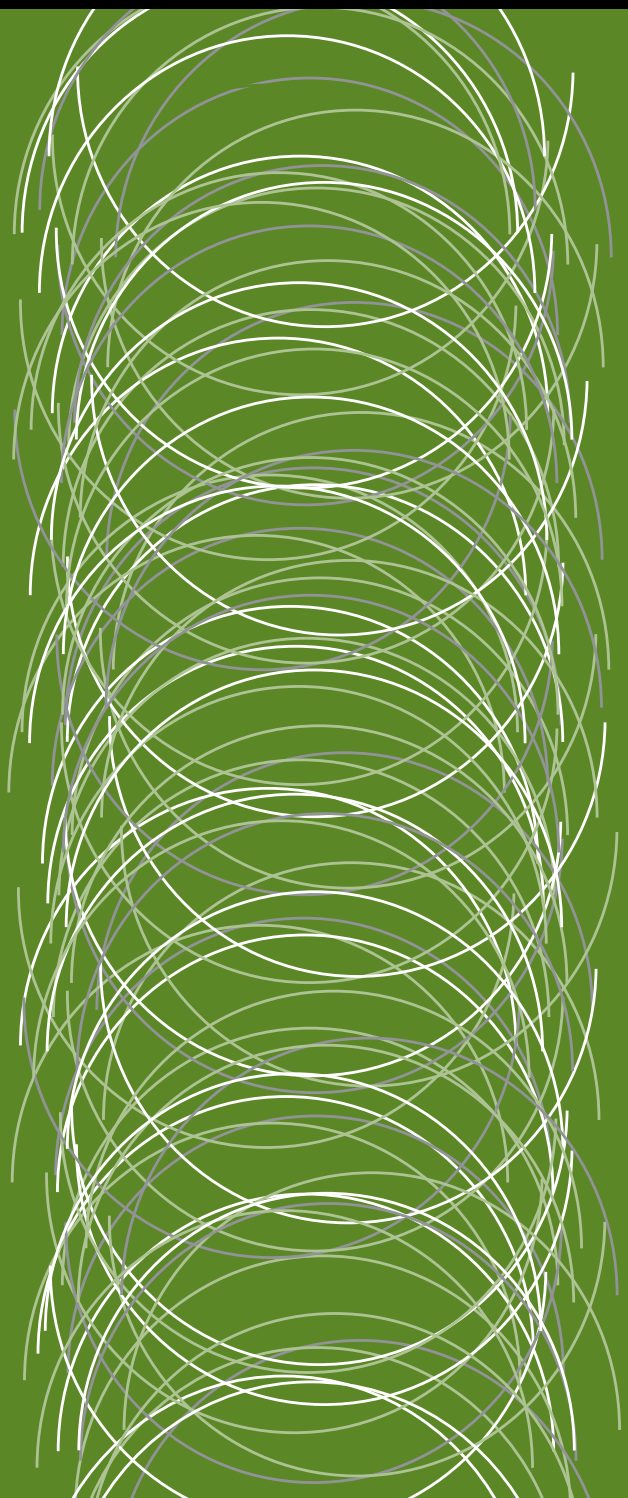
Australian Medical Council Limited

Accreditation Report: The Education and Training Programs of the College of Intensive Care Medicine of Australia and New Zealand

AMC



Specialist Education Accreditation Committee
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Executive Summary: College of Intensive Care Medicine of Australia and New Zealand

The Australian Medical Council (AMC) document, *Procedures for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council 2013,* describes AMC requirements for accrediting specialist medical programs and their education providers.

The AMC first assessed the Joint Faculty of Intensive Care Medicine's training program in 2002 during the AMC accreditation assessment of the Australian and New Zealand College of Anaesthetists (ANZCA). The 2002 assessment resulted in accreditation of ANZCA, the Faculty of Pain Medicine and the Joint Faculty of Intensive Care Medicine for six years, with a requirement for annual progress reports to the AMC. Based on a comprehensive report submitted in 2007, accreditation was extended to December 2012.

