Training Post Accreditation Regulations

Surgical Education and Training Program in Neurosurgery

Approved 4 December 2023

TRAINING POST ACCREDITATION REGULATIONS

1.1 Definition of terms and acronyms

Acronyms, definitions and terms used in these Training Post Accreditation Regulations (**Regulations**).

Acronym/term:	shall mean/is defined as:
Days	Unless otherwise specified, references to any days are to be read as calendar days, not business days
NSA	Neurosurgical Society of Australasia
Panel	The Panel appointed in accordance with these Regulations to conduct the accreditation or reaccreditation process and decision
Primary Unit	A neurosurgical unit which is accredited by the Training Board as satisfying the Primary Unit requirements in these Regulations
RRR Location	A training post in a rural, regional, or remote location as determined by clause 1.2.5 and 1.2.6.
RACS	Royal Australasian College of Surgeons
Regulations	These Training Post Accreditation Regulations which establish the terms and conditions for the assessment and accreditation of training posts for the SET Program
Secondary Unit	A neurosurgical unit which is accredited by the Training Board as satisfying the Secondary Unit requirements in these Regulations as part of a Training Network
SET	Surgical Education and Training
SET Program	The Surgical Education and Training Program in Neurosurgery
Surgical Supervisor	All accredited training posts have a neurosurgeon approved by the Training Board who satisfies the responsibilities and requirements for supervision and assessment of trainees at the post as part of the SET Program
Surgical Trainer	All accredited training posts have neurosurgeons who are members of a training unit who interact with trainees in the workplace and in other educational activities as part of the SET Program and met the requirements set forth by the Training Board
Trainee	A trainee registered in the SET Program in Neurosurgery
Training Board	The Surgical Education and Training Board of Neurosurgery responsible for the administration and management of the SET Program
Training Site	A stand alone neurosurgical unit applying for accreditation
Training Network	Multiple training units applying collectively for accreditation

1.2 Introduction

1.2.1 Training for the Surgical Education and Training Program in Neurosurgery (**SET Program**) is undertaken in accredited training posts in Australia and Aotearoa New Zealand.

1.2.2 The purpose of these Regulations is to establish the terms and conditions for the assessment and accreditation of training posts for the SET Program.

1.2.3 These Regulations are compliant with the Royal Australasian College of Surgeons (**RACS**) regulation: Training Post Accreditation and Administration.

1.2.4 As part of the Neurosurgical Society of Australasia (NSA), RACS and Board of Neurosurgery (Board) initiatives to support workforce and training initiatives and equitable health outcomes for Australians and New Zealanders living in rural, regional, or remote locations, these Regulations contain provisions for training posts in these locations, known as an **RRR Location**.

1.2.5 For clause 1.2.4, in Australia a rural, regional, or remote location is one classified by the Australian Statistical Geography Standard Remoteness (ASGS-RA) structure as Outer Regional Australia (Code RA 3) or higher.

1.2.6 For clause 1.2.4, in Aotearoa New Zealand a rural, regional, or remote location is one defined by the Geographic Classification for Health as R1, R2 or R3 (rural categories).

1.3 Training Posts and Accreditation Validity Periods

1.3.1 For accreditation as a **Training Site**, which is one neurosurgical unit, the neurosurgical unit must satisfy the **Primary Unit** requirements as outlined in these Regulations.

1.3.2 For accreditation as a **Training Network**, which includes multiple neurosurgical units, there must be one neurosurgical unit nominated as the **Primary Unit** for the Training Network which must satisfy the Primary Unit requirements as outlined in these Regulations. The remaining units will be classified as **Secondary Units** and must satisfy the Secondary Unit requirements as outlined in these Regulations. Secondary Units must be located near the Primary Unit, except for Secondary Units in an RRR Location.

1.3.3 Trainees are only allocated to Primary Units. Where Secondary Units are accredited as part of a Training Network, trainees may spend no more than 25% of their time in the rotation at the Secondary Units combined.

1.3.4 Where a Training Network includes a Secondary Unit in an RRR Location, the time the trainee may spend in the rotation at that Secondary Unit in clause 1.3.3 does not apply and the Board determines the length of time the trainee spends in the rotation in the Secondary Unit.

1.3.5 There are two types of accredited posts for the SET Program:

(a) A General Post which is focused primarily on adult neurosurgery. There is no prescribed maximum duration for trainee placement.
(b) A Paediatric Post which is focused primarily on paediatric neurosurgery. The maximum trainee placement in this post is 6 months per trainee.

1.3.6 Accreditation is normally granted for five years provided that all accreditation criterion and standards are met. Shorter accreditation periods may be granted where one or more criterion or standard has not been satisfied. The accreditation period is determined by the accreditation or reaccreditation panel (**Panel**).

