision of an appropriate and accessible CPD program for members of the Association.

The objectives of the CPD Committee are:

- To encourage members to pursue ongoing professional development throughout their career.

- To encourage members to participate in the Association's CPD program.
- To ensure the rules and requirements of the Association's CPD program provide appropriate flexibility, simplicity and relevance for members.
- To review the effectiveness of the rules, requirements and structure of the Association's CPD program and to recommend to the Board any necessary changes to the program.
- To ensure the provision of easy, user-friendly recording of CPD participation by members.
- To ensure CPD compliance is audited on a regular basis.

The CPD Committee's membership incorporates regional representatives, the Chair of the FTC, the Scientific Secretary and the Continuing Orthopaedic Education Chair.

The Chair of the CPD Committee represents AOA on the RACS Professional Development and Standards Board (PDSB).

1.3 Reconsideration, review and appeals processes

Accreditation standard 1.3.1

AOA has a Reconsideration, Review and Appeals policy whereby any Member adversely affected by a decision of the Association, may apply to have the decision reconsidered, reviewed and appealed.

In addition, a separate process of Reconsideration and Review is documented as part of the Regulations for Selection to SET. This process was developed with legal advice, based on the broader members Reconsideration, Review and Appeals policy but incorporating a much shorter timeline to enable the reconsideration and review process to take place within a timeframe that would allow the process to effect the Selection outcome should a decision be overturned.

An ongoing quality assurance process has been applied to the Appeals process with feedback considered and the policy refined. In particular, a protocol on Constituting Review Panels has been established which requires the review panel to be comprised of Fellows experienced in the area under review, in order to ensure the Review Panel is well informed with regard to the context around the original decision.

1.4 Educational expertise and exchange

Accreditation standard 1.4.1

AOA has previously reported on the significant external review, conducted by A/Professor Jason Frank from the Royal College of Physicians and Surgeons of Canada, which resulted in sixteen recommendations for change across AOA education and training programs.

The AOA Board approved recommendations for change in October 2013. Subsequently, a two stage, eight-year implementation plan for the AOA 21 Research Project was developed and approved covering 9 key areas as follows.

- A revised curriculum based on the key attributes required of an orthopaedic surgeon on their first day of independent practice. The 'non-technical' competencies (e.g. communication, professionalism, teamwork and leadership) were re-prioritised as 'Foundation' competencies, emphasized and assessed as the basis of quality patient care.
- A phased introduction of workplace-based assessments, both for learning and of learning, based on the principles of programmatic assessment developed by van der Vleuten and Schuwirth 1. A suite of workplace-based assessment tools all delivered through a smartphone App, including an eLogbook and a trainee-initiated Feedback App, encouraging deeper learning through concepts of 'entrustability' 2 and effective feedback 3.
- A significant investment in an eLearning structure supporting instructional delivery, data capture and analysis of trainee progress in real time using a 'dashboard' approach, facilitating trainee reflection.
- Alignment of pedagogy with the new curriculum and assessment tools.
- Development of a comprehensive suite of faculty development workshops, online seminars and educational resources to equip our surgeon members with evidence-based teaching methods, fit for purpose.
- A review of training site accreditation process and policy, based on the new curriculum.

- Improving on our current selection processes incorporating internal analysis and international experience.
- Restructuring of trainees' education and participation in orthopaedic research, to embed literature literacy and the surgeon scientist.
- Finally, to embed many of these developments into ongoing professional education after training and continuing professional development, creating a whole-of-practicing-life learning continuum.

The 'AOA 21' project, now two years into its eight year program, is incorporating global best-practice by:

- Modernizing and streamlining the orthopaedic curriculum.
- Introducing more valid and purposeful, programmatic assessment.
- Developing AOA member and resident skills to enhance the teaching experience.
- Using smarter technology to improve efficiency, flexibility and transparency of training.

AOA has continued to liaise with A/Prof Frank in an ongoing way and has contracted a medical education expert to guide the development of the AOA 21 project.

As mentioned at item 1.21, AOA has an experienced Education and Training Team, including the recently appointed Dean of Education, who provides additional expertise in the development, management and continuous improvement of its training and education functions. AOA also engages targeted consultant services in areas such as educational development and statistical analysis.

References

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3. Lefroy J, Watling C, Teunissen PW, Brand P. Guidelines: the do's, don'ts and don't knows of feedback for clinical education. *Perspect Med Educ*. 2015;4(6):284-299. doi:10.1007/s40037-015-0231-7.

Accreditation standard 1.4.2

AOA actively collaborates with International orthopaedic groups including: Asia Pacific Orthopaedic Association, American Orthopaedic Association, American Academy of Orthopaedic Surgeons, Canadian Orthopaedic Association, British Orthopaedic Association, South African Orthopaedic Association and the New Zealand Orthopaedic Association.

AOA also actively collaborates with other specialties and sub-specialties, the AMC, federal and state health services.

AOA has been involved in: ICRE, TISLEP, Ottawa conference, APEC, ethics, leadership in medical education through IMELF, COMOC and many other overseas Orthopaedic Association Meetings in the Asia pacific region.

The AOA Strategic Education Review referred to at item 1.4.1 delivered four main elements:

1. A review of existing structure and pedagogy across Australia using surveys of members and trainees, site visits and interviews
2. A summary of leading educational practices across postgraduate medical education across the globe
3. A frank account of the strengths and challenges within current orthopaedic surgery education and training in Australia, framed as 'opportunities for excellence'
4. An implementation roadmap to guide the journey towards world-recognised best practice in orthopaedic training

AOA would be pleased to present progress on the AOA 21 project to the AMC Accreditation Team.

1.5 Educational resources

Accreditation standard 1.5.1

AOA undertook a facilitated costing exercise, which aimed to evaluate the actual cost of the activities undertaken and delivered as part of the training program in order to determine appropriate fees on a cost

recovery basis. This exercise affected both the Training Fee and fees for particular training activities such as in training exams and courses. The process took into account staffing requirements, including time commitments and levels of activity. This information feeds into work planning and role definitions within the AOA team.

Accreditation standard 1.5.2

The AOA employs a dedicated Education and Training Team as follows:

- Ian Incoll – Dean of Education
- Ally Keane – National Education Manager
- Michelle van Biljon – Education Manager/AOA 21 Project
- Elizabeth Burrell – Education Manager
- Alexandra La Spina – Senior Training Officer
- Currently vacant – Training Officer
- Belinda Balhatchet – Senior Education Officer
- Vicky Dominguez – Education and Training Officer

The core Education and Training team in head office is supported by Regional Managers around the country as follows:

- David Parker – QLD
- Sarah Cartwright – VIC/TAS
- Kimberley Heinrich – SA/NT
- Julia Holloway - WA

AOA also employs staff in other service areas which support the activities of Education and Training including, Information Technology, Finance, Membership and Fellowships, and Executive Services.

1.6 Interaction with the health sector

Accreditation standard 1.6.2

AOA works closely with Training Sites to ensure provision of high quality teaching and supervision. The AOA Accreditation Standards incorporate requirements for Surgeons working with Trainees to be appropriately supported.

AOA has defined roles for Directors of Training and Trainee Supervisors. These surgeons are required to be CPD compliant; this requirement is also captured in the Accreditation Standards. AOA provides a CPD Program tailored to orthopaedic surgeons to facilitate ongoing learning.

AOA provides a number of workshops for Surgeons involved in training on topics such as: Trainee Supervision – A Planned Approach, Helping Underperforming Trainees, Effective Feedback, Teaching in the Clinical Setting and Workplace Based Assessment

Accreditation standard 1.6.3

AOA has active and regular involvement with a number of key stakeholders with regard 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), Federal Department of Health, Minister for Health (Chief of Staff), Private Health Organisations, and Industry.

A Jurisdictional Representative continues to sit on the AOA Federal Training Committee. This representative is a full, voting member of the committee.

Jurisdictional Representative involvement is actively sought in training site accreditation inspections and SET selection interviews. Work is underway to further refine and define this role.

In the interests of transparency, good governance and in order to safeguard trainees, AOA has implemented Accreditation Agreements with Training Sites which confirm acceptance of the AOA accreditation standards and the process by which those accreditation standards are to be applied.

Accreditation standard 1.6.4

AOA recently held a Continuing Orthopaedic Education Conference with a focus on 'Trauma in the Outback'. The meeting was held in Uluru in an attempt to bring education to our rural and remote surgeons. The meeting provided an excellent opportunity to promote consideration of the unique needs of the indigenous health sector.

1.7 Continuous renewal

Accreditation standard 1.7.1

AOA utilises a Strategic Planning process, which defines the Vision, Statement of Purpose and Core Strategies for AOA. The 2016-2018 Strategic Plan is the first of the four Core Strategies which relates to Education and Training, which the AOA Board have confirmed as core business for AOA.

AOA also follows an ongoing quality assurance review process across the organisation to monitor performance and determine prioritisation of workflows. This cyclical process includes project management, project planning, risk management, technology management and governance reviews.

As part of the AOA Strategic Education Review referred to at item 1.4.1, consideration was given to structures and functions for, and resource allocation to, training and education functions. This was also an element of the facilitated costing exercise referred to at item 1.5.1.

2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard 2.1.1

AOA's statement of purpose:

AOA is the peak professional body in Australia for advancing excellence of orthopaedic practice in the interests of patients and the community, and in the training of surgeons to world-class standards.

Accreditation standard 2.1.3

Consultation processes as part of the Strategic Education Review have been outlined above at item 1.4.1. AOA has taken advantage of recent opportunities to consult via COMOC South Africa; American Orthopaedic Association; AAOS; and meeting with other surgical specialties.

AOA also conducts an annual survey of the membership, which feeds into the Strategic Planning process.

AOA will shortly (2016) be circulating the draft revised curriculum developed via the AOA 21 Project to external stakeholders for consultation.

2.2 Program outcomes

Accreditation standard 2.2.2

Orthopaedic Surgery is the medical specialty that focuses on the diagnosis, care and treatment of patients with disorders of the bones, joints, muscles, ligaments and tendons. These elements make up the musculoskeletal system. Orthopaedic surgeons use medical, physical and rehabilitative methods as well as surgery in caring for their patients.

As noted at item 1.4.1, the AOA is in the process of revising the curriculum.

2.3 Graduate outcomes

Accreditation standard 2.3.1

The Curriculum defines graduate outcomes across Key Learning Areas of:

- Trauma and Injury
- Shoulder
- Elbow
- Hand & Wrist
- Hip
- Knee
- Foot & Ankle
- Spine
- Tumour & Tumour-like Conditions
- Paediatrics
- Systemic Medical Conditions

Current Curriculum modules on the Key Learning Areas and Foundation Competencies of Communication, Teamwork and Conflict, Management, Professionalism, Management and Leadership, Advocacy and Ongoing Learning, Teaching and Research. These will be represented in the revised curriculum outlined at item 1.4.1.

3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard 3.1.1

The Curriculum is currently delivered according to the 5 year SET Program structure. Instead of 5 one-year stages, in the future orthopaedic training will have three key Stages of Training diagram comprising: Introduction to Orthopaedics, Core Orthopaedics and Transition to Consultant Practice. Refer to item 1.4.1

3.2 The content of the curriculum

Accreditation standard 3.2.1

The Curriculum defines the multi-faceted roles of an orthopaedic surgeon. It builds on these definitions to outline the required competencies for each role. These will be represented in the revised curriculum outlined at item 1.4.1.

Accreditation standard 3.2.3

It is recognised that the foundation competencies interrelate to the role of Medical and Surgical expert. It is the combination of the roles that enable safe patient care. As Trainees progress through the training program, they demonstrate varying levels of competence. The training program entails sufficient flexibility to respond to Trainees who require additional support or who demonstrate exceptional performance. The curriculum allows for progressive development of skill, knowledge and experience facilitated by graduated levels of supervision and independence.

Recognising that Foundation Competencies, together with medical and surgical expertise are the foundations of quality patient care, as part of the AOA 21 project these have been included in Section 1 of the revised curriculum in order to emphasis their importance.

3.3 Continuum of training, education and practice

Accreditation standard 3.3.1

The Strategic Education Review outlined at item 1.4.1 incorporated all elements of the Education programs of the AOA. This included Selection and consideration for the experience of junior doctors, Surgical Education and Training and CPD. These three programs are considered as a continuum to ensure correlation between the programs and through the cycle of learning for an orthopaedic surgeon.

Accreditation standard 3.3.2

Current Trainees who believe their prior orthopaedic learning experience has led to demonstrated curriculum

competency can apply to the FTC for recognition of these experiences. RPL applications have been approved.

3.4 Structure of the curriculum

Accreditation standard 3.4.1

The current structure of the curriculum outlines what is required for each competency at the various SET levels. Moving forward, as part of the AOA 21 Project, delivery of training will be via three key stages comprising: Introduction to Orthopaedics, Core Orthopaedics and Transition to Consultant Practice Refer to item 3.1.1. The curriculum will clearly articulate expectations regarding requirements for each stage.

Accreditation standard 3.4.2

Currently, the training program is 5 years in duration. The minimum training time is 4 years with flexibility allowed for trainees who require additional support or who demonstrate exceptional performance. Training can be extended up to 8 years if required to demonstrate competence or shortened to 4 years where competence is demonstrated early.

Accreditation standard 3.4.3

The Applications for part-time training and interruption to training summary is available.

Accreditation standard 3.4.4

Trainees can request specific rotations in order to focus on areas of interest. Trainees have the option to apply to complete a paediatric term at Shriners Hospital for Children in the USA.

With the changes foreshadowed as part of the AOA 21 project, this will be approached in a more structured fashion.

4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1

There are a number of lectures/tutorials, practice exams, training courses, scientific meetings and conferences that a trainee attends. This includes the structured and targeted bone school program.

With the changes foreshadowed as part of the AOA 21 project, a number of new learning approaches will be adopted, including the development of online learning resources and Learning Management System.

4.2 Teaching and learning methods

Accreditation standard 4.2.2

Trainees attend regular bone school lectures and tutorials. The bone school program is mapped to the curriculum to ensure structured and targeted teaching of curriculum competencies. Each cycle of the program builds on the last to ensure both a solid foundation of knowledge and a progression towards application and synthesis of this knowledge. Content is delivered in clinically contextualised scenarios.

Trainees participate in regional practice exams, a national pre-exam course and the National Trial Fellowship Exam.

Trainees also attend a number of scientific meetings and conferences

In 2017 AOA will trial introduction of ‘Bone Camp’ a 3 day workshop for newly selected trainees providing an orientation to the training program and focusing on communication skills, research methodology, ethical decision making, history taking and physical examination, professionalism and feedback.

Accreditation standard 4.2.3

Trainees are actively involved in the delivery of bone school, presenting cases and teaching more junior trainees.

Trainees contribute to the teaching of junior doctors, and other colleagues.

Trainees are involved in departmental meetings where they present cases for discussion in a multi-disciplinary setting.

Trainee learning and assessment is trainee led, trainees are encouraged to set learning goals and to seek out feedback from their supervisors.

Accreditation standard 4.2.4

With the changes foreshadowed as part of the AOA 21 project, it is anticipated that there will be barriers to progression between the three stages of training, which will require demonstration of competence against predetermined milestones.

5 Assessment of learning

5.1 Assessment approach

Accreditation standard 5.1.1

Currently assessments are conducted against the expected standard of the trainee for their SET level. With the changes foreshadowed as part of the AOA 21 project, it is anticipated that trainees will be assessed against the level of consultant practice which will enable overall monitoring of progression towards competence as an orthopaedic surgeon rather than a trainee at a certain level.

Accreditation standard 5.1.2

Progression requirements are available to staff, trainees and supervisors via the Learn@AOA platform.

Accreditation standard 5.1.3

Under extraordinary circumstances, trainees may apply for special consideration of deviation from the progression requirements. Requests for special consideration will be considered on a case-by-case basis

5.2 Assessment methods

Accreditation standard 5.2.1

Workplace based assessments utilised include:

- Quarterly Assessment Reports (completed by the Director of Training)
- DOPS
- Mini-CEX
- CbD
- MSF

As part of the AOA 21 Project a number of new assessment tools are being developed. The following tools are currently being trialled:

- Surgical Skills Assessment (observation of procedural skills)
- Patient Consultation Assessment (observation of initial assessment of a patient)

Management Plan Assessment (observation of development and implementation of a patient management plan)

5.3 Performance feedback

Accreditation standard 5.3.1

The Director of Training completes a Quarterly Assessment Report (QAR) with the trainee at the completion of each three-month training period. A QAR Feedback meeting is held, where the rating on the form are discussed. Where deficiencies are identified an improvement or remedial plan is developed to assist in addressing the concerns.

Accreditation standard 5.3.2

Each training region has a Regional Training Committee (RTC) comprised of each Training Sites Director of Training. The RTC meets at the conclusion of each three-month training period to discuss trainee performance to ensure the continuity of trainee learning.

Where a trainee requires additional support and is due to change training sites, the supervisors from the old and new training site collaborate to determine the improvement or remedial plan for the trainee.

Accreditation standard 5.3.3

Trainees who require additional support may be identified at any time outside the QAR cycle via submission of an interim assessment report.

Whether identified via a QAR or interim assessment report, the trainee will meet with their Supervisor and Director of Training who will work with the trainee to develop an improvement or remedial plan to address the areas of concern. The trainee will meet with their supervisor monthly during the term to monitor progress and discuss performance. Use of additional workplace based assessment tools aimed at provision of feedback may be required as part of an improvement/remedial plan.

If a trainee performance fails to respond following provision of extra support, they may be considered for a further period of probation or dismissal.

Number of Dismissals during SET since 2013	Reason
6	Includes failure to complete SSE Exam requirements & Review Committee Decisions on performance

Accreditation standard 5.3.4

Where issues of patient safety are raised via workplace based assessment the Director of Training raises the concerns through the hospital pathways as an employee of the training site.

5.4 Assessment quality

Accreditation standard 5.4.1

The summary of withdrawals from training over the past five years is available

Accreditation standard 5.4.2

AOA provides clear instructions for use of workplace based assessment tools. The assessments are linked to curriculum competencies. Regular Federal and Regional Training Committee meetings facilitate discussion of the implementation of assessment & allow correlation between assessors. Furthermore, AOA runs workshops for supervisors on workplace based assessment and provision of feedback with a view to ensuring a national standard.

6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.2

Supervisors are routinely surveyed for feedback twice annually. In addition, Supervisors are actively involved in committees and working groups involved in review and development.

Accreditation standard 6.1.3

Trainees are routinely surveyed for feedback twice annually. In addition, trainees are actively involved in committees and working groups involved in review and development.

AOA has a highly engaged Trainee Association, which is an effective channel for two-way communication. As mentioned above, the President of the Trainee Association is a full voting member of the AOA Board and Federal Training Committee.

AOA also communicates with trainees via written correspondence, email and newsletters in addition to face-to-face communication at Bone School and meetings/conferences.

AOA investigated utilising social media as a mechanism of communication with trainees however feedback from the trainee body was not supportive of adopting this. Electronic or online communication is instead facilitated via the online learning platform.

6.2 Evaluation

Accreditation standard 6.2.3

Internal and external stakeholders contributed to the Strategic Education Review.

6.3 Feedback, reporting and action

Accreditation standard 6.3.1

Outcomes of the regular trainee and supervisor surveys are reported to Regional and Federal Training committees and the AOA Board for response and action as required.

Accreditation standard 6.3.2

Training Committees consider outcomes of program evaluation with a view to monitoring effectiveness of the training program. Aggregated, de-identified trainee feedback in particular is taken into account as part of the Accreditation process. Summary data is provided to the broader membership, and raised with other stakeholder groups for comment.

Accreditation standard 6.3.3

The AOA has a comprehensive risk management strategy incorporating but not limited to the training program. The risk process includes identification of risks and their potential impacts, identification of current controls and additional controls that may be implemented, and determination of the residual risk. Risk management activities are managed and monitored through the Audit and Risk Committee.

7 Trainees

7.1 admission policy and selection

Accreditation standard 7.1.1

In 2013 thirty-five (35)* trainees were appointed into the SET program to commence in 2014

In 2014 fifty-eight (58)* trainees were appointed into the SET program to commence in 2015

In 2015 fifty (50)* trainees were appointed into the SET program to commence in 2016

Accreditation standard 7.1.2

The Selection process is reviewed annually, with data from each round analysed by an external statistician. Advance notice is provided for any major changes to Selection.

A tailored process of Reconsideration and Review is documented as part of the Regulations for Selection to Surgical Education and Training (refer to Section 12). This process was developed with legal advice, based on the broader members Reconsideration, Review and Appeals policy but incorporating a much shorter timeline to enable the reconsideration and review process to take place within a timeframe that would allow the process to effect the Selection outcome should a decision be overturned.

Accreditation standard 7.1.3

AOA is supportive of facilitating mentoring relationships for Aboriginal and Torres Strait Islander Junior Doctors with an interest in orthopaedic surgery

Accreditation standard 7.1.4

AOA indicates that the training program requires trainees to rotate between a variety of training sites in information developed for undergraduate doctors considering a career in orthopaedic surgery.

Accreditation standard 7.1.5

AOA statistically reviews referee report and interview scores to identify anomalies, errors or indication of bias. Scores may be statistically adjusted as required.

7.2 Trainee participation in education provider governance

Accreditation standard 7.2.1

The AOA has an active Trainee Association, which is governed by the Trainee Executive Committee. The President of the Trainee Association is a full voting member of the AOA Board of Directors and The Federal Training Committee. The Trainee Executive Committee has regional trainee representation; these regional members also sit on the Regional Training Committees.

The trainee body elects members to the Committee. The Trainee Executive Committee meets at least four times each year and receives secretariat support from the AOA Head Office.

7.3 Communication with trainees

Accreditation standard 7.3.1

As noted above, AOA has a highly engaged Trainee Association, which is an effective channel for two-way communication. AOA also communicates with trainees via written correspondence, email and newsletters in addition to face-to-face communication at Bone School and meetings/conferences.

AOA investigated utilising social media as a mechanism of communication with trainees however feedback from the trainee body was not supportive of adopting this. Electronic or online communication is instead facilitated via the online learning platform.

Accreditation standard 7.3.2

AOA engages with a number of undergraduate programs to disseminate information regarding a career in orthopaedic surgery. Information regarding the structure and broad requirements of the training program are included in the information provided.

Major changes are foreshadowed and notified in advance.

Accreditation standard 7.3.3

Information relating to a trainees progress through training is communicated on a regular basis. In particular, where a trainee's status changes this is always confirm in writing along with any implications of this change in status.

As part of the AOA 21 project, AOA is building its capacity for online learning which includes better tools to enable trainees to monitor their progress through training via the learning platform.

7.4 Trainee wellbeing

Accreditation standard 7.4.1

AOA is working on expanding faculty development workshops to better equip surgeons involved in training for this role.

AOA has a Bullying, Harassment and Discrimination Policy, which confirms that all AOA staff, members and trainees are entitled to be treated fairly and to work and/or learn in an environment free from bullying, harassment and discrimination. AOA does not condone bullying, harassment or discrimination in any form and is committed to its prevention. The privacy and confidentiality of those who allege harassment and those who are alleged to have harassed are respected at all times.

7.5 Resolution of training problems and disputes

Accreditation standard 7.5.1

Trainees execute a Training Agreement on acceptance of a training post with AOA. The Training Agreement outlines the rights and responsibilities of the Trainee and AOA with regard to the training program. The Agreement outlines the avenues that a trainee may pursue for advice or assistance. Generally a Trainee's first point of contact is their Director of Training, however the Trainee is able to go directly to the Regional or Federal Training Chair where they have concerns within their department. Complaints and concerns may also be raised directly with AOA staff.

Accreditation standard 7.5.2

Where concerns are raised these are generally managed locally and resolved through mediation. Issues rarely require escalation to the Secretary of the Board. Where additional intervention is required, senior office bearers independent to the local situation are called on for review.

8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standard 8.1.1

The Accreditation Standards require training sites to provide a supervisor to trainee ratio of 1:2. Every training site must have an appointed Director of Training and each trainee has a nominated Trainee Supervisor who ideally provides one-on-one supervision of the trainee, but can supervise up to a maximum of two trainees at any time.

Accreditation standard 8.1.2

The roles of the Director of Training and Trainee Supervisor are defined.

The AOA Director of Training is the individual primarily responsible for training within each accredited training site. The DoT works with Trainee Supervisors, as well as with other surgeons and consultants within the training environment, to provide the best possible learning environment for the Trainee. Additionally, the DoT has responsibilities as a member of the relevant Regional Training Committee (RTC).

The Trainee Supervisor is the designated individual responsible for the day-to-day supervision and training of a Trainee. The Trainee Supervisor is expected to provide direction and feedback to the Trainee on a regular basis. The Trainee Supervisor reports on the Trainee's performance to the Director of Training

Accreditation standard 8.1.3

Directors of Training are nominated by the training site and appointed by the Federal Training Committee.

AOA has the following eligibility requirements for Directors of Training:

- Be FRACS qualified.
- Be an AOA Fellow (at least 2 years post-fellowship).
- Have completed their Continuing Professional Development (CPD) requirements for the preceding year.

Ideally, the nominated Director of Training will also:

- Be an operating member of staff at the training site.
- Have a level of seniority within the Department.
- Have experience as an AOA Trainee Supervisor.
- Have an active interest in education and training.
- Have demonstrated experience with clinical, administrative and teaching skills.
- Have completed appropriate workshops.

AOA offers a number of workshops for Directors of Training to aid in their performance in this role.

Accreditation standard 8.1.4

Trainee feedback, including on supervisors, is sought twice annually. Completion of this feedback is mandatory.

Accreditation standard 8.1.5

Trainee Supervisors are nominated by the Director of Training and

AOA offers a number of workshops for Trainee Supervisors to aid in their performance in this role.

8.2 Training site and posts

Accreditation standard 8.2.1

The AOA Accreditation Standards outlines the requirements for orthopaedic surgery.

The AOA assesses each site on a range of criteria to ensure that the site is appropriately equipped to host SET trainees. Areas assessed include:

- Education facilities and systems
- Quality education, training and learning
- Supervision and assessment
- Support services for trainees
- Clinical load and theatre sessions
- Equipment and clinical support services
- Clinical governance, quality and safety

AOA has scheduled a review of the Accreditation Standards and Processes to commence in 2017 as part of the AOA 21 project.

The list of Accredited Training Sites is available

Accreditation standard 8.2.2

The AOA accreditation process currently runs on an annual cycle to determine whether a training position is suitable at a particular site. This determination is made against the AOA Accreditation Standards to ensure that training site practices are acceptable for training and employ suitable quality assurance.

Hospitals are inspected quinquennially at a minimum, in line with all training sites in their region. Additional to this, a mini-inspection may be carried out at training sites not in the dedicated region depending on inspector

follow-up recommendations or AOA initiation. Occasionally a mini-inspection may be necessary when concerns are identified relating to the quality of training, breach of accreditation standards or other issues. Furthermore, the process of accreditation may be initiated by a hospital that wishes to undertake SET for the first time or apply for an additional training post.

Applications for new or additional accreditation posts must be received by 1 October of the year prior. Applications should be accompanied by all relevant documentary evidence in order for assessment to commence.

Following Regional Training Committee input (as needed), the Federal Training Committee reviews applications & determines which sites will be inspected at its February meeting. Hospital inspections occur in March/April annually. Inspections are conducted by approved hospital inspection teams comprised predominantly of orthopaedic surgeons and may include a jurisdictional representative or AOA staff member. The inspection team prepares a report, which is provided to the Hospital for comment prior to being submitted to the Federal Training Committee. Accreditation decisions, based on inspection recommendations, are made at the July Federal Training Committee meeting for implementation in the following training year.

The Standards incorporate:

- Availability of appropriate supervision (refer item 8.1) including a nominated Director of Training who is supported by the Department in delivery of regular training, assessment and provision of effective feedback
- The requirement for departments to demonstrate their commitment to training and the health and safety of their trainees
- Access to a range and volume of clinical and operative experience that will enable them to acquire the competencies outlined in the AOA SET Curriculum
- Access to the appropriate educational facilities and systems required to undertake the AOA SET Program
- Opportunities for trainees to participate in a range of activities, which will assist in the achievement of the competencies outlined in the AOA SET Curriculum.
- The facilities, equipment and clinical support services required to manage orthopaedic surgical cases
- Appropriate accreditation, and the presence of a governance structure to deliver and monitor safe surgical practices

The majority of trainees will complete at least one rural rotation during their training.

Trainee eLOGs, which document procedures trainees are involved in stratified by their level of involvement, are monitored to ensure the adequacy of the clinical experience in each post.

As part of the AOA 21 Project in addition to a broad review of accreditation, a number of changes to the way trainees are allocated to particular training posts are expected to allow better monitoring over curriculum coverage.

9 Continuing professional development, further training and remediation

9.1 Continuing professional development

The Continuing Professional Development program handbook outlines the ongoing needs and educational requirements for Association (AOA) members.

9.2 Further training of individual specialists

Accreditation standard 9.2.1

The Professional Conduct and Standards Committee manage requests for further training in orthopaedic surgery. These requests are rare and are managed on a case-by-case basis.

AOA accredits a number of advanced training Fellowship positions in sub-specialty fields.

9.3 Remediation

Accreditation standard 9.3.1

The Professional Conduct and Standards Committee manage requests for remediation of specialists in orthopaedic surgery. These requests are rare and are managed on a case-by-case basis.