In 2008, the Joint Faculty of Intensive Care Medicine advised the AMC it planned to separate from ANZCA and reconstitute itself as a college. In 2009, having considered the College's plans, the AMC granted initial accreditation to the College of Intensive Care Medicine of Australia and New Zealand as the training organisation for the recognised medical specialty of intensive care medicine and accreditation of training leading to fellowship of the College from 1 January 2010. Initial accreditation continues, subject to submission of satisfactory annual progress reports, until an AMC assessment team completes a full accreditation assessment.

The AMC conducted a full assessment of the College's programs in 2011. On the basis of this assessment the AMC granted ongoing accreditation to December 2015, subject to satisfactory progress reports. In 2011, the AMC found that the College substantially met the accreditation standards. It placed 23 conditions on the accreditation of the College and its programs. Six conditions were to be addressed by the 2012 progress report, seven to be addressed by the 2013 progress report, and nine to be addressed by the 2014 progress report.

In July 2015, an AMC team completed the follow-up assessment of the College's programs, considering the progress against the recommendations from the 2011 AMC assessment. Under the AMC accreditation procedures, the 2015 review may result in the extension of the accreditation to six years from the original accreditation decision, that is until March 2018.

The team reported to the 28 October 2015 meeting of the Specialist Education Accreditation Committee. The Committee considered the draft report and made recommendations on accreditation to AMC Directors within the options described in the AMC accreditation procedures.

This report presents the Committee's recommendations, presented to the 19 November 2015 meeting of AMC Directors, and the detailed findings against the accreditation standards.

Decision on accreditation

Under the *Health Practitioner Regulation National Law*, the AMC may grant accreditation if it is reasonably satisfied that a program of study and the education provider meet an approved accreditation standard. It may also grant accreditation if it is reasonably satisfied that the provider and the program of study substantially meet an approved accreditation standard, and the imposition of conditions will ensure the program meets the standard within a reasonable time. Having made a decision, the AMC reports its accreditation decision to the Medical Board of Australia to enable the Board to make a decision on the approval of the program of study for registration purposes.

The AMC's finding is that the education, training and continuing professional development programs meet the accreditation standards. The College is commended for the significant work it has undertaken to enhance its educational and training activities since the 2011 assessment. The College has completed a major review and redevelopment of its intensive care medicine curriculum and developed a number of resources to support learning and assessment. The new training program was implemented in January 2014. The College is in the process of finalising the paediatric intensive care medicine curriculum.

Since 2011, the College has also undertaken a review of the role of the intensive care medicine specialist. The College has established a Community Advisory Group as a mechanism for engaging consumers and community stakeholders and the AMC commended the input of this group in the review of the definition of the intensive care medicine specialist.

The College has developed a new selection into training policy which applies to all trainees registering with the College from January 2014. The AMC recommends that the College continue to review the processes for selection into training to ensure that they are rigorous, transparent and fair.

The AMC congratulates the College on its extensive program of evaluation. Since 2011, the College has introduced surveys for trainees, new fellows and supervisors and is accessing the Australian and New Zealand Intensive Care Society's Centre for Outcome and Resource Evaluation data to gather information on the quality and quantity of teaching and learning at training sites. Further work is to be completed on developing processes for the management and use of this data.

The Committee recommends:

(i) That the College of Intensive Care Medicine of Australia and New Zealand's training programs in intensive care medicine and paediatric intensive care medicine be granted ongoing accreditation to 31 March 2019, subject to satisfactory progress reports to the Specialist Education Accreditation Committee.