1.4 Applications and Assessments

1.4.1 All applications for accreditation or reaccreditation must be submitted using the prescribed forms only.

1.4.2 Applications should be received no later than 1 March in the year prior to accreditation or re-accreditation being sought to allow for the accreditation process to be completed prior to the final allocation of trainees. Applications received after 1 March may be held over to the following year at the sole discretion of the Training Board.

1.4.3 The Board of Neurosurgery (**Training Board**) Chair may initiate a reassessment for any training post at any time, particularly if an area of sufficient concern is identified which requires further investigation or if there has been a major change in circumstances affecting the training post or the SET Program. The Training Board Chair will communicate in writing the reason for the reassessment to the training post. Any documentation requested of the training post must then be submitted in the prescribed format by the required due date.

1.4.4 The Training Board Chair will appoint a Panel of not less than two neurosurgeons, with at least one Training Board member, to review the application and training post evaluation forms and/or re-accreditation forms as applicable. The Panel will be supported by a secretariat. The Panel may also include a trainee representative.

1.4.5 The Panel will determine whether a virtual, hybrid or physical inspection and/or interviews are required as part of the assessment and/or re-assessment process.

1.4.6 A fee may be charged at the discretion of the NSA to cover direct costs of hybrid and physical inspections and interviews. If the fee is not paid by the due date the accreditation application will be considered to have been withdrawn.

1.4.7 Where required, the applicant must make all arrangements to facilitate the requested physical inspection and/or interviews.

1.4.8 On completion of the initial assessment, the Panel will prepare a draft report. The draft report will be provided to the supervisor for reaccreditation applications or the nominated representative for new applications for comment and input before the report is finalised. The Panel may also request additional information from the applicant at any time to assist in the finalisation of the report.

1.4.9 After consideration of any comments, corrections and additional information from the applicant, the Panel will finalise the accreditation report and has the delegated authority of the Training Board to make the determination regarding the accreditation outcome.

1.4.10 It is the task of the Panel to determine if accreditation is granted. The purpose of the accreditation assessment is to determine whether the criteria have been met. The criteria must be met at the time of the assessment, not some future state which may or may not come to exist. If significant matters for compliance are not in place and are merely promised for the future, then a criterion is not met.

1.4.11 Where the accreditation standards, principles and criteria refer to Trainees, and the unit is not currently accredited and therefore has no Trainees, the arrangements in place for registrars (or equivalent occupying the proposed post) may be used in place of Trainees for assessment purposes.

1.4.12 The final accreditation report and determination will be forwarded to the nominated representative of the applicant who is responsible for distribution within the relevant sites.

1.4.13 When accreditation or reaccreditation is not approved or is withdrawn, the applicant will be notified in writing. The notification will include identification of the criteria and/or standards assessed as not met and communication of the requirements to be met for accreditation in the future.

1.4.14 The Panel will issue the final accreditation outcome to the Training Board for noting at its next scheduled meeting. The Training Board will report the outcome of the accreditation report to the next scheduled meeting of the RACS Committee of Surgical Education and Training.

1.5 Allocation of Trainees to Accredited Training Posts

1.5.1 The Training Board allocates trainees to Primary Units (employers) and makes a recommendation for appointment of trainees to accredited posts.

1.5.2 At all times, Primary Units (employers) retain the right to not employ recommended trainees.

1.5.3 A post may remain vacant if one or more of the following occur:

(a) there are no suitable applicants for appointment to the SET Program;
(b) the post is suitable only for a particular level of trainee and there is no active trainee able to be allocated to the post;
(c) the appointment of a trainee to the post would otherwise result in more trainees than posts in a subsequent year;
(d) the accreditation of a post is being reviewed and the allocation of a trainee may compromise the quality of the training afforded to that trainee;
(e) a post becomes vacant at a time when it is inconvenient to accommodate an appointment; or
(f) the allocated trainee fails to gain employment with the training unit.

1.6 Accreditation Criteria

Standard 1 – Building and maintaining a culture of respect for patients and staff	
1.The hospital culture is of respect and professionalism	All Primary and Secondary Units must: a) provide a safe training environment free of discrimination, bullying and sexual harassment; b) actively promote respect, including teamwork principles'; c) have policies and procedures, including training for all staff, that promotes a culture and environment of respect; and d) have policies, codes and guidelines which must align with RACS Code of Conduct and support professionalism.