10 Assessment of specialist international medical graduates

In accordance with RACS policy

Orthopaedic Surgery Australia supporting documentation available

No.	Document name	Relevant standards
OSA web	Australian Orthopaedic Association	
OSA web	Specialty Overview RACS Website	
OSA web	SET Selection Orthopaedic Surgery	7.1.1, 7.1.2, 7.1.4
OSA web	AOA 21 Project	1.4.1, 8.2.2
OSA01	AOA Service Agreement	
OSA02	2016-2018 Strategic Plan	1.7.1
OSA03	Regulations for Selection to SET in Orthopaedic Surgery in 2018	7.1.1, 7.1.2, 7.1.4
OSA04	AOA Syllabus and Curriculum	2.3.1, 3.1.1, 8.2.2
OSA05	Reconsideration, Review and Appeals Policy	1.3.1, 7.1.2
OSA06	AOA RPL Part Time Interrupted Withdrawal Summary	3.3.2, 3.4.3, 5.3.3, 5.4.1, 8.2.1
OSA07	Orthopaedic Surgery Training Schematic	3.1.1, 5.1.1
OSA08	Continuing Professional Development Program Handbook	9.1
OSA09	Accreditation Standards 2014	1.6.2, 8.2.1, 8.2.2
OSA10	Accredited Teaching Sites 2017	4.1.1, 4.2.1, 4.2.3, 8.1.1, 8.1.2, 8.2.1, 8.2.2

ORTHOPAEDIC SURGERY NEW ZEALAND

Specialty performance against AMC accreditation standards

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Orthopaedic Surgery NZ specialty-specific activities is presented here.

1 The context of training and education

1.2 Program management

Accreditation standard 1.2.1

The NZOA Education Committee takes responsibility in conjunction with the Senior Examiner and the Board of Specialty Orthopaedic Training for planning and implementing the delivery of the NZOA Training Curriculum. Review of the syllabus is a current project of the NZOA Education Committee.

NZOA has a CPD Committee which meets on an annual basis to set implement and evaluate the effectiveness of continuing professional development. The new CPD programme started in 2015 has recently been evaluated and updated.

A member of the Education Committee is specifically tasked with the assessment of IMGs and to make a recommendation to the Medical Council of New Zealand. NZOA follows the RACS processes for evaluating IMGs.

NZOA tracks and monitors the progress of trainees through the training program to ensure that all the required components are completed prior to final sign off for completion. In the last three years two trainees have been required to complete an extra six months of training as their final SET 5 term was not satisfactory.

1.3 Reconsideration, review and appeals processes

Accreditation standard 1.3.1

NZOA is committed to ensuring that all review and appeals processes are impartial and fair. NZOA has dealt with one Selection appeal in the last 3 years. NZOA has worked closely with RACs on this (as RACS have managed this process) and have forwarded all the information requested. Refer to the NZOA SET Selection Regulations for information about complaints and appeals sent to unsuccessful candidates.

1.4 Educational expertise and exchange

Accreditation standard 1.4.1

The NZOA Education Committee and Specialty Board have a wide range of consultants as members all of whom have a broad educational knowledge.

Accreditation standard 1.4.2

The New Zealand Orthopaedic Association has close ties with the Australian Orthopaedic Association, General Surgeons New Zealand, and Plastics New Zealand. The Education and Training Manger of NZOA meets regularly with General Surgeons New Zealand to discuss training issues and to compare the training programs. The Senior Examiners for Orthopaedics meet on an annual basis to discuss the joint curriculum. In addition the NZOA Presidential line fosters close links with a number of Orthopaedic Associations. These include the Canadian, British, South African American and Australian Orthopaedic Associations. NZOA members also participate in a number of overseas fellowships and exchanges. These include Hong Kong Young Ambassador, ASEAN Fellowship, ABC Fellows and ANZAC Fellow. NZOA is a member of APOA.

1.5 Educational resources

Accreditation standard 1.5.1

NZOA has a staff member dedicated to Education and Training and to support the Education Committee, Specialty Board and trainees.

In the next five years NZOA will be working on implementing activities around cultural competence, communication skills and how to foster an inclusive and supportive culture among trainees, and all members of NZOA. Also there is a need to keep abreast of new developments in surgical education and learning. One issue is competency based training as opposed to time based training.

1.6 Interaction with the health sector

Accreditation standard 1.6.2

The NZOA Education Committee has representation from all DHBs that have trainees. The Education Committee meets at least 3 times a year and this fosters close collaboration between the training sites and the education provider.

Accreditation standard 1.6.4

NZOA is very aware of the issues around health disparities in Maori and Pacific Islander groups in New Zealand. The New Zealand Medical Council is focused on improving cultural competence and reducing health inequities and has specific initiatives for working with the Colleges in 2016/2017. There have been two meetings of the New Zealand Medical Colleges to discuss this. In addition the chair of the Medical Council of NZ has met with the NZOA CEO and the current President to further the discussion. It is proposed that there be a session on Cultural Competence for NZOA Members at the 2017 Annual Scientific Meeting.

1.7 Continuous renewal

Accreditation standard 1.7.1

This is reviewed on a regular basis. The Education Committee Terms of Reference are reviewed every two years to ensure they reflect current practice. (Please note this document is in review at present and will be finalised in November 2016.)

The NZOA Council has input into this process as well. Extra resources are available if needed.

Refer to the NZOA Annual report 2015-16

Refer to the Education Committee Terms of Reference. Please note this document is in review at present and will be finalised in November 2016.

Standard 2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard 2.1.3

NZOA aims to select and train competent orthopaedic surgeons to meet the health needs of New Zealanders and the aging and increasing population. This is the primary purpose of the New Zealand Education Committee. Internal Consultation is primarily with the Workforce assessor, the Education Committee, the Specialty Board and NZOA Council. External consultation is primarily with the Ministry of Health.

2.2 Program outcomes

Accreditation standard 2.2.2

In New Zealand this is being addressed with a number of District Health Board (DHB) and NZOA tools such as prioritisation tool, reviewing trainee numbers on an annual basis, workforce surveying and planning and succession planning.

2.3 Graduate outcomes

Accreditation standard 2.3.1

This information is available in the NZOA Annual Report 2014-2015, this information is publically available on the NZOA website

RACS also compiles all this information on an annual basis in the 'Activities Report'.

3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard 3.1.1

The AOA/NZOA SET Syllabus provides this information and is available on the NZOA website. The syllabus was reviewed in 2015.

The Exams and Courses graphic outlines the NZOA structure of training and timeframes for completion of exams and skills courses.

3.2 The content of the curriculum

Accreditation standard 3.2.1

The Curriculum covers the science of orthopaedics plus the covers the 9 competencies required by RACS for a surgeon.

The skills and knowledge trainees should know when they complete their training is outlined in the SET Syllabus

The syllabus was reviewed in 2015.

Accreditation standard 3.2.2

THE AOA/NZOA Curriculum is scientifically and evidence based on Orthopaedic best practice.

Accreditation standard 3.2.3

The Curriculum covers a range of skills to enable safe patient care. Trainees have to sit exams (clinical, diagnostic skills) do research (communication, clinical, management skills), complete a range of

assessments each six months of their training such as Mini Clinical Exam, Direct Observation of Procedural Skills (communication, clinical, diagnostic, management and procedural skills).

Accreditation standard 3.2.7

It is expected that by the time a trainee is at SET 5 level they are functioning at a 'pre-consultant level. For example at the second SET 2-5 training weekend the SET 5 trainees take on the role as a consultant mentoring and teaching the other trainees. Also trainees are expected to takes on leadership roles in the hospital departments during their training – including being responsible for rosters, presentation at Education sessions, the ASM and mentoring non-training registrars.

3.3 Continuum of training, education and practice

Accreditation standard 3.3.2

NZOA has not had any requests of this nature in the last four years.

3.4 Structure of the curriculum

Accreditation standard 3.4.2

NZOA believes that trainees require 5 years of full time training in order to achieve the required standard to become a vocationally registered orthopaedic surgeon in New Zealand.

Accreditation standard 3.4.3

In the last few years NZOA has had a number of trainees on interruption and deferment. In 2015 two trainees applied for and were granted interruption for family reasons. In 2014 a trainee was selected but was deferred to December 2016 while he completed his PhD. In 2016 there is 1 trainee on 12 months interruption and 1 took six months interruption.

4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1

During training NZOA Trainees are supported by a number of learning/teaching opportunities. They are all fully supported by their various hospitals with dedicated teaching sessions, one on one mentoring, attendance at training weekends and access to a range of other courses during the SET years. The variety available to trainees – i.e. a mixture of didactic and hands on learning accommodate a range of learning styles.

4.2 Teaching and learning methods

Accreditation standard 4.2.2

The NZOA website has links to a number of websites of benefit to Members and Trainees. These include Clinical Orthopaedics and Related Research (CORR), The Bone and Joint Journal, Orthoevidence and Bone School Website. Access to these websites is funded by NZOA and as such is part of the "Members Only" content of the NZOA website. These are added to on a regular basis - the CORR website was made available to NZOA Members in 2016.

5 Assessment of learning

5.1 Assessment approach

Accreditation standard 5.1.1

There are a number of tools used to tracks trainees progress over the course of their training. For example trainees in SET 1-4 are required to do the OITE (Orthopaedic In Training Exam) each year. This is used as an Educational tool and the expectation is that trainees will improve their score each year reflecting their increasing knowledge. Also trainees performance is scored at the SET 2-5 training weekends and trainees are evaluated against their peer group and also if there has been a significant increase or decrease in performance. It is expected that trainees in SET 5 are performing at near consultant level. Refer to the Mid Term Training Days Assessment 2016

5.2 Assessment methods

Accreditation standard 5.2.1

NZOA trainees are assessed using a number of workplace based assessments – such a Mini CEX, DOPS, Performance -based Assessment (PBA) and Quarterly for End of Term assessments.

Accreditation standard 5.2.3

The NZOA/AOA Senior Examiners do this.

5.3 Performance feedback

Accreditation standard 5.3.1

Our training supervisors meet regularly with the trainees in their departments to discuss their progress and to ensure that feedback is timely and guides the learning of individual trainees. In addition the two training supervisors in the Auckland region meet with all the Auckland based trainees to discuss progress and their end of term assessments.

Accreditation standard 5.3.2

All exam results and if necessary, the results of the previous year assessments, are sent to Surgical Supervisors. However this is not done if a trainee is progressing as expected.

Accreditation standard 5.3.3

NZOA has processes in place to manage trainees in this situation. In the first instance the supervisor meets with the trainee to discuss concerns. A plan of action is then formulated and agreed to by the trainee and the supervisor with provision for regular follow up reviews. The Education Committee is kept appraised of the situation. If the trainee needs help with a particular issue for example a cultural issue counselling can be arranged and there have been situations where this has happened.

NZOA has not dismissed any trainees in the last 3 years.

Accreditation standard 5.3.4

In New Zealand doctors work under the Health Practitioners Competence Assurance Act 2003 and as such there may be occasions where NZOA may have to inform employers and the Medical Council of New Zealand where there are patient safety concerns. In practice NZOA has not had to do this to date however it would be managed by the Specialty Training Board and the Executive of the NZOA Council.

5.4 Assessment quality

Accreditation standard 5.4.1

NZOA Education Committee discusses these issues on a regular basis and will make changes as needed.

Accreditation standard 5.4.2

The hospital inspection process ensures that all departments are working to the same standard. It is expected that smaller departments will differ from the larger departments with regards to resourcing and teaching capacity. In these cases the smaller centre will work with a larger metropolitan centre - for example Whanganui is a small training centre and it works closely with Palmerston North to share teaching sessions. The Whanganui trainee travels to Palmerston North to access more teaching opportunities.

6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.1

There is opportunity for review at least 3 times a year at the Education Committee meetings. The syllabus review is currently in progress. Teaching and supervision issues are also raised at these meetings.

Trainees are individually discussed at the March and October meetings. This discussion allows committee members to be aware of any issues with a particular trainee and the Committee as a group can come up with a plan if necessary. Mostly this discussion is a confirmation that a trainee is at the expected level for his/her training level.

Accreditation standard 6.1.2

The majority of the Education Committee members are training supervisors. They are able to contribute to monitoring and program development at the regular committee meetings.

Accreditation standard 6.1.3

There is a trainee rep on the NZ Specialty Orthopaedic Training Board. The Board chair sits on BSET and is in that role is party to the RACSTA survey results.

Trainee feedback on proposed changes to the training program is via trainee representation on RACSTA and via the NZ Rep who sits on the Specialty Board.

6.2 Evaluation

Accreditation standard 6.2.2

Yes NZOA collects this data and as a small organisation with 48 trainees is usually aware of the status of the current and ex trainees.

Accreditation standard 6.2.3

A consumer representative would assist with this. Having a consumer representative is a new concept for NZOA and this will require work to ensure that NZOA can utilise a consumer representative in a mutually beneficial manner.

6.3 Feedback, reporting and action

Accreditation standard 6.3.1

The NZOA Council and NZOA CEO are involved in monitoring and evaluating the NZOA training program.

Accreditation standard 6.3.2

NZOA does report on the outcome of the Fellowship Exam in the annual report and the Members are also informed via the fortnightly members Update.

7 Trainees

7.1 admission policy and selection

Accreditation standard 7.1.1

In 2014 we selected 9 trainees for the 2015 year

In 2015 we selected 9 trainees for the 2016 year

In 2016 we selected 9 trainees for the 2017 year however there will be 10 SET 1 trainees in 2017 as one candidate was selected in 2013 and then deferred while he completed his PhD

Accreditation standard 7.1.2

The Selection process is evaluated at the October or November Education Committee meeting and if there are any changes made, these are included on the NZOA website The selection documents and webpage are updated in November each year.

Accreditation standard 7.1.4

Trainees selected to the NZOA training program are aware that they will have to move to different centres and the expectation is that they spend 1 or 2 years in a smaller or provincial centre prior to moving to one of the bigger centres. Trainees prefer to be based in a larger centre in SET 4/5 in order to maximise studying opportunities with peers and consultant assistance for exam preparation. Trainees do get input into this process – at the first training weekend of the years trainee will list their placement preference for the following year. SET 5 trainees have priority in their placement preferences. New Zealand does not have rural training sites.

7.2 Trainee participation in education provider governance

Accreditation standard 7.2.1

Yes there is a trainee representative who is voted into the position by the trainees. A trainee representative is on the Specialty Board and also attends RACSTA meetings and is also the trainee representative for all New Zealand surgical trainees.

7.3 Communication with trainees

Accreditation standard 7.3.1

NZOA uses a number of mechanisms to communicate to trainees about the activities of the decision making – these include the fortnightly members update which goes out to all Members on a Friday. There is a dedicated section in this newsletter on CPD Education and Training. However the main source of information to trainees is via emails from the Education and Training Manager.

Accreditation standard 7.3.3

The Education and Training Manager mainly manages this process – trainees are kept well informed of the training events coming up and how they manage this plus they are given plenty of notice about when assessments are due to be completed. In addition the training supervisor and trainee will meet regularly to complete assessments.

7.4 Trainee wellbeing

Accreditation standard 7.4.1

Providing a supportive learning environment is of utmost importance to NZOA as this will enable trainees to function at the highest level throughout their training. The advantage of being a small organisation is that it allows trainees and supervisors to develop a supportive learning environment. Trainees have full access to

their supervisor, the trainee representative, the chair of the Education Committee and all other members of the Education Committee if necessary.

Accreditation standard 7.4.2

Trainees have access to the trainee rep to discuss issues and these can be brought to the Education Committee or Specialty Board if required. The trainee rep meets with the Chair of the Education meeting to discuss any concerns that may have arisen during the trainees meeting that are held at the two training weekends.

7.5 Resolution of training problems and disputes

Accreditation standard 7.5.1

Issues from trainees are taken seriously and will be discussed at the Education Committee and NZ Specialty Orthopaedic Training Board meetings as necessary. In addition the trainee representative is available to talk to trainees and bring any trainee issues to the Education Committee. At the two main training weekends the trainees have a trainee only meeting where the trainee representative canvases the group for issues etc. Issues are taken to the Education Committee for further discussion as required. Refer to Support and Assistance Structure for NZOA Trainees

Accreditation standard 7.5.2

Trainees are aware that they take issues in the first instance to their supervisor but if that is not possible the Chair of the Education Committee or any other Committee Member is available to discuss their concerns with them directly.

8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standard 8.1.2

All training orthopaedic departments in New Zealand have a Clinical Director and a Supervisor of Training. These may or may not be the same person and in a larger centre they would most likely be different people. The Clinical Director has the role of being involved with the DHB and management whereas the Supervisor manages the trainees in the department.

Accreditation standard 8.1.4

All training orthopaedic departments in New Zealand have a Clinical Director and a Supervisor of Training. These may or may not be the same person and in a larger centre they would most likely be different people. The Clinical Director has the role of being involved with the DHB and management whereas the Supervisor manages the trainees in the department.

8.2 Training site and posts

Accreditation standard 8.2.2

Trainees are surveyed at the end of each year to give feedback on the run they have just completed.

The expectation is that trainees do move around a number of placements during their five years of training allowing them to experience dealing with a wide range of cultures including Maori.

It is expected and is part of the hospital accreditation process that trainee have access to all the required educational resources and technology to allow them to learn effectively. DHBs are required to fund essential text books trainees need during their training.

9 Continuing professional development, further training and remediation

9.2 Further training of individual specialists

Accreditation standard 9.2.1

NZOA members are involved in running a number of courses that are not mandatory for training but have come about as a result of an identified need. These include Introduction to Arthroscopy courses (held every 1 to 2 years as required), Shoulder Arthroscopy Course (held every second year, and Biennial Orthopaedic Pathology Course. The NZOA Practice Visit Programme also allows for individuals to discuss learning needs with their visitors.

9.3 Remediation

Accreditation standard 9.3.1

NZOA can identify members who are underperforming in a particular way via the CPD program and the Practice Visit Program. There is a process in place developed by the PVP Committee to assist consultants where a need has been identified.

10 Assessment of specialist international medical graduates

In accordance with RACS policy

Orthopaedic Surgery New Zealand supporting documentation available

No.	Document name	Relevant standards
OSN web	New Zealand Orthopaedic Association	7.1.2
OSN web	Specialty Overview RACS website	
OSN web	SET Selection Orthopaedic Surgery	7.1.1, 7.1.2, 7.1.4
OSN01	NZOA SET Selection Regulations for 2017	7.1.1, 7.1.2, 7.1.4
OSN02	Unsuccessful Candidate Letter	1.3
OSN03	Education Committee Terms of Reference	1.7.1
OSN04	NZOA Annual Report 2015-2016	1.7.1
OSN05	NZOA Annual Report 2014-2015	2.3.1
OSN06	Training Post Accreditation	4.1.1, 4.2.1, 4.2.3, 8.1.1, 8.1.2, 8.2.1, 8.2.2
OSN07	Application for Accreditation or Reaccreditation for Training Post	4.1.1, 4.2.1, 4.2.3, 8.1.1, 8.1.2, 8.2.1, 8.2.2
OSN08	Section 3 SET Syllabus	3.1.1, 3.2.1, 3.2.2, 3.2.3
OSN09	SET Training Course and Exams Graphic	3.1
OSN10	Mid Term Training Days Assessment 2016	5.1
OSN11	SET 1 Quarterly Assessment Form	5.2.1
OSN12	End of Term Assessment Form	5.2.1
OSN13	Mini-CEX Assessment Form	3.2.3, 5.2.1
OSN14	Direct Observation of Procedural Skills Form	3.2.3, 5.2.1
OSN15	Performance-based Assessment Form	5.2.1
OSN16	Education Committee Agenda	6.1
OSN17	Support and Assistance Structure for Trainees	7.5.1
OSN18	Trainee Retrospective Run Evaluation 2015	8.1

No.	Document name	Relevant standards
OSN19	NZOA Practice Visit Programme	9.2.1, 9.3.1

OTOLARYNGOLOGY HEAD AND NECK SURGERY

Specialty performance against AMC accreditation standards

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Otolaryngology Head and Neck Surgery specialty-specific activities is presented here.

Standard 1 The context of training and education

1.2 Program management

Accreditation standard 1.2.1

The Board of Otolaryngology Head and Neck Surgery is responsible for the following:

- Formulating and disseminating the curriculum of the training program
- Developing policy for the training program. Policies are developed to meet the requirements of the Principle Based Policies of the Royal Australasian College of Surgeons.
- Formulation of the Training Regulations for Otolaryngology Head and Neck Surgery for Australia and New Zealand.

Details of policies and regulations are disseminated to trainees via the following documents:

- Training Regulations for Otolaryngology Head and Neck Surgery Australia and New Zealand
- Trainee Handbook

Details of the policies and regulations are disseminated to Surgical Supervisors via the following documents:

- Training Regulations for Otolaryngology Head and Neck Surgery Australia and New Zealand
- Surgical Supervisors Handbook

The Board of Otolaryngology Head and Neck Surgery conducts administration for training and education for Australian and New Zealand trainees. These processes are undertaken by the Surgical Education and Training Program Administrator and include confirmation that trainees have satisfactorily completed all mandatory requirements of the training program:

Trainee details are held on the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) trainee database and also in hard copy files

1.5 Educational resources

Accreditation standard 1.5.1

Resources for the Board are provided by:

- SET Program Administrator, ASOHNS
- CEO ASOHNS
- Executive Officer, Board of Otolaryngology Head and Neck Surgery, Selection and Hospital Accreditation RACS
- Executive Officer: IMGs (NZ) and Training, RACS New Zealand Office
- Board Chair, Board of Otolaryngology Head and Neck Surgery
- Regional Training Subcommittee Chairs for each training Region

- Academic Representative to the Board
- Surgical Sciences Examination Representative
- International Medical Graduates Representative
- Senior Examiner in Otolaryngology Head and Neck Surgery
- Trainee Representatives

1.6 Interaction with the health sector

Accreditation standard 1.6.4

Members of the Board, supervisors and trainees undertake regular outreach clinics to provide essential health care in remote indigenous communities including:

- Deadly Ears Program - Queensland
- Kimberley Region Outreach Clinics – Western Australia
- Yatala Outreach Clinic – South Australia

Trainees are assigned to these visits as part of their training.

1.7 Continuous renewal

Accreditation standard 1.7.1

The Board of Otolaryngology conducts three (3) meetings annually at which it reviews its structures and functions to ensure that adequate resources are allocated to its training and education functions to meet changing needs and evolving best practice.

Standard 2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard 2.1.2

The Board of Otolaryngology Head and Neck Surgery is currently developing a specific Aboriginal and Torres Strait Island and Maori curriculum Module to ensure that the health needs of these groups are being met. A copy of the draft module is attached to this document.

The first indigenous Australian surgeon was an Otolaryngology Head and Neck Surgeon.

Accreditation standard 2.1.3

The following stakeholders were/are consulted when defining the educational purpose of the Board of Otolaryngology Head and Neck Surgery:

- Royal Australasian College of Surgeons
- Council of the Australian Society of Otolaryngology Head and Neck Surgery
- Surgical Supervisors
- Surgical Trainees

2.2 Program outcomes

Accreditation standard 2.2.2

The program outcomes are built on the required knowledge of a consultant practicing in OHNS, covering all aspects including:

- Otology
- Rhinology
- Head and Neck
- Laryngology
- Paediatric OHNS

2.3 Graduate outcomes

Accreditation standard 2.3.1

The defined outcomes of the training program of the Board are listed in section 5 of the Training Regulations for Otolaryngology Head and Neck Surgery, Australia and New Zealand.

The appropriateness of the training outcomes are currently being assessed as part of a review of the training curriculum.

Standard 3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard 3.1.1

The Board outlines the framework under which training is conducted in the Training Modules curriculum which is currently under review.

3.2 The content of the curriculum

Accreditation standard 3.2.2

The curriculum includes the learning module: Scientific Foundations of Otolaryngology Head and Neck Surgery.

The purpose of this module is to:

- Introduce a structured learning programme at the beginning of Specialist Surgical Training
- Enable the application of these basic sciences throughout the 5-year training period

The graduating trainee will be able to:

- Assess patients with otolaryngology head and neck disorders.

Accreditation standard 3.2.7

It is mandatory for trainees to take part in formal weekly tutorials at which they are expected to give a presentation on a topic relevant to Otolaryngology Head and Neck Surgery. Trainees are also expected to participate in mandatory Continuing Professional Development meetings at teaching hospitals throughout Australia and New Zealand.

Accreditation standard 3.2.8

The curriculum for Otolaryngology Head and Neck Surgery includes a specific Scholar and Teacher learning module. The module includes formal learning about methodology, critical appraisal of literature, scientific and evidence-based practice. A copy of the module is attached to this report.

Accreditation standard 3.2.9

The Board of Otolaryngology Head and Neck Surgery is currently developing a curriculum module specific to Aboriginal and Torres Strait Islander and Maori health.

3.4 Structure of the curriculum

Accreditation standard 3.4.2

The length of the Surgical Education and Training Program in Otolaryngology Head and Neck Surgery is generally 5 years. The Board is in the process of transitioning to a competency based curriculum.

Accreditation standard 3.4.4

During the last three years the number of trainees seeking part time training is one (1) This trainee was granted permission to obtain a suitable part-time training post.

The number of trainees seeking interruption to training in the past three years is ten (10). The number of trainees being granted interruption to training is eight (8).

The number of trainees selected into the training program seeking deferral of training to undertake research is 3. All trainees who have sought deferral to undertake research had their request granted.

Standard 4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1

A range of teaching methods, mapped to the curriculum are employed throughout training. These include:

- Formal weekly tutorial program
- Surgical simulators
- Cadaveric dissecting courses
- Surgical skills laboratories
- Supervised outpatient Clinics
- Supervised operating
- Supervised after hours Emergency Clinics
- Observing operations
- Recommended texts
- Anatomy Knowledge
- Web based educational resources for self-directed learning,
- Multi-disciplinary team management meetings.
- Trainee conferences
- Annual Scientific Meetings of the Australian and New Zealand Specialty Societies

4.2 Teaching and learning methods

Accreditation standard 4.2.2

The OHNS Training Modules includes use of radiological imaging facilities, video endoscopy with monitors for teaching and supervision, audiology, use of surgical simulators and anatomical models as adjuncts for learning in the hospital.

Accreditation standard 4.2.3

The OHNS Training Modules include a formal weekly tutorial program, surgical simulators to train on, cadaveric dissecting courses, surgical skills laboratories, web-based educational resources for self-directed learning, and multi-disciplinary team management meetings. Trainees learn how to make appropriate referrals to other specialities in the management of patients.

Standard 5 Assessment of learning

5.1 Assessment approach

Accreditation standard 5.1.1

Progressive judgements regarding a trainee's preparedness for specialist practice are undertaken via:

- Mid Term Assessments (training years 1 – 3). These assessments are formative and are aimed at providing feedback to trainees on their performance and at the mid-point of the rotation.
- End of Term Assessments (all trainees). These assessments are summative and rate the trainee's performance during the rotation. The outcomes of the assessment will determine the progression of the trainee in the training program.
- Learning Action Plan (LAP). These are implemented when the Surgical Supervisor feels that the trainee needs a more structured program. The LAP provides the trainee and supervisor with an agreed path to achieving competence in the identified areas of performance. This assists the trainee to reach competence prior to the end of a rotation.
- Probation and Performance Management Plan (PMP). When a trainee receives a rating of Unsatisfactory at an End of Term Assessment they will automatically commence Probationary Training and undertake a Performance Management Plan in the subsequent rotation. The Board will review the assessment and either agree or overturn the rating. Trainees undergoing probation must satisfactorily complete the PMP to return to normal training and continue progression in the training program.
- The LAP and PMP are tailored to address areas where the trainee is not meeting the expected level of competency.

5.2 Assessment methods

Accreditation standard 5.2.1

The Board of Otolaryngology Head and Neck Surgery utilises a range of methods in assessing trainees. The methods include:

- Mini Clinical Examination
- Direct Observation of Procedural Skills in Surgery
- Mid Term Assessment
- End of Term Assessment
- Temporal Bone Dissection exercises
- Head and Neck courses
- Functional Endoscopic Sinus Surgery Courses (FESS)
- 360 Degree Evaluation
- Examinations

The following are barrier assessments:

- End of Term Assessment being rated as Unsatisfactory
- Failure to complete 60 Temporal Bone Dissection Exercises
- Failure to complete 1 x Head and Neck Course
- Failure to complete 2 x FESS courses

- Failure to complete the Generic Surgical Sciences ,Specialty Specific Surgical Sciences and Fellowship Examinations

5.3 Performance feedback

Accreditation standard 5.3.3

Where a trainee has been identified as not meeting the outcomes of the training program they may be placed on a Learning Action Plan (LAP) or Probation and Performance Management. The LAP provides a structured method of providing assistance to the trainee to improve performance.

If a trainee fails to meet the requirements of an LAP they may be placed on probation and be required to satisfactorily complete a Performance Management Plan PMP. Failure to satisfactorily complete probation and the PMP will allow the Board to commence dismissal proceedings. The dismissal procedures are outlined in section 9 of the OHNS Training Regulations.

Accreditation standard 5.3.4

When patient safety concerns arise in assessment the Board will require the trainee to attend an interview to review the concern raised. Should the concern be validated the Board will place the trainee on probation and advise the employing hospital.