(ii) That this accreditation is subject to the conditions set out below:

(a) By the 2016 progress report, evidence:

That the College has addressed the following conditions from the accreditation report:

3 Finalise and implement the document, Competencies, Learning Opportunities, Teaching and Assessments for Training in Paediatric Intensive Care. (Standard 3.1 and 3.2)

4 Develop and publish specific learning objectives for the three-month rural term. (Standard 3.2)

5 Develop clear criteria for workplace-based assessments to ensure trainees understand what constitutes successful completion of each of these assessments. (Standard 5.1)

7 Implement methods for analysing and using trainee feedback in program monitoring and for responding to issues raised by trainees. (Standard 6.1.3)

14 Develop and implement processes to comply with specific New Zealand requirements regarding monitoring of continuing professional development and reporting of non-compliance to the Medical Council of New Zealand. (Standard 9.1)

(b) By the 2017 progress report, evidence:

That the College has addressed the following conditions from the accreditation report:

6 Finalise the blueprinting of all assessments to align with the new curriculum. (Standard 5.3)

10 Document and publish the weighting for the various elements of the selection process, in particular the marking criteria, including that applied to the structured references used by the Trainee Selection Panel to deem suitability for training. (Standard 7.1.3)

11 Implement a strategic approach to the development of a program to support and train supervisors of training. (Standard 8.1.2)

12 Implement formal and systematic processes to provide feedback to all supervisors of training on their performance in the role. (Standard 8.1.3)

13 Finalise, incorporate and publish the accreditation standards which are relevant to intensive care medicine training outcomes, for the medicine and anaesthesia terms in the relevant College accreditation documentation. (Standard 8.2.1)

(c) By the 2018 comprehensive report, evidence:

That the College has addressed the following conditions from the accreditation report:

1 Demonstrate that there are processes in place to ensure ongoing medical educational expertise is available for the development and implementation of programs and projects across the College. (Standard 1.3.1)

2 Develop a mechanism for seeking and incorporating input from stakeholders such as the jurisdictions, health service providers, consumer organisations and other specialist medical colleges in defining

the purpose of the College and reviewing the statement of graduate outcomes in relation to community need. (Standard 2.1.2)

8 Seek feedback from healthcare administrators and other healthcare professionals as part of the College's regular program evaluation activities. (Standard 6.2.2)

9 Review the processes for selection into the training program to ensure they are rigorous, transparent and fair. (Standard 7.1.2)

The accreditation conditions in order of standard are detailed in the following table:

Standard	**Condition:**	**To be met by:**
Standard 1	1 Demonstrate that there are processes in place to ensure ongoing medical educational expertise is available for the development and implementation of programs and projects across the College. (Standard 1.3.1)	2018
Standard 2	2 Develop a mechanism for seeking and incorporating input from stakeholders such as the jurisdictions, health service providers, consumer organisations and other specialist medical colleges in defining the purpose of the College and reviewing the statement of graduate outcomes in relation to community need. (Standard 2.1.2)	2018
Standard 3	3 Finalise and implement the document, Competencies, Learning Opportunities, Teaching and Assessments for Training in Paediatric Intensive Care. (Standard 3.1 and 3.2)	2016
	4 Develop and publish specific learning objectives for the three-month rural term. (Standard 3.2)	2016
Standard 4	Nil	
Standard 5	5 Develop clear criteria for workplace-based assessments to ensure trainees understand what constitutes successful completion of each of these assessments. (Standard 5.1.1)	2016
	6 Finalise the blueprinting of all assessments to align with the new curriculum. (Standard 5.3.1)	2017
Standard 6	7 Implement methods for analysing and using trainee feedback in program monitoring and for responding to issues raised by trainees. (Standard 6.1)	2016
	8 Seek feedback from healthcare administrators and other healthcare professionals as part of the College's regular program evaluation activities. (Standard 6.2.2)	2018
Standard 7	9 Review the processes for selection into the training program to ensure they are rigorous, transparent and fair. (Standard 7.1.2)	2018