2. Partnering to Promote Respect	All Primary and Secondary Units must: a) be committed to sharing with RACS and the Training Board relevant complaint information by or about RACS Fellows and Trainees; b) actively reinforce positive standards leading to improved behaviours and a respectful environment; and c) hold surgical teams to account against these standards.
3. Complaint Management Process	All Primary and Secondary Units must: a) have clearly defined and transparent policies detailing how to make a complaint, options, investigation process and possible outcomes; b) have clearly defined processes to protect complainants; and c) have documented performance review process for all staff, so it is aware of any repeated misdemeanours or serious complaints that need escalation/intervention to maintain a safe training environment. d) have a process in place to share with RACS summary data, including outcomes or resolution of hospital managed complaints alleging discrimination, bullying and sexual harassment.
Standard 2 - Education Facilities and Systems	
4. Computer facilities with IT support	At all Primary and Secondary Units there must be computer facilities and appropriate internet access.
5. Tutorial room available	At all Primary and Secondary Units there must be a tutorial room available for delivery of the educational programs.
6. Access to a private study area	At all Primary and Secondary Units there must be a designated private study area for trainees isolated from busy clinical areas and suitable for personal study.
7. General educational activities within the hospital	RACS requirement covered by criterion 8.

Standard 3 - Quality of education, training and learning	
8. Coordinated schedule of learning experiences	At all Primary Units there must be the following schedule of educational activities delivered, free from conflicting trainee obligations: a) Four hours of structured consultant led tutorials and teaching per month focused solely on neurosurgery topics and excluding multidisciplinary meetings; b) One neuropathology session per month; c) One hour of Journal Club meeting per month; and d) Four hours of neuro-radiological sessions per month. For a Training Network, the educational activities must be attended by all accredited trainees at both the Primary and Secondary Units. For a Unit in an RRR Location , the educational activities can be delivered virtually in conjunction with another accredited Primary Unit without the need to apply as a Training Network.
9. Access to simulated learning environment	Each Primary Unit must provide simple basic skills training equipment.
10. Access to external educational activities for trainees	Each Primary and Secondary Unit must provide trainees with negotiated educational leave to attend: a) Compulsory skills courses; b) Compulsory trainee seminars; c) The NSA Annual Scientific Meeting; and d) Compulsory examinations.
11. Opportunities for research inquiry and scholarly activity	Each Primary Unit must provide trainees with the opportunity to participate in neuroscience research. For a Primary Unit in an RRR Location, the research can be delivered in conjunction with another accredited Primary Unit without the need to apply as a Training Network.
12. Supervised experience in patient resuscitation	RACS requirement covered by criterion 13 and 14.
13. Supervised experience in an Emergency Department	In each Primary Unit trainees must manage patients in the Emergency Department on a weekly basis, acting in a neurosurgical capacity and under FRACS supervision.

14. Supervised experience in Intensive Care Unit (ICU)	In each Primary Unit, trainees must be involved in patient care in the ICU on a weekly basis, acting in a neurosurgical capacity and under FRACS supervision.
Standard 4 – Surgical supervisors and staff	
15. Designated supervisor of surgical training	A Primary Unit with an accredited training post must have a clearly articulated process for nominating a Surgical Supervisor who has the demonstrated capability for the role. The nominated Surgical Supervisor must satisfy the generic requirements, including the mandatory training, in the RACS Surgical Supervisor Policy. The nominated Surgical Supervisor must satisfy the specialty specific requirements in the Neurosurgery Surgical Supervisor Regulations.
16. Supervisor's role / responsibilities	The Surgical Supervisors must accept responsibility for the duties outlined in the RACS policy: Surgical Supervisors, the Neurosurgery Surgical Supervisor Regulations, the Training Program Regulations and these Regulations. The supervisor must sign an undertaking confirming their acceptance.
17. Credentialled specialist surgical staff willing to carry out surgical training	At each Primary and Secondary Unit there must be credentialled neurosurgical staff qualified to carry out surgical training and supervision known as Surgical Trainers. Surgical Trainers are involved in the education and assessment of accredited trainees. At each Primary and Secondary Unit, the Surgical Trainers must satisfy the generic requirements, including mandatory training, in the RACS policy: Surgical Trainers, and the following specialty specific requirements. The consultant must be: a) be a current FRACS in Neurosurgery; b) be a current member of the NSA; c) meet the compliance requirements for RACS Continuing Professional Development; and d) complete the mandatory training as specified in the RACS policy: Surgical Trainers For a Unit in an RRR Location in Australia, , the Surgical Trainers (not the Surgical Supervisor) may be a non-FRACS neurosurgeon provided they have specialist registration to practice as a neurosurgeon in Australia or limited registration in an area of need or public interest category

