September 2013

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

AMC PROGRESS REPORT 2013

COLLEGE DETAILS

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Date of last AMC assessment: 2011 Comprehensive report

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

1.1 Governance

1.1.1. The training organisation's governance structures and its education and training, assessment and continuing professional development functions are defined.
1.1.2. The governance structures describe the composition and terms of reference for each committee, and allow all relevant groups to be represented in decision-making.
1.1.3. The training organisation's internal structures give priority to its educational role relative to other activities.

Challenges and Changes

The College continues to renegotiate the Memorandum of Understanding and Service Agreements that support the arrangements of delivering the nine Surgical Education and Training programs. With the increased autonomy and capability of the Specialty Societies these are being reconfigured as Partnering Agreements. These agreements now can vary between all the specialty societies but continue to focus on the accreditation requirements and standards of the AMC. The majority of the agreements are now finalised and either have been signed or await signing

- If the AMC wishes to review these documents, the most up-to-date version can be made available.
- There has been no change in the Governance structure of the College. A map depicting the Governance structure and the relationship of all of the Education and Professional Development Committees to Council is available on the website.
- The terms of reference for each committee are available on-line.

1.2 Program Management

1.2.1 The training organisation has established a committee or committees with the responsibility, authority and capacity to direct the following key functions:
- *planning, implementing and reviewing the training program(s) and setting relevant policy and procedures*
- *setting and implementing policy and procedures relating to the assessment of overseas-trained specialists*
- *setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activities.*

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

Challenges and Changes

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

1.3 Educational Expertise and Exchange

1.3.1. The training organisation uses educational expertise in the development, management and continuous improvement of its education, training, assessment and continuing professional development activities.
1.3.2. The training organisation collaborates with other educational institutions and compares its curriculum, training program and assessment with that of other relevant programs

The College continues to be involved in a number of collaborative activities to enhance training and professional development.

- the annual Tripartite meetings between RACS; the Royal Australasian College of Physicians (RACP); and the Royal College of Physicians and Surgeons of Canada (RCPSC) (2011-2013).
- RACS staff are actively involved in a number of networks of staff representing specialist medical Colleges in Australia and New Zealand:
    - the Network of Medical College Educators (NMCE) which meets four times per year and reports to the Education Subcommittee of the Committee of Presidents of Medical Colleges (CPMC)
    - Medical Education e-Learning Network meets monthly by teleconference and reports to the NMCE
    - Continuing Professional Development Managers Network meet bi-annually, additional meetings can be held by teleconference if required.
    - The Network of College IMG Managers (NCIM) also meets bi-annually.
- In the past 12 months RACS Fellows and senior staff have presented papers at Surgical Education conferences in Canada and Sweden.
- See also Section 3.5, page 16

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

Challenges and Changes

A. Curriculum Changes

College - generic

- The College and the Specialty Training Boards continue to address the planned changes to a 'competency based' Training Program. See the attached Table in Appendix 2.

General Surgery

- The General Surgery Training Board has continued to work towards the introduction of SEAM (Surgical Education and Assessment Modules). In the process the Board has reviewed and reissued their curriculum modules.
- The curriculum now contains 16 modules (see Section B 'Changes to examination processes' for additional information).
- The revised curriculum modules also include a list of DOPS that can be undertaken to assist with the trainee's learning.

Neurosurgery

- The SET Board of Neurosurgery and Neurosurgical Society of Australasia have made modifications to the SET Program in Neurosurgery to deliver greater flexibly and an increased focus on competency based training within a time based framework. As part of this process the SET Program has now been divided into three stages as follows, applicable to trainees commencing from 2013 onwards:
    - Basic Neurosurgical Training (1- 2 years)
    - Intermediate Neurosurgical Training (3 – 4 years)
    - Advanced Neurosurgical Training (1 - 3 years)
- The new SET Program structure introduces flexibility so that the very competent trainee can complete the SET Program in 5 years, although it is expected that the majority of trainees will still take 6 years which is the previous standard duration. The maximum time allowed is 9 years.
- The new SET Program structure also replaces the full time compulsory research year with additional clinical training and a formal research requirement to be completed while undertaking Intermediate Neurosurgical Training.

- For all trainees commencing in 2012 or later the in-training assessment and workplace competency assessments were replaced by two new assessment tools (see Standard 5: Assessment - for more information about these tools).

Otolaryngology Head and Neck Surgery

- The SET training scheme for Otolaryngology Head and Neck Surgery is based on a longstanding curriculum which is currently actively under review by The Board. The Board is reviewing performance assessment, evaluation and curriculum content.
- The Board would like to move to an individual module style system of assessment based around entrustable professional attributes (EPAs).
- The Board assesses trainees using an end of term assessment tool based on the nine College competencies.
- Trainees in their SET 1 year are also assessed by exam and by case discussion and demonstration of clinical skill.
- It is anticipated that with the rolling out of a module system and EPAS that there will be a change in our teaching approach providing our trainees with a much better idea of what is required to become a competent surgeon in our specialty.
- See also planned changes to the research requirement

Orthopaedic Surgery

- As foreshadowed in the 2012 report, a curriculum review was commenced in the second half of 2012. Preliminary feedback was sought on the clinical/technical modules of the curriculum from sub-specialty groups and examiners to scope the size of the task of editing the clinical/technical content to ensure the breadth of orthopaedic surgical practice was appropriately incorporated. An internal review identified issues around structure, language and resources. The Federal Training Committee determined that a comprehensive review was required and has proceeded to convene a curriculum review committee.
- Concurrent to this, as an outcome of the AOA Board's Strategic Planning 2013 – 2015 the AOA has engaged Dr Jason Frank of the RCPSC to conduct a strategic external review of AOA Education Programs. This review commenced in November 2012 and will incorporate all aspects of AOA Education and Training. The AOA Board expect to consider recommendations of the review at its meeting in October 2013 with a view to implementation of significant and transformational change to ensure international best-practice across all educational activities of the AOA.
- The outcomes of the Review Project will feed into the curriculum review for a phased implementation of the recommendations. It is anticipated that this will be a multi-year project.
- The AOA also launched a new CPD program in 2013 (see Section 9.1)

Paediatric Surgery

- In 2013 the Board of Paediatric Surgery completed its review of the SET curriculum for Paediatric Surgery. Changes included specifying which competencies were expected to be accomplished by each stage of training (Early-, mid- or late- SET). These changes allow supervisors and trainees to accurately assess trainees against appropriate competencies. These changes have allowed for earlier completion of training for some trainees who demonstrated acquisition of all desired competencies in a time frame shorter than expected. These changes allow for accurate assessment of trainees who are returning from an interruption to SET training, whose level of competency cannot be expected necessarily to be that reached at the time of commencement of interruption.
- Commencing from the beginning of 2013, the duration of training has been extended to seven years through the addition of a paediatric training year to enable Trainees to better cope with particular challenges related to Paediatric Surgery SET. Previously new trainees commenced with two years of training in surgery in general (adult general surgical specialties) and then commenced their paediatric surgical rotations. The Board felt it was not desirable for trainees to be selected in June one year, and then not be assessed by paediatric surgeons for another 30 months. This is unfair for trainees, who in their third year of training might suddenly determine they did not like paediatric surgery. In some cases trainees who had difficulties acquiring surgical

competencies were not adequately identified or remediated until their third year of training, and in a minority of cases were dismissed from training years later than would otherwise have happened.

- The new year of training, SET ONE, is seen as an extension of selection. Trainees are in a tertiary paediatric surgical post and are closely monitored by a supervisor appointed to supervise just them (one on one).Trainees have specific competencies to demonstrate within a strict time frame to demonstrate their ability to successfully train, and demonstrate their genuine interest in paediatric surgery. It is hoped the clinical and operative skills acquired in this first year of training will enable them to train to best advantage in the subsequent year or two doing adult surgery in general. Given the Boards demonstrated adoption of competency based training, it is anticipated that for most trainees this notional increase in training time by one year will be negated by faster advancement through the program.

Urology

- The Board of Urology is planning to reduce the SET Program in Urology from 6 years to 5 years. This now has 'in principle' support from the Board of Surgical, Education and Training (BSET) at RACS.
- The Board plans to introduce the new 5 year program (nSET) for the 2016 intake and will be dropping the current SET 1 year (See Table below). The nSET 1 year, in the new program will be the similar to the current SET 2 year. In order to ensure sufficient posts to accommodate urology trainees throughout the program, the Board will not run a selection process in 2014 and will not appoint any new trainees into current SET 1 posts in 2015. Any deferred applicants for 2014 will start SET 1 in 2015.

Current Program	New Program
SET1	
SET2	nSET1
SET3	nSET2
SET4	nSET3
SET5	nSET4
SET6	nSET5

- In the interim, some of the current SET 1 posts will be returned to the jurisdictions as service posts and others may become part of the nSET 1 group. Similarly, some current SET 2 posts will be used as nSET 1 in the new program. Posts returned to the jurisdictions may be used as service posts to accommodate pre-vocational doctors.
- For further explanation of the planned changes to post accreditation see Section 8.2, page 35
- For a full explanation of the structure of the Urology nSET program see Appendix 3.

All other specialties

- No change

B. Changes to Examination processes

College - generic

- As reported in 2012, from 2014 the Generic SSE will become available for medical graduates prior to being selected into SET. Initially only a small number of places will be available to doctors who are not SET Trainees. However, later in the year and into 2015, when the examination can be made available on-line, an increasing number of examination places will be available.
- A modified 'expanded close marking system' (ECMS) was implemented by all nine specialties at the May 2013 Fellowship examinations after being trialled in the previous three Fellowship examination (September 2011, May 2012 and September 2012).

- A review of the May 2013 implementation has produced refinements for the next Fellowship exam in September 2013 and a continuous quality review cycle is now part of the examinations process.
- Policies relating to the conduct of all of the College and Specialty specific examinations are available on-line.

Cardiothoracic Surgery

- As reported in 2012, the new Cardiothoracic Surgical Science and Principles Examination (CSSPE) will be introduced in 2014. Trainees who commenced the program from 2012 are required to sit this exam and the first sitting will be in February 2014.
- A curriculum is currently being completed and prepared for publication. Information is available on the College website

General Surgery

- As reported in 2012, a series of on-line learning modules SEAM (Surgical Education and Assessment Modules) will be introduced in 2014 to replace the current SSE – (General Surgery Specialty Specific Examination.
- For further information about the rules and regulations for the implementation of SEAM assessment in the General Surgery Training Program see Appendix 4.

Urology

- As advised previously, the new SSE (Urology) examination will commence in February 2014. Information is available on the College website.

Vascular Surgery

- As part of their on-going evaluation of their program the Board of Vascular Surgery is revising the current specialty specific examination. It is expected that the new examination will be available in 2016.

All other specialties

- No change

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

- See pp. 12-17 in the 2012 Activity Report available for public assess on the RACS website.