Standard	Condition:	To be met by:
	10 Document and publish the weighting for the various elements of the selection process, in particular the marking criteria, including that applied to the structured references used by the Trainee Selection Panel to deem suitability for training. (Standard 7.1.3)	2017
Standard 8	11 Implement a strategic approach to the development of a program to support and train supervisors of training. (Standard 8.1.2)	2017
	12 Implement formal and systematic processes to provide feedback to all supervisors of training on their performance in the role. (Standard 8.1.3)	2017
	13 Finalise, incorporate and publish the accreditation standards which are relevant to intensive care medicine training outcomes, for the medicine and anaesthesia terms in the relevant College accreditation documentation. (Standard 8.2.1)	2017
Standard 9	14 Develop and implement processes to comply with specific New Zealand requirements regarding monitoring of continuing professional development and reporting of non-compliance to the Medical Council of New Zealand. (Standard 9.1)	2016

This accreditation decision relates to the College's programs of study and continuing professional development program in the recognised medical specialty of intensive care medicine and paediatric intensive care medicine.

In 2018, before this period of accreditation ends, the AMC will seek a comprehensive report from the College. The report should address the accreditation standards and outline the College's development plans for the next four years. The AMC will consider this report and, if it decides the College is continuing to satisfy the accreditation standards, the AMC Directors may extend the period of accreditation by a maximum of three years (to March 2022), taking accreditation to the full period which the AMC may grant between assessments, which is ten years. At the end of this extension, the College and its programs will undergo a reaccreditation assessment by an AMC team.

Overview of findings

The findings against the nine accreditation standards are summarised below. Only those sub-standards which are not met or substantially met are listed under each overall finding.

Conditions imposed by the AMC so the College meets accreditation standards are listed in the accreditation decision (pages 5 to 6) and below. The commendations in areas of strength and recommendations for improvement are given below for each set of accreditation standards.

1. The Context of Education and Training (governance; program management; educational expertise and exchange; interaction with the health sector; continuous renewal)	This set of standards is MET

Standard 1.3.1 (educational provider uses educational expertise) is substantially met.

Commendations

A The engagement and commitment of fellows who hold Board and committee responsibilities, and in particular the significant service some fellows have provided to the College over an extended period of time.

B The establishment of the Community Advisory Group as a mechanism for engaging consumers and community stakeholders.

Conditions to satisfy accreditation standards

1 Demonstrate that there are processes in place to ensure ongoing medical educational expertise is available for the development and implementation of programs and projects across the College. (Standard 1.3.1)

Recommendations for improvement

AA Review the regulations, organisational chart and terms of reference to ensure consistency and currency in line with the recent committee changes. (Standard 1.2.1)

BB Increase collaboration with the Royal Australasian College of Physicians and the Australian and New Zealand College of Anaesthetists to address how the anaesthesia and medicine terms are organised and allocated in order to achieve the learning objectives of the intensive care medicine training program. (Standard 1.3.2)

CC Increase engagement with jurisdictions regarding educational changes and the resulting impact on workforce and clinical service delivery. (Standard 1.4.1)

2. The Outcomes of the Training Program (purpose of the training organisation and graduate outcomes)	This set of standards is MET

Standard 2.1.2 (in defining its purpose relevant groups have been consulted) is substantially met.

Commendations

C The work of the Community Advisory Group in reviewing the definition of the intensive care medicine specialist and the content in the 'For Patient & Families' section of the College's website.

D The formation of the Paediatric Intensive Care Medicine section, the work being completed on the competencies, learning opportunities, teaching and assessments for training in paediatric intensive care medicine and the efforts thus far to address the needs of children in relation to graduate outcomes.