	and no conditions, undertakings or reprimands associated with their registration. For a Unit in an RRR Location in Aotearoa New Zealand, the Surgical Trainers (not the Surgical Supervisor) may be a non-FRACS neurosurgeon provided they have vocational or provisional vocational registration in neurosurgery and no conditions associated with their registration. For accreditation it is mandatory that the Primary Unit satisfy the following Surgical Trainer requirements: a) for one post there must be a minimum of three Surgical Trainers (including the Surgical Supervisor), with a combined minimum total of 4 half day elective operating lists per week at the Primary Unit; b) for two posts there must be a minimum of four Surgical Trainers (including the Surgical Supervisor), with a combined minimum total of 8 half day elective operating lists per week at the Primary Unit; and c) for three posts there must be a minimum of five Surgical Trainers (including the Surgical Supervisor), spending a combined minimum total of 10 half day elective operating lists per week at the Primary Unit. For each Secondary Unit, there must be a minimum of two surgical trainers with a combined minimum of 3 half day elective operating lists per week.
18. Surgeons committed to the Training Program	RACS requirement covered by criterion 15, 16 and 17.
19. Regular supervision, workplace-based assessment and feedback to trainees	Each Primary and Secondary Unit must provide trainees with access to supervision at all times from the neurosurgical Surgical Supervisor or Surgical Trainers. Supervision must be provided during work hours, on on-call and after hours. Supervision must be onsite or, where necessary and appropriate, there is a process for remote supervision. Where remote supervision is provided, the neurosurgical Surgical Supervisor, Surgical Trainer or neurosurgical consultant delegate must always be accessible by telephone or video-link and must be able to be onsite within 30 minutes. The Surgical Supervisor and Surgical Trainers should provide day to day observation, communication and interaction with the trainee including providing advice guidance and support. This should include but not be limited to:

	a) discussing and agreeing on goals between surgeon and trainee at the commencement of each surgical rotation; b) providing one-to-one clinical supervision; c) providing frequent informal feedback; d) providing structured constructive feedback and recorded assessment of performance in accordance with the Training Program Regulations; e) providing opportunities for the trainee to respond to feedback. f) participate in ward rounds.
20. Hospital recognition and support for surgeons involved in education and training	Each Primary Unit must provide: a) the Surgical Supervisor with paid, protected administrative time to undertake the relevant duties; b) the Surgical Supervisor and Surgical Trainers who attend mandated courses and meetings as outlined in these Regulations with negotiated leave for these; and c) accessible and adequate secretarial services and IT services for the Surgical Supervisor's role.
21. Hospital response to feedback	RACS requirement covered by criterion 1, 2 and 3.
Standard 5 - Support services for trainees	
22. Hospital support for trainees	Each Primary and Secondary Unit must: a) have rosters and work schedules in Australia that take into account the principles outlined in the AMA National Code of Practice, Hours of Work, Shift Work, and Rostering for Hospital Doctors and in Aotearoa New Zealand the principles outlined in the Multi-Employer Collective Agreement (MECA); and b) ensure trainees are on-call no more than 1:3; and c) ensure trainees work less than 70 hours per week, including meal breaks, overtime and recall duty and excluding time on-call when they are not required; and d) promote trainee safety and provide security when necessary; and e) have readily accessible Human Resources service available to trainees including counselling if required.
23. Trainees' remuneration and professional responsibilities – Duty of Care	Each Primary and Secondary Unit must ensure remuneration of the trainee: a) does not depend primarily on private practice assisting; b) is salaried; and

	c) is appropriate payment for work performed (including overtime) in accordance with or at least equivalent to the public sector awards.
24. Flexible training options	Each Primary Unit must have a commitment to working with the Training Board to facilitate flexible employment for trainees where feasible and approved by the Board.
Standard 6 - Clinical load and theatre sessions	
25. Supervised consultative clinics	Trainees must attend a minimum of one consultative clinic per week, up to a maximum of four. In these clinics, trainees must see new and follow-up patients. All clinics attended by trainees must be under the onsite supervision of the neurosurgical Surgical Supervisor or Surgical Trainers.
26. Beds available	Primary and Secondary Units must have a defined neurosurgical unit of sufficient beds to enable adequate turnover. As a guide for Primary Units, fifteen neurosurgical beds would be sufficient.
27. Consultant led ward rounds with educational as well as clinical goals	Trainees must participate in a minimum of one ward round or patient care meeting a week including the attendance of the neurosurgical Surgical Supervisor or Surgical Trainers and all trainees discussing all ward patients. The trainee must participate in at least two other ward rounds with a Surgical Supervisor or Surgical Trainer each week. This should include facilitation of learning for trainees, especially for feedback purposes. This does not include postoperative ward rounds.
28. Caseload and casemix	The number of major neurosurgical procedures, as identified in the training post accreditation logbook, required to be performed annually in the units are as follows noting <u>these are absolute and the minimum criteria for application for accreditation of a new training post</u>. <u>General Posts</u> • for one training post there must be 400 major cases of which a minimum of 300 must be in the Primary Unit; • for two training posts there must be 600 major cases of which a minimum of 450 must be in the Primary Unit; and • for three training posts there must be 900 major cases of which a minimum of 675 must be in the Primary Unit. For training posts in a Primary Unit in an RRR Location, the minimum major cases requirement is reduced by 100 cases.