1.4 Interaction with the Health Sector

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

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

Challenges and Changes

- The College, the Specialty Training Boards and the Specialty Societies continue to interact with the Health Sector at all levels of government across two nations being National, Commonwealth, and State based. For example:
    - Discussions at forums of Surgical Leaders continue to focus on issues such as credentialing, the viability of surgical health care and workforce. See Appendix 5 for details of the meetings in February and October 2012.
    - Over the past year the College has worked with the Australian Institute of Health and Welfare (AIHW) to review the urgency categories for elective surgery. The final report from this collaborative project is now published, following approval by the Standing Council on Health (see www.aihw.gov.org)
    - Senior surgeons serve as members on regional medical education committees such as HETI, SA MET, and Queensland Health.
    - Senior surgeons also provide advice on a wide range of consultative committees and Ministerial Advisory committees (see Appendix 6 for examples from NSW and Victoria)
    - Senior surgeons also serve on committees of other Colleges. For example, in Tasmania, Pauline Waites is the RACS rep on the Pain Medicine Unit Accreditation Committee of the Faculty of Anaesthetists Pain Medicine Section.
    - Representation at MPEG – Victoria meeting which seeks to integrate medical student training with interns positions and subsequent training pathways.
    - The Board of Regional Chairs (BoRC) and their regional committees have a very strong role in advocacy within each of the regions.
    - Where possible specialties continue to have JRs as members of their Training Board.
    - JR's involvement is actively sought in the accreditation inspection of training posts in Australia. It has been difficult to arrange these in New Zealand due to issues around Ministry of Health funding.
    - JR's involvement is actively sought in the selection of trainees.
    - Interactions with health services undertaken at a local (hospital) level between training supervisors and administration to ensure effective service-based training.
- For a more complete list see Appendix 6

<u>General Surgery</u>

- Once again JR's were invited to participate as inspectors on the NSW Quinquennial Inspections. Three JR's were nominated by the Health Department.

<u>Orthopaedic Surgery</u>

- No change - a JR continues to sit on the Federal Training Committee. JR involvement is also actively sought in accreditation and selection.
- Regular meetings are held between the AOA and Health departments.

<u>Paediatric Surgery</u>

- The Paediatric representative on Council has raised concerns at Council with respect to inaccuracies in the manpower figures for paediatric surgery as published by Health Workforce Australia. There are concerns that HWA has significantly underestimated future requirements.

<u>All other specialties</u>

- No change

1.5 Continuous Renewal

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

Challenges and Changes

- Given the proposed changes from the Memorandum of Understanding and Service Agreements to Partnering Agreements, the College has continued to change the policies relation to Surgical Education and Training (SET) from their previous format to 'principle-based' policies.

STANDARD 2: THE OUTCOMES OF THE TRAINING PROGRAM

2.1 Purpose of the Training Organisation

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

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

Challenges and Changes

- No change in the purpose of the training organisation.

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

2.2 Graduate Outcomes

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

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

2.2.3. The training organisation makes information on graduate outcomes publicly available.

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

Challenges and Changes

- The first cohort of SET trainees completed their training in 2012. Therefore the College has developed a program of evaluation to be implemented during the latter part of 2013 and in 2014. All of the processes and outcomes of the SET training program are under review.
  - On-line surveys have been developed and distributed to all Supervisors, Trainers, Trainees and recently graduated Fellows across all nine specialties in Australia and New Zealand
  - On-line surveys are being developed to invite feedback from the wider community of 'consumers'
  - The feedback from all of these surveys will be collated and the findings will be discussed in a workshop (in 2014) to which all specialty training boards, trainee representatives and other stakeholders will be invited. The purpose of this workshop will to consider the implications of the findings on the training programs.
- The number of trainees completing their Fellowship examination (by specialty; region and gender) is publically accessible on the RACS website. See pages 26; 30-33 in the 2012 Activity Report

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

- The new Partnering Agreements clearly define the documents (policies, regulations, and training requirements) that each specialty needs to be published on the public section of their websites.

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

The College has taken a number of steps to address this expectation. These include:

- Enquiries made amongst all of the other specialist medical Colleges and found that there were a number of different approaches (lay committees; community representatives; consumer groups for specific health issues; …)
- Following further discussion we wrote to the Consumers Health Forum of Australia (CHFA), inviting them to become advisory members of both our Education Board, and our Professional Development and Standards Board.
- Education Board Exec agreed that, as part of the SET evaluation, we would develop a survey to invite feedback from the wider community of ‘consumers’
- The advice from the CHFA was discussed by College Council Exec which agreed to advertise for honorary consumer representatives

STANDARD 3: CURRICULUM CONTENT

3.1 Curriculum Framework

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

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

3.2 Curriculum Structure, Composition and Duration

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

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

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

- See Appendix 2
- See detailed response to Standard 1.3, Recommendation 2, on page 5-8. As indicated there, several of the specialty training boards are currently working towards revising / redeveloping different components of their training programs. The work will continue throughout 2013 and 2014.

Cardiothoracic Surgery

- The Cardiothoracic Surgery Training Board are currently addressing a move to Competency based training having recently progressed one trainee up a SET level as he had demonstrated competency well beyond his previous SET level. Conversely the Board has moved another trainee back two SET levels commensurate with his competency level.

Paediatric Surgery

- At least three trainees have completed training sooner than expected as required competencies had been met, one IMG had oversight period reduced as desired competencies had been demonstrated.
- Continued efforts to educate trainees as to how competencies can be effectively demonstrated to the Board, continue to direct trainee attention to the curriculum which now clearly states competency levels expected at each stage of training.

Orthopaedic Surgery

- Competency-based progression is encouraged with consideration given to shortening/ lengthening training based on the demonstrated competence of trainees. Tools to better facilitate this are in development.

3.3 Research in the Training Program

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

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

Recommendation 13:
Define the educational objectives of the research components of training and review requirements against these objectives.

Challenges and Changes

College - generic

The College Research Working Party has prepared a discussion paper on possible measures for enhancing the role of research in the SET program. It is expected that the paper will be discussed at the October meeting of BSET.

General Surgery

- The Board is currently reviewing when trainees must complete the Research requirement.
- The Board has currently also reviewed its regulations to define more clearly what will be accepted. This includes:
  - A statement that the purpose of the research requirement is to enable a Trainee to gain competencies associated with scientific research
  - Requirements that:
    - Prospective application is required for all research projects to be approved by the Board by the end of SET3
- A period of full time research, **relevant to General Surgery**, during the SET Program continues to be strongly encouraged.

Neurosurgery

- The new SET Program structure replaced the full time compulsory research year in the SET Program with additional clinical training and a formal research requirement to be completed while undertaking Intermediate Neurosurgical Training.
- The formal requirement includes:
  - The RACS Critical Literature Evaluation and Research (CLEAR) workshop
  - A supervised research project relevant to neurosurgery during SET
  - An oral presentation of the research at a suitable scientific meeting
  - One neurosurgical publication in a peer reviewed scientific journal (not a case report)
- The proposal for the research project must be submitted and approved by the SET Board of Neurosurgery prior to the completion of Basic Neurosurgical Training and the research requirement must be successfully completed prior to the end of Intermediate Neurosurgical Training.
- Trainees who wish to undertake a period of full-time research may still apply to the Board for interruption of training for that period (as is currently the case for trainees in the current SET Program who wish to spend more than one year in research).

Otolaryngology Head and Neck Surgery

- All trainees commencing in 2014 or later will be required to have at least one publication published in a peer-reviewed MedLine journal prior to being allowed to sit the Fellowship Examination. The research on which this publication is base is to be done whilst they are in the OHNS training program.

Orthopaedic Surgery

- A review of the research requirement has been identified as a priority of the review activities

Paediatric Surgery

- The educational objectives of research in Paediatric Surgery are to demonstrate the understanding of how research contributes to clinical care. As per the training regulations this is to be done by conducting a study that is presented or published in a peer reviewed environment.

Plastic and Reconstructive Surgery

- The Board of Plastic and Reconstructive Surgery has introduced a points system for the assessment of the research requirement in which all SET Trainee must achieve four (4) or more points during their period of training in Plastic and Reconstructive Surgery. Details are available in the P&RS Training Handbook on the College website (Section 5.8)

Vascular Surgery

- The Board of Vascular requires trainees to complete a significant amount of research prior to completion of the training program. Specifically Trainees must have achieved a minimum of at least five points of the Research Requirement prior to presenting for the Fellowship Examination. Details are available on the College website.

All other specialties

- No change

3.4 Flexible Training

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

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

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

Challenges and Changes

- Flexible training has been identified as one of the issues that will be addressed under the umbrella of 'Advocacy' in the 2012 Strategic Plan. The Education Board set up a working party to investigate the issues.
    - The Progress Report from that working party has been published on the College website for comment. Feedback is to be provided to the Chair of the College Trainees Association (RACSTA)
- Training boards recognise the need of flexible training opportunities. They also recognise that these training opportunities require collaboration with hospitals as the employing bodies and during accreditation visits this topic is sometimes discussed.

General Surgery

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

Orthopaedic Surgery

- The Federal Training Committee has recently approved a policy on Flexible Training. The Committee is working with Trainees to facilitate these arrangements.

Paediatric Surgery

- Accreditation visits are now meant to include inquiry as to what flexible training opportunities exist at the facility. Opportunity is taken to express to administrators the Board's support for flexible training.

Urology

- The Chair, Board of Urology is currently a member of the Flexible Training Working Party.

3.5 The Continuum of Learning

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

Challenges and Changes

- In response to increasing pressure to provide information across the spectrum of education and training RACS following strategies are already in place:
  - Pathway to becoming a surgeon
  - The 'Essential surgical skills' document identifying skills that a doctor needs to be able to perform before applying for selection.
  - The booklet '*Becoming a competent and proficient surgeon: Training Standards for the nine RACS Competencies*'. Doctors applying for selection into a specialty are expected to have achieved suitable requirements for their pre-vocational status.
- The College is currently developing a plan to provide clearer guidance and more resources for aspiring surgeons. This is planned to provide some resources which are available for public access (such as those listed above); others which will be available on payment of registration; plus courses and examination application and resources which will be available on payment of relevant fees. This suite of resources will be formally announced later in 2013, to commence in early 2014, for interns and prevocational doctors who aspire to careers in surgery.
- Resources available on subscription will include:
  - Access to some e-learning resources such as 'Goal setting' and 'Self-assessment'
  - Access to the MCQ Practice Bank
- Resources available for fees could include:
  - Opportunity to sit the generic SSE examination prior to selection (see Section 1.3 B)
  - Courses including ASSET; CLEAR; CCrISP; and TIPS
  - An e-portfolio and e-logbook (in development)
  - Out of the box ASSET course (components)
  - Out of the box simulation courses addressing non-technical competencies
- As part of this planning, in September RACS will hold a consultation workshop with key stakeholders including representatives of regional Post Graduate Medical Councils as well as young doctors currently working in the PGY sector.

STANDARD 4: TEACHING AND LEARNING METHODS

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

Challenges and Changes

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

- The College successfully developed and piloted two new courses for IMGs, Supervisors and Trainees. Both of these courses will be included from 2014 in to the suite of courses provided by the College.
  - Training Standards – Interpretation and Application' (TSIA), introduces participants to the training standards, as defined in the booklet: "*Becoming a competent and proficient surgeon: Training standard for the nine RACS Competencies*"
  - 'Clinical Decision Making – a complex competency' (CDM), provides participants with training in the underlying principles and processes required to effectively adapt and apply Judgement – Clinical Decision Making in complex surgical situations.
- The Trainee version of the SAT SET course (TSET) is currently being developed to be published on-line.
- RACS Indigenous Health eLearning module was launched in 2013. The module aims to promote a multi-disciplinary approach for surgeons in rural and remote locations who care for Indigenous patients, and will also be of value to metropolitan based surgeons with Indigenous patients.
- The Surgical Teachers course has been revised. This is a 2.5 day course designed to enhance educational skills of surgeons who are responsible for teaching and assessing Trainees.
- The Academy of Surgical Educators , supported by College staff from Education and Professional Development departments has started to develop a new one day 'Foundation Course' focusing on workplace assessment and feedback. It is intended that this course will be trialed in 2014 and will be aimed at senior SET Trainees, trainers and supervisors.