5.4 Assessment quality

Accreditation standard 5.4.1

The Board regularly reviews the quality, consistency and fairness of assessment processes and their educational impact and feasibility.

The Board meets three times each year. During these meetings assessment methods may be reviewed.

During a review of assessment methods during 2014 it was determined that there was a need to support trainees who may be experiencing difficulty but who were not underperforming sufficiently enough to be placed on formal probation and performance management. The review led to the creation of the OHNS Learning Action Plan (LAP). The LAP aims to support trainees who are experiencing difficulty while undertaking Otolaryngology Head and Neck Surgery training, but who may not require formal probation or a Performance Management Plan. The Learning Action Plan and the LAP explanatory notes provides support to Surgical Supervisors in the identification, management and monitoring of trainees, who are experiencing difficulties.

The Board is currently reviewing assessment methods as part of its review of the curriculum. The Board plans to introduce the use of procedure based assessment as part of the curriculum.

Accreditation standard 5.4.2

Maintenance of the comparability in the scope and application of the assessment process across training sites is undertaken by the Regional Training Subcommittee (RTS) chairs on behalf of the Board. The RTS chairs meetings regularly with supervisors and trainees and provides feedback to the Board via the Regional Training Subcommittee Reports.

Standard 6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.1

The Board of Otolaryngology Head and Neck Surgery undertakes an annual review of its training and education programs. The review processes address the following:

- Curriculum content
- Assessment and training progression

- Supervision

The Board is currently reviewing the curriculum content and its effectiveness in meeting training program outcomes. At its meeting in August 2016 the Board agreed to amend the classification of training levels to better reflect the progress of trainees.

A review of Surgical supervisor training during 2016 has led the Board to increase training requirements for Surgical supervisors.

It is a mandatory requirement for Surgical Supervisors to attend RACS courses:

- Keeping Trainees on Track
- Foundation Skills for Surgical Educators

It is also a mandatory requirement for Surgical supervisors to complete the RACS eLearning modules:

- Let's Operate With Respect
- Supervisors and Trainers for Surgical Education and Training (SAT/SET)

Accreditation standard 6.1.2

Surgical Supervisors meet with Regional Training Subcommittee Chairs at six-monthly intervals. This meeting provides the opportunity for Surgical Supervisors to provide feedback on the training program. This feedback is reported to the Board at its meetings held three times annually. The Board analyses feedback received to assist in the improvement of the training program.

Accreditation standard 6.1.3

Contribution from trainees toward program development is received via the inclusion of Trainee Representatives on the Board at its meetings. The Trainee Representatives seek input from trainees on issues in the training program. The Trainee Representatives are invited to provide feedback on any changes proposed to the training program and curriculum.

6.2 Evaluation

Accreditation standard 6.2.1

The Board is currently reviewing the curriculum to provide a standard to which all trainees will be taught. Once the revised curriculum is in place its effectiveness will be evaluated by reviewing the time taken to successfully train a trainee. This will be compared to the previous length of training required.

Accreditation standard 6.2.2

As part of the curriculum review process a feedback questionnaire will be developed to survey trainees. The feedback obtained may be used to modify the curriculum.

Accreditation standard 6.2.3

Stakeholders contributing to the evaluation of the program and graduate outcomes include:

- Board of Otolaryngology Head and Neck Surgery
- RACS
- Trainees
- Supervisors
- Trainers
- Regional Training Subcommittee Chairs
- Court of Examiners
- Surgical Sciences Examination Committee
- Academic Representative

6.3 Feedback, reporting and action

Accreditation standard 6.3.1

The Board provides governance of the training structure. The Board reports to the Board of Surgical Education, RACS and the Council of the Australian Society of Otolaryngology-HNS (ASOHNS). The SET Administrator at ASOHNS provides administration. They report to the CEO of ASOHNS and the Board.

Accreditation standard 6.3.3

The Board meets three times per year face to face. The Board meets by teleconference as required between meetings to discuss specific concerns and trainee matters.

Standard 7 Trainees

7.1 admission policy and selection

Accreditation standard 7.1.1

The OHNS Selection Regulations Australian and the New Zealand Selection Regulations are reviewed annually and amended, if required.

Accreditation standard 7.1.2

At its meeting held on 6 August 2016 The Board agreed to support increased recruitment of Aboriginal and Torres Strait Islander and Maori trainees. Applicants to the Australian program must be registered with AIDA. A minimum standard will be set to allow appropriate selection for Indigenous applications.

A committee was established to progress development of the minimum standard. They will report back to the Board at its next meeting with a recommendation for 2017

7.2 Trainee participation in education provider governance

Accreditation standard 7.2.1

Trainee Representatives from Australia and New Zealand are members of the Board. The representatives provide feedback from trainees to the Board on the training program.

The Trainee Representatives are in regular contact with all trainees to ensure trainees are aware of changes to the training program and its governance.

Trainees may also make direct representation to the Board regarding training matters.

7.3 Communication with trainees

Accreditation standard 7.3.1

Information regarding activities and decision-making by the Board are conveyed to trainees via email.

Emails regarding activities and decision-making by the Board are sent to trainees as required, generally after Board meetings, to advise of any changes to the program with impacts on trainees. The SET Program Administrator sends the emails on an Ad Hoc basis as required.

Accreditation standard 7.3.2

Trainees are provided with a Progress Report at six-monthly intervals. These reports provide details of all components of the training program, the Status of training and the level of training.

7.4 Trainee wellbeing

Accreditation standard 7.4.1

Trainees are encouraged to approach their Surgical supervisor to discuss issues with training. Trainees are also able to contact the SET Program Administrator. The SET program Administrator is able to provide trainees with information on administrative training matters and can refer trainees to other sources on non-administrative matters, including the RACS Support Program and the RACS Trainee Association.

Trainees meet with the Regional Training Subcommittee chair and are formally reviewed by Surgical supervisors on a six monthly basis throughout training.

Trainees attend a standardised tutorial each week in their state.

Standard 8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standard 8.1.1

The Board allocates trainees to Accredited Teaching Hospital posts which have been accredited by the Board.

Accreditation standard 8.1.3

All supervisors must adhere to the conditions and requirements set out in the Surgical Supervisors Handbook published by the Board.

Accreditation standard 8.1.4

The Board reviews the effectiveness of supervisors as part of the Mid Term Assessments and the End of Term assessments. Mid Term assessments are undertaken at 3 monthly intervals during the first 3 years of training. End of Term Assessments are undertaken on a 6-monthly basis. At each Mid Term or End of Term Assessment trainees are given the opportunity to provide feedback on the effectiveness of the training and supervision that has been undertaken.

In addition all trainees meet with the relevant Regional Training Subcommittee Chair to discuss any issues regarding training and supervision.

8.2 Training site and posts

Accreditation standard 8.2.2

The Hospital Accreditation Manual outlines the process and criteria for accreditation.

Rural and Regional locations

The Board fully supports training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand.

Training sites are provided in regional and rural locations including:

- Toowoomba QLD
- Gold Coast QLD
- Newcastle NSW
- Wollongong NSW
- Canberra ACT
- Geelong VIC
- Darwin NT

- Dunedin NZ
- Whangarei NZ
- Christchurch NZ
- Wellington NZ

Aboriginal and Torres Strait Islander and Maori

Trainees undertake outreach visits which provide experience of the provision of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand.

In Australia trainees participate in outreach visits to remote communities to assist in the delivery of health care to Aboriginal and Torres Strait Islander populations. Trainees gain experience in the provision of care for conditions specific to these communities (e.g. Aboriginal ear disease).

Standard 9 Continuing professional development, further training and remediation

In accordance with RACS policies

Standard 10 Assessment of specialist international medical graduates

In accordance with RACS policies

Otolaryngology Head & Neck Surgery supporting documentation available

No.	Document name	Relevant standards
OHN web	The Australian Society of Otolarygnology Head & Neck Surgery	
OHN web	Specialty Overview RACS Website	
OHN web	SET Selection Otolarygnology Head & Neck Surgery Australia	7.1.1, 7.1.2, 7.1.4
OHN web	SET Selection Otolarygnology Head & Neck Surgery New Zealand 2017	7.1.1, 7.1.2, 7.1.4
OHN01	SET Selection Otolarygnology Head & Neck Surgery Regulations Australia 2017	7.1.1, 7.1.2, 7.1.4
OHN02	SET Selection Otolarygnology Head & Neck Surgery Regulations New Zealand	7.1.1, 7.1.2, 7.1.4
OHN03	Training Regulations for Surgical Education in Otolaryngology Head and Neck Surgery	1.2.1, 1.3.1, 2.3.1, 3.3.2, 3.4.1, 3.4.2, 3.4.3, 5.2.2, 5.3.3,7.1.4, 7.3.2, 9.2.1
OHN04	Direct Observation of Procedural Skills Assessment Form 2015	3.2.4, 5.1.2, 5.2.1, 5.3.1, 5.3.3
OHN05	Mini CEX Assessment Form	3.2.4, 3.2.9, 5.1.2, 5.2.1, 5.3.1, 5.3.3
OHN06	360 Degree Evaluation	5.2.1, 5.3.3
OHN07	360 Degree Information for Trainees	
OHN08	360 Degree Information Sheet for Evaluators	
OHN09	Learning Action Plan	5.1.1, 5.3.3, 5.4.1, 9.3.1
OHN10	Performance Management Plan	5.1.1, 5.3.3, 9.3.1
OHN11	Trainee Progress Report	7.3.3
OHN12	Trainee Handbook 2016	1.2.1, 1.3.1, 5.1.2

No.	Document name	Relevant standards
OHN13	Surgical Supervisors Handbook	1.2.1, 1.3.1, 8.1.2. 8.1.3
OHN14	Hospital Accrediation Manual	8.2.2
OHN15	Accredited Teaching Hospitals	8.1.1
OHN16	Draft Aboriginal Torres Strait Islanded – Maori cultural Awareness Curriculum module	2.2.1. 8.2.2

PAEDIATRIC SURGERY

Specialty performance against AMC accreditation standards –

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Paediatric Surgery specialty-specific activities is presented here.

1 The context of training and education

1.2 Program management

Accreditation standard 1.2.1

The Board of Paediatric Surgery (the Board) is responsible for the delivery of the SET Program in Paediatric Surgery, the accreditation of hospital posts and the supervision and assessment of Paediatric Surgery trainees.

The Board regularly reviews the training program, including the Training Regulations, assessment forms and Curriculum for ongoing development and the maintenance of a high quality surgical education program.

The Board recently reviewed and updated the Training Regulations, in particular to include further detail and clarification regarding SET One (first year of training).

Successful completion of program

The Paediatric Training Regulations detail the requirements trainees need to undertake to successfully complete the training program.

1.4 Educational expertise and exchange

Accreditation standard 1.4.1

The Board, comprised of the following members, has been delegated the powers required to exercise responsibility for the regulation and delivery of the surgical education and training program in Paediatric Surgery.

- Board Chair
- The President of the Australian and New Zealand Association of Paediatric Surgeons (ANZAPS)
- Deputy Chair
- Five members elected to represent the states and territories of Australia and New Zealand
- The Senior Examiner, Paediatric Surgery
- The Specialty Elected Councillor for Paediatric Surgery
- A Younger Fellows Representative
- A Trainee Representative

The Board regular reviews the curriculum. The Board is currently in the process of reviewing the Paediatric Pathophysiology Examination syllabus. The Board aims to have the draft completed at the end of 2016.

Accreditation standard 1.4.2

The Board recently compared its SET One assessment tasks to the JDocs framework and learnt that tasks in the JDocs framework are also present in the SET One Assessment Plan Record. Much of what the Board expects of the SET One trainees includes competencies expected of trainees when they commence training (as outlined in the JDocs framework).

The Board will consider all elements of the Set One Assessment Plan Record and determine if there are tasks or competencies that should be added or removed.

1.5 Educational resources

Accreditation standard 1.5.1

An Executive Officer (0.8 FTE), employed by RACS, provides administration support to the Board.

1.6 Interaction with the health sector

Accreditation standard 1.6.2

To ensure the education and training sites provide learning environments that facilitate the training of safe and competent surgeons, the Board conducts hospital inspections to accredit hospitals for surgical training. The Hospital Post Accreditations information is available.

The accreditation team, which includes two Board members and a Jurisdictional Representative, inspect the hospital and meet with appropriate members of the hospital.

Upon completion of the accreditation visit, the accreditation team prepare an agreed draft accreditation report, a copy of which is sent to the hospital for review.

After consideration of any comments, the Board makes a recommendation of accreditation to BSET, Education Board and Council.

Accreditation standard 1.6.3

The Paediatric Surgical Supervisors at each hospital are regularly kept informed of any changes or updates to the training program including any other matters of mutual interest via email and/or formal written correspondence.

The Board also holds an annual meeting with the Surgical Supervisors.

Accreditation standard 1.6.4

The Board will be looking at Indigenous Health partnerships in the future.

1.7 Continuous renewal

Accreditation standard 1.7.1

The MOU between the Board and RACS is regularly reviewed.

2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard 2.1.2

The aim of the SET Program is to produce competent Paediatric Surgeons with the skills, experience and knowledge necessary to provide their communities and health systems with the highest standards of ethical professional care and leadership.

Accreditation standard 2.1.3

The Board will discuss this further for the 2017 Selection Process.

Accreditation standard 2.1.4

We have made formal contact with Patient support groups (Cystic Fibrosis and the Pullthrough Network for Hirschsprungs and Anorectal Malformation) who have agreed to canvass their membership regarding current thoughts on paediatric surgical training. No feedback has been received on this activity to date.

2.2 Program outcomes

Accreditation standard 2.2.2

The Paediatric Curriculum provides trainees and supervisors with a guide as to the scope and competency levels expected to be achieved by the end of the SET program. The Fellowship Examination in Paediatric Surgery is directly based on the curriculum.

The modules were updated and approved in 2013.

2.3 Graduate outcomes

Accreditation standard 2.3.1

The SET Training Regulations, the SET Selection Regulations and the Assessment forms are publicly available on the RACS website.

3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard 3.1.1

The Curriculum stipulates the following for each technical area of Paediatric Surgery:

- Trauma and Burns
- Tumours
- Genito-Urinary Tract
- Head and Neck
- Neonatal Surgical Abnormalities
- Skin, subcutaneous and Extremities
- Thoracic (non-cardiac) Conditions
- Ventral Abdominal Wall
- Abdomen

The non-technical curriculum includes modules based on the RACS nine competencies.

3.2 The content of the curriculum

Accreditation standards 3.2.1, 3.2.2 and 3.2.3

The Curriculum, both technical and non-technical, is assessed through a variety of methods including:

- In Training Assessments
- Logbooks
- Mini-CEX assessments
- DOPS assessments
- MOUSE assessments
- Critical Appraisal Tasks
- Directed Online Group Studies
- SET Examinations
- Paediatric Anatomy and Embryology Examination
- Paediatric Pathophysiology Examination
- Fellowship Examination

The Guide to Paediatric Surgical Training that the Board developed for trainees and trainers. Its purpose is to better inform all stakeholders regarding the competency based program and the changes that have occurred in the Paediatric Surgery program over the last ten years. It is meant as a guide only to emphasise how competency based training is conducted. It also includes descriptors that are used for each stage of training for the non-technical competencies.

Accreditation standard 3.2.7

This is assessed through In Training Assessments, including 360 degree surveys which are mandatory during SET One.

Accreditation standard 3.2.8

Research is a compulsory requirement of the SET program in Paediatric Surgery (detailed in the Training Regulations).

Evidence of completion is submitted to the Board for approval. Trainees prospectively approved for a research project are advised in writing of the evidence required on completion for approval of the research requirement.

Trainees may apply to the Board to have research undertaken prior to commencing SET assessed for recognition as fulfilling the Paediatric SET research requirement.

The RACS Critical Literature Evaluation and Research (CLEAR) course is also a mandatory requirement and must be completed either prior to their training or by the end of the first three years of training.

Accreditation standard 3.2.10

This is covered in the non-technical competencies as mentioned above.

3.3 Continuum of training, education and practice

Accreditation standard 3.3.1

Progression through the training program is outlined in the Training Regulations.

The Training Regulations and curriculum also clearly stipulate what requirements have to be met at each SET Level.

Accreditation standard 3.3.2

As the SET Program in Paediatric Surgery is a competency based program the Board does not accept applications for recognition of prior learning and does not grant time credits for Paediatric rotations based on prior learning alone. Prior learning is implicit in the ability of a trainee to demonstrate the attainment of competence.

Data on RPL from 2013 to 2016:

YEAR	No. of trainees granted RPL	No. of trainees rejected RPL	Total No. applied
2013	0	0	0
2014	5	0	5
2015	0	0	0

3.4 Structure of the curriculum

Accreditation standard 3.4.1

The Paediatric SET Curriculum is based on the attainment of a standard of competency specified by the Board.

It is expected that the average trainee who commenced in or after the 2012 training year will take seven years to attain the required standard of competency.

It is expected that the average trainee who commenced prior to the 2012 training year will take six years to attain the required standard of competency.

The maximum period for the completion of the Paediatric SET program is seven years (or six years for those who commenced prior to 2012) plus four years from the commencement of approved clinical rotations.

Leave taken for illness or family leave will not be included in the calculation of the maximum period for completion.

The time taken by each individual trainee to complete the training program will depend on attainment of competency, but cannot exceed the maximum period.

Accreditation standards 3.4.3 and 3.4.4

Trainees may apply for the following types of interruption:

- Medical
- Parental
- Carer's
- Personal
- Compassionate
- Study
- Conference

The Board supports part-time training while recognising the complexities in arranging appropriate posts.

Applications for flexible training (i.e. undertaking clinical training in a post between 50% and 100% of full time equivalent) must be made no less than six (6) months prior to the commencement of the rotation. Approval of such an application will be subject to approval of the employing hospital

4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1

Teaching is not only undertaken onsite during a Trainee's rotation, but is also undertaken throughout education sessions per year.

The Registrar Annual Training Seminar (refer to Training Regulations)
The Registrar Annual Training Seminar (RATS) is held annually over four consecutive days and is compulsory for all active trainees; and optional for Trainees on interruption (inactive).

By accepting accreditation as a Paediatric SET post, hospital management has agreed that accredited trainees will be granted appropriate leave to attend the RATS and no trainee will be required to perform clinical duties or meet on-call requirements whilst the RATS is in progress (including the night before the RATS commences).

Practice exams
Various Board members conduct practice exam sessions at various times throughout the year.

4.2 Teaching and learning methods

Accreditation standard 4.2.1

The following courses are mandatory for Paediatric Surgical trainees:

1. Paediatric Life Support (PLS) Course
2. Early Management of Severe Trauma (EMST) Course
3. Australian and New Zealand Surgical Skills Education and Training (ASSET) Course
4. Care of the Critically Ill Surgical Patient (CCrISP®) Course
5. Emergency Management of Severe Burns (EMSB) Course
6. Critical Literature Evaluation and Research (CLEAR) Course

Trainees are allocated to a clinical training post which provides clinical training.

Accreditation standard 4.2.3

Trainees are required to complete the following mandatory assessments:

Directed Online Group Studies (DOGS)
DOGS is designed to encourage discussion and understanding of management plans related to clinical paediatric surgical problems and are based on our curriculum modules. The answer will be in the style of a medium or short clinical exam question, either in the written paper or viva section of the Fellowship Exam. Marking will take into account the SET level of the candidate.

Two DOGS are completed annually and each will be available through Moodle on the RACS website for a period of 3 weeks.

Critical Appraisal Task (CAT)
A CAT is a training tool designed to enable trainees to address a clinical question using the best available evidence. Trainees are expected to appraise the relevant literature and, based upon this, to concisely provide a rationale for their chosen management. These tasks equip the trainee to continually adjust management approaches during their career as a paediatric surgeon, as new information becomes available. CATs are designed to approximate the framework expected during written components of the Fellowship Examination.

Two CATs are completed annually. Trainees have approx. 3 months to submit their answer.

Accreditation standard 4.2.4

The program is designed to provide trainees with varying responsibilities as they progress through their training. Trainees are then assessed at the appropriate level.

5 Assessment of learning

5.1 Assessment approach

Accreditation standard 5.1.1

The requirements of the program are also designed to be undertaken at different stages of training as they are targeted for the various SET levels.

Accreditation standards 5.1.2 and 5.1.3

The Training Regulations set out the requirements and assessment process.

The Training Regulations provide an overview of each SET level and what is required and also includes the progression requirements.

In relation to end of rotation assessments, the Training Regulations detail the process to be undertaken for both Formative and Summative assessments.

The Regulations are available on the RACS website and are accessible to staff, supervisors, trainees and the public.

Particular issues raised by trainees are discussed, either by email or face to face, at Board level. The Board also meets with trainees individually and as a group annually at RATS.

The Trainee Evaluation Form is conducted at mid-term and end of term. It is an assessment of the Trainees performance in the workplace. The completed assessment form is signed and dated by the trainee, surgical supervisors and trainers and reflect the discussions held during the applicable performance assessment meeting.

Where there is an unsatisfactory rating the Trainee will be informed of the deficiencies and a remedial performance management plan developed. The duration of the probationary period and the consequences of failure to improve will also be specified.

5.2 Assessment methods

Accreditation standard 5.2.1

The Training Regulations document the requirements and assessment process for each SET level.

The Trainee Evaluation Form is conducted at mid-term and end of term. It is an assessment of the Trainees performance in the workplace. The Trainee Evaluation form covers the following areas:

- Clinical Knowledge/ Medical Expertise
- Clinical Skills
- Clinical Decision-Making
- Technical Skills
- Scholarship
- Medical Communication Skills
- Attitudes

Under each competency area the ratings have a description as to the behaviours/skills the trainee is displaying.

Trainees are rated as one of the following on the above:

- Not Satisfactory
- Borderline
- Satisfactory
- Well above average

Trainees also undertake a self-assessment using the same form. This is to enable the trainee to contemplate their own behaviours, skills and areas for improvement.

The completed assessment form is signed and dated by the trainee, surgical supervisors and trainers and reflect the discussions held during the applicable performance assessment meeting.

Accreditation standard 5.2.2

The curriculum is used as a guide to the minimum level of competency and clinical judgement for the different levels of training in Paediatric Surgery.

The curriculum templates are used as a guide in the overall assessment of progress of competency attainment for individual trainees in, application of knowledge to clinical situations, judgment in case management, interpretation of investigations, clinical diagnosis and operative performance. These are assessed during day to day work and as a component of work-based assessments such as case based discussions, Mini-CEX, MOUSE, 360 degree evaluation forms, quarterly Trainee Evaluation assessments, ward rounds and case presentations.

Accreditation standard 5.2.3

The Court of Examiners is responsible for setting the questions and defining the standards of the examinations (i.e. Paediatric Anatomy and Embryology Exam).

Trainees are advised to discuss with their Surgical Supervisor their preparedness prior to applying for and sitting any Examination in the SET program. Approval to sit the examination is dependent on progress in training.

5.3 Performance feedback

Accreditation standard 5.3.1

Trainees in SET One complete a face-to-face assessment report at the end of each rotation. There are no mid-rotation assessments in SET One.

Trainees in Early, Mid and Senior SET complete a face-to-face mid-term assessment and an end-of-term assessment with their Surgical Supervisor, in which any deficiencies or areas of potential improvement are discussed with mechanisms for correction identified. Positive feedback is equally advisable in the assessment process.

Areas of above or below average performance should be highlighted with constructive comment as to further development. Development of a Performance Management Plan may be considered by the Supervisor of Training at this stage for below average performance or may be directed by the Board. This meeting should include a review of the Goals and Objectives established at the start of the rotation.

Accreditation standard 5.3.2

Trainee assessments are reviewed by the Board four times a year. This certifies satisfactory or otherwise progression. Formal correspondence advising the trainee of their assessment outcome is sent to the trainee with a copy also sent to their Supervisor of Training.

Accreditation standard 5.3.3

Formative assessments are completed at the middle of each rotation and are aimed to identify areas of good performance and areas of performance that require improvement to reach competence.

Summative assessments are completed at the end of each rotation and are aimed at indicating whether a trainee has demonstrated satisfactory performance or not in the RACS competencies to permit accreditation of a period of training.

When areas of performance are identified as “Borderline” or “Unsatisfactory” in the summative assessment, the following assessment at the middle of the next rotation (or earlier if directed by the Board) will be treated as a summative assessment.

Where deficiencies or training issues are identified, the Board will assist in co-ordinating a remedial action or a performance management plan with the Trainee and surgical supervisor.

Where areas are identified and recorded on the trainee evaluation form as “Borderline” or “Unsatisfactory”, the Surgical Supervisor will discuss this formally with the trainee and agree to an appropriate remedial action plan or performance management plan. Advice may be sought from the Board in developing a performance management plan.

The areas of deficiency that resulted in the unsatisfactory assessment are identified by the Board and advised in writing to the trainee. The trainee is also advised that he/she is on probation and of the duration of the period of probation. The current surgical supervisor will be informed.

Refer to section 9 of the Training Regulations - Unsatisfactory performance and Probation.

Trainees may be dismissed from the SET program for one or more of the following:

- Unsatisfactory performance
- Misconduct
- Failure to complete training requirements within specified timeframes
- Failure to comply with written direction of RACS, its Boards and Committees
- Failure to pay training related fees by due deadlines
- Failure to maintain general medical registration or general scope registration
- Failure to achieve or maintain employment in accredited training posts
- Other circumstances as specified by the relevant Specialty Training Board (refer to section 11 of the Training Regulations in Paediatric Surgery).

Should a Trainee be considered for dismissal, the Board will follow the process under section 11 of the Training Regulations in Paediatric Surgery.

The table below lists the number of Trainees dismissed in the last three years:

Year	Number of Trainees	Reason
2014	2	Failure to complete the Generic Surgical Sciences Exam.
2014	1	Failure to complete Clinical Exam and Generic Surgical Sciences Exam.

If a safety concern is raised that may constitute mandatory or voluntary reporting to APHRA or MCNZ, the Board would discuss this with the trainee involved and report the issue to RACS.

5.4 Assessment quality

Accreditation standard 5.4.1

The Board regularly reviews the training program, including the Training Regulations, assessment forms and Curriculum for ongoing development and the maintenance of a high quality surgical education program.

Accreditation standard 5.4.2

All training sites are bound to follow the processes outlined in the Training Regulations. Regional representation on the Board allows for standardization of assessment standards and practices

6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.1

The Board recently reviewed and updated the Training Regulations in particular to include further detail and clarification regarding SET One (first year of training).

Ongoing evaluation of the program will be a key component of any new areas implemented.

Accreditation standard 6.1.2

The Paediatric Surgical Supervisors at each hospital are regularly kept informed of any changes or updates to the training program including any other matters of mutual interest via email and/or formal written correspondence.

The Board will seek the viewpoint of Supervisors when determining if a change to the program is required.

The Board also holds an annual meeting with the Surgical Supervisors to discuss trainees/IMGs, examinations, assessments, Training Regulations etc.

Accreditation standard 6.1.3

A Trainee Representative is appointed every two years by the trainees.

The Trainee Representative is a full member of the Board. The role of the Trainee Representative is to inform the Board (on behalf of the trainees) of any training issues that may require discussion and report back to the trainees any issues/changes that are relevant to their training. This method allows an open and transparent communication process.

Particular issues raised by trainees are discussed, either by email or face to face, at Board level. The Board also meet with trainees individually and as a group annually at RATS.

6.2 Evaluation

Accreditation standards 6.2.1, 6.2.2 and 6.2.3

The data is reviewed and discussed at relevant meetings for ongoing development and the maintenance of a high quality surgical education program.

The Board meets with trainees annually, and the Board Chair addresses the Australian and New Zealand Association of Paediatric Surgeons at its Annual General Meeting and takes questions. The Board has also discussed with consumer groups (CF and Pullthru organisations) the desirability of feedback in the last 12 months but has yet not received any response.

6.3 Feedback, reporting and action

Accreditation standard 6.3.1

The Board provides quarterly reports to BSET with updates or changes on the SET Curriculum in Paediatric Surgery. The report usually consists of the trainee status of all trainees and IMGs, examination results, changes to Surgical Supervisor's and hospital accreditation visits.

Accreditation standard 6.3.2

The Board holds an annual meeting with the Surgical Supervisors to discuss each trainee's progress, examination results, changes to the Training Regulations, assessment forms etc.

Surgical Supervisors are also copied into correspondence sent to the Trainees regarding assessment and examination results.

Accreditation standard 6.3.3

The Board regularly reviews the training program, including the Training Regulations, assessment forms and Curriculum for ongoing development and the maintenance of a high quality surgical education program.

The Board recently reviewed and updated the Training Regulations, in particular to include further detail and clarification regarding SET One (first year of training).

Any concerns/changes to be made to the program/assessment forms etc. are discussed and approved by the Board at its Board meeting. The Board then provides the appropriate department at RACS with the relevant information for ratification before advising the Trainees, Supervisors and other relevant parties.

7 Trainees

7.1 admission policy and selection

Accreditation standard 7.1.1

The Board reviews the Selection Regulations each year.

The purpose of the Selection Regulations is to establish the principles terms and conditions for the selection process for the RACS Surgical Education and Training program in Paediatric Surgery. These selection regulations in combination with the RACS Selection to Surgical Education and Training Policy are the final authority and policy governing the Paediatric Surgery Selection Process.