Conditions to satisfy accreditation standards

2 Develop a mechanism for seeking and incorporating input from stakeholders such as the jurisdictions, health service providers, consumer organisations and other specialist medical colleges in defining the purpose of the College and reviewing the statement of graduate outcomes in relation to community need. (Standard 2.1.2)

Recommendations for improvement

DD Implement a process for the College to be informed of changes to the criteria for accreditation of the medicine and anaesthesia terms accredited by the Royal Australasian College of Physicians and the Australian and New Zealand College of Anaesthetists so CICM is assured the terms continue to meet the graduate outcomes of the intensive care medicine training program. (Standard 2.2)

3. The Education and Training Program – Curriculum Content (framework; structure, composition and duration; research in the training program; continuum of learning)	This set of standards is MET

Standard 3.1.1 (curriculum framework) and 3.2.1 (curriculum structure, composition and duration) are substantially met.

Commendations

E The completion of the curriculum review and the implementation of the new training program in 2014.

F The College's comprehensive review of the objectives of training for core intensive care, anaesthesia and medicine terms.

G The introduction of the Transition Year, which aims to address the gaps in the previous curriculum, by allowing time to acquire non-clinical skills such as expertise in administration, teaching and quality assurance and prepare trainees for entry into specialist practice.

H The development of cultural competence outcomes and associated training resources for trainees.

Conditions to satisfy accreditation standards

3 Finalise and implement the document, Competencies, Learning Opportunities, Teaching and Assessments for Training in Paediatric Intensive Care. (Standard 3.1 and 3.2)

4 Develop and publish specific learning objectives for the three-month rural term. (Standard 3.2)

Recommendations for improvement

EE Develop a mechanism to ensure as new training resources are developed they are mapped to learning objectives in the curriculum. (Standard 3.2)

4. The Training Program – Teaching and Learning	This set of standards is MET

Commendations

I The College's significant investment of resources in developing and identifying courses and online resources that complement the training program and that are considered useful by trainees, in particular by targeting the skills that were previously identified as deficient.

J The development of the Quality in Training and New Fellow surveys and accessing of Australian and New Zealand Intensive Care Society's Centre for Outcome and Resource Evaluation data to provide information that illuminates the quality and quantity of teaching and learning at training sites.

K The development of the Competencies, Learning Opportunities, Teaching and Assessments for Training in Intensive Care Medicine document which lists expectations as trainees progress through training from novice to expert trainee.

Conditions to satisfy accreditation standards

Nil

Recommendations for improvement

FF Finalise and implement a process for assessing the educational relevance and quality of external courses. (Standard 4.1.2)

5. The Curriculum – Assessment of Learning (assessment approach; feedback and performance; assessment quality; assessment of specialists trained overseas)	This set of standards is SUBSTANTIALLY MET

Standard 5.1 (assessment approach) and 5.3 (assessment quality) is substantially met.

Commendations

L The College's summative examinations, the First and Second Part Examinations, are comprehensive and each incorporate a variety of assessment formats.

M The development and introduction of a comprehensive suite of workplace-based assessments as part of the new curriculum.

N The College's comprehensive review of its procedures and processes associated with the Overseas Trained Specialist and Area of Need Pathways in accordance with the Medical Board of Australia's review of the specialist pathway for international medical graduates.

Conditions to satisfy accreditation standards

5 Develop clear criteria for workplace-based assessments to ensure trainees understand what constitutes successful completion of each of these assessments. (Standard 5.1)

6 Finalise the blueprinting of all assessments to align with the new curriculum. (Standard 5.3)

Recommendations for improvement

GG Review the assessment of professionalism to ensure that it is adequately assessed and there is appropriate remediation for unprofessional behaviours. (Standard 5.1)

HH Communicate to trainees and supervisors how the In-training Evaluation Report (ITER) works and how it can be used by trainees to understand their deficiencies and areas for improvement. (Standard 5.2)

II Improve feedback provided to trainees on their performance in workplace-based assessments to ensure these assessments become critical learning points. (Standard 5.2)

6. The Curriculum – Monitoring and Evaluation (Monitoring and outcome evaluation)	This set of standards is MET

Standard 6.1.3 (trainees contribute to monitoring) and 6.2.2 (healthcare administrators, other healthcare professionals contribute to evaluation processes) are substantially met.