Otolaryngology Head and Neck Surgery

- Currently the specialty provides a large number of formal courses including an annual Registrar Conference.

Orthopaedic Surgery

- Changes to teaching and learning approaches will be informed by the current review activities
- A new eLearning Platform is under development, which will facilitate better use of online teaching and learning opportunities.
- A pilot Teaching Trainees to Teach course was conducted in December 2012. The pilot was a success and plans are in place to roll this out nationally. A number of other topics for provision by course/workshop have been considered as a result of member feedback. A pilot of a private practice course is planned for later in the year.
- An inaugural National Trial Exam is being held in conjunction with the Trainee Conference in October 2013.

Paediatric Surgery

- For the past two years a one day "Boot Camp" has been run for all new Trainees appointed to SET. The course is conducted a few months prior to the commencement of SET. The course covers educational theory, the framework of SET, how assessment tools can be used to trainee advantage in a competency based program, and a review of the training regulations. Participants

are taken through the SET ONE curriculum. Supervisors and other Fellows of the College can attend the course:- at the last course there was one Fellow for every new trainee – this made discussions relevant and assisted new trainees to build valuable network to assist with their training trajectory. In 2013 the three day PCM communication course will be bolted on to the Boot Camp. It is anticipated that the usefulness of other courses will be similarly trialled in the future. It is hoped that PCM will provide tools not only valuable for workplace communication and training, but also provide awareness and skills that will assist trainees in keeping their personal life as stress free as possible during training. PCM is seen to be a natural course to do early in training, with NOTSS in Mid SET, and TIPS in Late SET completing the natural flow of courses dealing with non-technical competencies.

- A laparoscopic skills course continues to be run annually at the Children's Hospital at Westmead, and a Fellowship Examination Preparation Course has similarly been run regularly at the Royal Children's Hospital in Melbourne.

<u>Plastic and Reconstructive surgery</u>

- The Board of Plastic and Reconstructive Surgery has standardised regional tutorial programmes by mandating fortnightly clinical didactic tutorials in each region. These tutorials cover the syllabus over a two year period.
- The P&RS Training Board conduct annual conferences for SET 1 Registrars and for SET 2-5 Registrars
- The Board is investigating developing online learning modules to cover aspects of the curriculum.

<u>All other specialties</u>

- No change

STANDARD 5: ASSESSMENT

5.1 Assessment Approach

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

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

Challenges and Changes

- See also Section 1.3, Recommendation 2, pp. 7-8

College – generic

- Changes in the early examinations (Generic Surgical Sciences) are being introduced to reduce the workload demands on trainees in the first two years of training.
- Changes in the scoring of the Fellowship Examination are to improve reliability.

Specialty Specific SSE

Changes in specialty specific surgical sciences examinations are being introduced for a number of reasons:
- Changes in timing to:
  - spread the workload on the trainees more evenly across the training program
  - provide increased opportunities to monitor progress
- Changes of content to make the examination more specific to the requirements of the specialty.

General Surgery Examination

- The General Surgery Training Board has recently introduced a requirement for all Exam Pending trainees to provide evidence of exam preparation before being signed off to present for the Fellowship Exam. This has allowed the Board to continually monitor the performance and readiness of the trainees.

Urology Examination

- No change – as per advised previously, the new SSE (Urology) examination will commence in February 2014.

Vascular Surgery Examination

- The Training Board of Vascular Surgery is revising the current speciality specific exam in vascular surgery, the new exam is expected to be available in 2016.

All other specialties

- No change

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

on it is using the available research findings in making decisions about the assessment tools it employs.

Work-based assessment

- As outlined in Section 1.3 (Recommendation 2) the specialty training boards are at varying stages in their curriculum reviews and on-going development. In conducting their review they are consulting internationally to ascertain current trends in work-based assessment in their specialty.
- Entrustable professional activities (EPAs) are being drafted, that could cover all specialties and these will be discussed at Board of SET in October.

Cardiothoracic Surgery

- After a year of DOPS' implementation the Board are addressing feedback indicating the current forms were lengthy. The Trainee Rep on the Board is leading these proposed changes.

Neurosurgery

- For all trainees commencing in 2012 or later the in-training assessment and workplace competency assessments were replaced by two new assessment tools.
  - The in-training assessment has been replaced by a Professional Performance Assessment (PPA) Report which must be submitted quarterly during Basic Neurosurgical Training. The PPA report is focused on minimum standards of behaviour and attitudes (this assessment tool does not focus specifically on clinical skills, technical skills and knowledge).
  - The standards in the PPA Report are the minimum standards we would expect trainees to have prior to entering SET, and therefore this assessment is not expected to be onerous for the vast majority of trainees. These minimum standards must be maintained or exceeded at all times during SET by all trainees.
- All assessment tools are currently being reviewed by a Curriculum and Development Working Party which contains a mix of supervisors and recently graduated trainees.
  - The current core and elective workplace competency assessments are being replaced by three new competency assessments being a Basic, Intermediate and Advanced. These are aligned with the three stages of training. These assessments are submitted six monthly during all years of training.
  - The workplace competency assessments focus on core procedural competencies and components of the previous in-training assessment form relating to clinical and technical skills. Trainees are assessed as either 'competent' or 'not yet competent' for each area within the form and as such there is no unsatisfactory, just a failure to have attained competence at that time. Attainment of competence in all areas of the requisite assessment must be obtained in order to progress from one SET level to the next.

Otolaryngology Head and Neck Surgery

- As part of the revision of the modules, specific procedures will be selected for all trainees to be assessed using Procedure Based Assessments (PBAs) and EPAs.

Orthopaedic Surgery

- Changes to assessment tools will be informed by the review activities (see Section 1.3)
- A new eLearning Platform is under development, which will provide better delivery of e-assessments and a more user-friendly e-logbook.
- Assessment policy documents were refined over the past 12 months to ensure clarity, and provide better guidance on process for all involved. This new documentation has been very well received. Supervisors indicate more confidence in utilisation of assessment tools and deviations from proper process have decreased. It would seem the new policies might also be contributing to better delivery of timely feedback.

- A number of optional assessment tools are often mandated as part of an improvement or remedial plan for under-performing trainees as appropriate, according to areas of weakness (mini-CEX, MSF, CBD)

Paediatric Surgery

- The Board continues to favour the MOUSE (Measure of Understanding and Surgical Expertise) over DOPS as an assessment tool as the MOUSE provides evidence of the trainee's insight into their own performance. The CAT and DOG have matured as learning and assessment tools over the past few years.
- Feedback from examiners has been used as a needs assessment to determine topics best addressed in CATs and DOGs. Trainee responses to CATs have proved of great interest to their consultant colleagues, and in some instances unit protocols have been changed as a result of the critical literature review (e.g. antibiotic management of complicated appendicitis in children).

All other specialties

No change in work-based assessment tools

Statistical data:

a) The number of Trainees completing their Fellowship examination (by specialty; region and gender) is publically accessible on the RACS website. See pages 26; 30-33 in the 2012 Activity Report

b) The number of Trainees completing the generic Surgical Sciences examination; the Clinical Examination and the Specialty Specific Surgical Science Examinations are publically accessible on the RACS website. See pp. 26-29 in the 2012 Activity Report

c) Data from the 2013 May examinations is in Appendix 7 (see also Section 5.3)

5.2 Feedback and Performance

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

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

Challenges and Changes

A. Underperforming Trainee

College - generic

- The College has developed a range of resources that are being used by supervisors to identify and assist trainees who are progressing through the training program more slowly than expected. Those resources are:
  - The document '*Becoming a competent and proficient surgeon: Training Standards for the nine RACS Competencies*' published in 2012
  - The on-line resources for self-assessment and goal setting, also published in 2012

  - Early in 2013 the College published the on-line resource for Supervisors and Trainees that provides ready access to both generic and specialty specific materials to address all stages of identification, remediation and management of underperforming trainees. This website has restricted access via College password.
- The College has received positive feedback from several of the specialty training boards, as well as from individual supervisors, that this combination of resources has been found to be very useful.

General Surgery

- No change. Trainees on Management Programs receive feedback monthly.

Orthopaedic Surgery

- A suite of policy documents regarding assessment, including trainees requiring additional support have been developed and implemented.
- Also see Section 5.1

Paediatric Surgery

- See Section 5.1

All other specialties

- No change

B. Feedback to Trainees

See response to Section 7.3, pp. 30-31

C. Feedback to Supervisors

No change

5.3 Assessment Quality

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

Challenges and Changes

- As shown in Appendix 7 there was a significant reduction in the pass-rate in the Fellowship Examination in some specialties. This reduction is a matter of great concern and is being investigated in a number of different ways.
  - A state by state (region) comparison of results in each specialty, and each of the seven sections of the examination.
  - As one of the specialties which had the greatest reduction in pass rate, OHNS Training Board reviewed all of their candidates' results at their recent Board meeting and determined that as the highest proportion of failed candidates were 'first attempt' they will review the requirements that trainees must meet prior to being permitted to sit the Fellowship Examination, and the advice given to prospective candidates.

5.4 Assessment of Specialist Trained Overseas

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

Challenges and Changes

- No change to the processes of assessing IMGs
- The forms are accessible on the College website

Monitoring of IMGs

College - generic

- A Clinical Assessment of an IMG is carried out every three months
  - IMGS under supervision/oversight are also assessed on DOPS, Mini-CEX and MSF or 360^0 evaluation.
- The forms are accessible on the College website.
- To streamline the clinical assessment processes the College IMG Department has implemented standard three monthly reporting periods for all IMGs commencing clinical assessment in 2013(rather than according to their commencement date).
- IMGs are required to complete professional development activities (previously MOPS) during their clinical assessment period inclusive of attainment of Fellowship Examination (if applicable).

Otolaryngology Head and Neck Surgery

- International Medical Graduates continue to be monitored on a monthly basis. Each IMG is supervised by two OHNS fellows. At least one of these Fellows is locally based.
- At each meeting the Board is made aware of their progress.

Orthopaedic Surgery

- The revised assessment templates for IMGs have been well received

Paediatric Surgery

- The assessment and monitoring of IMGs has continued in a similar manner to that of trainees. All courses and training opportunities available to SET trainees are made available to IMGs.
  - The SET training calendar produced will be sent to IMGs so that they have adequate fore-warning of these activities; unfortunately this has not previously been done.
  - The MOUSE is used instead of DOPS for the SET trainees working in paediatric institutions. It is also asked that IMGs complete MOUSE and Mini-CEX as part of their assessments.
- Discussion has occurred at ANZAPS as to whether a new committee is required to assist with assessing and monitoring IMGs, together with assessing and monitoring standards of Fellows in our craft group. Some IMGs resent being assessed or supervised as if they are trainees. It would seem more stringent CPD oversight will be required of Fellows in the future, perhaps this is a better arrangement than IMG supervision with Board involvement.