Accreditation standard 7.1.2

The selection process is transparent as each candidate is assessed against the same criteria.

Requirements

Applicants to the SET in Paediatric Surgery program must meet the following specific eligibility requirements:

1. All applicants to Paediatric Surgery must have satisfactorily completed a total of six months supervised postgraduate clinical work in surgery in an Australian or New Zealand unit comprised of terms no shorter than ten weeks. This experience must have been completed within the last three years before the closing date for applications.
2. All applicants to Paediatric Surgery must complete a minimum ten week term in a clinical postgraduate post in an Australian or New Zealand paediatric surgical unit with at least one Paediatric Surgical SET training post. This experience must have been completed within the last five years before the closing date for applications. A letter of verification from a FRACS paediatric surgeon must verify this experience and be submitted with the application.
3. All applicants to Paediatric Surgery must have successfully completed the Generic Surgical Sciences Examination (GSSE) at the time of application.

4. Applicants who attend the Paediatric Surgery interview will be ranked on the basis of the following selection tools providing an overall percentage mark out of 100%;
5. Structured Curriculum Vitae out of 30%
6. Structured Referee Report out of 25%
7. Panel Interview out of 45%

CV Scoring

Applicants submit an application and are asked to submit information on the following areas:

- Surgical and Medical Experience (maximum 25 points)
- Skills Courses (maximum 7 points)
- Qualifications (maximum 14 points)
- Publications and Presentations (maximum 14 points)

The CV is scored by two members of the Board of Paediatric Surgery. In the instance of a discrepancy between scorers, the Board Chair will make the final scoring decision.

Referee Reports

Applicants must provide the contact details of all of their supervising surgical consultants with whom they have worked with in a clinical rotation during the last two years.

An online referee report will be sent to the six of the identified consultants with whom the applicant has worked in a clinical capacity.

An applicant must receive a minimum of five valid reports to continue in the selection process. Of the five reports received at least one must be obtained from a FRACS Paediatric Surgeon (or a Vocationally Registered Paediatric Surgeon in New Zealand).

Interview

The interviews will be conducted by a series of four interview panels comprised of two members of the selection committee with applicants rotating between panels. Each panel will be for no more than fifteen minutes in duration.

Each panel forms an assessment both on the panel question and separately makes an assessment of the candidates communication skills demonstrated during the interview. The communication scores of each of the four panels are averaged to provide a fifth component contributing to the overall mark achieved in the interview.

Applicants will be asked the same initiating questions by each panel, with follow-up probing questions to explore the breadth and depth of the applicants experience and insight in relation to each selection criteria particularly as they correlate to the nine college training competencies.

Below is a list of the number of trainees who were successfully appointed to the SET program in Paediatric Surgery in the last 3 years:

- 2016 Seven trainees
- 2015 Seven trainees
- 2014 Six trainees
- 2013 Six trainees

Accreditation standard 7.1.3

The Board has not implemented this at this stage.

Accreditation standards 7.1.4 and 7.1.5

The selection requirements are published on the RACS website and are publicly available and apply to all Australian and New Zealand applicants.

There are no exemptions to the criteria.

7.2 Trainee participation in education provider governance

Accreditation standard 7.2.1

Refer to 6.1.3.

7.3 Communication with trainees

Accreditation standard 7.3.1

Updates are provided to trainees via the Executive Officer of the Board and/or Trainee Representative via formal correspondence, email communication and face-to-face discussions.

Accreditation standard 7.3.2

Any changes to Training Regulations are communicated to all Trainees and Supervisors via the Executive Officer of the Board.

Accreditation standard 7.3.3

Trainees are notified as soon as practical after a Board meeting of their training progress via email and mail.

The Board reviews each trainee's progress four times a year.

7.4 Trainee wellbeing

Accreditation standard 7.4.1

The Board ensures the learning environment in the hospitals is at the standard set out by the RACS Accreditation Standards.

Accreditation standard 7.4.2

Surgical Supervisors are encouraged to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training. They are also advised to notify the Board.

Trainees are also encouraged to bring any issues they may have to the Board in writing. The Board will in turn review their case individually.

The Board also actively promotes the RACS Counselling Service for any trainees who are experiencing either personal or work related issues.

7.5 Resolution of training problems and disputes

Accreditation standard 7.5.1 and 7.5.2

Trainees are requested to attend inspection visits to provide feedback.

8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standard 8.1.1

Each accredited training position has a RACS approved Surgical Supervisor nominated by the hospital and approved by the Board. Surgical Supervisors coordinate and are responsible for the management, education, training and assessment of trainees rotating through their designated accredited training posts.

Accreditation standard 8.1.3

All Surgical Supervisors must be Fellows of RACS and must be compliant with the RACS CPD program. They must undertake appropriate training in supervision which includes the SATSET and KTOT course.

Accreditation standard 8.1.4

The Board meets with both Supervisors and Trainees annually to assess and discuss training issues. The Board recognises that improved training of supervisors and improved feedback to supervisors regarding changes to training are a priority.

Accreditation standard 8.1.5

Refer to 8.1.1 – 8.1.3.

8.2 Training site and posts

Accreditation standard 8.2.1

The Board conducts accreditation.

Hospitals are provided with the opportunity to comment on the draft report before the Board's recommendation is forwarded to BSET for final approval. If the hospital provides comments or suggested changes, these are reviewed by the Board.

Each Hospital unit inspected has the right to appeal any decision through the RACS Appeals Mechanism. If the unit is found to be of a satisfactory standard, the Board may recommend accreditation for up to 5 years.

Refer to 1.6.

The Accredited Hospitals list outlines the accreditation decisions from the Board in the last 5 years. There were no unplanned accreditation visits.

Accreditation standard 8.2.2

Refer to 8.2.1.

9 Continuing professional development, further training and remediation

In accordance with RACS policy

10 Assessment of specialist international medical graduates

In accordance with RACS policy

Paediatric Surgery supporting documentation available

No.	Document name	Relevant standards
PAE web	Paediatric Surgery Specialty Overview RACS website	2.3.1
PAE web	Paediatric Surgery selection information	7.1.1, 7.1.2, 7.1.4
PAE01	Paediatric Selection Regulations 2016	2.3.1 & 7.1.1
PAE02	Paediatric Selection Regulations 2017	3.2.1, 7.1.1, 7.1.2, 7.1.4
PAE03	Paediatric Training Regulations	1.2.1, 1.3.1, 2.3.1 3.3.1, 3.3.2, 3.4.3, 4.1.1, 4.2.2, 4.2.3, 5.1.1, 5.1.2, 5.1.3, 5.2.1, 5.2.2, 5.2.3, 5.3.3, 6.2.1, 6.3.3, 7.3.2, 7.4.1, 7.5.1, 7.5.2

No.	Document name	Relevant standards
PAE04	Paediatric Surgery Curriculum	2.2.2, 2.3.1, 3.1.1, 3.2.1 – 3.2.10, 3.4.1
PAE05	Guide to Paediatric Surgical Training	3.2
PAE06	Agenda for Board and Supervisors Meeting	6.3.3, 8.2.1
PAE07	SET One Assessment Plan	1.4.2
PAE08	SET One Assessment Plan Record	1.4.2
PAE09	Paediatric Surgery Assessment Plan	1.4.2
PAE10	Trainee Evaluation Form	2.3.1, 5.2.1, 5.2.2
PAE11	DOPS Form	2.3.1
PAE12	Mini-CEX Form	2.3.1, 5.2.2
PAE13	MOUSE Form	2.3.1, 5.2.2
PAE14	Paediatric Surgery Expected Minimum Performance	2.2.2
PAE15	Hospital Post Accreditations	1.6.2, 4.1.1, 4.2.1, 4.2.3, 8.1.1, 8.1.2, 8.2.1, 8.2.2
PAE16	Memorandum of Understanding	1.7.1

PLASTIC AND RECONSTRUCTIVE SURGERY AUSTRALIA

Specialty performance against AMC accreditation standards

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Plastic and Reconstructive Surgery specialty-specific activities is presented here.

1 The context of training and education

1.2 Program management

Accreditation Standard 1.2.1

The Australian Board of Plastic and Reconstructive Surgery (ABPRS) conforms to its Terms of Reference .

The Australian Board of Plastic and Reconstructive Surgery (ABPRS) meets at least 3 times a year, often more, to discuss the SET program, governance, supervision of SET trainees and accreditation of hospital training positions. The ABPRS report to RACS' BSET, the PRS Oversight Committee and ASPS Council. The Relationship diagram is available.

Continuing Professional Development (CPD) activities are undertaken by ASPS Council and its Education Committee. This Committee applies prospectively for CPD points approval from RACS for local and international meetings. For example:

- Biennial Plastic Surgery Congress (delegates include related RACS Fellows, SET Trainees and unaccredited registrars);
- 17th International Course on Perforator Flaps (ICPF 2016) (delegates include RACS Fellows, SET Trainees and unaccredited registrars).

The Australian Society of Plastic Surgeons (ASPS) has no role in management and administration of International Medical Graduates as per our signed collaboration agreement with RACS.

ASPS validates for the ABPRS when SET trainees have met or not met all training requirements at the time of apply for Fellowship of RACS. This is done in collaboration with RACS personnel. RACS awards the Fellowship.

Accreditation Standard 1.3.1

ABPRS Training Regulations are published on the ASPS website for trainees to access:

- Assessment of Clinical Training;
- Recognition of Prior Learning;
- Trainee Misconduct;
- Variations to Training.

These ABPRS Training Regulations embed RACS' Appeals Mechanism Policy. Reviews are performed impartially and, where possible, by individuals who have not been involved in related decisions about an individual. RACS has developed processes for handling complaints about training. ASPS Council has processes and policies for handling complaints in relation to the ethical behaviour of its members. The ASPS Code of Practice 2015 is available.

Within the last three years appeals and reconsideration requests were recorded as follows:

Selection – 14 requests over 3 years.

In 2014: five appeals to ABPRS, four upheld and one dismissed.

In 2015: five appeals (four to ABPRS were not upheld and one via RACS' Appeals Mechanism was not upheld

In 2016: four appeals (two via RACS CIC Review Committee were not upheld, one to ABPRS for an internal review was not upheld, and one to ABPRS requesting reconsideration was not upheld).

Assessments – 7 requested over 3 years

2016 = 3 reconsideration requests. Outcome pending ABPRS meeting.

2015 = 2 appeals, 1 upheld, 1 re-appealed and response provided (no further information at this time)

2014 = 2 appeals, 1 not upheld (Hearing panel for decision outcome) 1 not upheld (PRS Board decision)

Training time expired

2014 = 1 appeal was not upheld by ABPRS

Examination

2014 = 1 appeal was upheld by RACS CIC Review Committee.

IMGs - refer to RACS.

Note: De-identified (redacted) appeals are managed internally by the ASPS Education Unit Manager

1.4 Educational expertise and exchange

Accreditation Standard 1.4.1

ASPS employs professionals to deliver the SET program. Should a gap in expertise be identified, qualified consultants are engaged for discreet projects. For example, development of Training Regulations (2016-2018) and the current review of the Plastic and Reconstructive Surgery (P&RS) Curriculum (2015 – present). ABPRS members are RACS Fellows or surgical registrars.

Accreditation Standard 1.4.2

The ABPRS coordinates with the New Zealand Board (NZBPRS) to deliver the annual SET 2-5 and SET 1 Registrars' conferences. The 2016 SET 1 Conference Program is available.

The Australasian Foundation for Plastic Surgery Limited (AFPS) partners with both PRS Training Boards to deliver skills workshops, conferences and educational activities throughout the year.

ASPS may acquire sponsorship from industry (monetary and sponsorship in-kind) to support the delivery of a scientific program. Refer to 2016 Conference Program.

Currently the ABPRS is reviewing the P&RS Curriculum with a consultant and working group of fellows. The Curriculum is being reviewed in the context of RACS Core Competencies and international curricula, for example, CanMEDS 2015. The NZBPRS is informed of the review via the PRS Oversight Committee mechanism.

1.5 Educational resources

Accreditation Standard 1.5.1 1.5.2

ASPS education unit is staffed with 1.6 FTE equivalent including one full time senior staff working on policy, governance, technical issues and management and one part time staff for system administration. The senior manager reports to the ASPS Chief Operating Officer.

The ABPRS is fully represented by all the Board members listed in its Terms of Reference.

1.6 Interaction with the health sector

Accreditation Standard 1.6.2

Administered through the accreditation process, ASPS supports supervisors of training and ABPRS Regional Chairs. Supervisors have support from local administrative staff in hospitals (which may vary from site to site) to coordinate meetings (Registrars' Conference) and state based teaching sessions For example, a visiting

plastic surgery expert, Fred Menick, presented to registrars on Thursday 11 February 2016 at Concord Hospital (NSW). Similar meetings are held throughout Australia when the opportunities arise.

Training centres for conference (ICPF 2016, PSC 2013 and PSC 2015) include visiting speaker and local fellows who are trainers and supervisors who have direct contact with SET trainees at other times of the year.

Accreditation Standard 1.6.3

Teaching opportunities, research, patient safety, clinical service and trainee welfare are integral to the successful accreditation of hospital training posts. For example, hospitals that undergo inspections have a dedicated time to discuss local issues with both accreditors and hospital administrators. These include mutual concerns and how to work towards overcoming hurdles together.

Accreditation Standard 1.6.4

The ABPRS, via the Australian ASPS partnership, provides access to SET trainees to a host of learning resources.

Locally, the Australasian Foundation for Plastic Surgery Limited (AFPS) is a regular educational partner at SET conferences. The AFPS is a not-for-profit organisation that supports research in Plastic Surgery and Skills for Excellence Program to provide education and training to a wide range of healthcare practitioners, including surgical trainees.

1.7 Continuous renewal

Accreditation Standard 1.7.1

ASPS systematically reviews its structure to match activities with functions and resources. This usually occurs at each cycle of development or review of its strategic plan (every 2-3 years).

2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation Standard 2.1.2

The ABPRS and ASPS supports RACS in addressing indigenous issues as addressed through the relevant Board of SET Working Parties.

Accreditation Standard 2.1.3

ASPS undertook a review of education activities in 2013 with other specialty societies to help form and identify its purpose prior to renewal of a service agreement with RACS. In August 2013 ASPS and RACS signed a new five year collaboration agreement that accurately defines the Society and College's roles in relation to the delivery of SET.

ASPS Council and senior management consults with its internal stakeholders which include its governing Councillors (elected from ASPS membership), to surgical trainers (FRACS Plast. consultants) and supervisors of training, as required.

The ASPS Education Committee oversees the educational activities of ASPS both for pre-fellowship and post fellowship medical education and training. ASPS produces several communications to communicate with stakeholders including its members and SET trainees.

2.2 Program outcomes

Accreditation Standard 2.2.2

These are defined by the ABPRS and RACS policy. The ABPRS comprises Specialist plastic surgeons, a trainee representative, a RACS Councillor, a Senior Examiner and a representative for international medical graduates to ensure outcomes are based on field of specialty practice.

The ABPRS considers 47 criteria / standards when evaluated new or existing training posts for accreditation. using the published RACS Accreditation Guide (2008) as its foundation, these criteria were slightly modified in 2014 to align them to specialty specific needs. The majority of criteria are unchanged. Casemix, case load and patient clinics form a major part of hospital training post accreditations. These are driven by community need for plastic surgery care (including hand, breast, cancer, reconstructions, etc.).

2.3 Graduate outcomes

Accreditation Standard 2.3.1

Together with the Australian Orthopaedic Association (AOA), the Australian Society of Plastic Surgeons (ASPS) and the Australian Hand Surgery Society (AHSS) developed a post fellowship education and training (PFET) Hand Surgery Program. The AHSS runs the programme. This was done within the RACS PFET Committee. ASPS Council nominates a representative to the PFETC to keep dialogue open.

ASPS publishes further information about post-fellowship opportunities on its website.

3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation Standard 3.1.1

The P&RS SET Curriculum encompasses eight (8) modules of equal weight. Modules are anatomically based providing sub-specialty specific training. P&RS SET trainees undertake five (5) years of accredited training time comprised of sixty (60) months or ten (10) six-month (6 month) terms. Examinations are augmented by an Australasian conference (NZ and Aus trainees), research, logbooks and mandatory.

SET Selection 2017 outlines the requirements for selection to the P&RS program.

The public face of the ASPS website directs all potential trainee applicants to the RACS website, where the SET requirements are specified for all surgical trainees, including the 9 RACS competencies and common selection criteria.

Online resources and specific specialty information is provided on the ASPS website only through a member login.

3.2 The content of the curriculum

Accreditation Standard 3.2.1

The curriculum is currently under review by the Curriculum Revision Working Group.

Accreditation Standard 3.2.2

The recommended reading list for the P&RS contains the scientific foundations of the specialty. Together with setting research target for P&RS SET trainees, this develops skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge. The Training Regulation Research During SET requirements is available.

Accreditation Standard 3.2.3

In-training assessments are performed on a quarterly basis to evaluate P&RS trainees against the RACS' 9 core competencies. Refer to Professional Performance Assessment.

Non-technical competencies pose a challenge for objective evaluation and surgical training using an apprenticeship-type model. The revised curriculum (currently under development) will set the objective measures for evaluation of non-technical competencies.

Accreditation Standard 3.2.4

In-training assessment evaluates P&RS SET trainees against the 9 RACS core competencies. The Plastic and Reconstructive Surgical Science and Principles (PRSSP) Examination in SET 4, Mock Exam in SET 4-5 and the Fellowship Examination evaluate a trainees preparedness to transition to specialist status in the community. The combination of formative and summative assessments advance demonstrates the shared role of the patient/carer in clinical decision-making.

Accreditation Standard 3.2.5

The curriculum is currently under review..

Accreditation Standard 3.2.6, 3.2.7 and 3.2.10

As above. The curriculum supports the RACS SET policies which require 9 RACS Core Competencies to be taught and assessed.

3.3 Continuum of training, education and practice

Accreditation Standard 3.3.1

The Curriculum is under revision and is progressing towards horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice.

Accreditation Standard 3.3.2

The Training Regulation RPL is available.

3.4 Structure of the curriculum

Accreditation Standard 3.4.1

The current curriculum has not changed since the previous report to AMC. The curriculum is currently under review, to strengthen the program.

Accreditation Standard 3.4.2

Affirmative. The maximum training time is nine (9) years as set in the training regulation. The Training Regulation Variations is available.

Accreditation Standard 3.4.3, 3.4.4

Additionally the ABPRS recently discussed the options for accrediting 3 months of training time as the shortest meaningful time frame for a SET trainee as well as options for job sharing and 0.5 FTE workloads. The ABPRS plans to develop its training regulation further to meet community and RACS expectations.

4 Teaching and learning

4.1 Teaching and learning approach

Accreditation Standard 4.1.1

The P&RS SET program is structured to deliver education and training in an apprenticeship model using various assessments such as formative DOPS and Mini-CEX and summative quarterly Professional Performance Assessments (PPA) at defined points in each term or along the SET 1 to SET 5 continuum. These assessments support acquisition of knowledge, technical and non-technical competencies.

Unsatisfactory assessments trigger corrective processes for trainees. Between 2013 to late 2014, communication around the ABPRS' expectations of unsatisfactory SET trainees improved significantly with the provision of transparent processes to follow. In late 2015, the ABPRS and RACS developed PRS-specific Training Regulations to support the RACS Principles based policies.

Mandatory annual SET conferences augment on the job learning. The each module in the curriculum is covered at least once every triennium.

4.2 Teaching and learning methods

Accreditation Standard 4.2.1

Training positions are all accredited by the ABPRS and are within public and private hospitals. Supervision of SET trainees is assessed as part of the accreditation process. Logbooks demonstrate the varying role in surgery for each trainee along the SET continuum and in specific hospitals.

Accreditation Standard 4.2.2

All trainees must attend a mandatory SET Conference each year. Certain courses (CCrISP®, EMST, EMBS) must be attended before SET 1 is complete and some examinations also have deadlines, namely PRSSP Exam by the end of SET 4 and other exams determined by RACS. ASPS promotes conferences it runs as well as skills development courses (including cadaveric laboratory course).

Accreditation Standard 4.2.4

No change. The current curriculum review will incorporate Enstrustable Professional Activities (EPAs) to foster trainees' development of an increasing degree of independence in relation to learning.

5 Assessment of learning

5.1 Assessment approach

Accreditation Standard 5.1.1

The Mini CEX and DOPS are currently used as effective work based assessment tools for P&RS SET trainees.

Accreditation Standard 5.1.2

The Training Handbook (2015 edition) clearly documents assessment and completion requirements. The Training Regulations (also see standard 1.2.1 and 1.3.1) further define the requirements. Documents are available via the ASPS website or secretariat.

RACS website defines common assessment and completion requirements. ASPS website links to RACS website where necessary.

5.2 Assessment methods

Accreditation Standard 5.2.1

The Mini CEX and DOPS are currently used as effective work based assessment tools for P&RS SET trainees. Unsatisfactory trainees comment monthly performance review meetings with documented remedial action plans. The Remedial Action Plan is available.

Trainees on probation are assessed using additional tools including the Multisource feedback (MSF)form and additional DOPS and Mini CEX forms.

Accreditation Standard 5.2.2

The Training Handbook contains the structure of the program.

Accreditation Standard 5.2.3

P&RS use the RACS standard DOPS and Mini CEX forms. The MSF assesses non-technical competencies.

5.3 Performance feedback

Accreditation Standard 5.3.1

Trainees are assessed twice each term (interim and final professional performance assessments) for feedback against the expected competency level. In addition, SET 1 and SET 2 trainees must also provide one DOPS and one MiniCEX per term. Outside of the mandatory assessments, Supervisors provide feedback as soon as practicable to trainees.

Accreditation Standard 5.3.2

Trainee performance is discussed at Regional subcommittee meetings. The ASPS Office administrates feedback about less than adequate feedback to supervisors (especially when trainees transition to new training posts). In 2016, the ABPRS implemented a process for satisfactory trainees who have scored below the “met” grade for any individual competency.

Accreditation Standard 5.3.3

Quarterly assessments in each rotation (for each particular stage of SET) provides the opportunity identify trainees not meeting the meeting the outcomes of the specialist medical program.

5.4 Assessment quality

Accreditation Standard 5.4.1

The ABPRS meeting at least three times a year to discuss assessments of trainees at which time a review of quality, consistency and fairness of assessment methods is discussed, when applicable.

Accreditation Standard 5.4.2

The P&RS SET program is national and uses a single system to administrate in-training assessments or single version of an assessment tool to collect uniform information about trainees’ assessments.

Standard 6 Monitoring and evaluation

6.1 Monitoring

Accreditation Standard 6.1.1

In 2014-2015 ABPRS and RACS developed principle based policy and relation PRS-specific training regulations. At each stage of SET supervision of trainees and assessments as made appropriate. The Curriculum is currently under review by a Working Group.

Accreditation Standard 6.1.2

Supervisors (and trainees, where relevant) provide feedback, suggestions for development and interview questions for consideration at each annual round of selection.

Supervisors report through the regional subcommittees on challenges to trainees and potential improvements to the training program.

Accreditation Standard 6.1.3

All trainees complete a Trainee Evaluation of Hospital Rotation at the conclusion of each training period. These assist to inform hospital post accreditation. These also inform the ABPRS to quality of supervisors. Feedback is confidential.

Clinical teacher awards are produced in some regions based on direct feedback from trainees about teaching units, clinical instructors and teaching sessions.

6.2 Evaluation

Accreditation Standard 6.2.1

ASPS Council developed a set of ethical standards that apply to the practice of plastic surgery. ASPS Council collaborates formally with ABPRS to incorporate those standards into the curriculum.

Accreditation Standard 6.2.2

Data is collected following each education activity (conference, course) and reviewed to identify excellence in delivery of education and potential gaps in the program.

6.3 Feedback, reporting and action

Accreditation Standard 6.3.1, 6.3.2

Internally the ASPS Education Unit's reporting line is via the Education Manager, Chief Operating Officer and Chief Executive to the ASPS Council. An Education Committee (of ASPS Council) governs the education portfolio (pre-fellowship, post-fellowship and CPD). The ABPRS reports vertically to RACS Board of SET and horizontally to ASPS Council's Education Committee.

Accreditation Standard 6.3.3

In the case that a risk is identified by ASPS or a stakeholder, prompt action is taken to mitigate or address the risk/s directly where possible or via legal counsel at RACS or ASPS lawyers. ASPS conforms to timeframes documented in the Training Regulation Assessment Clinical Training.

7 Trainees

7.1 Admission policy and selection

Accreditation Standard 7.1.1

Selection Regulations are published on the ASPS website in October annually for selection registration in January/February and selection applications in March/April of the following year. The 2017 for 2018 Selection Regulations is available.

Accreditation Standard 7.1.2

All conditions are met.

Formal appeals in relation to selection decisions have occurred and have decisions have been upheld when subjected to independent scrutiny.

Accreditation Standard 7.1.3

The ABPRS and ASPS supports RACS in addressing indigenous issues as addressed through the relevant Board of SET Working Parties.

Accreditation Standard 7.1.4

Refer to section 4.6 in the 2015 for 2016 Selection Regulations for minimum eligibility requirements.

Accreditation Standard 7.1.5

Selection is administered by the ASPS office in Sydney for the entire country. Selection interviews which are held in each regional capital (Sydney, Brisbane, Melbourne, Perth and Adelaide) are provided with identical interview packs (question and assessment forms) and interview guides. Interviewers are encouraged to undertake the RACS eLearning module for interviewer training.

7.2 Trainee participation in education provider governance

Accreditation Standard 7.2.1

The ABPRS has a trainee representative who attends all ABPRS meetings (face to face, teleconference, email meetings) and has full voting rights. There are at least 3 ABPRS meeting per year. (The same person represents trainees on RACSTA).

In each regional, trainees elect a regional trainee representative as their conduit to the regional subcommittee. Meetings are held as required in each region. Regional subcommittees meet twice a year and report to the ABPRS.

7.3 Communication with trainees

Accreditation Standard 7.3.1

Trainees receive quarterly newsletter updates from ASPS office. Supervisors receive quarterly newsletter updates from ASPS office to support their supervision of training.

Information of an urgent nature is disseminated as soon as possible via ASPS communication platform.

Accreditation Standard 7.3.2

All information disseminated by email is also added to the ASPS website which has clearly dedicated sections for

Accreditation Standard 7.3.3

Within 10 days of an official assessment (interim or final PPA), the Board Chair formality notifies trainees with unsatisfactory assessments of the effect on their SET status and the necessary corrective processes that follow.

7.4 Trainee wellbeing

Accreditation Standard 7.4.1

Mentoring programs have been implemented across Australia. Trainees are kept informed of RACS programs to support trainees (following on from the EAG report).

Accreditation Standard 7.4.2

The Training Regulation Variations is available.

7.5 Resolution of training problems and disputes

Accreditation Standard 7.5.1, 7.5.2

The process for complaints can be directly to the ABPRS, via RACS or through the Regional Subcommittee. ABPRS Chair and ASPS senior management consult on process matters such as due process and fairness and sensitive matters such as confidentiality and trainee's or supervisor's well-being.

8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation Standard 8.1.1

Supervisors are selected and evaluated against eligibility criteria. The ABPRS reserves to right to reconsider a surgical supervisors at any time. The ABPRS requires separation of the roles of Head of Unit and Surgical Supervisor in the majority of cases.

Accreditation Standard 8.1.2

Refer to clauses 2.1, 2.2, 2.6, 3.1 and 3.2. in the Training Regulation Surgical Supervisors.

Accreditation Standard 8.1.3

Supervisors are required to:

- Participate in Continuing Professional Development (CPD) activities and have met CPD requirements for the previous year
- Be familiar with the regulations of the PRS SET Program
- Have demonstrated experience with appropriate clinical, administrative and teaching skills.

Surgical Supervisors should undertake appropriate training in supervision, which as a minimum should include completion of the College SAT SET and KTOT courses or others.

Accreditation Standard 8.1.4

All trainees complete confidential Trainee Evaluation of Hospital Rotation forms at the conclusion of each training period. These inform the ABPRS of the quality of supervision and any potential issues.

8.2 Training site and posts

Accreditation Standard 8.2.1

All conditions met.

Notification to hospitals of inspections are sent at least 6 weeks in advance of an inspection. They clearly define the accreditation process, standards and criteria of assessments.

In addition the required supporting evidence is highlighted on the Hospital Accreditation Application form.

Accreditation Standard 8.2.2

All conditions (excluding criterion for indigenous Australians) met.

Accreditation Standard 8.2.3

There are 5 accredited training positions that are within the Specialist Training Program (STP) administered by RACS. These positions expose SET registrars to private sector healthcare.