Commendations

O The College's ongoing efforts to monitor and evaluate all aspects of the intensive care medicine training program.

P The implementation of the six-monthly Quality of Training survey and annual Supervisor of Training survey which allows for systematic collection of feedback on training supervision and clinical experiences.

Q The College's plans for collating and analysing feedback gathered from the Quality of Training survey and feeding de-identified information back to the training units.

R The introduction of the online Training Portal which enables greater interaction and opportunities for feedback with all supervisors including those supervising the medicine and anaesthesia terms.

Conditions to satisfy accreditation standards

7 Implement methods for analysing and using trainee feedback in program monitoring and for responding to issues raised by trainees. (Standard 6.1.3)

8 Seek feedback from healthcare administrators and other healthcare professionals as part of the College's regular program evaluation activities. (Standard 6.2.2)

Recommendations for improvement

JJ Implement an overarching evaluation framework to ensure systematic monitoring and evaluation including how feedback is analysed and used in program monitoring. (Standard 6.1 and 6.2)

KK Develop a formal and more rigorous process for the management and use of data obtained from the Quality of Training survey and the Australian and New Zealand Intensive Care Society's Centre for Outcome and Resource Evaluation data, including closing the feedback loop, whilst protecting trainee confidentiality. (Standard 6.1.3)

7. Implementing the Curriculum - Trainees (admission policy and selection, trainee participation in governance of their training, communication with trainees, resolution of training problems, disputes and appeals)	This set of standards is SUBSTANTIALLY MET

Standard 7.1 (admission policy and selection) is substantially met.

Commendations

S The College's commitment to open and transparent communication with trainees and its commitment, through its processes, to ensuring existing trainees are not disadvantaged by changes to the training program.

T The implementation and modification of the Quality of Training survey, which now allows the identification of training issues at specific training sites.

U The College's plans for the development of a more sophisticated Trainee Dashboard which will give trainees greater detail about their progress through the training program.

Conditions to satisfy accreditation standards

9 Review the processes for selection into the training program to ensure they are rigorous, transparent and fair. (Standard 7.1.2)

10 Document and publish the weighting for the various elements of the selection process, in particular the marking criteria, including that applied to the structured references used by the Trainee Selection Panel to deem suitability for training. (Standard 7.1.3)

Recommendations for improvement

LL Strengthen trainee involvement in the governance of their training by:

- Creating a position for a trainee on the Education Committee
- Giving consideration to having a trainee as the Chair of the Trainee Committee
- Creating an induction package for trainee representatives on College committees
- Ensuring trainees of both the new and old curriculum are adequately represented on the Trainee Committee
- Collaborating with the Trainee Committee to develop mechanisms to improve representation and communication with all trainees. (Standard 7.2)

MM Provide additional information on the processes for recognition of prior learning and flexible training options for trainees on the website. (Standard 7.3.2)

NN In response to trainees' concerns about job prospects in intensive care medicine, collaborate with the jurisdictions and other stakeholders to provide information on career pathways, addressing workforce distribution issues and training opportunities in different regions. (Standard 7.3.2)

OO Make information concerning dispute and appeals processes clearer and more easily accessible to trainees. (Standard 7.4.3)

PP Develop transparent processes to assist trainees having difficulty with their supervisors, providing easily accessible information on the website explaining these processes and who to contact. (Standard 7.4.1 and 7.4.2)

8. Implementing the Training Program – Delivery of Educational Resources (Supervisors, assessors, trainers and mentors; clinical and other educational resources)	This set of standards is SUBSTANTIALLY MET

Standard 8.1.2 (facilitates training of supervisors), 8.1.3 (evaluates supervisors and trainer effectiveness) and 8.2.1 (process and criteria to select training sites) are substantially met.

Commendations

V The significant contribution and engagement of fellows in supporting, supervising and monitoring of trainees.

W The development of robust processes for the professional development of examiners.