All other specialties

- No change

STANDARD 6: MONITORING AND EVALUATION

6.1 Ongoing Monitoring

6.1.1. The training organisation regularly evaluates and reviews its training programs. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.
6.1.2. Supervisors and trainers contribute to monitoring and to program development. Their feedback is systematically sought, analysed and used as part of the monitoring process.
6.1.3. Trainees contribute to monitoring and to program development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training program to ensure that existing trainees are not unfairly disadvantaged by such changes.

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

Challenges and Changes

College - generic

- With the approval of BSET the College has developed evaluation surveys to collect data on the introduction, implementation and impact of SET. These surveys have been sent to:
  - every supervisor and trainer
  - every recently graduated Fellow,
  - all current trainees
- An additional survey is being designed to invite feedback from the wider community
- All of this information will be collated within the College and then used as the basis for a planning workshop involving a wide range of stakeholders in 2014.
- See also Section 1.4, Recommendation 5.
- See also Section 2.2, Recommendation 10.
- All specialty training boards receive feedback from hospital administrators as an integral part of post inspections.

Orthopaedic Surgery

- See section 1.3

Plastic and Reconstructive Surgery

- Trainee and supervisor evaluations are undertaken at each hospital accreditation meeting.

All other specialties

- No change

Recommendation 23:
Report in annual reports to the AMC on plans for trainee and supervisor evaluation of SET. Please include the results of this in the next report.

Challenges and Changes

College - generic

- All specialty groups have an annual scientific meeting (ASM) at which a meeting of supervisors is usually held. These meetings provide the Training Boards with an opportunity to both provide information to the supervisors, and to listen to their concerns.
- Many of the specialty groups continue to conduct their end-of-term evaluations with their own Trainees. The results of these evaluations are used within the specialty to inform on-going development.
- The College continues to monitor the end-of-term survey of all trainees designed and conducted under the auspices of the Trainee Association (RACSTA).
    - RACSTA representatives take issues and themes emerging from the collated information from these surveys to the relevant Boards (BSET; EB; Council) for discussion and consideration.
    - Whilst over 85% of trainees rated their recent rotations as good (or better), and their clinical experience as 'about right', some Trainees expressed concerns about:
      a. bullying
      b. access to part-time training
      c. dilution of training caused by the increase of Fellow positions
      d. an over-representation of procedures in logbooks, and
      e. decreased access to out-patients
- The College has instituted an number of responses to each of these issues:

a. Bullying

- The College has published a policy and a booklet relating to this issue
- The College Code of Conduct states: "a surgeon will … seek to eradicate bullying or harassment from the workplace"
- Bullying is specifically defined as an example of poor behaviour is the Surgical competence and Performance Guide and, as such will be assessed in the on-line 360^0-MSF tool when it becomes available
- At the June meeting Education Board (EB) supported the suggestion that as a leadership issue RACS engage in discussions with Health Departments, Jurisdictions and work with the CPMC and other Specialty Colleges in an attempt to eradicate the bullying culture which exists in hospitals.
- EB also agreed to support a working party on Mentoring as proposed by the Younger Fellows committee
- RACSTA are hopeful that trainee representation at hospital post inspections will continue to address the issue of bullying (see also Section 8.2)

b. Access to part-time training

- See Section 3.4 (pp. 15-16)

c. Increased number of Fellows

- This is an issue which has been referred to the specialty Training Boards to review

d. Logbooks

- This is an issue which has been referred to the specialty Training Boards to review

e. Decreased access to outpatients

- Even though 88.2% of the Trainees who responded to the RACSTA survey stated that they did have outpatient experience it continues to be treated as an issue of concern. It is:
    - Defined as a requirement for hospital post accreditation and is discussed with hospital representatives during accreditation visits
    - A topic for discussion at meetings between College and jurisdictional representatives (see also Section 1.4 Recommendation 5; and Section 6.2 Recommendation 25)

General Surgery

- The General Surgery Training Board has continued to send Trainee Feedback forms following each end of Term. These are then de-identified and provided to Regional committees for review. Trainees and supervisors are also a valuable participant in all hospital inspections.

Neurosurgery

- The SET Board of Neurosurgery continues to collect training position evaluations from trainees in confidence at the end of each six month rotation. The main issues identified primary relate to the educational tutorials. Where serious issues are identified further discussions are held with trainees and remedial action is put in place for training units.

Orthopaedic Surgery

- No change – AOA continues to collect 6 monthly feedback from Trainees and Supervisors. Additional feedback is also sought on a project/activity basis.

Paediatric Surgery

- The Paediatric Surgery Training Board has carefully responded to problems identified by Fellowship Examiners, CAT markers and the DOG moderator by directing future CAT and DOG topics and by carefully updating the curriculum modules.
- MALT (Morbidity Audit and Logbook Tool) is being adopted by the training program as of July 2013:- the MALT team are planning to audit the implementation of this new resource
- The Board continues to liaise closely with each training post to identify particular problems that arise with each post and assist with remediation. These problems can result from budget cutbacks, staff turnover and similar issues.

All other specialties

- No change

6.2 Outcome Evaluation

6.2.1. The training organisation maintains records on the outputs of its training program, is developing methods to measure outcomes of training and is collecting qualitative information on outcomes.
6.2.2. Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.

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

Challenges and Changes

- See Section 1.4, Recommendation 5 in regards to on-going communication with health care administrators and the jurisdictions.
- See Appendices 5 & 6 for examples of interactions and collaborations between representatives of the College, jurisdictions, and the wider medical community.
- See Section 2.2, ‘Graduate Outcomes’
- See Section 2.2, response to Recommendation 10.
- Quantitative date on the outputs of the training program are available in the Activity Reports for public assess on the RACS website.

Brief summary of any completed training program evaluations

- Each year the Education Development and Research Department evaluates the selection process for most surgical specialties (some do their own) providing feedback on the effectiveness of the various selection tools and suggestions for improvements.
- A staff member in the Education Development and Research Department (EDRD) is currently undertaking her PhD, researching to find the level of congruence between the different selection tools and trainees' performance on examinations and workbased assessment during training. Whilst the work is not yet completed, her preliminary findings have been presented at a number of forums including the relevant Training Board Meetings; 2013 ASC; BSET; and the May meeting of the Network of Medical College Educators.

STANDARD 7: ISSUES RELATING TO TRAINEES

7.1 Admission Policy and Selection

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

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

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

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

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

Recommendation 24:
Report to the AMC on the evolution of the selection process, taking account of feedback from the specialty societies, the applicants and other stakeholders.

Challenges and Changes

College - generic

- As part of the new Partnering Agreement the policy on selection has been modified to articulate the principles on which selection must be based whilst giving the specialty training boards more flexibility in the way in which they implement their selection processes.

Cardiothoracic Surgery

- Based on applicant and stakeholder feedback following the implementation in the 2014 selection process the Cardiothoracic Training Board are planning to provide significantly more detailed updates to the Cardiothoracic selection documents.

General Surgery

The General Surgery Training Board changed the selection process this year (2013 for 2014 intake) in Australia (only) as follows:
- increased the weighting of Referee reports
- decreased the CV and Interview weightings.
- all candidates were required to nominate at least two General Surgeons as referees
- Interview stations were changed to include two clinical stations and one skills based station together with two non-technical stations

Neurosurgery

- The selection tools were modified for the 2014 intake. The weightings were as follows:
  - Structured Curriculum Vitae 15%
  - Structured Referee Reports 35%
  - Basic Clinical and Sciences Examination 10%
  - Neurosurgery Semi-Structured Interview 40%

  - The Basic Clinical and Sciences Examination has been designed to assess knowledge expected to be obtained at an intern/house surgeon level.
  - The interview has been revised to four scenario based sections, each with multiple questions designed to assess the suitability of the applicant.

- Changes for the next selection process will be determined in the latter half of 2013.

Otolaryngology Head and Neck Surgery

- For selection of applicants in 2014 the OHNS Training Board plan to introduce significant changes to the selection process to help the specialty more adequately assess appropriate candidates for training. Further details cannot be provided until approved by BSET.

Orthopaedic Surgery

- A comprehensive review of Selection was conducted in September 2012 and the outcomes incorporated into the Selection Regulations approved by the College in October 2012. These changes were implemented for the recent selection round (2014 intake). Significant changes included:
  - Introduction of an active Selection Committee final QA review of top ranking applications
  - A reduction in the ratio of candidates-interviewed to number-of-positions-available to 2:1, according to the recommendations of the Brennan Report
  - All requirements (pre-requisite and for CV points) must have been completed by the date of opening of applications in order to be accepted
  - Removal of an ICU term as a pre-requisite
  - Removal of the CV section for Teaching, inclusion of a new CV section for Leadership
  - A reduction in the number of CV points awarded to Anatomy courses
  - Introduction of the need for peer-reviewed journals to have a minimum impact factor in order to be eligible for CV points
  - An adjustment to the number of In-depth Referee Reports collected (5 Surgeons, 3 non-surgeons)
  - All referees to be nominated by AOA
  - Discontinuation of verbal feedback sessions for unsuccessful applicants
  - Provision to all applicants with their decile for each tool completed, their overall decile and the cut off decile (i.e. No scores or ranking provided).

- A further review is planned for September 2013.
- Also see Section 1.3, Recommendation 2

Paediatric Surgery

- Heavier weighting has been placed on the CV score to allow for more sensible numbers of candidates passing through to interview. Approximately half of applicants now are accepted for interview (previously most, if not all applicants reached interview). Approximately a quarter of those interviewed end up being selected.
- As stated previously (see Section 1.3 Recommendation 2), our first year of training is now structured to specifically act as an extension of selection.

Urology

Based on the finding of the 2012 review the following changes will be made to the Urology selection processes:

- The Board will not be able to run selection in 2014 (for trainees to commence in 2015) as there will already be trainees entering the current SET 2 year in 2015. If the Board appointed more into the new program, they would enter at the same SET level and this would result in double the number of trainees than can be accommodated in posts. The transition period is designed to not have a *bloated* year which, if carried through, would result in a double graduation year which creates a further set of problems. The proposed change will graduate similar numbers of urologists without a change of numbers in the exit year.
- The eligibility criteria for the new program is *likely* to be:

- 20 weeks of terms in general surgery (at PGY2 level or above)
- 26 weeks of combined other surgery in general (including, at least 10 weeks in urology),
- One term (at least 10 weeks) of HDU/ICU/ED (at PGY2 level or above)
- In time, the Board will add the Generic Surgical Sciences Examination (Generic SSE) as an eligibility criterion once it is available to all who wish to sit (planned for 2017 intake). For the 2016 intake, it will remain a scored item on the CV.

- There may also be some modifications to the selection tools, including the incorporation of assessment of surgical experience via analysis of logbooks.
- It is anticipated that some candidates may be able to acquire the requisite terms to commence the nSET Program at PGY3 level but most will be PGY 4 or higher.

All other specialties

- No change

Statistical data:

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

7.2 Trainee Participation in Training Organisation Governance

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

Summary of interactions with Trainee Associations

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

Significant issues raised

- See Section 6.1 Recommendation 23, page 25

7.3 Communication with Trainees

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

Challenges and Changes

College - generic

- The College continues to communicate with all members (Trainees, Fellows, IMGs) through the weekly e-journal – Fax Mentis, and the monthly e-news of Council Highlights. The latter is also published on the website
- Fees for all activities are available for public access
- The College is responsible for advising trainees on their training status in relation to:

  - All examinations administered by the College (generic SSE; specialty specific scientific examinations; the Clinical Examination and Fellowship Examination)
  - All courses administered by the College (e.g. ASSET; EMST; CLEAR; CCrISP; TIPS)

- The specialty training boards are responsible for advising trainees of their training status in relation to:
  - In-training assessment (mid-term and end of term)
  - Workplace-based assessment
  - Any course offered by the specialty
  - Eligibility to sit the Fellowship Examination
- The specialty training boards are responsible for providing advice to their trainees of any proposed changes in their training program.