9 Continuing professional development, further training and remediation

Accreditation Standard 9.3.1

Criteria met. See attachments

- Training Regulation Variations
- Remedial Action Plan pro forma
- Multi Source Feedback

Standard 10 Assessment of specialist international medical graduates

In accordance with RACS policy

Plastic and Reconstructive Surgery Australia supporting documentation available

No.	Document name	Relevant standards
PRA web	Australian Society of Plastic Surgeons	
PRA web	Specialty Overview RACS Website	
PRA web	Plastic and Reconstructive Surgery selection	7.1.1, 7.1.2, 7.1.4
PRA01	RACS P&RS Terms of Reference	
PRA02	Reporting Relationship Chart	1.7.1
PRA03	ASPS Code of Practice	1.7.1
PRA04	Plastic and Reconstructive Surgery Curriculum	2.2.2, 2.3.1 3.2.1 – 3.2.10, 3.4.1
PRA05	SET 1 Conference 2016	1.4.2
PRA06	Hand Surgery Program	2.3.1
PRA07	SET Selection for Plastic and Reconstructive Surgery Regulation 2017	7.1.1, 7.1.2, 7.1.4
PRA08	Curriculum Revision Working Group 2016	2.2.2, 2.3.1 3.2.1 – 3.2.10, 3.4.1
PRA09	Training Regulation: SET Research	3.2.2
PRA10	Professional Performance Assessment 2015	3.2.2 & 4.1.1 & 5.2
PRA11	Training Regulation Recognition of Prior Learning	1.3.1 & 3.3.2
PRA12	Training Regulation Variations to Training	1.3.1 & 3.4.2 & 7.4.2 & 9.3.1
PRA13	Remedial Action Plan	4.2.4 & 9.3.1
PRA14	Training Regulation Assessment of Clinical Training 2016	1.3.1, 4.1.1, 5.1.3, 6.3.3 & 9.3.1
PRA15	Multi Source Feedback	5.2.3 & 9.3.1
PRA16	Training Regulations Surgical Supervisors	8.1
PRA17	Hospital Accreditation 2016	2.2.2 & 8.2
PRA18	Training Regulation Misconduct	1.3.1
PRA19	Reconsideration of Appeal Outcome Selection 2014	1.3.1
PRA20	Sectrariat Organisational Chart 2016	1.7.1
PRA21	Letter to RACS	2.3.1

PLASTIC AND RECONSTRUCTIVE SURGERY NEW ZEALAND

Specialty performance against AMC accreditation standards

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Plastic and Reconstructive Surgery New Zealand specialty-specific activities is presented here.

1 The context of training and education

1.2 Program management

Accreditation standard 1.2.1

Evaluation

The NZBPRS was established in November 2014 and consists of a Chair and five supervisors of Training from each PRS Unit plus a trainee representative. There are 5 meetings per annum. Activities include:

Moved to use the MALT logbook and is involved in the migration of SNOMED for use with the logbook.

Review of research component of training program

Annual review of the Plastic and Reconstructive Surgery Selection Regulations and Assessment requirements.

Annual review of New Zealand PRS regulations and requirements handbook.

Curriculum

The Board is collaborating with the ABPRS on a review of the PRS curriculum.

Curriculum matters are discussed at an annual meeting of the Oversight Committee – a joint Committee with representation from the NZBPRS, ABPRS, NZAPS, ASPS and RACS.

Procedures and Policies

The Board works within the framework of the College Policies. Regulations are routinely reviewed to ensure they are fit for purpose.

Successful completion of Program

The Board's regulations set out the requirements for completing the programme and when an application for Fellowship is approved by the Board Chair before consideration by RACS.

1.3 Reconsideration, review and appeals processes

Accreditation standard 1.3.1

The Boards uses the RACS Appeal process. Where required, the Board will review and reconsider requests from trainees.

No appeals have been heard.

1.4 Educational expertise and exchange

Accreditation standard 1.4.1

The Board consists of various members including:

- Chair
- Supervisors of Training

- Senior Examiner
- Trainee Representative
- SEC

NZAPS President

Accreditation standard 1.4.2

The NZBPRS collaborates with RACS and the ABPRS.

1.5 Educational resources

Accreditation standards 1.5.1 and 1.5.2

Currently NZ PRS training and education is administered through NZAPS with executive support for the Board provided by NZAPS staff. RACS NZ provides the resources for Selection and Hospital Accreditation functions.

NZAPS employs a part time training staff member who reports to the Executive Director. Budgets and resourcing for all training activities are reviewed annually.

1.6 Interaction with the health sector

Accreditation standards 1.6.2 and 1.6.3

This is undertaken through the Hospital Inspection/Accreditation process. All supervisors of Training are members of the Board which enables them to be informed of changes and communicate these to the PRS Units.

Feedback from the PRS Units is provided through the supervisors

Accreditation standard 1.6.4

The Board has not engaged in this activity but liaises with RACS NZ over their Maori Health Action plan. RACS is also working on policy relating to community representation boards.

1.7 Continuous renewal

Accreditation st5andard 1.7.1

Refer to 1.5.1 and 1.5.2

The Collaboration Agreement with RACS is reviewed every five (5) years.

2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard 2.1.2

This has been undertaken by the RACS new Selection Policy for Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand

Accreditation standard 2.1.3

The Board seeks regular feedback from trainees through a survey and Supervisors and trainers through the Board members in each PRS Unit. The Curriculum covers the depth and scope of PRS. This is then translated into the Fellowship Examination. Trainee rotations ensure that all aspects of the curriculum are covered by all trainees.

2.2 Program outcomes

Accreditation Standard 2.2.2

The Curriculum covers the depth and scope of PRS. This is then translated into the Fellowship Examination. Trainee rotations ensure that all aspects of the curriculum are covered by all trainees.

2.3 Graduate outcomes

Accreditation Standard 2.3.1

Refer to 2.2.2 and 3.1.1

3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard 3.1.1

The Curriculum has 8 modules of PRS:

- Surgical Sciences and Principles Module I
- Craniomaxillofacial Module 2
- Facial Soft Tissues Module 3
- Hand, Upper Limb & Foot Module 4
- Head & Neck Module 5
- Lower Limb & Foot Module 6
- Skin & Integument Module 7

Trunk, Perineum & Breast Module 8 SET Competencies are also covered.

3.2 The content of the curriculum

Accreditation standard 3.2.1, 3.2.2 and 3.2.3

Refer to 2.2.2, 3.1.1 and 3.2.1

The Curriculum, both technical and non-technical, is assessed through a variety of methods including:

- SSE Generic
- In Training Assessments
- Logbooks
- Mini-CEX
- DOPS
- Fellowship Examination
- Meetings

Accreditation standard 3.2.4, 3.2.5, 3.2.6 and 3.2.7

Refer to 2.2.2, 3.1.1 and 3.2.1

The non-technical Curriculum includes modules on the following based on the RACS Competencies:

- Collaboration
- Communication
- Health Advocacy
- Management and Leadership
- Professionalism and Ethics
- Scholar and Teacher

These are also assessed through the In-Training Assessment Process.

Accreditation standard 3.2.8

Research is a compulsory requirement of the NZ PRS Program. The RACS CLEAR course is also a mandatory requirement.

The Board is reviewing the NZ PRS research requirements for 2017.

Accreditation standard 3.2.10

This is covered in the non-technical competencies.

3.3 Continuum of training, education and practice

Accreditation standard 3.3.1

Refer 3.4.1

Accreditation standard 3.3.2

The following RPL is covered in the Training Regulations Handbook:

- Recognition of Prior Learning for Clinical Experience
- Recognition of Prior Learning for Skills Courses

Criteria for Recognition of Prior Learning for Research Requirement

3.4 Structure of the curriculum

Accreditation standard 3.4.1

The progression through the training program is outlined in the Regulations.

The Regulations also clearly stipulate what requirements have to be met at each SET Level.

Accreditation standard 3.4.2

Trainees begin training at SET 1 and are required to satisfactorily complete five years of SET in PRS. Trainees will have a maximum of nine years from the time they are accepted onto the program in which to complete SET in PRS. Approved interruptions due to medical reasons (illness, family leave) shall not be included in the calculation of the maximum period of training. Trainees may be required to participate in training rotations in all available training

Accreditation standards 3.4.3 and 3.4.4

Trainees may apply for interruption:

- Medical
- Family leave
- Other

The Board supports the concept of part-time training while recognising the complexities in arranging appropriate posts. The Board requires it to be no less than 50% of FTE in any one year.

4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1

Teaching undertaken onsite at the PRS Units during a Trainee's rotation, and trainee educational conferences.

- NZ Training Conference
- Australasian SET 2-5 Conference
- Australasian SET 1 Conference

Trainees must also complete the online PRS modules provided through the American Society of Plastic Surgery (PSEN).

4.2 Teaching and learning methods

Accreditation standard 4.2.1

See 4.1.1

Accreditation standard 4.2.2

All trainees are allocated to a clinical rotation which provides the clinical training. These posts are accredited for clinical training.

The RACS can provide information on teaching methods for the ASSET, CCrISP, CLEAR and EMST courses.

Accreditation standard 4.2.3

See 4.1.1

Accreditation standard 4.2.4

The program is designed to provide trainees with increasing responsibility and knowledge as they progress through their training. Trainees are assessed at the appropriate level as they progress through the program.

5 Assessment of learning

5.1 Assessment approach

Accreditation standard 5.1.1

The program is designed to provide trainees with increasing responsibility and knowledge as they progress through their training. Trainees are assessed at the appropriate level as they progress through the programme.

This is taken into account within the schedule of regular assessment.

Accreditation standards 5.1.2 and 5.1.3

The Regulations (Training Regulations Handbook) set out the requirements and assessment process.

The Training Regulations Handbook is available on the RACS website and on the NZAPS website - these are accessible to staff, supervisors and trainees.

5.2 Assessment methods

Accreditation standards 5.2.1 5.2.2

The following assessment tools are used:

- Professional Performance Assessment (PPA)
- DOPS
- Mini CEX
- Performance Review Meetings
- Logbooks

Competency Areas:

- Surgical Expertise
- Knowledge
- Judgement/Decision Making Ability

- Patient Communication
- Interaction with Medical Staff
- Interaction with Nursing Staff and other staff
- Teaching Skills
- Patient Assessment and Communication to Medical Staff
- General Attitude

Trainees are rated on a 7 point scale for each competency area. There is a descriptor for each rating.

There are 8 PSEN modules to be completed by the end of SET 4. (American Society of Plastic Surgery Online modules)

sAccreditation standard 5.2.3

The College Standard Sets the Fellowship, SSE and Clinical Examination.

5.3 Performance feedback

Accreditation standard 5.3.1

Trainees undertake a mid-term and end of term assessment. Therefore assessment is undertaken approximately every three months.

Procedures entered into the MALT Logbook are also approved by the trainer or supervisor. The supervisor then reviews the logbook during the In-Training Assessment Process.

Accreditation standard 5.3.2

The Supervisor has to sign off on the assessment forms for mid-term or end of term.

Accreditation standard 5.3.3

Formative assessments aim to identify areas of good performance and areas of performance that require improvement to reach competence. Formative assessments also provide opportunities for improving performance.

The process for identification and management of unsatisfactory performance and dismissal is outlined in Training Regulations Handbook.

New Zealand Trainees

No trainees were dismissed in the last three years.

Accreditation standard 5.3.4

If a safety concern is raised that may constitute mandatory or voluntary reporting to MCNZ, the Board would discuss the trainee involved and report this to the College who are then responsible for reporting issues.

5.4 Assessment quality

Accreditation standard 5.4.1

The Board reviews assessment methods/process annually.

Accreditation standard 5.4.2

All training sites are required to follow the processes outlined in the Training Regulations Handbook.

6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.1

The Board has a rolling programme of review and updates the Training Regulations Handbook annually or when required due to changes in RACS policy or other factors.

Curriculum

The Board is collaborating with the ABPRS to review the curriculum.

Accreditation standard 6.1.2

Board members are located in PRS Units and seek feedback from supervisor on programme issues and areas for development. There are routine alerts for supervisors re changes in regulations at its Board meetings and PRS Unit meetings.

The Board will consider implementing a supervisor survey in 2016/17.

Accreditation standard 6.1.3

The Board has a Trainee Representative who participates in Board meetings and reports on trainee issues. The Trainee representative also reports back on key issues to trainees.

6.2 Evaluation

Accreditation standards 6.2.1, 6.2.2 and 6.2.3

This area has not yet been developed – the Board has been in existence since late 2014.

7 Trainees

7.1 Admission policy and selection

Accreditation standard 7.1.1

The Royal Australasian College of Surgeons (RACS) and the New Zealand Board Plastic and Reconstructive Surgery (NZBPRS) publish selection policies and principles online on the RACS website.

As the New Zealand Plastic and Reconstructive Surgery Surgical Education and Training (SET) programme is a national programme and successful applicants rotate through all accredited NZ training sites during the course of their training selection policy is implemented at national level. CVs are scored by staff at the NZ national office of the RACS and interviews are held at a single location in Wellington.

Selection policy supports merit-based selection through its use of three selection tools to rank applicants. Offers are made to applicants based on rank. Selection tools include:

1. A structured CV which captures information about applicants' qualifications, surgical experience, research, professional development and achievements. Those CVs are scored using published scoring guidelines.
2. Structured referee reports, gathered to obtain information regarding applicants' medical expertise, judgement, communication, collaboration, management and leadership, scholar and teacher, professionalism, technical expertise.
3. Semi-structured interviews which ask the same initial questions of all applicants but different follow-up questions in order to explore the depth and breadth of each applicant's experience and insight. Interviews are scored using a structured scoring system.

RACS is primarily responsible for selection and the employer is represented in responses to structured referee reports. Those reports are sought from consultants and nurses.

RACS offers selection interviewer training to Fellows and International Medical Graduates as an eLearning activity via its website.

Accreditation standard 7.1.2

RACS and the NZBPRS selection policies and principles are published on the RACS website:

SET Selection Regulations information - Plastic and Reconstructive Surgery New Zealand

The NZBPRS reviews SET selection and specialty specific policies annually. Those are submitted to the RACS for review and verification to ensure they align with selection principles.

The Education Development and Research Department of the RACS produces SET Selection Review Reports annually. Those reports use statistics to evaluate the three selection tools and to make recommendations for improvements.

Accreditation standard 7.1.3

The RACS Māori Health Action Plan 2016-8 outlines a range of strategies to increase the Māori surgical workforce.

New Zealand Process

The New Zealand RACS office has been working with Maori groups on how best to improve selection of Maori candidates. It is expected that a consultation process on how these initiatives may be incorporated in selection in the future will be discussed at the NZ National Board with all specialties.

Accreditation standard 7.1.4

The minimum requirements for Registration are published by the RACS. The minimum eligibility requirements are then published in the Selection Regulations available on the RACS website.

There are no exemptions to the criteria.

Mandatory requirements of the SET programme in Plastic and Reconstructive Surgery including "Hospital Placement Guidelines" informing doctors of the need to rotate through a range of training sites are published in the NZBPRS Training Regulations available on the RACS website.

The RACS Trainee Registration and Variation Policy outlines mechanisms by which trainees may apply for variations to their registration status.

Accreditation standard 7.1.5

At the conclusion of the SET selection process all documentation pertaining to that process is submitted to the College for review.

7.2 Trainee participation in education provider governance

Accreditation standard 7.2.1

The Board has a Trainee Representative as one of its members.

7.3 Communication with trainees

Accreditation standard 7.3.1

Changes to Regulations are communicated to all Trainees via email by NZAPS Staff.

Trainee Representative contact details are provided to all trainees.

Accreditation standard 7.3.2

Specialist Trainee fee for SET Training is determined by NZAPS for PRS in NZ. The College advertises the fees on their website.

Changes to Regulations are communicated to all Trainees via email by NZAPS Staff. Information is available on the RACS website. The Training Regulations Handbook is available on the NZAPS website in the Members area.

Accreditation standard 7.3.3

NZAPS staff maintains trainee files with all documentation. Trainees are able to contact NZAPS staff with any queries. Trainee files and progress are reviewed annually and trainees are notified of unmet requirements.

7.4 Trainee wellbeing

Accreditation standard 7.4.1

The Board ensures the learning environment in the hospitals is at the standard set out by the RACS Accreditation Standards.

Accreditation standard 7.4.2

The Supervisors undertake the majority of this work with the hospitals.

The Board actively promotes the RACS Counselling Service for any trainees who are experiencing either personal or work issues.

7.5 Resolution of training problems and disputes

Accreditation standard 7.5.1 and 7.5.2

The Board conducts a trainee survey annually.

Any complaints about Bullying, Harassment and Discrimination are handled through the RACS Complaint Department.

8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standard 8.1.2

The Training Regulations Handbook outlines the role of the Supervisors and Trainers in terms of assessing trainees.

The Hospital Accreditation Standards detail the support required by the hospitals to supervisors and trainees for each accredited training posts. These standards are reviewed during inspections of posts.

Accreditation standard 8.1.3

The appointment of the supervisors is undertaken at the hospitals.

This is an area identified for further development

Accreditation standard 8.1.4

The results of the annual trainee survey are reviewed by the Board.

The RACS Complaints service is available to support trainees resolve concerns.

This is an area identified for further development

9 Continuing professional development, further training and remediation

In accordance with RACS policy

10 Assessment of specialist international medical graduates

In accordance with RACS policy

Plastic and Reconstructive Surgery New Zealand supporting documentation available

No.	Document name	Relevant standards
PRN web	New Zealand Association of Plastic Surgeons	
PRN web	Specialty Overview RACS Website	
PRN web	Plastic and Reconstructive Surgery SET selection	7.1.1, 7.1.2, 7.1.4
PRN web	Board of Plastic and Reconstructive Surgery	
PRN01	New Zealand Board Plastic and Reconstructive Surgery Training Regulations Handbook	1.2.1, 1.3.1, 3.3.1, 3.3.2, 3.4.3, 4.1.1, 4.2.2, 4.2.3, 5.1.1, 5.1.2, 5.1.3, 5.2.1, 8.1.2 5.2.2, 5.2.3, 5.3.3, 6.2.1, 6.3.3, 7.3.2, 7.4.1, 7.5.1, 7.5.2
PRN02	Maori Health Action Plan 2016	1.6.4
PRN03	Plastic Reconstructive Surgery Curriculum	1.2.1, 2.1.3, 2.2.2, 3.1.1, 3.2.1, 3.2.2, 3.2.3, 3.2.4, 3.2.5, 3.2.6, 3.2.7 6.1.1
PRN04	Mini-Clinical Evaluation Exercise	1.2.1, 3.2.1, 3.2.2, 3.2.3 5.2.1, 5.2.2, 5.3.1
PRN05	Direct Observation of Procedural Skills	1.2.1, 3.2.1, 3.2.2, 3.2.3 5.2.1, 5.2.2, 5.3.1
PRN06	Professional Performance Assessment 2015	1.2.1 5.2.1, 5.2.2
PRN07	SET Selection Regulations 2016 for 2017	1.2.1, 7.1.1, 7.1.2, 7.1.3, 7.1.4, 7.1.5,
PRN08	SET CV Scoring Guide	1.2.1

UROLOGY

Specialty performance against AMC accreditation standards

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Paediatric Surgery specialty-specific activities is presented here.

1 The context of training and education

1.2 Program management

Accreditation standard 1.2.1

In 2015, an external review was undertaken of the Board structure and functioning to determine a more sustainable model.

The review recommended a restructure of the operational activities within the Board of Urology, comprising the formation of four sub-committees (Education, Training Post Accreditation, Selection and IMGS), with the Board maintaining overall responsibility for specific trainee related matters.

Specific terms of reference have been formulated for each sub-committee, which outline the composition of the committee, their responsibilities and reporting obligations. (Refer Terms of Reference). Each sub-committee is chaired by a Board member but comprises other individuals from outside the Board. The terms of reference gives individual Board members direct responsibility for specific functions of the Board and as such considerably spreads the workload. It also allows for and includes the development of working parties that report to the committees for project-based work - with clear outcomes and timeframes (e.g. new standards of post accreditation, revised curriculum).

Members of the sub-committees are selected for their experience and enthusiasm in the area. It was recognised that many members of the society are prepared to be involved in defined areas. The structure also allows the Board to capitalise on members with skills, qualifications and interests in the area.

The Board acknowledges the importance of developing a strategic plan for education and training and preliminary work will shortly commence within the Education Sub-Committee. It is anticipated that members, trainees and other relevant stakeholders will be consulted regarding the content of the plan.

1.3 Reconsideration, review and appeals processes

Accreditation standard 1.3.1

The College Appeals Policy outlines the process for managing reconsideration of a decision, and an appeal. Specific information is also provided in Section 14 of the SET Urology Training Regulations. These are predominantly triggered for dismissal decisions.

There are many less formal avenues for trainees to have any decisions reviewed:

- Trainees may feed back to their state representatives any personal grievances they may have against particular trainers. This can be fed back to state or national members of the Board (and has in the past)
- Trainees have the opportunity to voice their disagreement with their progress reports – which will trigger a review at the sectional Training and Education meeting. They are also invited to submit a response to any assessment they may have, which will also be tabled.
- These trainee reports are then discussed at the National Board meeting, including possible issues regarding fairness.
- Clarification may include direct dialogue between trainee and Sectional chair, or a representative of the National body.
- Trainees are advised in these circumstances to seek out the guidance of a surgical mentor who may provide perspective for both parties.

Development of a handbook to guide trainers (and trainees) on their obligations and rights is planned. At that time, we will seek feedback from both trainers and trainees on the fairness and real world applicability of the processes. The use of impartial arbiters will be considered in these cases. Although they make the system more robust, the potential penalty is on the workload of the training body.

1.4 Educational expertise and exchange

Accreditation standard 1.4.1

Fellows, RACS staff and other personnel with experience in medical education are involved in the development, management and continuous improvement of the SET Program in Urology. By nature of the fact that the educational Board's profile is entirely in training, existing contributing members tend to share the institution's goals already. In addition, the Board engages external expertise to advise and assist with educational developments and operational issues (e.g. the governance review).

A number of members of Urological Society of Australia and New Zealand (USANZ) have an interest in educational policy and the creation of the Education Sub-Committee will facilitate their active involvement. The committee will comprise individuals with skills and background in education. The Board will continue to oversee any decisions that are made, but the generation of policy and direction of training initiatives will be via this Committee.

The Education and Training Manager, USANZ has qualifications and significant experience in adult education, human resources and education administration. Her long experience in this organisation brings much corporate knowledge and background into the training environment.

Accreditation standard 1.4.2

USANZ has established relationships with a number of international urological associations within the training arena. Each year, 10 overseas urology trainees attend the USANZ Trainee Week from the British Association of Urological Surgeons, European Association of Urology, Canadian Urological Association and the Urological Association of Asia. USANZ also sponsors 6 final year trainees to 3 international training meetings including; the Asian Urology Resident's Course (URC), European Urology Resident's Education Program (EUREP) and Canadian Urology Resident's Teaching Program (CRP).

Through discussions between USANZ and the American Urological Association, European Urological Association and the Societie International Urology, formal arrangements have been made to secure memberships for all SET Urology Trainees to these associations. These memberships provide trainees with unparalleled access to a comprehensive range of practical and useful educational resources, webinars, recordings of international meetings as well as discounted or free registration to scientific meetings.

Relationships have been forged with other surgical specialty societies/ associations in Australia and the Board continues to collaborate with these bodies. As well as training resources, involvement with these bodies will serve to share any initiatives regarding training (for the Board), and may open up opportunity for our own trainees to participate within other training schemes (overseas fellowships). So far there have been official meetings at the Annual Scientific Meeting with representatives from international Urological Bodies discussing commonalities and differences. In the future, there may be an avenue to co-develop educational policy and resources.

1.5 Educational resources

Accreditation standard 1.5.1

The establishment of the sub-committees with designated members, roles and responsibilities has resulted a more manageable workload for all involved in the training program. It is anticipated that this initiative will allow the Board to focus on the strategic aspects of the program while the Sub-Committees focus on specific tasks/projects within their terms of reference. The Sub-Committees will also be means of contributing to changes through the gathering of feedback and exploration of realistic options.

It is anticipated that each sub-committee will comprise sufficient members with the necessary skills, expertise and knowledge to undertake their roles effectively. The terms of reference have only recently been drafted, but could be expanded if needed.

Younger Fellows, including suitably qualified recent graduates will be actively encouraged to contribute to the management of the training program and it is anticipated that each sub-committee will include a Younger Fellow. It is important to reach out to the new generation of Urologists and shape their expectations of involvement within a training body. For too long there has been a perception that the Training Board was the preserve of an elite few and detached from the running of teaching hospital units. The future direction is to change the perception of training from that of something which occurs passively from working in hospitals, to that of an active and deliberate process.

An educational provider that depends on fees paid by trainees is always going to have limitations:

- As bodies have to be more responsive, and there are added layers of regulation/policies, there will be a need for increased administrative support.
- The benefit of small organisations is that they are responsive, and a few people have all the background knowledge to take responsibility for decisions. As the organisation becomes larger the power to make real change moves from individuals to committees.
- Educational goals still have to realistically fit within the goals of service provision. Courses, exams and formal requirements are conflicts whose cost effectiveness must be measured.

The training workforce functions effectively pro-bono. There are limitations on how much compliance can be imposed on them before engagement is lost.

Accreditation standard 1.5.2

The USANZ provides the administration of the SET Program in Urology is undertaken by one full-time and one part-time USANZ personnel

The sub-committee structure will assist the USANZ personnel in the delegation and management of tasks and projects.

USANZ has enhanced its information and record keeping system and will be developing an online information management system to administer and store training related information more efficiently. The introduction of automated mechanisms to collect and disseminate trainee progress reports and the collation of hospital post inspections will be invaluable to the administration of the program.

The provision of sufficient high level administrative and educational support is being monitored to ensure the workload to support the sub-committees can be sustained.

The cost of the infrastructure to run the Board of Urology is borne by the trainees. It is with that limitation in mind that the progress of some initiatives has to be framed. Future partnerships with sponsorship may offer an avenue for more resources.

1.6 Interaction with the health sector

Accreditation standard 1.6.2

The Board engages with clinicians in each accredited training post to ensure they are provided with the support and infrastructure to perform their roles within the training program. This is an ongoing process which is formalised within the training post accreditation process. There are specific accreditation standards and criteria in relation to the support and infrastructure (by teaching hospitals) for supervisors and trainers. If there is a major change to structure or resources that is expected to impact on training (staff changes, theatre closure etc.) or information comes to light indicating that a post no longer provides an educational environment of an acceptable quality, the Board will initiate a reinspection.

In many situations, the goals of the training body, and hospital employer are aligned. Both the employer and the training Board share goals of having smoothly run operating lists, wards, and outpatients with the appropriate level of supervision. Where there can be conflict is in areas where hospitals prioritise disproportionately service tasks which will limit progression of training.

Moving forward, the most pressing need is for trainers to become aware of contemporary training attitudes, and to be more active in their supervision. With more members being involved with the Board activities, it will be much more realistic for enquiries on the best methods of delivery of training to be taken by an “expert” group. With our limited resources, a generic course is unlikely to hold all the answers, not is it going to be cost-effective. A core group of training experts may be more appropriate for personalised advice.

Accreditation standard 1.6.3

The Board delegates the day-to-day management of accredited training posts to Training Supervisors who are responsible for ensuring the quality of training is maintained within their post. Training Supervisors work with the relevant jurisdictional representatives on matters of mutual interest such as the balance between service provision and education/training as well as ensuring that trainees are in a supported environment. Any issues are tabled at the quarterly Regional Training Committee meeting and subsequently reported to the Board if there are aspects that require Board intervention.

The Board formally works with training posts through the accreditation process. Minor issues can simply be addressed by feedback with no penalty. In the future we will work toward tighter communication between the groups that determine policy, and the hospital trainers.

Accreditation standard 1.6.4

The Board does not have any formal partnerships with Indigenous organisations or individuals in the health sector to support training and education.

1.7 Continuous renewal

Accreditation standard 1.7.1

A comprehensive review of the SET Curriculum in Urology has not been undertaken in recent years. The Board has undertaken a Governance review as the first step of this process. The conclusion was to increase involvement of more of the Urological community. Establishment of Sub-Committees to drive work and development of policy within their individual briefs has taken place in mid-2016.

With the new structure, there is a plan to undertake a comprehensive review of the curriculum (including assessment practices) every 3-5 years. Importantly, we also plan on survey of stakeholders including hospital posts, and recently qualified urologists to see where the emphasis should be with regard training. Committee structure is start of review process to review all aspects of the training program.

There is a natural renewal of policy direction as office bearers are succeeded by new members. Membership of the Board as well as its subcommittees is limited in their terms of reference.

2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard 2.1.2

The Board has not developed any specific policy or processes in this regard.

Accreditation standard 2.1.3

The current Board structure and goals have been inherited from the times prior to the national training scheme. The endpoints of the program have in the past not strictly been defined. The goal loosely has been to train to the level of an independent general urologist. The definition of Urologist was based on the scope of practice of existing Urologists in the community.

More recently a working group of USANZ has been working on a scope of practice document on behalf of NSW Health. Although not complete, the standards are likely to affect the standard of mandatory training for our trainees prior to fellowship. Apart from that request, the Board has had few requests to alter the competencies expected of its trainees, nor the way training is delivered (via workplace based training).

In 2015, the Board of Urology commissioned a review of its activities and workflows. It had been recognised that the duties pertaining to management of trainees had left little time for strategic change. Policy change was becoming reactionary rather than proactive. The review suggested formation of the Sub-Committees to co-opt more expertise from within the USANZ. Their final composition and range of responsibilities will be a matter of review.

It is the intention when these Sub-Committees are finalised and functional, formal feedback will be sought via regular questionnaires of Training Supervisors, final year trainees at the end of their training, and fellows who have recently commenced practice (within 5 years). In addition to existing current surveys of trainees, and hospital inspections, this feedback will drive strategic change.