X The well-defined process for accreditation of intensive care units with clearly articulated requirements, documented in policies and guidelines which are accessible on the College's website.

Conditions to satisfy accreditation standards

11 Implement a strategic approach to the development of a program to support and train supervisors of training. (Standard 8.1.2)

12 Implement formal and systematic processes to provide feedback to all supervisors of training on their performance in the role. (Standard 8.1.3)

13 Finalise, incorporate and publish the accreditation standards which are relevant to intensive care medicine training outcomes, for the medicine and anaesthesia terms in the relevant College accreditation documentation. (Standard 8.2.1)

Recommendations for improvement

QQ Implement workshops to assist and support fellows in undertaking workplace-based assessments. (Standard 8.1.2)

RR Provide access to professional development for all supervisors, in particular those from regional and rural locations. (Standard 8.1.2)

SS Finalise the requirements for the accreditation of intensive care units for the Transition Year and publish these once finalised. (Standard 8.2.1)

TT Map the College's accreditation standards against the accreditation domains as outlined in the Accreditation of Specialist Medical Training Sites Project Final Report. (Standard 8.2.1)

9. Continuing Professional Development (programs; retraining; remediation)	This set of standards is MET

Standard 9.1 (Additional MCNZ criteria for continuing professional development) is substantially met.

Commendations

Y The introduction of the College's new continuing professional development program which effectively uses an online process and that requires reflection and consideration of learning needs through a 'learning cycle' approach.

Z The formation of the College's Continuing Professional Development Committee to provide increased oversight, and the inclusion of a trainee representative as a way of seeking trainee feedback into the program.

Conditions to satisfy accreditation standards

14 Develop and implement processes to comply with specific New Zealand requirements regarding monitoring of continuing professional development and reporting of non-compliance to the Medical Council of New Zealand. (Standard 9.1)

Recommendations for improvement

UU Given the changing nature of intensive care medicine, develop or link to, a range of modules that would cover a limited scope curriculum for continuing professional development which would ensure all fellows undertake training in such critical domains. (Standard 9.1)

VV Develop standards for education providers wishing to deliver continuing professional development activities. (Standard 9.1)

Introduction: The AMC Accreditation Process

The Australian Medical Council (AMC) was established in 1985. It is a national standards body for medical education and training. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

The process for accreditation of specialist medical education and training

The AMC implemented the process for assessing and accrediting specialist medical education and training programs in response to an invitation from the Australian Government Minister for Health and Ageing to propose a new model for recognising medical specialties in Australia. A working party of the AMC and the Committee of Presidents of Medical Colleges was established to consider the Minister's request, and developed a model with three components:

- a new national process for assessing requests to establish and formally recognise medical specialties
- a new national process for reviewing and accrediting specialist medical education and training programs
- enhancing the system of registration of medical practitioners, including medical specialists.

The working party recommended that, as well as reviewing and accrediting the training programs for new specialties, the AMC should accredit the training and professional development programs of the existing specialist medical education and training providers – the specialist medical colleges.

Separate working parties developed the model's three elements. An AMC consultative committee developed procedures for reviewing specialist medical training programs, and draft educational guidelines against which programs could be reviewed. In order to test the process, the AMC conducted trial reviews during 2000 and 2001 with funding from the Australian Government Department of Health and Ageing. These trial reviews covered the programs of two colleges.

Following the success of these trials, the AMC implemented the accreditation process in November 2001. It established a Specialist Education Accreditation Committee to oversee the process, and agreed on a forward program allowing it to review the education and training programs of one or two providers of specialist training each year. In July 2002, the AMC endorsed the guidelines, *Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures*.

In 2006, as it approached the end of the first round of specialist medical college accreditations, the AMC initiated a comprehensive review of the accreditation guidelines. In June 2008, the Council approved new accreditation standards and a revised description of the AMC procedures. The new accreditation standards apply to AMC assessments conducted from January 2009. The relevant standards are included in each section of this report.