<u>Otolaryngology Head and Neck Surgery</u>

- Trainees are immediately informed of any changes to their curriculum or training via email and posting information on the Society website.
- There is an annual trainee meeting at which issues of concern are discussed.

<u>Orthopaedic Surgery</u>

- Trainees can currently view any personal assessments submitted online. Other information provided on request. Individual live progression data to be available to trainees following the eLearning Platform upgrade.
- A Trainee representative is incorporated as an observer on the AOA Board and as a full voting member of the Federal Training Committee. Ongoing input sought routinely for projects/ activities. There are also regular trainee-specific communications.

<u>Paediatric Surgery</u>

- Trainees receive a feedback letter from the Board after each mid-term and end of term review. Each trainee is annually interviewed by the Board at RATS.
- A trainee representative meets with the Board at each Board meeting

<u>All other specialties</u>

- No change

7.4 Resolution of Training Problems and Disputes

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

Challenges and Changes

- The College policies and process have not changed
- See Section 5.2, Recommendation 17 in relation to underperforming trainees

- The College appointment for the part-time 'In-house Counsel' has increased from .5 to .6 so that she can more often be available to provide advice on any issue relating to underperformance, disputes, complaints and/or appeals.
- The Appeals mechanism policy is available for public access on the College website

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

8.1 Supervisors, Assessors, Trainers and Mentors

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

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

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

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

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

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

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

Challenges and changes

College - generic

- The policies outlining the process for the selection of Supervisors and assessors and requirements and responsibility for surgical Supervisors and Trainers have not changed. These policies are available on the College website for public access.
- The College continues to provide training for Supervisors, Trainers and assessors in the SAT SET and KTOT courses which are free for members of the College.
- See information about the two new courses that have been developed in Section 4, page 17.
- See the information about Trainee evaluation in Section 6.1, Recommendation 23, pp. 25-26.

Cardiothoracic Surgery

- The Cardiothoracic Surgery Training Board invites fellow cardiothoracic surgeons to take part in the Selection interviews.
- Surgical supervisors are regularly updated in training issues and surgical trainers are included in these communications as appropriate (e.g. DOPS, Logbook involvement).
- There is a small but improved uptake in supervisors and trainers taking part in the MALT electronic logbook and DOPS assessments.
- Some trainees still have some difficulty in accessing appropriately approved trainers to complete DOPS and the Board will continue to communicate with units to attempt to increase trainer involvement.

General Surgery

- The Training Board continues to provide support to supervisors through the Supervisors Manual
- See Section 6.1, Recommendation 23 re feedback from trainees in relation to post accreditation.

Neurosurgery

- The Board now holds annual supervisor workshops to discuss issues and to provide training on revised assessment tools.

Otolaryngology Head and Neck Surgery

- Surgical Supervisors are selected by individual training hospitals.
- Supervisors and trainers are supported by the OHNS Training Board. The Board is currently revising its Manual for Supervisors.
- Numerous courses are provided by the College with regards to mentoring and training.
- Each State Regional Training Scheme meets at least six monthly, at which time issues of concern are expressed.
- It is planned to have an annual discussion between supervisors and trainers at the Society Scientific Meeting.

Orthopaedic Surgery

- New role descriptions developed and implemented for Directors of Training and Trainee Supervisors. The Role Descriptions include a process for nomination and appointment as well as responsibilities and requirements for eligibility.
- An inaugural Training and Assessment workshop was held in October 2012. Topics included an educational session on assessment policy and processes and a workshop on Giving Effective Feedback. The session was well attended and evaluations were positive.
- A further workshop is scheduled for October 2013. Topics are scheduled to include information sessions on the Fellowship Exam and Teaching Trainees to Teach, as well as a workshop on Teaching on the Run. The intention is to continue to expand on delivery of workshops of this kind to better support and prepare those members involved in delivery of the training program.
- Handbook materials for Regional Training Committee Chairs and Directors of Training have been developed around specific topics. This work is continuing. A significant amount of work is also being invested in better documentation of training program policies and procedures.
- See Section 6.1, Recommendation 23 re feedback from trainees

Paediatric Surgery

Supervisors are usually nominated by individual departments of surgery. The Board prefers that Supervisors have completed SAT SET (and ideally also KTOT) courses.

The Board has endeavoured to improve communication with supervisors by means of regular newsletters. The Board also encourages supervisors to complete SAT SET and KTOT courses if they had not already done so. Annual meetings between the Board and Supervisors occur (coordinated with ANZAPS annual conferences), and all supervisors, assessors and trainers are welcome to attend the boot camp that is held annually. The Board recognises the difficulty in upskilling Fellows in clinical practice in these areas, and has endeavoured for the past five years to ensure that trainees complete SET training with these skills. The curriculum has been extensively re-written to make it a more useful document for assessors and supervisors. Competencies required at different levels of training are clearly identified.

All other specialties

- No change

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

College - generic

- The College provides a range of free training courses that are available for all Fellows (including Supervisors, Assessors, Trainers, and Mentors). Currently these include: SAT SET; KTOT; and NOTSS and the two new courses CDM and TSIA.

- The College also encourages Fellows and IMGs to attend the 'Process Communication Model' course
- Information about all of these courses is available for public access on the website

- The College has redesigned the Academy of Surgical Educators to focus specifically on the competence of 'Scholar and Teacher' to provide better supports for, and educational development opportunities for, its surgical educators – who include the supervisors and trainers.

Specialty specific

- See pp. 33-34, responses to Recommendation 27

8.2 Clinical and Other Educational Resources

8.2.1. The training organisation has a process and criteria to select and recognise hospitals, sites and posts for training purposes. The accreditation standards of the training organisation are publicly available.
8.2.2. The training organisation specifies the clinical and/or other practical experience, infrastructure and educational support required of an accredited hospital/training position in terms of the outcomes for the training program. It implements clear processes to assess the quality and appropriateness of the experience and support offered to determine if these requirements are met.
8.2.3. The training organisation's accreditation requirements cover: orientation, clinical and/or other experience, appropriate supervision, structured educational programs, educational and infrastructure supports such as access to the internet, library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated time for teaching and training and opportunities for informal teaching and training in the work environment.
8.2.4. The training organisation works with the health services to ensure that the capacity of the health care system is effectively used for service-based training, and that trainees can experience the breadth of the discipline. It uses an appropriate variety of clinical settings, patients and clinical problems for training purposes, while respecting service functions.

Challenges and changes

College - generic

- The College Hospital Accreditation requirements have not changed
- See information in response to Section 1.4, Recommendation 5, page 9.

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

College – generic

- No change

General Surgery

- The General Surgery Training Board Chair reported to the June meeting of BSET that trainee representatives (RACSTA) participating in the recent NSW hospital training post inspections and provided valuable in-put.
- See Section I.4, Recommendation 5

Otolaryngology Head and Neck Surgery

- The Board actively reviews and reaccredits training posts each year. This includes new posts; posts which are part of the quinquennial rotation; or posts that have been given a shorter time-frame at their previous accreditation.
- It is expected that each training post provide appropriate access to outpatient and ambulatory experiences. This is a condition of accreditation of hospitals.
- The accreditation process requires discussion with individual services to ensure that training is appropriate.

Orthopaedic Surgery

- An accreditation review has been conducted in last 12 months with Standards and accompanying forms/ templates re-drafted for clarity and ease of use. New standards make clear expectations around issues such as supervision, accommodation for rural rotations, the impact of fellows and safe working hours.
- 26 quinquennial and mini-inspections were carried out between March and June 2013
- Access to outpatient and ambulatory experiences has been identified as an issue in NSW, and has been incorporated in review activities outlined at Section 1.3.

Paediatric Surgery

- No change. All available training positions are filled, the rate limiting factor for the training numbers continues to be constraints on availability of posts for the surgery in general years.
- The Board of Paediatric Surgery has continued to identify and accredit posts to be used for our trainees in their general surgery years of training. Availability of these posts is the main factor limiting trainee throughput at this point in time. Two new posts were identified and made available for 2014, efforts will continue.
- The Paediatric Surgery Training Board has had most experience in the area of cultivating general surgical posts suitable for Paediatric trainees. Board members have liaised closely with adult Departments of Surgery to identify posts suitable for the trainees, making use of opportunities that are unsuitable for BiGS trainees. The Board appreciates the efforts of BiGS to accommodate the trainees when they do their surgery in general years, but hope to minimize the inconvenience potentially caused to BiGS by developing alternate positions.
- All training posts are re-visited according to the regulations.
- In recent years, some hospitals (e.g. Sydney Children's Hospital at Randwick) have had shortened spans of accreditation applied to allow for close monitoring of problem issues. Other hospitals have had trainees withdrawn from the hospital until satisfactory re-accreditation has occurred.
- The Board is most concerned about hospitals which have accredited posts that are often unfilled as trainees do not nominate to go there. they are working with these hospitals to develop strategies to redress this.
- NSW is the state that provides least exposure to outpatient and ambulatory experiences for trainees. This is less of an issue for paediatric surgery as all paediatric hospitals in the state have busy outpatient departments.
- Sufficient outpatient clinics exist in NSW for paediatric surgery. Limitations have been placed on certain consultants during 2013 (e.g. at Westmead) to restrict access of new patients to their clinics as a way of controlling patient flow into the system.

Urology

- Interactions are undertaken at a local (hospital) level between training supervisors and administration to ensure appropriate training experiences.
- Changes to the accreditation of posts in urology

- The transition to nSET will require consideration of how posts are currently accredited. The current model has 4 stages;
  - SET 1 (1 year)
  - SET 2 (1 year)
  - SET 3→5 (3 years)
  - SET 6 (1 year)
- The nSET program will have 3 stages (banding) of accreditation;
  - nSET 1 (1-2 years)
    - nSET 1 is designed to introduce surgery in general. In some posts, a component of urology will exist.
  - nSET 2→3 (2-3 years)
    - nSET 2&3 (Intermediate stage)
  - nSET 4→5 (2-3 years
    - nSET 4&5 (Advanced stage) may be separate or conjoint depending on the level & type of work available, as well as, supervision a post can offer.
- Hospitals where only 1 post currently exists will need to be designated for Intermediate or Advanced (or both) by the Section TA&E.
- Hospitals where 2 or more posts exist, may find it appropriate to have a mix of Intermediate and Advanced stage positions.

<u>All other specialties</u>

- No change

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

- No change

Summary of Post accreditation activities

See Appendix 8

STANDARD 9: CONTINUING PROFESSIONAL DEVELOPMENT

9.1 Continuing Professional Development Programs

9.1.1. The training provider's professional development programs are based on self-directed learning. The programs assist participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine as well as changing societal expectations.
9.1.2. The training provider determines the formal structure of the CPD program in consultation with stakeholders, taking account of the requirements of relevant authorities such as the Medical Board of Australia and the Medical Council of New Zealand.
9.1.3. The process and criteria for assessing and recognising CPD providers and/or the individual CPD activities are based on educational quality, the use of appropriate educational methods and resources, and take into consideration feedback from participants.
9.1.4. The training provider documents the recognised CPD activities of participants in a systematic and transparent way, and monitors participation.
9.1.5. The training provider has mechanisms to allow doctors who are not its fellows to access relevant continuing professional development and other educational opportunities.
9.1.6. The training provider has processes to counsel fellows who do not participate in ongoing professional development programs.