	<u>Paediatric Posts</u> • for one training post there must be 200 major paediatric neurosurgical cases.
29. Operative experience for trainees	Trainees must have significant hands-on involvement in surgical cases, increasing based on their skill level to primary surgeon. As a minimum during the rotation, the trainee must have the opportunity for primary surgeon experience in: • all Type 1 DOPS procedures identified in the Training Program Regulations; and • at least eight of the Type 2 DOPS procedures identified in the Training Program Regulations. The trainee must also participate in a minimum of 100 major neurosurgical cases per six months in General Posts and 75 major cases in Paediatric Posts. Trainees must participate in a minimum of 12 half day elective operating lists per month.
30. Experience in perioperative care	As a minimum in Primary and Secondary Units the trainees must have a major involvement in perioperative management of all patients where they participate in the surgery. There must be: a) adequate facilities available to enable appropriate clinical examination of all preoperative patients; and b) daily postoperative ward rounds
31. Involvement in acute/emergency care of surgical patients	In all Primary Units, trainees must have regular weekly involvement in acute/emergency care of surgical patients. As a guide a minimum 1:5 involvement in acute/emergency care of surgical patients would be appropriate.
Standard 7 – Equipment and clinical support services	
32. Facilities and equipment available to carry out diagnostic and therapeutic surgical procedures	There must be evidence of accreditation of all sites with Primary and Secondary Units by ACHS or NZCHS to undertake surgical care.

33. Imaging – suitable diagnostic and intervention services	The following services must be available in all Primary Units: a) CT with 24 hour access, 7 days per week b) Digital subtraction angiography with 24 hour access c) MRI access with 24 hour access, 7 days per week
34. Diagnostic laboratory services	The following services must be available in all Primary Units: a) General pathology with 24 hour access b) Neuropathology access
35. Theatre Equipment	The following equipment must be available in all Primary and Secondary Units: a) Stereotactic equipment b) Modern operating microscopes c) Operative Ultrasonic Aspirator
36. Support/ancillary services	The following services must be available in all Primary Units: a) Rehabilitation access b) Neuropsychology and neuropsychiatry access c) Dedicated secretarial support and office space d) Radiology e) Medical neurology
Standard 8 - Clinical Governance, Quality and Safety	
37. Hospital accreditation status	There must be evidence of accreditation of all sites with Primary and Secondary Units by ACHS or NZCHS to undertake surgical care.
38. Risk management processes with patient safety and quality committee reporting to Quality Assurance Board	In all Primary and Secondary Units, there must be: a) a quality assurance board or equivalent (with senior external member) reporting to the appropriate governance body; and b) documentation published by the hospital on HR, clinical risk management and other safety policies.
39. Head of surgical department and governance role	In all Primary and Secondary Units there must be a designated head of the neurosurgical department with a defined role in governance and leadership. In all Primary and Secondary Units there must be minimum six-monthly department meeting.

40. Hospital credentialing or privileging committee	In all Primary and Secondary Units, clinicians must be credentialed at least every 5 years.
41. Morbidity and mortality and audit activities constituting peer review	In all Primary and Secondary Units there must be regular (at least quarterly) review meetings of morbidity/mortality averaging one hour per month related to recent unit activities. This does not include weekly patient care/surgical unit meetings. The morbidity/mortality must be attended by all Surgical Supervisors, Surgical Trainers and trainees participating. In RRR Locations, these meetings can be delivered virtually in conjunction with another accredited Primary Unit without the need to apply as a Training Network.
42. Higher-level Hospital systems reviews	Surgeons and trainees should participate in reviews of systems as appropriate. This can include targeted projects and/or root cause analysis.
43. Experience available to trainees in root cause analysis	Training and participation should occur in root cause analysis.
44. Occupational safety	All Primary and Secondary units must have documented measures available to ensure safety against hazards such as toxins, exposure to infectious agents transmitted through blood and fluid, radiation and potential exposure to violence from patients and families.