Whilst the Board has not sought formal feedback in relation to the overall SET Program in Urology, issues influencing training is fed back by trainees and hospital trainers. The network of training supervisors and quarterly training and education meetings serves well to allow communication of issues of concern directly to Board members. The issues that have been topical include suggestions on how trainees are selected, and which attributes will prepare them best for training.

2.2 Program outcomes

Accreditation standard 2.2.2

The intention of the Training Program is to produce specialists who can function independently in a general sense within urology. This definition is currently loose as it reflected the product of non-uniform training posts, across Australia and New Zealand on trainees who all have a range of background experience, aptitude and motivation. This educational goal had served well when the Urological community was still small with much commonality between practitioners.

As the definition of a Urologist widens and with the advent of sub-specialisation, the competencies that define a newly qualified fellow must be better defined. It is not possible to train in all the varied fields of Urology within the predominantly public funded training posts. Many procedures that community urologists perform are outside what is available within the public system outside of subspecialty units. The challenge is to examine what is feasibly trained with our resources currently (trainees and training posts within a finite time) and compare this to what is expected by the stakeholders (trainees, hospitals and community).

There is a working body of USANZ to examine the reasonable scope of practice for Urologists requested by NSW Health. This will contribute to the definition of the final goals of the Training Program. In addition, the Board of Urology is aware of increased focus on the role of Surgeons within the hospitals, and community. Where relevant, we incorporate formally the RACS non-technical competencies.

The definition of a Urologist will continue to require review into the future as patient needs, the workforce and workplaces change. The Board of Urology will need to continue to be central in this review via consultation with subspecialty groups (Special Advisory Groups) within the USANZ. Surveys of recently qualified fellows also will shape the goals of the training program.

2.3 Graduate outcomes

Accreditation standard 2.3.1

There is only a single Graduate outcome of the Urology Training Program. That is the attainment of skills and proficiencies of a “General Urologist”. This is defined in part by the Curriculum which is available on the USANZ website.

Subsequent competencies in subspecialty are via activities post Fellowship – such as courses and further fellowships. Some are also trained via workplace mentors. The Board of Urology scope is in the standards and training of pre-fellowship trainees.

3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard 3.1.1

The SET Urology Training Regulations outline the educational framework for the SET Program in Urology. The Regulations are available on the USANZ website.

When the SET Program was introduced, Urology adopted a 6 year program:

1. Entry to SET had no real prerequisites in operative or assessment skills. The program set out to give a basic level of training to inductees.
2. SET1-SET2: Basis of surgery in general where skills in assessment of patients and the basis of surgical operating were attained. Many skills were shared with General Surgery, and posts at this level had significant input by General Surgeons.
3. SET3-SET5: Core urological knowledge and skills acquisition.
4. SET6: Consolidation of skills and preparation for consultant practice. Some sub-specialty interest could be adopted.

It became apparent that the training received in SET1 - SET2 had deteriorated and was no longer contributing to trainee progress. Reasons included the lack of suitable General Surgery rotations that were not already used to accommodate General Surgery trainees. These General Surgical terms were largely outside the control of the Board of Urology. As a response to SET1 reflecting such poor learning, the Board decided to remove this year from training. The very basic level of training in SET1 was incorporated into SET2. Applicants for Urology training however could not start without a background in surgery, and conditions of entry incorporated minimum surgical experience prior to application.

Introduced in 2016, as planned, the structure of nSET is available on the USANZ website.

3.2 The content of the curriculum

Accreditation standard 3.2.1

It is recognised that review of the curriculum in Urology is overdue.

The existing document comprises of academic topics and technical competencies in Urology reflecting preparation for the Fellowship Exam. Non-technical skills such as ethics and professional conduct may be new inclusions into the curriculum. Cultural awareness issues may also be included.

The Board is soon able to undertake a comprehensive review (via the newly formed Education Sub-Committee) and update the curriculum to ensure it matches the scope of contemporary urological practice. Invited reviewers will include members of the Urological Society with a special area of interest, those with experience in formulation of professional guidelines, and experience in medical education. Other reviewers will reflect newly qualified urologists and trainees who are abreast of current practice trends across Australia and New Zealand.

Accreditation standard 3.2.2

The current Modular Curriculum (and much of the future revised curriculum) comprises of the scientific basis of Urological Practice. Much of this is also aimed to develop critical thinking and problem solving. Many of the major treatment areas in urology (e.g. Prostate cancer, Urolithiasis) have many alternative management options. The training program is designed to develop problem solving skills, and a tailored approach to management according to patient, surgeon, and resource factors. The appraisal of the merits of competing treatments is a central competency in Urology.

The educational activity of Trainee Week aims to cover the curriculum over three years ensuring formal tutorials across the scientific topics. The sessions are often debates, judging the merits of various points of view.

Knowledge of, and contribution to the creation of medical evidence is central to the preparation for the award of Fellowship and preparation for the final exam. Requisite courses for trainees include the Critical Literature Evaluation and Research (CLEAR) Course. Participation in research is also compulsory prior to progression to Fellowship.

Accreditation standard 3.2.3

Core to the curriculum is the ability of a training Urologist to gain skills to allow them to care for patients safely. Trainees in their early SET years are taught the breadth of conditions, and their individual operative and non-operative treatments. As they progress toward fellowship, the emphasis is placed on problem solving, and the appraisal of the treatment and how it can be applied to the situation. The variety of these treatments and diagnoses, and their selection is central to the practice of Urology.

Safety is strongly emphasised in the teaching of operative and non-operative management. It is a culture promulgated through emphasis in the Fellowship examination. Not only are the operations part of the syllabus, but also troubleshooting within them, and how to rescue a situation. Knowledge of complications of treatments are also requisite.

Accreditation standard 3.2.4

This competency is actively taught clinically and examined in the advanced Urology years. The aim of the training program is to produce a clinician who is sophisticated in their treatment choices to reflect patient and community goals. As one of the latter assessments, the Fellowship Examination has been structured to examine the curriculum within this context.

The Board recognises however that this objective needs to be formally written into the curriculum.

Accreditation standard 3.2.5

The current curriculum does not document these skills, and they are not currently taught formally in all training posts. The Board however does recognise their importance, and provides time for a session within Trainee Week devoted to the development of professionalism skills.

These skills in professionalism and leadership are assessed via the quarterly assessment reports and feedback is provided to trainees at that time. Currently instruction in their development is formally mandated for trainees who have been identified as deficient (via the TIPS Course). The Board is examining how to more deliberately and formally incorporate this into training

Accreditation standard 3.2.6

Understanding of the health care system is currently not part of the formal curriculum. Cost effective management is however a feature of what is taught and examined in the training program. Trainees are most exposed to this with interactions with the private health care system. Attention will be made to include this component into the curriculum.

There will however be a challenge in how to frame and instruct this competency. It is perhaps best a subject raised in the context of a surgical mentor conversation.

Accreditation standard 3.2.7

SET6 trainees encouraged to undertake the RACS Surgical Teachers Course. The USANZ funds the costs of their attendance. Trainees are also exposed to their role as educators via their hospital employment where supervision and instruction of other staff is a condition.

Accreditation standard 3.2.8

Research is a mandatory component of the SET Program in Urology as outlined in Section 3.8 of the Training Regulations. SET Urology trainees must also complete the CLEAR course.

The Board also supports research by allowing trainees to interrupt their training to participate in research activities. Previously when the program was time based, a PhD contributed to formal time during the training program. Currently however that no longer applies as the program measures competencies in operative, and non-operative as outcomes of training (a competency based program).

Accreditation standard 3.2.9

The current Curriculum does not include a specific component focusing on an understanding of Aboriginal and Torres Strait Island issues as they relate to the provision of urological services, the Board plans to incorporate this into the revised Curriculum. The Board plans to incorporate training modules developed by RACS.

Accreditation standard 3.2.10

Whilst the current Curriculum does not incorporate cultural awareness, the Board plans to incorporate this aspect into the revised Curriculum. Again this is a difficult subject to instruct formally without consuming much resource and time. Increasing the emphasis on this topic and making it an area of assessment and

discussion within the context of the workplace is likely the most effective means of engagement. A formal course may have the potential of being seen as a compliance requirement, and not have the same resonance in the trainee.

3.3 Continuum of training, education and practice

Accreditation standard 3.3.1

The selection of trainees imposes minimum requirements on prior exposure and competencies. These are complimentary to the RACS JDocs framework.

Within the SET training program, the stage of training determines the emphasis on competencies. In early SET, assessment of patients and basic sciences is the emphasis. In later SET, this knowledge is built on to target problem solving skills, and the ability to make treatment decisions that are individualised to disease, patient, surgeon and health service variables. The examinations and their timing reflect this planning.

Accreditation standard 3.3.2

The SET Program in Urology allows trainees to apply for Recognition of Prior Learning as outlined in the Regulations.

3.4 Structure of the curriculum

Accreditation standard 3.4.1

This is outlined in the Training Regulations, which is readily available on the USANZ website and will be incorporated into the revised curriculum.

Accreditation standard 3.4.2

The duration of the SET Program in Urology is outlined in the Training Regulations (Section 2: Program Administration). The duration reflects the traditional time that it has taken to train a Urologist in the past. Current trainees are free to extend training to address their own needs and deficiencies. Extension may also be mandated for trainees not attaining competencies at a satisfactory level in accordance with the terms outlined in the Training Regulations (Section 5.7 of Regulations).

Current trainees have showed an increased interest in extension of training. The Board of Urology will be involved in a research project reviewing logbook trends over the last decade to examine if current training hospital conditions of shorter rostered hours and fewer elective patient numbers are able to meet the same targets as in previous years. When this survey is complete, the conclusions will aid change in policy regarding training duration, and requisite clinical load.

Training can also be interrupted by trainees for reasons of family, health, and professional development. The Board of Urology has been accommodating with requests in this area.

Accreditation standard 3.4.3

The Board of Urology is amenable to part-time, deferral and interrupted training as per SET Urology Training Regulations (Section 2: Program Administration)

There have been no applications by urology trainees for part-time training in the last three years.

The number of trainees who have applied for deferral or interrupted training in the last three years (i.e. all applications have been approved) are as follows:

Type	2014	2015	2016
Deferral	2	Nil	4
Interruption	2	0	1

Note deferral/interruption may have been for maternity or other reasons

Challenges for the design of part-time training are to account for the individual needs (part week / part day), duration, as well as the ability to continue academic studies (reading) when not fulfilling clinical duties. A system can be made flexible easiest within units that have multiple trainees and junior medical staff. A culture of innovative rostering for financial reasons by hospitals (overtime minimisation) brings more opportunity for trainees who have to train part time.

Other challenges are in the assessment of progress for these trainees. As surgery is a manual skill where currency of practice is important, there can be limitations in how rapidly progression through training can be achieved.

Accreditation standard 3.4.4

Trainees are permitted to apply for interruption of training to pursue studies of their choice (i.e. outreach, higher degrees). The content is not vetted by the Board and the trainee is not required to report to the Board nor is the study monitored by the Board.

Whilst the creation of the SET6 year was to control the quality of experience for final year trainees (as opposed to an overseas fellowship), there is still flexibility to select posts that offer a sub-specialty flavour. The awarding of positions is via competitive application by trainees in SET4.

Post Fellowship opportunities can also be facilitated via a network of fellows and trainers with contacts within Australia and New Zealand, and also further overseas.

4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1

The SET Program in Urology employs and encourages a range of teaching and learning approaches.

- Self-directed learning – as per the Modular Curriculum. Although there is no formal mapping of each level with the SET stages, there is a deliberate change in emphasis to expected knowledge. Much of the learning is directed at preparation for exams. The basic sciences are required for the first two years of SET training as is reflected in the examination focus (Surgical Science (Urology) Examination). Knowledge and capacity for advanced decision making skills are the focus of the Fellowship Examination at the end of SET5.
- Work-based experiential learning – outlined in the Modular Curriculum, Training Regulations and Training Post Accreditation Standards. Supervisor targeted teaching and questioning is aimed at stimulation toward exam end points. Basic science knowledge is built on in latter training to reflect change in emphasis toward special relevance to choice and application of treatment (e.g. basic anatomy becomes operative anatomy, which is more relevant to surgical technique).
- Supplementary learning experiences – sectional education programs are conducted within each section according to timely opportunities (such as a visiting speaker). There are also semi-formal tutorial programmes targeted toward general topics, and coverage of areas relevant to exam preparation.
- On-line resources – The Urology online Journal Club is available for trainees.
- A mandatory annual trainees meeting during Trainee Week. The programme of this is based on a three year cycle through the curriculum. Content of the week long meeting includes didactic tutorials, interactive sessions, trainee debates, and sessions on non-technical skills. Practice examinations are also conducted to this course targeted to SET2-5 (nSET1-4)
- SET Urology Induction Course in the first few weeks of entering the Urology Training program. This is a primer on important skills including adult learning, and mandatory competencies such as laser safety, use of fluoroscopy, ureteroscopy and TURP. The target for this is trainees entering Urology.

Challenges of the Training Program

Future directions in training may involve the use of simulators. In Urological surgery, the fields of laparoscopy and endoscopy lend themselves well to the use of suitable simulators. New high-fidelity simulators are emerging in these areas. The challenge that we face as a smaller but geographically dispersed training program is to provide adequate (still costly) simulator exposure to our trainees equitably at the correct phase in training.

Administrators of hospital posts often have a higher priority on service provision over that of less efficient mentoring and training. The reassessment and post Accreditation Sub-Committee is tasked with maintenance of the focus on training, and preservation of learning opportunities.

The traditional apprenticeship model of training is under pressure as caseload is eroded, and there is increasing concern regarding patient safety. Developments in the process of determining entrustable activities, and training of hospital supervisors in contemporary methods of instruction have not yet reached full potential. Some work by the entire surgical profession is required. Urology is somewhat privileged that endoscopic and laparoscopic surgery (under direct vision on a monitor) is easier to monitor and instruct directly.

As we increasingly strive to ensure trainees attain a standardised level of competencies, the challenge is for trainers to be able to also deliver an effective teaching experience. There is little formal instruction for trainers in general. The Board of Urology encourages it's SET6 trainees to participate in the Surgical Teachers Course. Further development in this area and a change in the culture of trainers to value formal qualifications are needed.

4.2 Teaching and learning methods

Accreditation standard 4.2.1

The SET Program in Urology is practice-based. The current Curriculum and the Training Regulations outline the breadth and depth of clinical and operative exposure that must be attained over the course of the program. Trainees are however encouraged to take advantage of any subspecialty attributes to their training posts.

The requisite exposure is provided in accredited training posts and occurs in the outpatient clinical settings, inpatient activity (emergency and elective), and operating sessions as well as when on-call. A standard of accreditation of training posts is the involvement of multi-disciplinary care where trainees are exposed to other team practices, and are called on to liaise.

The level of supervision and expectations of trainees in each of these settings is aligned to their level of competence, to ensure patient safety. Accreditation of training posts ensures that trainees are provided with the requisite clinical and operative exposure. There is emphasis on supervision and mentorship, but also opportunity to put practical skills into practice. The aim of the program is to produce specialists with the skills of independent practice. This is reflected in the creation of a proportion of unsupervised (remotely supervised) operating lists in the final year of the program (SET6).

Accreditation standard 4.2.2

There are a range of formal adjuncts to clinical learning that are available to SET Urology Trainees. These are outlined in Section 6: Courses & Educational Activities SET Urology Training Regulations.

Australian & New Zealand Surgical Skills Education and Training (ASSET)

- Basic surgical skills, musculoskeletal injuries and minimal access surgery
- Targeted to trainees in their first year

Care of the Critically Ill Surgical Patient (CCrISP)

- Management of the critically ill patient in a multidisciplinary setting
- Targeted to trainees in their first year

Early Management of Severe Trauma (EMST)

- Assessment and management of patients in a trauma setting
- Targeted to trainees prior to the completion of their second year

Critical Literature Evaluation and Research (CLEAR)

- Targeted to trainees prior to the completion of their second year
- Aim to develop skills in assessment of literature
- Re-imbursement of fees by the Australasian Urological Foundation (AUF)

USANZ Trainee Week

- Participation for nSET1-nSET4
- Includes didactic tutorials, interactive sessions, trainee debates, and sessions on non-technical skills
- Practice examinations are also conducted to this course

In 2016, the Board introduced a 3 day Induction Course for new trainees, which comprises an overview of the SET Program as well an introduction to endoscopic and surgical instrumentation and skills (Refer Program Outline – Induction Course). This course has instruction on laser safety and use of fluoroscopy which are often requisites prior to their use in workplaces.

For the last 3 years (2014-2016), trainees in SET4 have also had the opportunity to attend an Anatomy and Prosthetics Course. In 2016, SET3 trainees were given the opportunity to attend an Endourology Course conducted at the Annual Scientific Meeting.

Accreditation standard 4.2.3

Didactic Teaching:

All training posts seeking accreditation for training have to offer some didactic teaching in the form of a tutorial program. Many hospital networks offer similar training in addition, often after hours. Trainees may also be made aware of (non-compulsory) educational opportunities that may be provided by medical industry.

Self-Directed Learning:

The Board of Urology supports the learning of SET Urology trainees by the provision of a range of resources:

Textbooks/Reference Material – The Modular Curriculum provides a framework to assist in the structured learning SET trainees can use in preparing for the requisite examinations. The principles and detail required is harnessed from a variety of resources. All trainees are encouraged to select reference material that suits them.

Access to online resources from the American Urological Association (AUA) University and European Association of Urology (EAU) Guidelines have been secured via educational partnerships with these associations by the Board of Urology at greatly subsidised cost. These associations represent a different emphasis of practice that still can be applied to the Australian and New Zealand setting.

Trainees have access to the RACS library for a variety of textbooks and online journals.

Peer-to peer learning:

A number of trainees in SET4/SET5 have established their own study and support groups via teleconferencing. The composition of these is not only limited to trainees from States where geographical factors of isolation may disadvantage those who have few contemporaries to study with. The focus of these groups is often on preparation for the fellowship examination.

The Urology Trainee Forum has established an online journal club with rotating presenters. The journal articles are chosen in advanced, and a dial in / webinar discussion takes place after trainees have opportunity to appraise the materiel. Some challenges are that online live participation is difficult for a program encompassing multiple time zones.

Working with Interdisciplinary Teams:

Trainees are expected to be actively involved in regular MDT meetings and are required to collate, interpret and present their clinical findings and contribute to the discussion regarding management plans. This facilitates interaction with other health professionals. Hospital posts applying for training positions are strongly encouraged through the accreditation process to have these meetings regularly as teaching opportunities.

Within the workplace, trainees are also encouraged to maintain a respectful and professional relationship with other units in the hospital (Emergency, anaesthetics, and other consulting specialties).

Role Modelling:

The alignment with a role model is suggested for all trainees. For those who are identified as underdeveloped in a surgical competency, one of the steps to shaping improvement is the use of mentor (a trusted individual outside the hospital unit) interaction. The perspective gained from mentors outside the formal workplace is valuable in developing insight into which areas for improvement need to be targeted. The Board of Urology does not generally assign mentors, choosing to allow the trainee build trust with the person of their choice.

In a less formal way, trainees have self-allocated mentorship relations between early and later SET levels. The purpose of these is to provide guidance for new trainees to navigate the training "system".

Accreditation standard 4.2.4

The development of clinical and surgical competence is monitored on a regular basis by the trainers in each accredited post. As a trainee's clinical and surgical competence develops, they are afforded greater responsibility and independence. There is also an expectation of development of more and more independent clinical management. Trainees transition from acting only on instruction from a senior, to a clinician who appropriately consults for opinion outside their experience, to independence. The accreditation criteria for SET6 posts stipulate specific requirements for independent decision making to develop this competency.

The development of a trainee's knowledge, skills and competence is measured via the examinations in part. Emphasis during earlier training is on acquisition of the building block knowledge with examinations at that stage reflecting this. Later in training, the Fellowship Exam specifically targets the ability to individualise treatments based on the appraisal of complex scenarios. The exam preparation requirements reflect this.

In-training assessment reports and logbook summary reports also capture information on development of surgical independence. It is expected that with higher stages in training, that the proportion of cases done as primary operator increases, with less direct input from consultant supervisors.

In the final year of training, recognition is given to development of independence, and also subspecialty skills of interest. There is flexibility for trainees to target areas for future development by requesting and applying for posts across Australia and New Zealand via a competitive process.

Strengths

Trainees have access to a diversity of teaching and learning methods.

Increase in numbers and availability of practical skills courses.

Many urological consultants and senior trainees are very motivated, and offer additional teaching sessions and exam practice outside work hours.

There is flexibility within the program to account for different progression rates. Extension of training which was highly stigmatized is much less so now.

Challenges

Whilst training occurs in accredited posts, there can be a significant variation in the quality and quantity of trainee education between hospitals. The Accreditation Sub-Committee is attempting to audit posts to ensure at least a minimum high standard.

Preparation for the Fellowship Examination is largely self-directed. Many however see the advantages, and are choosing to prepare within a peer group.

Accreditation criteria specify an amount of scheduled teaching that must be undertaken. Much of that teaching and additional teaching is undertaken by consultants in their own time. Whilst this teaching is extremely valuable to trainees, the challenge is maintaining the goodwill of urologists.

Most surgeons and trainees equate surgical training to the acquisition of surgical skills and competence but there is a multitude of non-technical skills that need to be taught and learnt. They play a significant role in

day-to-day practice and need to be mastered. There is greater recognition of these competencies within the changing culture of the specialty. This will evolve as these skills are incorporated formally into the curriculum.

Changing technological developments and new procedures continue to be developed. Often trainers have to acquire their own skills concurrently. Structured learning is required to ensure acquisition of skill and patient safety. The challenge is to ensure that trainees are not left out of the process when new procedures and techniques are being incorporated into practice (such as robotic surgery).

The need to constantly review teaching methods and styles of delivery to facilitate optimal learning. Trainees come from different backgrounds and prior experiences. Training needs to adapt to the current stage of learning, and the attitude toward learning of a new generation of trainees.

Teaching and learning needs to be delivered in the context of day-to-day provision of 24 hour surgical services. The previous traditional 'apprenticeship' model is no longer efficient and needs to be improved.

Many trainers have never been formally taught how to teach. Instruction style between hospital posts and trainers is highly variable. More training is required to develop this legitimate skill. The ideal time for this development is likely within the training program itself, as the trainees will become the instructors of the future.

5 Assessment of learning

5.1 Assessment approach

Accreditation standard 5.1.1

The assessment of SET Urology trainees includes both formative and summative assessments. Assessment is aligned with the curriculum and requirements for each SET level. The In-Training Assessment Form (applied quarterly by Training Supervisors and discussed at a Sectional level) broadly covers the current curriculum – both technical and non-technical areas and includes surgical expertise. Additionally assessment is provided informally with frequent interaction between trainees and trainers in the clinical setting (operating lists, ward rounds and outpatient clinics).

Future opportunities exist for a mechanism of feedback that would be more responsive than the formal 3 month review. This may be in the form of an online "dashboard" incorporating assessment from trainers in real-time. This may aid trainees identify areas to work on as they are identified. It would also be a means of hospital trainers to get a picture of any deficiencies needing attention identified by other trainers. This could also serve as a mechanism for trainees to communicate self-identified specific needs in their training.

The forms used to assess SET Urology trainees on a quarterly basis have evolved over time and now include a variety of non-technical competency assessments. In 2013, the Board determined that surgical training demanded a high standard and having 'met' the standard was all that was required. The earlier version of the in-training assessment report had placed an emphasis on performing 'above' expectations. A rating of 'met' expectations for a particular domain means that the necessary requirements have been met and no further remedial intervention is required. A rating of 'just below' expectations means that there are minor issues in that parameter that need attention. A 'significantly below' expectation rating is used for more serious issues and are often not related to a single issue but are coupled with other 'just below' or 'significantly below' expectation ratings. These ratings are usually an indicator of an under-performing trainee.

In 2013, the Board amended the overall performance rating scale to include a new category 'Borderline' (including slow to progress). Where there are concerns regarding a trainee's performance during the term, supervisors are advised not to use the Satisfactory rating but to consider using the Borderline rating. A rating of Borderline means that a trainee's performance is not to the satisfaction of the unit in some areas. Use of this category has allowed the earlier identification of more trainee issues prior to them developing into major deficiencies.

This initiative was implemented to change the culture of workplace assessment, where previously the repercussions of marking a trainee as unsatisfactory discouraged reporting of trainee issues. The binary nature of assessment (pass / fail) resulted in resistance by both trainers and trainees to identify concerns. The emphasis now is for trainers to be more forthright and honest with feedback, earlier, allowing for more

opportunity for the trainee to address and remediate. Trainees are also encouraged to see this feedback as constructive and aimed at guiding them towards their goal of consultant practice, rather than punitive.

Trainers still need to be supported in this paradigm change. Many will have trained in an environment where feedback was perceived as threatening, and there may be reluctance in delivery of "negative" feedback. The college has initiatives targeted at giving feedback in a way that is not construed as bullying. Much work needs to be done to help post supervisors become empowered to deliver this guidance. The Board of Urology via the Education Sub-Committee will have to equip trainers with robust, accepted goalposts expected of trainees. This will hopefully empower trainers to be more perceptive and afford more feedback.

Summative assessments include the SSE and CE, SSE (Urology) and the Fellowship Examination (FEX) in Urology. The program of assessments is outlined in the Training Regulations, and on the USANZ website. Although there is a perception of the FEX as an exit exam, eligibility to sit the exam is made on recommendation of assessment by the trainee's supervisors of competencies with reference to future specialist practice. The role of the exam has changed from an "exit" exam, which defined competency, to one where it validates a trainee's final competency.

Accreditation standard 5.1.2

All requirements for assessment and completion are outlined in Section 3: General Requirements, Section 5: Assessment, Section 6: Courses & Educational Activities, Section 7: Examinations of the SET Urology Training Regulations. The Regulations are sent via email to all trainees and supervisors and are published on the USANZ website.

Accreditation standard 5.1.3

The Board of Urology does not have separate policies relating to special consideration in assessment. These are covered under RACS policies.

Future Plans

The Board recognises that the assessment of training is an area that is in need of revision. Whilst there is a need to modify the templates and tools, there is also a need to provide greater resources to support supervisors, particularly in terms of managing under-performing trainees. The Education Sub-Committee will undertake this review to determine the modifications that need to be made and any additional resources that need to be developed.

The challenge of the assessment process is ensuring that it is practical and workable within the time and resource constraints of a busy clinical urology unit.

5.2 Assessment methods

Accreditation standard 5.2.1

The assessment tools of the program are outlined in Section 5: Assessment and Section 7: Examinations of the Regulations.

With respect to the examinations, there has been a move from an all-encompassing final exam, to progressive assessment of basic sciences and groundwork to earlier stages in training. This reduces the responsibility of the final Fellowship Examination (FEX) and drives acquisition of knowledge at earlier stages in training.

Completion of the earlier examinations (Clinical Examination and Surgical Science (Urology) Examination) are all prior to the advanced stages of training (completion of SET4 /nSET3). The Surgical Science (Generic) Examination is required now prior to application to enter the training program. Surgical Science (Urology) Examination and Clinical Exam have a limited number of attempts available to trainees (4). Failure to complete these exams within the time frame will result in dismissal.

Within clinical training, the formalised tools used are the Direct Observation of Procedural Skills in Surgery (DOPS) and the Mini Clinical Examination (Mini-CEX). The requisite number of assessments is documented:

It is recognised that the number of formal assessments is comparatively few in relation to the duration and volume of training. Less formal assessment (at every trainer / trainee interaction) comprises the bulk of

assessment. Although it is desirable to have more formal assessments such as DOPS and mini-CEX, the process imposes a significant barrier to the delivery of services within hospital units. The validity of a few handpicked episodes of assessment is also questioned. It is therefore desirable to move toward a continuous assessment and feedback process. The tools as yet remain to be developed and implemented. In any case, there is no limitation on the number of formal assessments conducted by trainee and supervisor in a term by negotiation.

The FEX has evolved to an examination targeting advanced problem-solving and application of knowledge. Some basic sciences are examines, but within a clinically relevant setting.

Accreditation standard 5.2.2

There is no current blueprint to stage by stage assessment. The Board of Urology however is in the process of developing expected competencies for each SET stage, and the overall program. It is not envisaged that trainees develop in a strict linear fashion, but with different classes of skills relatively independent of each other (e.g. open versus endoscopic surgery).There is expected to be some flexibility and overlap in when the different operative, non-operative and non-technical proficiencies are attained, allowing for different trainee backgrounds and attributes of training posts.

When there is consensus in the endpoints, development of review tools can mapped to the competencies. The existing tools of DOPS and mini-CEX are only some of the possibilities. Far more likely is direct observation of proficiency of the skills in the workplace, and documentation in quarterly training assessment reports (and any future prospective tools). Many of the assessments are already currently performed, but in a less systematic manner. Through identification of the key competencies, a more formal and directed process of assessment, and documentation of achieved skills can occur.

Accreditation standard 5.2.3

The Board of Urology is not directly involved in the standard setting process. Urologists who participate in the RACS process as members of the relevant Examinations Committees and Court of Examiners determine the reasonable pass mark based on what is expected for a functional consultant in the specialty.