Summary of significant developments introduced or planned

College - generic

A. Changes to policy or principles relating to continuing professional development

In early 2012, the College undertook an extensive review of its CPD program and emerging trends in professional development both in Australia and overseas. In undertaking this review, the College consulted widely with specialty societies and key stakeholders to develop a robust and relevant program for Fellows in 2013. During this process the College was conscious of developing a program that supported Fellows to participate in activities relevant to their scope of practice, provide a more timely reflection of CPD compliance, simplify participation, enable the College to respond proactively to changes in the professional development sphere and align with reporting mechanisms of relevant authorities (i.e. AHPRA, MCNZ).

The result of the review led to the College moving away from the traditional triennium model to an annual program. This change will simplify CPD participation as all Fellows now have an annual requirement rather than a combination of annual and triennial requirements. The change also requires Fellows to participate consistently in CPD rather than sporadically which was evident for Fellows who had a triennial requirement but no annual requirement. The mandatory requirement to attend a College Annual Scientific Congress has also been removed.

B. Changes to categories of activity recognised for continuing professional development

The number of practice types has been reduced to reflect the type of work undertaken by Fellows and intended to better enable Fellows to move between practice types as they transition into different phases of their career. The practice types for the 2013 program are:

- Operative practice in hospitals or day surgery units
- Operative procedures in rooms only
- Operative practice as a locum only
- Clinical consulting practice only
- Other practice type (research, administration, academic, teaching, assisting etc.)

The categories Fellows participate in has also been reduced to streamline and simplify the program without reducing the breath or type of activities a Fellow can claim for their CPD. The categories for 2013 are:

- Category 1: Surgical Audit

  This requirement remains unchanged from 2012 with all surgeons in operative practice required to participate in a surgical audit each year, and to subject the audit to peer review. The requirement regarding ANZASM participation also remains unchanged. *S*urgeons who have been requested to complete and return a Case Record Form must do so and any surgeon who believes that they were not the treating surgeon must notify their mortality audit.

- Category 2: Clinical Governance – Quality Improvement, Evaluation of Patient Care and Professional Advocacy

  This requirement remains unchanged and all surgeons who work within hospitals or day surgery units (other than locums) should be involved in ensuring the safe provision of pre-operative, operative and post-operative management of patients and the maintenance of surgical standards.

  Category 3: Performance Review
  Performance Review is a new category for 2013 which is in line with broader trends both in Australia and internationally, encouraging surgeons to seek feedback and analysis of their performance. The College believes this is a valuable learning opportunity for all surgeons with the principles of the process articulated in the Surgical Competence and Performance Guide. The College is also in the final stages of developing an online tool to facilitate this process for Fellows.

  The CPD points allocated encourage surgeons to give up some time and participate in peer performance review with colleagues. It is hoped that the online MSF tool will assist this.

- Category 4: Maintenance of Knowledge and Skills

  Maintenance of Knowledge and Skills incorporates categories 4-7 from the previous program and includes workshops, small group learning, teaching, examination, research, publication and other professional development activities.

The College's verification policy was reviewed and the rate of Fellows required to verify their CPD participation was increased from 3.5% to 7%. The increase was based on a review of other CPD programs and an external report which undertook a statistical analysis of the rate in 2010-2012, the number of Fellows participating in the program and principles regarding the determination of an appropriate sample size. In 2013, Fellows will also be required to verify all components of their CPD participation rather than one component as required in 2010-2012.

Finally the College amended its 'Code of Conduct – Potential Breaches' policy to incorporate failure to comply with CPD. While the College is committed to supporting Fellows in maintaining their CPD, persistent failure to comply with CPD requirements will be classified as a breach of the College's Code of Conduct. There is a measured response to breaches of the Code:- however the ultimate penalty for persistent breaches is loss of Fellowship.

C. Changes to processes for endorsement of educational activities/meetings

The College continues to maintain a Continuing Medical Education accreditation system, with the only change for 2013 being an amendment to activities which have over 75% 'hand on' learning being eligible for 3 points per hour (as opposed to 5 points per hour).

In addition to accrediting external providers of professional development activities, the College also develops, delivers and reviews a suite of educational programs addressing the non-technical competencies of the RACS Surgical Competence and Performance Guide. The Professional Development Department coordinates the delivery of around 60 programs per year with between 800 – 900 Fellows, IMGs and Trainees participating. All College delivered programs must still complete and comply with the College's CME accreditation process. Participation in all College programming results in automatic uploading of the accredited points to the participant's CPD record.

D. Changes to evaluation of professional development programs

The professional development programs have been historically evaluated in a paper based format at the start or end of the face to face programming. With the advent of more online and blended programming, the need for more flexible evaluation methods has arisen. Throughout the 2013 period the Professional Development Department is trialling the use of Survey Monkey to distribute online evaluations for its educational programs. This is a process of change management and faculty

engagement and it is envisaged that all evaluations will be disseminated via an online format by the start of 2014.

E. Statistics and annual updates

Statistical data:

Data for CPD participation is published in the Activity Reports (from page 45) which are available for public assess on the RACS website.

Continuing Professional Development - Compliance

As of 16 August 2013:

- **4274** Fellows had a requirement to participate in the RACS CPD Program for 2012.
- Of the **4274** Fellows, **3785 (88.5%)** have participated by returning their CPD data.
- Of the **3785** Fellows who returned**, 3614 (95.5%)** have complied with the requirements of their practice type.
- The overall compliance rate (Fellows with a requirement/ Fellows compliant) is **84.5%.**

Of the Fellows required to participate in the RACS program, **204** were also selected for verification. As of 16 August 2013:

- **171 (84%)** Fellows have returned documents to support their CPD participation.
- Of these **171** Fellows, **156 (90%)** are compliant with **7** required to send further verifying documents and **8** exempted.

In total, **489 (11%)** Fellows have made no return to date. Reminders are sent to Fellows in March and July, with a final reminder to be sent in November.

Professional Development Activities

- Currently the Professional Development Department has delivered **34** activities registering **618** attendees (**452** Fellows, **41** Trainees, **14** IMGs and **111** non-members).
- Another **25** activities are scheduled for the remainder of the year, with **300** registrants thus far.
- In 2012, 47 activities were delivered with 864 participants (694 Fellows, 32 Trainees/IMGs, 138 non-members).
- In 2011, 65 activities were delivered with 809 participants; 570 Fellows, 39 trainees/IMGs and 200 non-members.
- In 2010 – 670 Fellows and 132 non-Fellows (42 trainees/IMGs and 90 non-members)
- In 2009 – 872 Fellows and 321 non-Fellows (74 trainees/IMGs and 247 non-members)
- In 2008 – 740 Fellows and 164 non-Fellows (60 trainees/IMGs and 104 non-members)

Orthopaedic Surgery

- A new CPD Program was implemented for 2013. This program saw the introduction of a personal learning plan. The Hospital Credentialing Section was removed and the Audit section expanded.
- Education activities are endorsed on request. AOA has a proforma available to facilitate this.
- Other CPD programs are evaluated for comparability on a case by case basis.
- Processes for retraining and remediation are available and are managed through the Professional Conduct & Standards Committee.

9.2 Retraining

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

- The College has a process of retraining and reskilling surgeons. However as noted in the 2011 report the two terms are not synonymous.
    - Retraining applies to surgeons who previously possessed the skills in the areas where there are now deficiencies. These deficiencies may be technical or non-technical skills.
    - Reskilling requires the attainment of skills not previously possessed which may pertain to a new procedure or an alteration in devices used. This is particularly relevant to surgeons returning to practice after an absence, or those who have not kept up with surgical developments. This pertains mainly to technical skills and less commonly to non-technical areas.
- These areas are managed through the Offices of the Executive Directors for Surgical Affairs. There has been no change since the policy was reviewed in 2012

9.3 Remediation

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

Challenges and Changes

- RACS regards remediation as one of the collegial obligations to our Fellows/Trainees/IMGs on a pathway to Fellowship.
- An on-line version of the RACS 360^0 (MSF) assessment tool for measuring Surgical Competence and Performance is being developed. The Surgical Competence and Performance Guide can be accessed via the College website.

APPENDICES:

Appendix 1	List of Acronyms
Appendix 2	Educational Expertise and Exchange
Appendix 3	The structure of the Urology nSET program
Appendix 4	General Surgery revised assessment processes
Appendix 5	Surgical Leaders Forum 2012
Appendix 6	Interaction with the Health Sector
Appendix 7	Data from the Fellowship Examination May 2013
Appendix 8	List of hospital posts accredited in 2012

Appendix 1 List of Acronyms

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

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

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

Surgical Specialties

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

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

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

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

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

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

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

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

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

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

- Introduction of competency-based assessment in the Fellowship Examination has already begun as the content is being aligned to the curricula. This will be a work in progress over several years and will be informed by experience as well as workplace-based assessment. Despite the publications available on the methodology to undertake this type of assessment, there is as yet no literature on its actual use in major examinations such as the Fellowship. For this reason it is not possible to give a specific timeline but reports to the AMC will cover the progress.

- Selection is being reviewed each year with clear recommendations made before the next round is undertaken.

- Curricula have been converted to a competency-based format and these will be continuously reviewed in the light of experience by each specialty and the published international literature.

- The increased use of simulation for training of technical skills is being carefully monitored

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

September 2013

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

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

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

Appendix 3 The structure of the Urology nSET program

It is planned that this program will commence with the 2016 intake of Trainees.

Basic Urology Training (1 year) –"nSET1"
The first stage is focused on core surgery in general skills. This is usually completed in 1 training year (maximum 2 training years#).
Acquire basic surgical & clinical skills which include:

- Appraising & managing ward/emergency surgical patients
- Acquiring basic surgical skill –
    - basic open surgery - suturing, anatomical layers, acquiring basic operative techniques
    - basic laparoscopic surgery - placement of ports, camera assisting, basic dissection
    - basic general endoscopy - orientation, coordination & dexterity skills
- Understand team work, group management, collaboration and delegation concepts
- Demonstrate broad based general medical knowledge and application (including judgment)
- Demonstrate professional, ethical & responsible behaviour
- Awareness of basic leadership roles
- Awareness of health care issues including preventive measures as they apply to everyday care
- Awareness of the importance of continuing professional development, clinical governance and audit
- Demonstrate communication ability including respect of others, professionalism and confidentiality
- Demonstrate an ability to learn from peers and seniors but also to teach juniors in the team

Urology **Intermediate** Training (2 years) – "nSET2-3"
The second stage is where the trainee involvement should be increasing in complexity. The trainee should be assuming more responsibly and building on the foundational experience, knowledge, skills and attributes towards the required level of competence. This is usually completed in a minimum of 2 training years (maximum of 3 training years allowed#) including successfully completing the *Specialty Specific Examination.
Pursue increasingly advanced skills including mastering the Basic requirements (above), including general pre & post-surgical care, as well as, care of the critically ill patient.
In addition;

- demonstrate acquisition of basic to advanced endourological skill
    - completion of this level will include performance of common procedures;
        - All cystoscopic procedures (biopsy, fulguration, TURBT, RGPG, stents)
        - All ureteroscopy (including flexible URS/laser where available)
        - Endoscopic prostatectomy
        - Advanced (endoscopic) stone surgery
        - Establishing laparoscopic skills
        - Acquiring major open urology skills
        - Performing all minor open skills (e.g. peno-scrotal surgery, inguinal)
        - Acquiring other skills – e.g. urodynamics, TRUS prostate biopsy, continence procedures, implant surgery, etc.