5.3 Performance feedback

Accreditation standard 5.3.1

The backbone of formalised feedback is via the direct observation of proficiency of the skills in the workplace, via tutorials and other interaction, and documentation in quarterly training assessment reports. DOPS and mini-CEX serve to formalise what should be a continual process. Although formal feedback and assessment at 3 month intervals within a 5 year program is reasonable, the move to “real time” assessment and feedback should be strived for.

Workplace based feedback is done well by motivated, proactive and confident individual trainers in some training posts. Many supervisors however have neither the background skills not the motivation to train in such a manner. The Board already imposes a frequent protocolised feedback system where underperforming trainees on probation formulate a mutually agreed performance management plan, which is the subject of monthly discussion and review. This process allows the trainee to make and apply changes to practice, and gauge their effectiveness. The trainers are also directed to address specific training goals.

Future direction would be to place all trainees on a continual feedback process reflecting their current competencies according to a “map” of attributes. Trainees and trainers could work toward negotiated goals toward final attainment of specialist qualification. Such an initiative would be best done via an online portal, which would describe achieved competencies, and targeted goals.

Accreditation standard 5.3.2

Training Supervisors undertake direct assessments, which are discussed initially at the Sectional Training and Education (TAE) meeting. There potential solutions for any deficiencies are explored. The overall rating (Satisfactory / Borderline / Unsatisfactory) for the 3 month term is also discussed and ratified. These issues are also discussed at the National training Board and interventions discussed. These can include a

probationary period, and/or a period where there is more frequent feedback and assessment according to a tailored performance management plan designed to address the deficiencies.

This plan is formulated by the trainee with input from the Board of Urology and the immediate hospital supervisor. It is designed to highlight specific issues and actions to remedy them. The plan can be altered depending on progress / the identification of new issues.

It has been recognised that hospital supervisors may not be familiar with the processes involved with managing an under-performing trainee. The Board of Urology is in the process of developing a Guide for Supervisors outlining this process and providing advice in the formulation of an appropriate remedial plan. We hope to also include strategies for monitoring progress, and delivery of feedback

This management plan places the trainee, Board, and training post on common ground where any issues are highlighted. There is an onus on all the supervisors in the post to contribute to the implementation of this plan. Progress is assessed 3 monthly via the process above, with further recommendations. Communications between the parties are via formal email / letters to eliminate ambiguity of responsibility. Any repercussions of non-compliance are also communicated.

Accreditation standard 5.3.3

The processes listed in standards 5.3.1 and 5.3.2 ideally will identify underperformance for management early. Practical issues arise however at the start of any new term where trainers are unfamiliar with suitable entrustable duties for an unfamiliar trainee. The Board of Urology has tried to reduce this “bedding in” process with a more formal process between hospital positions in trainees who have identified performance issues. The trainee benefits by having their needs addressed from the start of the term.

Another initiative for the early identification of the underperforming trainee was the creation of the “Borderline” category of assessment. Trainers were less reluctant to provide that mark than a straight “Unsatisfactory”. A “Borderline” report can be discussed further on its merits and modified either to “Satisfactory”, or to “Unsatisfactory” either by the Sectional TAE, or National Board of Urology. If there is a revision of rating, the trainee, Hospital Supervisor, and the Sectional Chair are notified at once.

The potential outcomes of underperformance include extension of training, or dismissal from the SET program. From the time the trainee is placed onto probationary status, or as a consistent pattern of underperformance is identified, these outcomes are formally disclosed in correspondence.

There are criteria within the Training Regulations regarding dismissal for unsatisfactory performance (Section 10). These are communicated early to the trainee when they may fulfil any of the criteria. Where the situation is not as serious as to mandate dismissal, after discussion at a Sectional and National level, the Board may impose an additional period of training (and probation).

Other criteria for dismissal are listed in the above regulation. There has only been one trainee within the last 3 years who has been dismissed by the Board of Urology.

Accreditation standard 5.3.4

Existing hospital protocols exist for the documentation of critical incidents and their notification. The Board has not had to explicitly notify regulatory bodies as yet for any incidents arising from Assessment Reports.

In the past the Board has had to make notification to the Medical Board / AHPRA where trainees have become impaired due to a psychological illness (depression), and physical disability (closed head injury). Management of these cases was with consultation of the relevant employer bodies and their occupational health physicians.

The Board will incorporate into the Regulations a clear process for informing employers and registration authorities if required about patient safety concerns arising in an assessment.

5.4 Assessment quality

Accreditation standard 5.4.1

In 2013, the Board redesigned the In-Training Assessment Reports in accordance with the performance expectations of each SET level. There were specific reports for trainees in SET1-SET2 and a common report

for trainees in SET3-SET6. The emphasis in each assessment area was highlighted to assist supervisors when determining their assessment of a trainee's performance.

The Board also revised the rating scale for assessment areas and determined that trainees would be assessed in accordance with the expected level. The motivation for this modification was to eliminate the argument that "Above expectation" competency would compensate for "Below expectations". It was and is the Board's stance that all domains of underperformance would be addressed. The current rating scale for individual assessment areas comprises:

MET expectations; performed in a manner expected for SET level

Just below expectations; repeated mild deficiency, and need for some improvement

Significantly below expectations; needs immediate and substantial remedial attention.

The overall performance rating scale was also amended to include a new category:

- Satisfactory
- Unsatisfactory
- Borderline (including slow to progress)

Supervisors have been encouraged not to rate a trainee as Satisfactory when there is doubt regarding their performance during the term. If they have doubts, they can use the Borderline rating. A rating of Borderline means that the trainee has not performed to the satisfaction of the unit in some areas.

Any areas of concern must be outlined and discussed with the trainee. As outlined in the report, two Borderline assessments can lead to Probation and/or Extension of Training, or other remedial measures.

The In-Training Assessment Report must be based (as much as possible) on direct observation of actions and behaviours. It should be carefully considered, and as objective as possible. All consultants in the Unit are expected to contribute to the In-Training Assessment Report and the opinions of others (such as Anaesthetists, Emergency Specialists, Nurses, and Junior Medical Staff) may be sought as they too can provide valuable information regarding the performance of the trainee.

Future direction of this formal assessment is in clarification of the terms within the document to reduce ambiguity. The move to an online form will mandate the completion of text fields in the case of any less than satisfactory observations. In spite of education of supervisors, these reports still can be unclear as to why a grade has been applied in assessment. Currently the Sectional TAE can request clarification, however the process is cumbersome as it does not involve the trainee at the time. The adoption of frequent continual recorded feedback may also alleviate these issues.

Pass rates for the examination are fed back to the Board of Urology via the Chief Examiner who is a Board member. In 2011, a cohort was identified with an unacceptably low pass rate. At the time, it was accepted that the FEX was attempted in the May sitting of SET5. The reason for the low pass rate was identified to be inadequate clinical exposure. A move to change the culture of first attempt at the exam to September of SET5 was made, with a restoration of high pass rate.

Accreditation standard 5.4.2

Currently there are no formal processes for standardisation of assessment reports between sections and individual posts. Reports are discussed however at a Sectional, and later at a National level to determine validity and if there are any extenuating circumstances. These reports are discussed with reference to known factors that differentiate posts such as workload, other trainees, and the personalities of the supervisors. The training history of the trainee is also used to identify if they are the victim of an unduly harsh review.

In the future the Board of Urology would hope to review its benchmarks in assessment documentation to reflect objective goals rather than qualitative values. This may reduce unjustified observer bias between training posts. The use of an electronically based term report would include prompts and definitions to reduce bias in supervisor documentation.

6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.1

Prior to 2016, review of the entire training program was in reaction to changes in circumstances and identified need.

Program structure has undergone change every few years to reflect the change in trainee and hospital factors.

1. The addition of SET6 in 2011 as it was identified that trainees were not achieving requisite surgical competencies by the end of their 5 year training before setting off on an overseas fellowship. Because of the variable and unverifiable nature of the fellowship year it was thought that this post exam year take place within Australia and New Zealand in Board sanctioned posts.
2. Omission of intake in 2014 and change to a 5 year training program after it was identified that the Board of Urology could no longer assure quality training for SET1 as those hospital positions were under control of General Surgery. Trainees entering the program were made responsible for the acquisition of those skills as the Board focussed on delivery of Urology learning units.
3. Currently the program seeks to be competency and achieved skills based. Most trainees progress on time (SET year) unless specific issues are identified however. As the Education Sub-Committee maps more explicitly the requisite competencies, it may come to be that the program will take on a variable number of years to truly reflect competency. Trainees have different backgrounds, experience and aptitude. Training should be seen as more flexible and taking more time to achieve skills should not be seen as a failure. Conversely a trainee who has prior skills already has opportunity to apply for accelerated training.

The selection process is reviewed every year to be responsive to various challenges:

1. The introduction of SET by RACS opened training to all levels of postgraduates in an attempt to start training at an earlier age
2. As it became clear that some trainees were poorly prepared for the responsibility of running a surgical unit, selection criteria changed to recognise the benefit of prior surgical experience
3. Recognition of trainee underperformance in non-technical areas resulted in a change of the selection interview to examine and rank communication skills / judgement
4. More innovative selection questions have been used to counter the phenomenon of over-rehearsing
5. Reduction of the emphasis of research as it was found not to discriminate between a well and poorly performing trainee

The curriculum **will** need ongoing revision:

- Examination of current trends in clinical management
- Include non-technical and professional competencies essential to reflect contemporary expectations of surgical behaviour and conduct

Hospital posts have also had a revision in expectations:

- Greater obligation to document teaching (as opposed to service) activities as part of accreditation
- Higher requirement of identification and remediation of performance issues of trainees. Greater accountability in passing trainees.
- Increased emphasis on auditing of supervision during the inspection process.

Accreditation standard 6.1.2

Trainers and supervisors have a feedback mechanism to the Board to influence the delivery of training. The lines of communication are from trainers, to the hospital supervisor, and then the Sectional Training and Education body. The Chair of the Sectional TA&E Committee sits on the Board of Urology. The vastly

increased involvement of more fellows in the newly formed sub-committees also allows for more feedback pathways.

Supervisors meet Board members regularly and are invited to provide feedback. There are interactions at:

- The trainee selection interviews
- Trainee week practice examinations

There are no current moves to regularly survey supervisors. The Board however consults hospital posts on important measures (recently soliciting feedback on modifications to the SET6 trainee allocation process). In the future the Board will conduct research via the subcommittees on matters of program direction.

Accreditation standard 6.1.3

Trainees currently have several feedback mechanisms:

1. Public question and answer meetings between the Board and trainee body during Trainee Week, and the Trainee Session of the Annual Scientific Meeting
2. Individually via discussion with the Education Manager
3. Individually and confidentially via the Sectional trainee representatives
4. As a group (and online Urology Trainee Forum) via the Trainee Representative who sits on the Board of Urology
5. As formal but confidential training post feedback between Trainee Representatives and the Board of Urology (at the Annual Scientific Meeting)
6. Several trainees sit on the new Board Sub-Committees (Education and Accreditation of posts). Existing terms of references can be modified to allow for more trainee participation if necessary

Planned future initiative:

Survey of trainees on exit of the program for feedback

6.2 Evaluation

Accreditation standard 6.2.1

A subcommittee of USANZ is working on minimum standards of scope of practice that health boards can use to accredit Urologists. This is likely to have repercussions on the standard that the Board of Urology will set of its trainees. It will likely impose some obligation to ensure trainees meet those criteria before fellowship.

Up till now the standard was set as a “reasonable level of competencies allowing practice as a general urologist”. Individual hospitals had varying opinion on what was the standard was.

The Board of Urology plans on commissioning a survey of recently qualified fellows to identify areas where training (final competencies) in Urology needs development / expansion.

Accreditation standard 6.2.2

Data regarding the program and graduate outcomes has not been collected and analysed in a formal manner to date. Informal feedback is only anecdotal via the supervisor and Sectional Chair network. The Board plans to develop and distribute a survey to Younger Fellows (<5 years post-fellowship) seeking their feedback on the outcomes of the training program, their preparedness for independent practice, and recommendations on what could be improved.

The Board will also determine a mechanism for obtaining formal feedback from external stakeholders (e.g. jurisdictions and existing urological units). It may be interesting to know what qualities employers and prospective employers are looking for in a newly accredited fellow.

Accreditation standard 6.2.3

Current feedback to members of the Board of Urology is via interaction with sectional members (other urologists who may be in the community, or be training supervisors themselves). Meetings are periodically

held amongst urologists within each Section (Australian States and NZ), not just those who work in training posts. The relevant Training and Education Section Chair sits on the executive of the State Board and makes a report to the section regarding training. Feedback can be shared at this forum. Supervisors provide more frequent feedback via the Regional Training Committees. These Committees meet quarterly to discuss trainee progress reports.

Other internal and external stakeholders have the opportunity to comment on the program and graduate outcomes during the inspection of training posts. The inspectors meet with hospital administrators where views on training in that post are shared.

From this feedback, the Board has made modification most visibly on the selection criteria of new trainees awarding more merit on surgical experience and skills. It was thought that specialists produced by the training program had not started with the necessary skills to capitalise from the program. The limitation in making this change has been identifying the ideal standard of candidate, but also what is realistic within the medical post-graduate pool across Australia and New Zealand. Deliberate attempt was made not to change criteria too quickly as it may have resulted in excluding a large cohort of talented candidates, or alienated those who had devoted a great deal of time in preparation for their application.

Unfortunately there is limited control over the fundamental method of learning skills (exposure to Urological medicine within relatively varied Urology units). Background skills in other disciplines and basic competencies have to be built up elsewhere to allow steady learning in Urology. Some compensation can be made through academic studies, but there is often no simple substitute.

Ongoing, the proposed survey of recently qualified fellows will be evaluated by the Education Sub-Committee and potential changes and recommendations discussed. The report and conclusions will be tabled to the Board of Urology, which has ultimate responsibility for changing policy for training.

6.3 Feedback, reporting and action

Accreditation standard 6.3.1

Feedback is discussed at a Board level where it may contribute to change in policy and direction. In the future the Education Sub-Committee will be responsible for collecting the results of evaluation of the program and formulate a report with recommendations to the Board of Urology for discussion and implementation.

Accreditation standard 6.3.2

Through the Education Sub-Committee, the Board of Urology plans to expand the number of people directly responsible for evaluating directions for program change. It is thought that consultation take place via dissemination through the Board Sectional Chairs to the Sections and supervisors for discussion (and implementation). The Supervisors will have opportunity to feed back on the changes, and suggest modifications directly to the Board members (Sectional Chairs) who may direct enquiries to the Sub-Committee.

Currently structural changes in the program, or requirements of supervisors / trainees are disseminated via email bulletins. Feedback is solicited via Sectional Chairs. The advantage of a relatively small body is there is direct feedback to the Sectional Chairs (who comprise the Board of Urology) from both trainees and post Supervisors.

Accreditation standard 6.3.3

The Board of Urology has been concerned for some time that threats to the pro-bono nature of training would endanger the goodwill which is necessary to administer the program, and supervise / mentor the trainees. Service requirements for hospitals can be obtained by employing non-training staff with far less compliance paperwork and supervision obligations. There has been a danger of disenfranchising trainers if there was a perception that the cost of training outweighed the benefits.

The Board of Urology has moved to try to be more responsive to sectional concerns in the nature of training:

- Perceived difficulties in managing trainee underperformance fairly
- The perception that training is becoming a burden as there are more formal requirements of trainers, and more areas where they have to bear ultimate responsibility

- The perception that trainers are vulnerable to accusations of bullying / legal threat if they mark a trainee less than satisfactory
- Concerns regarding trainee selection appropriateness
- Concerns about maldistribution of region of trainee selection and bias
- That training goals and standards are inexact

7 Trainees

7.1 admission policy and selection

Accreditation standard 7.1.1

The process for entry to the SET Program in Urology is undertaken in accordance with the RACS Selection Policy and the SET Urology Selection Regulations. These were developed with the aim of being fair, transparent, and recognising merit and potential for training.

The areas examined include references (of both medical specialists and allied health professionals via online survey), a structured CV where points are awarded for defined attributes, and a semi-structured interview, which has prescribed discussion points. The subject of the interview is confined to the prescribed 9 competencies of a surgeon.

Employers have little role in this process apart from:

- Verification of minimum terms done prior to training application
- Past supervisors providing references
- Anecdotal feedback shaping policy via prior discussion by the Board 7.1.2

Accreditation standard 7.1.2

The processes for selection to the SET Program in Urology are clearly outlined in the SET Urology Selection Regulations.

- The timeline for selection is published on the USANZ website.
- The application is a customised form, which is provided online via the USANZ website.

The Board of Urology reviews the selection process in the following areas:

The Application process (for applicants) - feedback is obtained from applicants via the post-selection feedback survey and an analysis is undertaken of the queries lodged in relation to the Selection Regulations or online application form. This information is used to determine the changes that may need to be made to the Regulations or application form to assist applicants in the future

Interview process (for interviewers) – members of the Board of Urology rotate through a number of interview panels to assess if there are any components that require modification.

Feedback is also obtained from the interviewers, which can be incorporated into future selection rounds.

Informal feedback is gathered via contacts in the USANZ community on the adequacy of the selection process. This is certainly an area where feedback from members is very forthcoming.

Accreditation standard 7.1.3

The Board of Urology does not have a designated Regulations or processes in this regard. We however will work with any initiatives to support the increased profile of Aboriginals, Torres Strait Islanders, and Maori candidates and trainees. The limitations are recognised that admission to the Urology training program will still have to comply with the principle of merit based selection.

Accreditation standard 7.1.4

All information is clearly outlined in the Selection Regulations, which is available to prospective applicants via the USANZ website. In addition, any queries where there is need to clarify regulation are fielded via email. These enquiries are put through to the Chair and / or member of the Selection Sub-Committee.

The Board of Urology has determined not to be explicit with its scoring key with marking the CV. In the past this has led to an artificial situation where activities (research, meeting and other activities) were performed only to meet the criteria of selection. The exact number of points and maximum number which count are modified year by year (with view not to deliberately exclude a group of candidates, but to gradually readjust emphasis in scoring activities. The categories of activities that are counted are published as a guide to where a candidate may have activities counted is however published as a guide.

Accreditation standard 7.1.5

Scoring of the CV and references is automated by a template awarding points according to a pre-determined table determined by the Selection Sub-Committee. Manual inspection of the submissions is performed only to verify factual information within the CV. Candidates are not “coached” by any of the selection team.

Interviews are discussed by the Board and Selection Sub-Committee prior. Their design is crafted to examine a defined competency. These interview questions are semi-scripted, and interviewers have prescribed points for discussion. A marking key is designed to remove ambiguity in score awarded. There is also a Pre-interview training course to ensure all interviewers are trained in a consistent manner. Although interviews take place in two sites, all these measures are designed to minimise bias.

Observation and calibration of interview panels is done to ensure consistency of assessment of applicants. This audit function is undertaken by the Board Chair, and Deputy Chair who circulate and observe the interviews on the day.

7.2 Trainee participation in education provider governance

Accreditation standard 7.2.1

The body that represents urology trainees is the Urology Trainee Forum (UTF). The UTF comprises one trainee from each Section (NSW, VIC, QLD, SA, WA and NZ). The Victorian representative also sits on the Victorian Regional Training Committee and the Board is likely to recommend trainee representation on all other Regional Training Committees. The Chair of the UTF represents all trainees on the Board of Urology as an ex-officio member. Currently the UTF Chair does not participate in trainee performance discussion on the Board of Urology, however there are plans to explore full involvement.

Each UTF member is appointed by the trainees in the particular section, normally for a period of 2-3 years. Their role is to provide support to the trainees in their section and to facilitate the flow of communication between the Board and trainees.

The UTF meet at least twice per year (once at the USANZ ASM and once at Trainee Week). The Education and Training Manager attends to provide advice and guidance where required. The UTF members bring to the meeting the views of trainees within their Section. From these meetings, the Chair of the UTF prepares a consolidated report to present to the Board of Urology. There are no restrictions or controls on what can be included in the Trainee Representative Report.

The Board does not mandate how or when the trainee representatives communicate with their fellow trainees but it is expected that all trainees are given the opportunity to voice their opinion or concerns to their representative and that they are provided with an outcome or explanation.

In addition to the UTF raising issues with the Board of Urology, the Board uses the UTF to discuss any proposed changes to aspects of the training program and to gain their input and feedback. This body is also not funded formally, however expenses concerned with participation with Board activities is reimbursed.

Moving forward, more trainees are going to be integrated into Board processes via the Subcommittees (Education and Post Accreditation). They will have opportunity to comment on and shape future policy as full members. Currently the number of trainees additionally involved is 2. This number can also change if necessary.

7.3 Communication with trainees

Accreditation standard 7.3.1

The Board of Urology communicates regularly with trainees via email. More comprehensive information regarding changes to aspects of the program are also provided via semi-regular newsletters.

Plans for establishing an online portal which will serve as a means for lodgement of trainee progress reports, the logbook, and also as contemporaneous feedback between trainees and their immediate hospital supervisors may also facilitate communication lines.

Accreditation standard 7.3.2

All information regarding the SET Program in Urology is readily available on the USANZ website. Whilst trainees are responsible for checking the Regulations, they are also sent direct emails regarding any changes to the training program to ensure they are aware. Additionally, all trainees attend a meeting with the Board Chair twice each year (at the USANZ ASM and at Trainee Week) where comprehensive information is conveyed regarding developments within the program. Trainees have been vocal in their feedback in the past

Accreditation standard 7.3.3

Trainees are given feedback by their immediate hospital supervisors in a face to face manner. This is hopefully immediate and guides their development. The Board recognises that verbal feedback is often misinterpreted and may be unrecognised if given in a rushed manner. The Board is exploring options with the formation of an online portal where trainers can post feedback which can be recorded for the purposes of the assessment report. This feedback should also be visible by the other trainers in the hospital so that they are made aware of issues as soon as they arise to help the trainee.

The trainee progress report is filled out 3 monthly and a consolidation of the views of the department. It is not expected that all members will agree exactly (a consensus), but a summation view is necessary and the responsibility of the hospital post supervisor. This is a formal report which the trainee has to acknowledge. At this point there can be guidance offered on required changes.

During this process (and after) trainees are invited to submit information especially if they do not agree with their reports. The report and submission are discussed together where the context can be preserved.

Any less than satisfactory reports are then discussed at a Sectional then National level (with any information that the trainee may append). It is here that any major changes to the trainee's individual training circumstance can be recommended (extension of training, any courses, ultimately dismissal). This is communicated formally by correspondence outlining the circumstances, findings, and relevant determinations. Relevant potential consequences are also communicated at this time. Particularly when trainees are in danger of dismissal, a formal audience with the Board Chair / Vice-Chair, and / or Sectional Chair is convened. At this time, again the trainee is afforded the opportunity to raise their concerns and perspectives. A support person may attend these meetings.

The future is in clearer, honest, constructive feedback given in a timely fashion. Hopefully this can be successfully achieved relatively soon by the formation of online resources.

7.4 Trainee wellbeing

Accreditation standard 7.4.1

In the accreditation of posts, the Board of Urology has minimum standards of hospital governance over employment conditions. This include access to leave, administrative support, safe hours, and a focus on the training aspect (over service). In previous cases trainees were referred to employer occupational health services (for a case of closed head injury) as well as the trainee's own GP and treating physicians. Where it is identified that psychological issues are at the root of performance issues (stress and anxiety), the Board has advised for the engagement of a psychologist. In absence of the trainee having their own psychologist, the Board provides the details of a psychologist who has worked in this area before with other trainees.

On admission to the training program, trainees attend an induction course where amongst other things, they are advised of processes for complaints, particularly where they may feel bullied or intimidated.

The Board of Urology has not developed its own processes to deal with bullying, sexual harassment and intimidation, but choses to work with RACS on this. Direct action has been taken in several instances as a result of this collaborative approach.

Accreditation standard 7.4.2

Trainees in difficulty are assessed for underperformance, and the circumstances examined. If there are supportive measures needed, the Board has recommended in the past Psychologists, Surgical Mentors and the use of College resources (courses). These are not as yet published, however the approach individualised for the particular situation.

The Training Board does not currently have resources for the provision of these services, but keys into natural networks in the workplace and other professionals available. The Board is considering strengthening the profile of mentors and / or a special trainee welfare liaison.

In the past, trainees have either identified their own needs, or their direct hospital supervisors have for them. By the time it comes to the attention of the Board of Urology, the situation has developed from a potential issue to a real one affecting training progression. The Board's task is twofold – to manage both the training, and the underlying problem. Possibly because of small numbers of trainees within a relatively close knit community, major situations are infrequent.

7.5 Resolution of training problems and disputes

Accreditation standard 7.5.1

It is the stance of the Board of Urology that training can best progress when supervision of trainees is appropriate. The archaic practice of learning by experimentation (under supervision / no supervision), and by observation (not allowing the trainee to put into practice their skills) is discouraged. Much of the attempts at eliciting feedback from trainees is regarding how their trainers' supervision practice facilitates the rapid acquisition of skills.

The Board of Urology seeks to receive feedback via:

- Hospital inspections (confidential interviews of current and past trainees)
- Via the training forum (other trainees)
- Via post feedback review (at annual meetings)

As a result the Board has achieved good progress into the modification of some positions to address these issues as well as disaccreditation of some posts which have not been able to meet the standards.

Accreditation standard 7.5.2

Where there has been a conflict between hospital supervisor and trainee, the involvement of external assessors is advocated. Again there haven't been many issues brought to our attention (yet) where personality conflict is the basis of disputes. Ranges of responses may be to:

- Arrange remediation processes to engineer a mutually acceptable understanding
- Suggest that the supervisor nominate another replacement supervisor for this trainee
- If convenient find another training position for the trainee

8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standard 8.1.1

The accreditation criteria for all SET Urology posts stipulate the requirements for supervision of trainees in operative and clinical environments (Standard 5 – Clinical Load and Theatre Sessions).

The accreditation criteria for all SET Urology posts stipulate the requirements in relation to the number of consultants that must be actively involved in education, training and supervision as well as the requirements for the designated Training Supervisor (Standard 3 – Surgical Supervisors and Staff). Details regarding the appointment and responsibilities of Training Supervisors are outlined in the SET Urology Training Regulations (Section 12 – Training Supervisors).

Verification of the degree of adequacy of supervision is via:

- Yearly post confidential feedback via the trainee forum and representative
- Written feedback by the trainee submitted with training term reports

Solicited by the inspectors of the current and previous trainees during Training post inspection.

Accreditation standard 8.1.2

The accreditation criteria for all SET Urology posts stipulate the requirements of those responsible for the delivery of the SET Program in Urology at the hospital level. The accreditation standards and criteria are available on the USANZ website. Posts are provided with accreditation submission templates and an overview of requirements for a site inspection at least 6 weeks before the inspection date.

Any changes to the program (i.e. curriculum or Regulations) are conveyed to Training Supervisors via direct communication (emails or letters) and are also tabled as agenda items at Regional Training Committees Meetings.

The Board communicates changes to the program to Training Supervisors directly and via the Regional Training Committees. Training Supervisor is responsible for conveying this information to the relevant parties within the hospital as per Section 12 – Training Supervisors of the SET Urology Training Regulations.

Accreditation standard 8.1.3

The process for appointment of SET Urology Training Supervisors is outlined in Section 12 – Training Supervisors of the Training Regulations.

Supervisors are required to have a familiarity with the training program and the requirements of being a Urologist in Australia. The mandated requirement of a FRACS is to ensure this competency.

RACS courses on education (SAT/SET and Keeping Trainees on Track) are the minimum requirement of our supervisors. Attendance at sectional Training and Education meetings to discuss trainee matters is also a source of support for supervisors.

Supervisors are supported directly by the Board and state training and education when trainees are found to be in difficulty and placed on probation. There is requirement between the trainee and supervisor, which is further discussed at a state and national board level.

Challenges remain within our small subspecialty to offer formal training to all our supervisors. With the new subcommittee structure: we will aim to create a guide for supervisors to manage underperforming trainees. This has already been identified as a need via feedback from supervisors. The Board of Urology will survey formally supervisors for other areas requiring attention. A guide of expected competencies at various stages in training will also be produced to benchmark training.

With increasing expansion of the education portfolio, the Board will strive to create more informal channels for supervisors to contact the Board via the subcommittee on training matters. This will help to clarify issues of expected trainee competencies.

Accreditation standard 8.1.4

There are two formal times when trainee feedback is solicited on the quality of the training posts:

1. The training posts are discussed and evaluated annually via the trainee session at the Annual Scientific Meeting of USANZ. Trainees convene in groups defined by state section where each hospital posting is discussed. Issues of supervision, caseload, experience, and supervisor issues and conduct are tabulated and fed back via the state trainee representatives. There is opportunity to discuss issues with trainee peers, some of whom will have past experience with the post. Peers also are valuable as a guide of how delivery of training occurs in other posts, and reasonable expectations. This feedback is received by the Education Board Chair, Chair of the Accreditation Sub-committee and the Education Manager later during the convention. This feedback in the past has been used to trigger early post inspections into underperforming units, as well as direct intervention where relevant via correspondence, and face to face discussion.
2. Prior to every training post inspection, interviews of the current and relevant past trainees (2-3 years usually) are performed by phone call. Any issues are explored during the physical hospital inspection. This feedback is confidential and used to identify areas where posts may be improved. During the physical inspection, the current trainees are again interviewed with view to formulation of workable solutions to any issues.