Advanced Urology Training (2 years) – "nSET4-5"
The third stage is where the trainee should increasingly be functioning towards full emergency competence, operating as primary surgeon in core urological procedures and acquiring the foundation for subspecialist practice. This is usually completed within 2 training years (maximum of 3 training years#) including successfully completing the final *Fellowship examination.
This stage includes mastery of Intermediate level, progressing to a leadership role and completion of core urological skill acquisition
At the completion of this stage, trainees will be established in their ability to understand and undertake elective and emergency urological care. Trainees will use their time to finalise their urological skill base and be performing all aspects of all common urological surgery safely and competently. Trainees will demonstrate all aspects of advanced independent, safe, competent urological performance. They may, be acquiring sub-specialised advanced skills. They should also be engaged in teaching juniors.

#the program will have the flexibility to allow for (non-punitive) extension of a stage. Punitive extension may also apply.
**specific examination regulations apply separately.*

Appendix 4 General Surgery revised assessment processes (SEAM)

Trainees must complete the following eight modules during the first two (2) clinical years of SET in General Surgery:

a. Acute Abdomen

b. Operating Theatre

c. Haematology

d. Anatomy

e. Critical Care and Trauma

f. Nutrition

g. Peri-operative Care

h. Rehabilitation and Palliative Care

- Delivery of the modules and the assessment will be on-line
- There is no specific order in which Trainees must complete the modules. Each module stands alone in terms of content and assessment.
- Trainees are recommended to undertake a minimum of two (2) modules per six month term.
- The Formal Assessment component of each module will consist of 20 questions. Each module may also require Trainees to complete other requirements such as Mini-CEX and DOPS (this will be determined upon development of each module).
- There will be a time limit of 30 minutes in which the Trainee must complete the Formal Assessment component of the module
- Trainees will have a maximum of four attempts per module.
- Trainees must pass 80% of the Formal Assessment questions in order to satisfactorily complete the module, in conjunction with any other requirements such as Mini-CEX and DOPS (subject to results from the pilot study).
- Trainees who do not satisfactorily complete all eight (8) modules by the end of their second clinical year will be recommended for dismissal from the Training Program to the Board of Surgical Education and Training. *Note: The Board may wish to consider altering this time-frame to mid-term to allow regions to*

Appendix 5 Surgical Leaders Forum X2 (2012)

SURGICAL LEADERS FORUM
8.30AM – 12.30PM, THURSDAY 23 FEBRUARY 2012
RACS TRAINING AREA, LEVEL 2

8.30 – 8.35 5 mins	Chair: *Mr Ian Civil RACS President* Welcome
8.35 – 8.55 20 mins	Continuing Professional Development - International developments and considerations for Australia and New Zealand Mr Michael Gorton AM, Member, Australian Health Practitioners Regulation Agency Management Committee Mr Martin Fletcher, CEO Australian Health Practitioners Regulation Agency
8.55 - 9.15 20 mins	Continuing professional development or re-validation? What is the future? Dr Stephen Bradshaw FRACS, Medical Board of Australia
9.15 – 9.35 20 mins	Continuing Professional Development - How should our leading clinicians encourage this? Dr Russell Stitz AM, Chair National Lead Clinicians Group
9.35 – 9.55 20 mins	Recent changes in CPD programs: Towards self-regulation using regular peer practice review - the New Zealand Orthopaedic Association experience Mr Rod Maxwell, NZ Orthopaedic surgeon
9.55 – 10.15am 20 mins	Recent changes in CPD programs: Inclusion of formal 'reflection' – Australian and New Zealand College of Anaesthetists initiative Dr Rod Mitchell, Chair ANZCA CPD Committee
10.15 – 10.45am 30 mins	Morning tea
10.45 – 10.55 10 mins	Continuing Professional Development – How will RACS stay at the forefront of standards for surgeons? • On line developments • How to handle the non-compliant? • Performance assessment tool • Matching CPD to clinical practice Mr Graeme Campbell, Chair RACS Professional Standards
10.55 – 12.30 95 mins	Panel Discussion moderated by Prof Michael Grigg, Chair RACS Professional Development and Standards Board
12.30 – 1.30pm 60 mins	Informal lunch

SURGICAL LEADERS FORUM
8.30AM – 12.30PM, THURSDAY 25 OCTOBER 2012
RACS TRAINING AREA, LEVEL 2
MELBOURNE

8.30 – 8.40 10 mins	**Introduction** Chair: A*/Prof Mike Hollands, RACS President*
8.40 – 9.00 20 mins	**The Razor of Harsh Economics** Dr Jeremy Sammut, Research Scholar, Centre for Independent Studies
9.00 - 9.40 20 mins 20 mins	**The Health Minister's view of a health budget squeeze? What do I do?** Hon Jim McGinty, Chair Health Workforce Australia (HWA) and former Western Australian Health Minister. Hon Rob Knowles AO, former Victorian Health Minister
9.40 – 10.20 20 mins 20 mins	**My hospital/health service has just had a 10% budget cut (again). The CEO's view.** Mr Alan Kincade, Group Chief Executive of Epworth HealthCare Mr Mark Cormack, CEO of HWA, former CEO of ACT Health.
10.20 – 10.45 25 mins	Morning tea
10.45 – 11.30 15 mins 15 mins 15 mins	**Surgical Services. The usual place they slash. What can the Surgical Services Director do?** Professor Michael Grigg, Director Surgical Services, Eastern Health A/Prof Patrick Cregan, Chair of the Board of the Nepean Blue Mountains Local Health District Professor Spencer Beasley, Department of Paediatric Surgery, Christchurch Hospital.
11.30 – 11.55 25 mins	***Panel discussion* of the speakers** **Facilitated and summarised by Professor Watters, Chair RACS Professional Development and Standards Board**
11.55 – 12.20 25 mins	**Update from Health Workforce Australia** Hon James McGinty, Mr Mark Cormack Workforce projections for specialist medical workforce How will we handle the real crisis - lack of nurses
12.20 – 12.30 10 mins	**Review of clinical registries to support high risk implantable medical devices** Dr Heather Wellington, consultant with Australian Commission on Safety and Quality in Healthcare
12.30 – 1.30pm 60 mins	Informal lunch

Appendix 6 Examples of Interactions with the Health Sector

NSW REGIONAL OFFICE

2013 College Representatives on External Organisations

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

VICTORIA REGIONAL OFFICE

2013 College Representatives on External Organisations

Organisation	Representative
AMA (Victoria Council)	A Cochrane
Scientific Advisory Committee of the Cancer Council	Nicole Yap
ANTI-CANCER COUNCIL OF VICTORIA (Rep. On Council)	R Thomas
ANZCA VICTORIAN REGIONAL COMMITTEE	Craig Noonan
Bariatric Surgical Working Group	
Clinical Incident Review Panel (replacing Clinical Risk Management and Sentinel Events Committees)	Sean Mackay
Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM)	M Dobson
Credentialing and Scope of Practice Policy Implementation (CSPPI)	B Waxman
DHS EMEAC working group,	Graeme Campbell
DHS - State Trauma Committee,	Martin Richardson
DONOR TISSUE BANK OF VICTORIA	H Cleland A Saunder
GP Procedural Training Program	
Hand Hygiene Committee	
Health Services Group (HSG)	Mr Anthony Buzzard
MACSS Endoscopy Review Board,	Ian Faragher
Ministerial Advisory Committee on Surgical Services (MACSS)	Mr Jason Chuen
PMCV Accreditation Sub-committee	Wanda Stelmach
Psychosurgery Review Board	Mr Peter McNeill , Prof Jeff Rosenfeld (principal Representative)
Chair of the RACS Victorian Trauma Committee (NOT State Trauma Committee)	Francis Miller
TRANSPORT ACCIDENT COMMISSION	F McDermott
VICNISS Hospital Acquired Infection Surveillance Program - Advisory Committee	David Love
Victorian Advisory Committee on Infection Control (VACIC)	
VICTORIAN DOCTORS HEALTH PROGRAM	Mr Michael Dobson
Victorian Surgical Consultative Council (VSCC)	Mr Stephen Clifforth, Professor John Royle, Mr John Owen, Associate Professor Ian McInnes,
Bariatric Surgery Register steering committee	Meron Pitcher
RACS Rural Surgery Section executive committee	Francis Miller

Appendix 7 Data from the Fellowship Examination May 2013

Candidates who passed the Exam by Location

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
Total Sitting	1	57	0	33	18	0	51	16	31	207
Pass	1	27		18	12		36	13	23	130
Pass Rate	100%	47.4%		54.5%	66.7%		70.6%	81.2%	74.2%	62.8%

Candidates who passed the May 2013 Exam by Specialty and Location

		ACT	NSW	QLD	SA	VIC	WA	NZ	Total	Pass Rate
CAR	Sat	0	1	0	1	2	0	0	4	
	Pass	0	0	0	0	2	0	0	2	50%
GEN	Sat	0	21	11	8	15	5	11	71	
	Pass	0	11	6	5	10	2	7	41	57.5%
NEU	Sat	0	3	4	0	2	1	0	10	
	Pass	0	1	1	0	1	1	0	4	40%
ORT	Sat	1	16	7	3	11	6	11	55	
	Pass	1	8	6	3	8	6	9	41	74.5%
OTO	Sat	0	8	3	4	3	1	2	21	
	Pass	0	1	1	2	1	1	2	8	38.1%
PAE	Sat	0	2	0	0	2	0	0	4	
	Pass	0	2	0	0	0	0	0	2	50%
PLA	Sat	0	2	4	0	4	1	5	16	
	Pass	0	1	3	0	4	1	4	13	81.2%
URO	Sat	0	2	2	1	3	2	0	10	
	Pass	0	2	0	1	3	2	0	8	80%
VAS	Sat	0	2	2	1	9	0	2	16	
	Pass	0	1	1	1	7	0	1	11	68.7%
Total		1	57	33	18	51	16	31	207	