Trainee concerns outside formal instances are also fed back directly to the State Sectional training representatives, via the Urological Trainee Forum (UTF) or to the State Sectional Training and Education Chair.

Recommendations for supervisors in the past have included:

- Making the supervisor aware of the perception of bullying
- Participation in non-technical communications courses such as Training in Professional Skills (TIPS)
- Suggestion of modification in entrustable duties and priorities
- Becoming more mindful of trainee needs and priorities over service obligations
- Facilitation of mutually acceptable plans

Accreditation standard 8.1.6

Within the existing Board of Urology structure, there is a representative of the trainees with full access to the discussions of training posts and their assessment. The Board does seek feedback of the effectiveness of post assessments from the incumbent trainees directly and via the representative on the Board. The Board has a process of review each post (via annual, quinquennial or periodic formal inspection, and via feedback processes documented in standard 8.1.4) in the context of previous inspections and any recommendations. This is used to assess the effectiveness of prior assessments (and assessors).

With the formation of the Accreditation Sub-Committee, another representative of the trainees is planned within the terms of reference. Their role would be as a full member of the subcommittee, potentially participating in inspections where appropriate. They would also perform a feedback role for the assessors. The subcommittee is also tasked with the development and refinement of standardised processes (interview questions and areas to be examined) which will aid the assessors of training posts.

8.2 Training site and posts

Accreditation standard 8.2.1

The relevant regulations, requisite documentation and policies are available.

Accredited SET Urology Training Posts in six Sections (NSW, VIC (inc TAS), WA, QLD, SA and New Zealand) in public teaching hospitals either in metropolitan or regional settings. There has been no submissions for training positions in the Northern Territory.

The Training Post Accreditation Committee oversees all aspects of the accreditation process. This Committee is a sub-committee of the Board of Urology. The creation of this body in 2016 is in recognition that the workload in ensuring a satisfactory environment for training has been increasing. The Board has recognised a need to apply greater scrutiny into the quality of training given trainees enter the program generally earlier in their medical careers, with less developed surgical skills. There also has been a

recognition via feedback from the sectional bodies, and individual fellows who have completed their training that there has been a wide variance in quality of training experience across the training posts. The Board has had to work toward change in the culture of providing trainees not only for service requirements, but also for training of future members of our specialty for the care of the greater public.

Any eligible urology unit that fulfils the minimum educational and employment criteria for the training program may apply for accreditation and subsequent allocation of a trainee. The documentation is reviewed, and the quality of training is verified via telephone interviews of any incumbent or past registrars, and relevant supervisors. Onsite post inspections are undertaken by at least two urologists from a Section (Aust/NZ) outside that being inspected. This ensures no perception of bias but also brings broad experience to the process. Where exceptional circumstances exist a third inspector from the Board of Urology or RACS may participate.

The post may then be granted accreditation if satisfactory for generally a period of 12 months. Where a new post is added to an existing training position, the accreditation period may be longer (up to 5 years) depending on when the other training positions are to be re-inspected.

Conditions and suggestions for change may be applied to the posting to be reviewed prior to any allocation of a trainee. Compliance is monitored by the original inspectors. When a trainee is finally allocated, the post is subject to the usual regular trainee feedback (documented in standard 8.1.4) as well as oversight through quarterly Training and Education meetings conducted at a sectional level (TAE Meetings) conducted by the Sectional Chair.

Inspections are undertaken of training posts on a five year cycle. New posts, or posts requiring review of training conditions are granted accreditation for one year and then reinspected to determine ongoing accreditation. Depending on the issues identified, earlier review either by physical inspection, or by remote confirmation of change may occur. Existing posts may be inspected more frequently or before the end of their 5 year cycle should there be an issue in training or substantive change identified by the post itself, regional TAE committee or trainee feedback. Examples of potential issues affecting training would include factors that result in a post not meeting the required Standards such as reduction in theatre time, reduction in supervised clinics, reduced number of supervisors, dilution of training by fellows in fellowship positions, equipment deficiencies, and dilution of theatre cases due to private patients on the lists.

Transparency and consistency of the process is ensured by inspectors being outside the section of the training post. Selection of inspectors is to ensure at least one member having experience in inspections. Where there may have been disagreement in a previous inspection report, inspectors that have not previously reviewed that particular post are chosen. Finally the conclusions of the inspection are discussed at the Sub-Committee a provisional report made. This report is returned to the training post for review and comment. Any issues of dispute can be clarified before final discussion at the Board level.

Accreditation standard 8.2.2

The mandatory criteria is available on the USANZ website. The points are summarised.

Health, welfare and trainee interests:

- Maximum 1:2 on call
- Adequate clerical support
- Guaranteed salary
- Supportive Human Resources
- Hospital trainee safety and security policy
- Hospital financial support
- Hospital network policy to detect and deal with workplace harassment and abuse
- Supervision and opportunities for knowledge and skill development
- Infrastructure such as internet, library and skills trainers
- Tutorial programs, and journal club
- Teaching ward rounds
- Multidisciplinary meetings
- Leave to attend mandatory training activities
- Research activities

In addition to mandated standards, the Accreditation Sub-Committee seeks to quantify the quality of training to aim toward preparation of the trainee toward independent competent practice as a general urologist.

- The quantity, and type of clinical caseload of outpatients, emergency referrals, and inpatients. The degree of operative and non-operative mentorship is also assessed
- Mandatory supervised outpatient clinics (1/week)
- At least 4 General anaesthetic supervised (>14 hours) lists
- Priority made to training
- Diversity of case-mix
- Appropriateness of supervision is monitored via trainee feedback (Standard 8.1.4) as well as formal inspection

Training posts reflect contemporary urological practice in the community. There is a breadth of metropolitan and regional positions available. One limitation is that there are no positions in remote areas due to requirements for a minimum infrastructure and volume of training. Much like contemporary urology practice however, trainees are exposed to patients who are transferred from remote regions.

The endpoint of the Urology Training Program is a Urologist able to practice in General Urology within the community safely. As such, posts are approved with the view toward facilitating that goal. There are no strict targets with regard to numbers of patients seen, or procedures completed, as the quality of training is not wholly dependent on quantity. Notwithstanding, trainee logbooks are reviewed at a Sectional TAE level to assess if the quantity of workload is adequate. It has become more apparent that the quality and enthusiasm of trainers also is central to the effectiveness of training. We currently have no metrics to measure these parameters, but are responsive to trainee feedback (who benchmark with peers). In the future a survey of recently qualified Fellows will be commissioned to look at adequacy of the program to address their needs.

There is a challenge in the culture of surgical training in the perceived role of the trainee. Traditionally surgical training was almost seen as secondary to the provision of clinical service. Contemporary attitudes however recognise that training, and the final product has to be better regulated for quality. A constraint of the honorary nature of training is that the Board however is still reliant on hospitals to provide the training in exchange for service provision by the trainee.

The methods of cultural change that have been used recently:

- Re-designing the post assessment / application form to emphasise measurement of training activities
- Actively soliciting feedback form trainees regarding their mentorship
- Feedback of the new emphasis at TAE sectional meetings
- The discussion of appropriate delegation in newsletters to post supervisors
- Deliberate feedback to posts as part of the assessment process
- Disaccreditation of posts that cannot fulfil their obligations

Another challenge identified of our pro-bono run training program is the increasing workload and scrutiny on the trainers and hospital supervisors. There are increasing demands on trainers to monitor and supervise trainees, give feedback, and mentor any necessary changes. There are also formal training courses and compliance paperwork / meetings. Financial compensation is unrealistic, and cannot be a substitute for altruistic and motivated trainers. The Board of Urology aims to support our trainers in the formulation of their training plans, remediation interactions and also guidance regarding standards. We also will be more responsive to concerns regarding future selection of trainees and standards setting via the Sub-Committees. We aim to reduce as many barriers to effective training as a result.

Future initiatives may include the partnering with medical administration and health boards to find mutually beneficial solutions to the aims of service and training. The Accreditation Sub-Committee has included in its terms of reference inclusion of a Hospital administrator to aid with those aims.

Continuing review is performed for each trainee and their adequacy in their preparation for practice. Already there has been an increased tendency for extending training (both self-initiated, and after Board discussion). If it is identified that existing positions are not able to fulfil the objective of educating sufficiently our current trainees (who enter the program with a different range of prior experiences), structural change such as increasing the duration of training may occur. This has already occurred in one form with the introduction of an additional SET year (SET6) replacing what was a Fellowship year in 2012. The motivation for this was the need for increased quality control and logbook numbers in the final year experience for our trainees.

Trainees are still free to complete an elective fellowship in a subspecialist area on completion of their SET6 year.

Current cultural awareness initiatives in Australia regarding Aboriginal and Torres Strait Islander healthcare are limited to those provided by RACS. Individual hospitals may mandate individual learning packages. In New Zealand however, Maori cultural sensitivities are integrated as a condition of hospital appointments.

The Board of Urology has partnered with the trainees in endorsing an online Journal club. This initiative is a moderated webinar / live video forum to discuss contemporary literature. Access and participation are priorities. The challenges however are in participation for trainees across many time zones.

Further online and web based interactions remain undeveloped. Training opportunities for regional trainees still lag behind their metropolitan colleagues. Individual trainee for a however implement workarounds such as teleconferencing via Skype and similar platforms.

9 Continuing professional development, further training and remediation

9.2 Further training of specialists

Accreditation standard 9.2.1

The formal processes for responding to requests for further training of urologists is managed by the RACS. According to the relevant College policies, the RACS will consult with the President, USANZ when a formal retraining process needs to be implemented.

9.3 Remediation

Accreditation standard 9.3.1

Underperforming urologists are currently identified through non-compliance with the RACS CPD program, or through peer or public complaints.

At times, the RACS is contacted by employers (i.e. hospitals or area health services) when there are concerns about the performance of an individual urologist and the possible need for remediation. In these situations, the RACS seeks assistance from the USANZ in nominating one or two suitably qualified urologists to undertake an independent review of the practice and performance of the urologist of concern.

10 Assessment of specialist international medical graduates

In accordance with RACS policy

Urology supporting documentation available

No.	Document name	Relevant standards
ORO web	Urological Society of Australia and New Zealand	
ORO web	Urology Surgery RACS web pages	
ORO web	Urology Surgery Selection Information	7.1.1, 7.1.2, 7.1.4
ORO01	SET Selection Urology Surgery Regulations 2018 Intake	7.1.1, 7.1.2, 7.1.4
ORO02	Sub-Committee Terms of Reference	1
ORO03	SET Urology Training Regulations (entry before 2016)	1, 3.1.1, 3.2.8, 3.4.2, 3.4.3, 4.1.1, 4.2.1, 4.2.2, 5.1.2, 5.2.1, 5.3.3, 8.1.1, 8.1.2, 8.1.3
ORO04	nSET Urology Training Regulations (entry in or after 2016)	1,3.1.1, 3.2.8, 3.4.2, 3.4.3, 4.1.1, 4.2.1, 4.2.2, 5.1.2, 5.2.1, 5.3.3, 8.1.1, 8.1.2, 8.1.3
ORO05	Modular Curriculum Portfolio	3.2.2, 4.1.1, 4.2.1, 4.2.3
ORO06	SET Urology Training Post Accreditation Standards 2016	4.1.1, 4.2.1, 4.2.3, 8.1.1, 8.1.2, 8.2.1, 8.2.2
ORO07	Trainee Week Program 2015	3.2.2, 4.1.1, 4.2.2
ORO08	Anatomy and Prosthetics Course Program 2016	4.2.2

No.	Document name	Relevant standards
ORO09	Endourology Workshop Program 2016	4.2.2
ORO10	SET Urology Induction Course Program 2016	4.1.1, 4.2.2
ORO11	NSW Education Program 2016	4.1.1
ORO12	Victorian Education Program 2016	4.1.1
ORO13	USANZ Hospital Inspections Policy	8.2.1, 8.2.2
ORO14	SET Urology Assessment Report SET 1 SET 2	5.1.1, 5.3.2, 5.3.3, 5.4.1
ORO15	SET Urology Assessment Report SET 2-SET 3	5.1.1, 5.3.2, 5.3.3, 5.4.1
ORO16	SET Selection Regulations 2016 for 2017	7.1.1, 7.1.2, 7.1.3, 7.1.4

VASCULAR SURGERY

Specialty performance against AMC accreditation standards

Surgical specialty training boards implement the SET program in accordance with RACS policies and agreements. Information unique to Paediatric Surgery specialty-specific activities is presented here.

1 The context of training and ed ucation

1.2 Program management

Accreditation standard 1.2.1

The Board of Vascular Surgery conducted a review of the program in 2015, the revised regulations included:

- The management of underperforming trainees
- The role of the Board in rating of assessments
- The role of supervisors
- The review of required rotations of each trainee

The Board will undertake an annual review of all regulations

The Board works within the framework of the College Policies.

The Board has a member who is responsible for the Curriculum and it is reviewed regularly.

The Board's regulations outline the sign off process to complete the exam, this process has several steps, including the review of the application and trainee file by the Board Chair for final sign off. (item 2.6.1 of Training Regulation Handbook)

1.3 Reconsideration, review and appeals process

Accreditation standard 1.3.1

RACS Appeals committee and its policies are used for any appeals against decisions made by the Board of Vascular Surgery.

1.4 Educational expertise and exchange

Accreditation standard 1.4.1

The Board of Vascular Surgery comprises of:

- Member with primary responsibility for IMGs
- Senior Examiner
- Member with primary responsibility for selection, and reviewing logbook and assessments
- Member with primary responsibility for trainees
- Member with primary responsibility for SET 1/ SET 2 Examinations
- Member with primary responsibility for the Trainees' Skills Course
- Member with primary responsibility for updating online modules
- Member with primary responsibility for hospital accreditation
- Trainee Representative with primary responsibility for trainees and trainees' newsletter
- Speciality Society President
- Specialty Elected Councilor

The members in the above positions have interest and expertise in their area of responsibility.

During the review of the Board's online curriculum modules, members with expertise in certain areas of Vascular disease are assigned a module to review and update.

The Board also selects surgical subject matter experts to sit on the various exams committees.

Accreditation standard 1.4.2

The Board takes an interest in the curriculum and regulations of other surgical specialities and will make recommendations to the Board on any items that should be introduced into the Vascular Surgery program.

1.5 Educational resources

Accreditation standard 1.5.1

The Vascular Surgery training program is managed by Australian and New Zealand Society for Vascular Surgery (ANZSVS). The ANZSVS has two staff members who manage the administration of the Board.

Accreditation standard 1.5.2

The ANZSVS General Manager reviews the resources annually to ensure that support is adequate

Vascular has two staff members which is adequate and is supported by a Board of specialists surgeons.

1.6 Interaction with the health sector

Accreditation standard 1.6.2

The Board works with various clinical schools to offer quality teaching.

The Board collaborates with the Royal Brisbane Clinical Skills Centre, Royal North Shore Clinical School, Royal Melbourne Anatomy School, MERF Animal Lab, QLD. All these centres have been used to assist in running our annual trainee skills courses.

Accreditation standard 1.6.3

This is undertaken through the Hospital Inspection process. The Board runs two supervisors meetings each year so the training supervisors can be informed of changes and communicate these to the hospitals.

While the Board would like to include jurisdictional representatives it has been difficult to source the appropriate people.

Accreditation standard 1.6.4

The Board has not undertaken this.

1.7 Continuous renewal

Accreditation standard 1.7.1

ANZSVS reviews its Partnering Agreement with RACS every 5 years.

2 The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standard 2.1.2

This has been undertaken by the RACS new Selection Policy for Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand. The Board is yet to decide whether to implement this policy.

Accreditation standard 2.1.3

The Board consulted with members of the ANZSVS Executive Committee and RACS Education department, including the RACS In house counsel.

2.2 Program outcomes

Accreditation standard 2.2.2

The curriculum covers all components of Vascular Surgery. The rotations completed by trainees are in Vascular Units and the Fellowship Exam is based on their knowledge in Vascular Surgery. The curriculum modules (attached) are the depth of knowledge expected.

2.3 Graduate outcomes

Accreditation standard 2.3.1

Training Curriculum topics are available.

3 The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standard 3.1.1

The online learning modules are the bases for the Vascular Curriculum, each module includes the Objectives, Required Reading, MCQs.The curriculum modules are available through the RACS website.

3.2 The content of the curriculum

Accreditation standard 3.2.1, 3.2.2 and 3.2.3

The Curriculum topics and is assessed through the following:

- Exam
- Online Modules
- In Training Assessments
- Logbooks
- Mini-CEX
- DOPS
- Fellowship Examination

Accreditation standard 3.2.4, 3.2.5, 3.2.6 and 3.2.7

Refer to 2.2.2, 3.1.1 and 3.2.1

The In-training Assessment addresses the essential criteria of:

- Professionalism and Ethics
- Scholarship and Teaching
- Health Advocacy

Accreditation standard 3.2.8

Research is a compulsory requirement of the Vascular Surgery Program (item 2.3 of program regulations).

The Board does not accredit research projects in lieu of clinical training.

Accreditation standard 3.2.10

This is covered in the non-technical competencies

3.3 Continuum of training, education and practice

Accreditation standard 3.3.1

The progression of trainees is covered in the program regulations.

Accreditation standard 3.3.2

The Board considers applications on RPL for experience equivalent to a clinical rotation in Vascular Surgery. (item 2.1.6 of training regulations)

YEAR	No. of trainees granted RPL	No. of trainees rejected RPL	Total No. applied
2014	1		1

3.4 Structure of the curriculum

Accreditation standard 3.4.1 and 3.4.3

The progression of trainees is covered in the program regulations

Accreditation standard 3.4.2

The expected duration of the training program is 5 years, the maximum time allowable is 5years plus an additional 4 years. (Item 2.1.3 in program regulations)

Accreditation standard 3.4.3

Trainees are permitted to apply for interruption to the training program, (Item 5.3 of program regulations).

Accreditation standard 3.4.4

The Board is supportive of part time training; the Board has not had any requests for part time training to date.

4 Teaching and learning

4.1 Teaching and learning approach

Accreditation standard 4.1.1 and 4.2.1

Teaching is primarily undertaken during the clinical rotations.

The Board runs an annual skills course for trainees. This course is a 3 day course which includes practical and theory sessions. The 2015 program is available.

4.2 Teaching and learning methods

Accreditation standard 4.2.2

All trainees are allocated to a clinical rotation which provides the clinical training. These posts are accredited for clinical training.

The RACS can provide information on teaching methods for the ASSET, CCrISP and EMST courses.

Accreditation standard 4.2.3

The Board uses a range of teaching methods including:

- Clinical Training in training positions
- Annual Skills Course
- Online Modules
- Required RACS Courses

Accreditation standard 4.2.4

Trainees are provided with more responsibility as the progress through the training program, the matrix on the assessment form outlines what is expected at each SET level.

5 Assessment of learning

5.1 Assessment approach

Accreditation standard 5.1.1

See 4.2.4

Accreditation standard 5.1.2 and 5.1.3

The Regulations set out the program requirements and assessment process.

The Regulations and assessment form matrix provide an overview of each SET level and what is required. All program requirements for the Fellowship Examination and Fellowship are included in the program regulations.

5.2 Assessment methods

Accreditation standard 5.2.1 and 5.2.2

The assessment form is used for both mid-term and end of term assessment in each year of training. The assessment form covers all the RACS competencies and allows training supervisors to rate the trainee as

Exceptional, Satisfactory, Borderline or Unsatisfactory for each competency. The Assessment Form is available.

The form also allows for a trainee self-assessment, this allows the Board to assess the trainee insight and allows the trainee to reflect on their own performance,

The form also includes essential criteria to be rated.

Accreditation standard 5.2.3

RACS Exams committee standard sets the Fellowship, SSE and Clinical Examination.

5.3 Performance feedback

Accreditation standard 5.3.1

The Board requires trainees to complete 3 assessments per year, performance management meetings are completed for any trainees who are not rated satisfactory. The Board conducts an annual face-to-face interview with every trainee on the program to discuss performance and progression.

In training Mini CEX and DOPS are also used for trainee feedback.

Accreditation standard 5.3.2

Supervisors are required to complete and sign off all assessment forms.

Accreditation standard 5.3.3

Yes, performance management meetings and plans are put in place for underperforming trainees.

Accreditation standard 5.3.4

Performance Management Meetings are recorded and result in a performance management plan being developed and provided to the trainee and supervisor. The supervisor is the Board's contact at the hospital. If a safety concern was raised the Board would report to the appropriate regulators.

5.4 Assessment quality

Accreditation standard 5.4.1

The Board member responsible for assessment completes an annual review of the assessment form and presents any changes as recommendations to the Board.

Accreditation standard 5.4.2

Training posts are required to adhere to the processes outlines in the training program regulations and hospital accreditation standards.

6 Monitoring and evaluation

6.1 Monitoring

Accreditation standard 6.1.1

The Board in Vascular Surgery undertook a review of the training program regulations in 2015. The majors changes included a supervisor's handbook, and required minimum number of rotations to be completed by each trainee.

The Board will review the training program regulations yearly at its' October meeting

The Board has a member dedicated to the curriculum, and the curriculum is regularly reviewed.

Accreditation standard 6.1.2

Supervisors are regularly kept up to date with changes to the regulations and the Board conducts twice yearly supervisors' meetings.

Accreditation standard 6.1.3

The Board has a Trainee Representative who is a full voting member on the Board. The Trainee Representative is in regular contact with the Board and Trainees. The Trainees have an annual meeting at the yearly skills course.

6.2 Evaluation

Accreditation standard 6.2.1, 6.2.2 and 6.2.3

The Board is currently discussing an Evaluation Program.

During the review of the Training Program Regulations the following stakeholders were contacted:

- Board of Vascular Surgery members
- Hospital Surgical Supervisors
- ANZSVS President
- RACS, Legal counsel
- RACS, Manager, Surgical Education and Training

6.3 Feedback, reporting and action

Accreditation standard 6.3.1, 6.3.2 and 6.3.3

The Board is currently discussing an Evaluation Program.

7 Trainees

7.1 admission policy and selection

Accreditation standard 7.1.1

The Board of Vascular Surgery has selection regulations for the application process in Australia and New Zealand. Selection Regulations attached.

Each candidate is assessed against the same criteria, and the CV scoring guidelines are published on the RACS website before applications open.

Candidates are requested to submit information at the CV stage on the following areas:

1. Surgical Rotations
2. Skills Courses and Scientific Meetings
3. Qualifications
4. Publications
5. Presentations
6. Leadership

Each application is scored by two Board members. If there is disagreement the Board Chair acts as the third and deciding scorer.

The candidates provide the names of 5 referees they wish to have contacted, and the Board must receive at least 4 completed reports. The College's standard referee report is utilized.

During interviews, each candidate is asked the same questions and marked against the same criteria.

The Employer (i.e. Hospital) is not involved in the CV or Referee stage of the selection process. However hospital representatives are invited to be a panel member at the interviews.

The Employer has the right to refuse employment of a trainee at the allocation stage.

Accreditation standard 7.1.2

The Selection Regulations and the Board of Vascular Surgery adheres to the College's Selection Policies.

Candidates are informed at each stage via email that they are able to appeal a decision under the RACS Appeal Mechanism; however they need to demonstrate that process has not been followed.

The Selection Process is reviewed annually following a report provided by the Education department of the College suggesting changes and reasons behind the changes.

Accreditation standard 7.1.3

The Board has not implemented this as this has not been mandated by RACS.

Accreditation standard 7.1.4

The minimum eligibility requirements are then published on the RACS website.

Accreditation standard 7.1.5

This is undertaken during selection as follows:

- CV - Each application is scored by two Board members. If there is disagreement the Board Chair acts as the third and deciding scorer
- Referee – Each section has defined criteria that referees can determine if they are applicable to the candidates they are completing the form for
- Interviews – Each questions has a set criteria answers that panel members rank the candidate against

In 2014 eight (8)* trainees were appointed into the SET Program to commence in 2015

In 2015 eight (8)* trainees were appointed into the SET Program to commence in 2016

In 2016 nine (9)* trainees were appointed into the SET Program to commence in 2017

*includes deferred offers

7.2 Trainee participation in education provider governance

Accreditation standard 7.2.1

The Trainee Representative is a full voting member on the Board.

7.3 Communication with trainees

Accreditation standard 7.3.1

The Trainee Representative is a full voting member on the Board. Changes to Regulations are communicated to all Trainees via email.

The Trainee Representative's details are provided to each trainee so that they are aware of who to contact if they have issues they wish to discuss with a colleague or if they wish to have this raised at Board level.

Accreditation standard 7.3.2

Specialist Trainee fee for SET Training is determined by RACS and advertised on the RACS website.

Accreditation Standard 7.3.3

Trainees meet with the Board yearly at the trainee skills course to review the course requirements and their progress. Which includes?

- Current SET Level
- End and Maximum dates to complete requirements
- Rotations including hospital allocation and assessment outcome at mid and end of term – past and current
- Logbook figures – per term and total across training
- All Requirements completed and those outstanding
- Probationary periods (if any)
- Online Modules

7.4 Trainee wellbeing

Accreditation standard 7.4.1

The Board ensures the learning environment in the hospitals is at the standard set out by the RACS Accreditation Standards through quinquennial hospital accreditation.

Accreditation standard 7.4.2

The Supervisors undertake the majority of this work with the hospitals.

If a trainee requests support from the Board then each case is looked at individually and if required the Board works with the hospital.

The Board also actively promotes the RACS Counselling Service for any trainees who are experiencing either personal or work issues.

7.5 Resolution of training problems and disputes

Accreditation standard 7.5.1 and 7.5.2

The Supervisors monitors trainee progress and provides feedback (summative and formative) via the attached in-training assessment form.

Any complaints about Bullying, Harassment and Discrimination are handled via the Board.

8 Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

Accreditation standard 8.1.1

Every hospital training post has a supervisor assigned to it; this supervisor must have completed specific RACS courses and attend the supervisor meetings. Additionally each post must have two FRACS, Vascular Surgery.

Accreditation standard 8.1.2

The Board has developed a Supervisors Manual which details the responsibilities. The Regulations also detail the responsibility of the Supervisors and Trainers in terms of assessing trainees.

The RACS Hospital Accreditation Standards detail the support required by the hospitals to supervisors and trainees for each accredited training posts. These standards are reviewed during inspections of posts.

Accreditation standard 8.1.3

The appointment of supervisors is undertaken by the hospitals, then approved by the Board.

The Board has a supervisor's manual which provides guidelines to supervisors

Accreditation standard 8.1.4 and 8.1.5

The trainees complete a Feedback Form every year This is also reviewed at the annual trainee skills course and during Hospital Accreditation. Some of the areas reviewed are:

- Workload
- Education and Training
- Professional Development
- Hospital Supervisors/Unit Supervisors/Hub Supervisors

If concerns about the educationally validity of a post are identified, the Board will review the concerns and determine the most appropriate course of action which may include, but is not limited to: discussion with the trainee, the hospital supervisor, re-inspection, notification of the RACS complaints resolution.

8.2 Training site and posts

Accreditation standard 8.2.1 and 8.2.2

The Board adheres to the RACS Accreditation Standards which cover the aspects in the AMC Standard.

9 Continuing professional development, further training and remediation

9.2 Further training of individual specialists

Accreditation standard 9.2.1

This is not something undertaken by the Board. A query of this nature would be forwarded on to the RACS CPD.

10 Assessment of specialist international medical graduates

In accordance with RACS policy

Vascular Surgery supporting documentation available

No.	Document name	Relevant standards
VAS web	Australian and New Zealand Society for Vascular Surgery	
VAS web	Specialty Overview RACS Website	
VAS web	Vascular SET Selection Information	7.1.1, 7.1.2, 7.1.4
VAS01	SET Selection Vascular Surgery Regulations 2017	7.1.1, 7.1.2, 7.1.4

No.	Document name	Relevant standards
VAS02	SET Selection CV Score Sheet	7.1.1, 7.1.2, 7.1.4
VAS03	Vascular Curriculum Modules	2.2.2, 2.3.1 3.2.1 – 3.2.10, 3.4.1
VAS04	Supervisors Handbook	8.1.2
VAS05	Training Regulations Handbook SET Program in Vascular Surgery	1.2.1, 1.3.1, 3.3.1, 3.3.2, 3.4.3, 4.1.1, 4.2.2, 4.2.3, 5.1.1, 5.1.2, 5.1.3, 5.2.1, 5.2.2, 5.2.3, 5.3.3, 6.2.1, 6.3.3, 7.3.2, 7.4.1, 7.5.1, 7.5.2
VAS web	Surgical Science Examination in Vascular Surgery	5.2.1
VAS06	Conduct of the Surgical Science Examination in Vascular Surgery Policy	5.2.1
VAS07	Vascular Assessment 2016	3.2.4 and 7.5
VAS08	360^0 Assessment Form	5.2.1
VAS09	Mini-CEX Assessment Form	5.2.1
VAS10	Direct observation of Procedural Skills Form	5.2.1
VAS11	Vascular Logbook	5.2.1
VAS12	Trainee Hospital Post Evaluation	8.1.4
VAS13	Skills Course Program	4.1.1
VAS14	Score Sheet for 2018 Entry	7.1.1
VAS15	Selection Process Regulations 2017 Intake	7.1.1, 7.1.2, 7.1.4