Appendix 8 List of hospital posts accredited / reaccredited in 2012

Hospital Name	Specialty	Region	Country
Townsville Health Service District	CAR	QLD	AUSTRALIA
St Vincent's Hospital Melbourne	CAR	VIC	AUSTRALIA
Monash Medical Centre	CAR	VIC	AUSTRALIA
Epworth Hospital - Richmond	CAR	VIC	AUSTRALIA
Royal Children's Hospital (VIC)	CAR	VIC	AUSTRALIA
Geelong Hospital (Barwon Health)	CAR	VIC	AUSTRALIA
Royal Melbourne Hospital	CAR	VIC	AUSTRALIA
Royal Hobart Hospital	CAR	TAS	AUSTRALIA
Dunedin Hospital	CAR	NZ	NEW ZEALAND
Auckland City Hospital	CAR	NZ	NEW ZEALAND
Ballarat Base Hospital Campus	GEN	VIC	AUSTRALIA
Broome District Hospital	GEN	WA	AUSTRALIA
Bundaberg Base Hospital	GEN	QLD	AUSTRALIA
Cairns Base Hospital	GEN	QLD	AUSTRALIA
Flinders Medical Centre	GEN	SA	AUSTRALIA
Joondalup Health Campus	GEN	WA	AUSTRALIA
Liverpool Hospital	GEN	NSW	AUSTRALIA
Lyell McEwin Hospital	GEN	SA	AUSTRALIA
Mackay Health Service District	GEN	QLD	AUSTRALIA
Mildura Base Hospital	GEN	VIC	AUSTRALIA
Mersey Community Hospital - Northwest Regional	GEN	TAS	AUSTRALIA
Norwest Private Hospital	GEN	NSW	AUSTRALIA
Port Lincoln Health Services Inc	GEN	SA	AUSTRALIA
Port Macquarie Base Hospital	GEN	NSW	AUSTRALIA
Repatriation General Hospital Daw Park	GEN	SA	AUSTRALIA
Rockingham Kwinana District Hospital	GEN	WA	AUSTRALIA
Royal Adelaide Hospital	GEN	SA	AUSTRALIA
Royal Darwin Hospital	GEN	NT	AUSTRALIA
Royal Melbourne Hospital	GEN	VIC	AUSTRALIA
Sir Charles Gairdner Hospital	GEN	WA	AUSTRALIA
Frimley Park Hospital (SW Thames)	GEN	SA	AUSTRALIA
Tamworth Base Hospital	GEN	NSW	AUSTRALIA
Wagga Wagga Base Hospital	GEN	NSW	AUSTRALIA
Werribee Mercy Hospital	GEN	VIC	AUSTRALIA
Wollongong Hospital	GEN	NSW	AUSTRALIA
Auckland City Hospital	GEN	NZ	NEW ZEALAND
Christchurch Hospital	GEN	NZ	NEW ZEALAND
Dunedin Hospital	GEN	NZ	NEW ZEALAND
Hawkes Bay Hospital	GEN	NZ	NEW ZEALAND
Hutt Hospital	GEN	NZ	NEW ZEALAND
Invercargill Hospital	GEN	NZ	NEW ZEALAND
Middlemore Hospital (NZ)	GEN	NZ	NEW ZEALAND
Nelson Hospital	GEN	NZ	NEW ZEALAND
North Shore Hospital (NZ)	GEN	NZ	NEW ZEALAND
Palmerston North Hospital	GEN	NZ	NEW ZEALAND
Rotorua Hospital	GEN	NZ	NEW ZEALAND
Taranaki Base Hospital (New Plymouth)	GEN	NZ	NEW ZEALAND
Tauranga Hospital	GEN	NZ	NEW ZEALAND
Waikato Hospital	GEN	NZ	NEW ZEALAND
Wellington Hospital	GEN	NZ	NEW ZEALAND

Whanganui District Health Board	GEN	NZ	NEW ZEALAND
Whangarei Hospital	GEN	NZ	NEW ZEALAND
Flinders Medical Centre	NEU	SA	AUSTRALIA
Royal Adelaide Hospital	NEU	SA	AUSTRALIA
Royal North Shore Hospital	NEU	NSW	AUSTRALIA
Royal Prince Alfred Hospital	NEU	NSW	AUSTRALIA
Women's & Children's Hospital	NEU	SA	AUSTRALIA
Auckland City Hospital	NEU	NZ	NEW ZEALAND
Canberra Hospital	OHN	ACT	AUSTRALIA
Geelong Hospital (Barwon Health)	OHN	VIC	AUSTRALIA
Liverpool Hospital	OHN	NSW	AUSTRALIA
Monash Medical Centre	OHN	VIC	AUSTRALIA
Royal Adelaide Hospital	OHN	SA	AUSTRALIA
Royal North Shore Hospital	OHN	WA	AUSTRALIA
Westmead Hospital	OHN	NSW	AUSTRALIA
Dunedin Hospital	OHN	NZ	NEW ZEALAND
North Shore Hospital (NZ) and Watakarei	OHN	NZ	NEW ZEALAND
Starship Childrens Hospital	OHN	NZ	NEW ZEALAND
Wellington Hospital	OHN	NZ	NEW ZEALAND
Albury Wodonga Health	ORT	VIC	AUSTRALIA
Austin Health	ORT	VIC	AUSTRALIA
Ballarat Base Hospital Campus	ORT	VIC	AUSTRALIA
Bendigo Hospital	ORT	VIC	AUSTRALIA
Box Hill Hospital	ORT	VIC	AUSTRALIA
Cairns Base Hospital	ORT	QLD	AUSTRALIA
Dandenong Hospital	ORT	VIC	AUSTRALIA
Epworth Hospital	ORT	VIC	AUSTRALIA
Frankston Hospital	ORT	VIC	AUSTRALIA
Geelong Hospital (Barwon Health)	ORT	VIC	AUSTRALIA
Gold Coast Hospital	ORT	QLD	AUSTRALIA
Goulburn Valley Health Shepparton	ORT	VIC	AUSTRALIA
La Trobe University Medical Centre	ORT	VIC	AUSTRALIA
Launceston General Hospital	ORT	VIC	AUSTRALIA
Maroondah Hospital	ORT	VIC	AUSTRALIA
Mater Misericordiae Hospital (NSW)	ORT	NSW	AUSTRALIA
Mona Vale Hospital	ORT	NSW	AUSTRALIA
Monash Medical Centre	ORT	VIC	AUSTRALIA
Wangaratta Base Hospital - Northeast Health	ORT	VIC	AUSTRALIA
Royal Children's Hospital (QLD)	ORT	VIC	AUSTRALIA
Royal Hobart Hospital	ORT	VIC	AUSTRALIA
Royal Melbourne Hospital	ORT	VIC	AUSTRALIA
Sandringham & District Memorial Hospital	ORT	VIC	AUSTRALIA
St Vincent's Hospital Melbourne	ORT	VIC	AUSTRALIA
St Vincent's Hospital Sydney	ORT	NSW	AUSTRALIA
Alfred Hospital	ORT	VIC	AUSTRALIA
Northern Hospital	ORT	VIC	AUSTRALIA
Tweed Hospital	ORT	NSW	AUSTRALIA
Western Hospital Footscray	ORT	VIC	AUSTRALIA
Auckland City Hospital	ORT	NZ	NEW ZEALAND

Christchurch Hospital	ORT	NZ	NEW ZEALAND
Dunedin Hospital	ORT	NZ	NEW ZEALAND
Hawkes Bay Hospital	ORT	NZ	NEW ZEALAND
Invercargill Hospital	ORT	NZ	NEW ZEALAND
Starship Childrens Hospital	ORT	NZ	NEW ZEALAND
Taranaki Base Hospital (New Plymouth)	ORT	NZ	NEW ZEALAND
Tauranga Hospital	ORT	NZ	NEW ZEALAND
Waikato Hospital	ORT	NZ	NEW ZEALAND
Wellington Hospital	ORT	NZ	NEW ZEALAND
Whangarei Hospital	ORT	NZ	NEW ZEALAND
Canberra Hospital	PAE	NSW	AUSTRALIA
Gold Coast Hospital	PAE	QLD	AUSTRALIA
Mater Children's Hospital	PAE	QLD	AUSTRALIA
Monash Medical Centre	PAE	VIC	AUSTRALIA
Royal Children's Hospital (QLD)	PAE	QLD	AUSTRALIA
Sydney Children's Hospital	PAE	NSW	AUSTRALIA
The Children's Hospital At Westmead	PAE	NSW	AUSTRALIA
Starship Childrens Hospital	PAE	NZ	NEW ZEALAND
Royal North Shore Hospital	PRS	NSW	AUSTRALIA
Royal North Shore Hospital Hand	PRS	NSW	AUSTRALIA
Sydney Hospital Hand	PRS	NSW	AUSTRALIA
Westmead Hospital	PRS	NSW	AUSTRALIA
Westmead Children's Hospital	PRS	NSW	AUSTRALIA
Macquarie Aesthetic & Reconstructive	PRS	NSW	AUSTRALIA
Albury-Wodonga Health	URO	VIC	AUSTRALIA
Bankstown - Lidcombe Hospital	URO	NSW	AUSTRALIA
Bega District Hospital	URO	NSW	AUSTRALIA
Box Hill Hospital	URO	VIC	AUSTRALIA
Bundaberg Base Hospital	URO	QLD	AUSTRALIA
Calvary Public Hospital ACT	URO	ACT	AUSTRALIA
Canberra Hospital	URO	ACT	AUSTRALIA
Concord Repatriation General Hospital	URO	NSW	AUSTRALIA
Frankston Hospital	URO	VIC	AUSTRALIA
Gold Coast Hospital	URO	QLD	AUSTRALIA
Gosford Hospital	URO	NSW	AUSTRALIA
Hornsby Ku-ring-gai Hospital	URO	NSW	AUSTRALIA
Nambour Hospital	URO	NSW	AUSTRALIA
Orange Base Hospital	URO	NSW	AUSTRALIA
Port Macquarie Base Hospital	URO	NSW	AUSTRALIA
Prince of Wales Hospital	URO	NSW	AUSTRALIA
Princess Alexandra Hospital & Health Service District	URO	QLD	AUSTRALIA
Queen Elizabeth II Hospital & Health Service District	URO	QLD	AUSTRALIA
Redcliffe Hospital	URO	QLD	AUSTRALIA
Royal Brisbane and Women's Hospital	URO	QLD	AUSTRALIA
Royal Melbourne Hospital	URO	VIC	AUSTRALIA
St George Hospital	URO	NSW	AUSTRALIA
St Vincent's Hospital Melbourne	URO	VIC	AUSTRALIA
Austin Health	URO	VIC	AUSTRALIA
Northern Hospital	URO	VIC	AUSTRALIA

Western Hospital Footscray	URO	VIC	AUSTRALIA
Westmead Hospital	URO	NSW	AUSTRALIA
Wollongong Hospital	URO	NSW	AUSTRALIA
Auckland City Hospital	URO	NZ	NEW ZEALAND
Christchurch Hospital	URO	NZ	NEW ZEALAND
North Shore Hospital (NZ)	URO	NZ	NEW ZEALAND
North Shore Hospital (NZ)/Middlemore	URO	NZ	NEW ZEALAND
Alfred Hospital	VAS	VIC	AUSTRALIA
Gold Coast Hospital	VAS	QLD	AUSTRALIA
Princess Alexandra Hospital & Health Service District	VAS	QLD	AUSTRALIA
Royal Brisbane and Women's Hospital	VAS	QLD	AUSTRALIA
Royal Hobart Hospital	VAS	TAS	AUSTRALIA
Royal Melbourne Hospital	VAS	VIC	AUSTRALIA
Royal North Shore Hospital	VAS	WA	AUSTRALIA
Sir Charles Gairdner Hospital	VAS	WA	AUSTRALIA
St George Hospital	VAS	NSW	AUSTRALIA
St Vincent's Hospital Melbourne	VAS	VIC	AUSTRALIA
Townsville Health Service District	VAS	QLD	AUSTRALIA
Wollongong Hospital	VAS	NSW	AUSTRALIA
Christchurch Hospital	VAS	NZ	NEW ZEALAND