A new National Registration and Accreditation Scheme for health professions began in Australia in July 2010. The Ministerial Council, on behalf of the Medical Board of Australia, has assigned the AMC the accreditation functions for medicine.

From 2002 to July 2010, the AMC process for accreditation of specialist education and training programs was a voluntary quality improvement process for the specialist colleges that provided training in the recognised specialties. It was a mandatory process for bodies seeking recognition of a new medical specialty. From 1 July 2010, the *Health Practitioner Regulation National Law Act 2009* makes the accreditation of specialist training programs an essential element of the process for approval of all programs for the purposes of specialist registration. Similarly, the Medical Board of Australia's registration standards indicate that continuing professional development programs that meet AMC accreditation requirements meet the Board's continuing professional development requirements.

From 1 July 2010, the AMC presents its accreditation reports to the Medical Board of Australia. Medical Board approval of a program of study that the AMC has accredited forms the basis for registration to practise as a specialist.

Assessment of the College of Intensive Care Medicine of Australia and New Zealand

The AMC first assessed the training program in intensive care medicine offered by the Joint Faculty of Intensive Care Medicine in 2002 during the AMC accreditation assessment of the Australian and New Zealand College of Anaesthetists (ANZCA).

The 2002 assessment resulted in accreditation of ANZCA, the Faculty of Pain Medicine and the Joint Faculty of Intensive Care Medicine for six years, with a requirement for annual progress reports to the AMC. Based on a comprehensive report submitted in 2007, accreditation was extended to December 2012.

In 2008, the Joint Faculty of Intensive Care Medicine advised the AMC that it planned to separate from ANZCA and reconstitute itself as a college. The AMC decided that this would fit its definition of a major change to an accredited program. It advised the Joint Faculty that it would wish to review the plans before the College changed its organisational structure, and would then complete a full accreditation assessment of the training provided by the new College 12 to 18 months after the changes.

In 2009, the College provided detailed information on the planned changes and this was considered by the AMC's Specialist Education Accreditation Committee. On the basis of this information, the November 2009 meeting of AMC Directors resolved:

(i) That the AMC grant initial accreditation of the new College of Intensive Care Medicine of Australia and New Zealand as the training organisation for the recognised medical specialty of intensive care medicine and of training leading to fellowship of the College from 1 January 2010, subject to satisfactory annual reports to the AMC.

(ii) That the AMC advise the Australian Government Minister of Health and Ageing that the lists of recognised medical specialties should be amended to reflect that the College of Intensive Care Medicine of Australia and New Zealand is the

training organisation in the specialty of intensive care medicine, with the recognised qualification of Fellowship of the College of Intensive Care Medicine.

Under AMC policy, initial accreditation continues subject to satisfactory annual reports and until the AMC conducts a full accreditation assessment of the training programs. In mid-2010, the AMC and the College of Intensive Care Medicine of Australia and New Zealand commenced discussions concerning the arrangements for the assessment by an AMC team, and agreed the assessment would take place in June 2011.

In late 2010, the AMC appointed Associate Professor Cameron Bennett to chair the assessment of the programs of the College of Intensive Care Medicine of Australia and New Zealand, referred to as the College from here in the report. The AMC then began discussions with the College about the timing of the review and the process that would be followed in the review.

The AMC appointed other members of the assessment team (called 'the team' in this report) after the College had an opportunity to comment on the individuals proposed. The membership of the 2011 team is given at Appendix 1.

The review process followed the standard AMC accreditation procedures, namely:

- preparation by the College of a detailed accreditation submission.
- a team meeting in April 2011 to consider the College's submission and plans for the assessment.
- feedback to the College on the team's preliminary assessment of the submission, the additional information required, and the plans for visits to accredited training sites and meetings with College committees.
- AMC surveys of CICM supervisors of training. The team was given access to the data from the College's recent survey of trainees.
- invitations to other specialist medical colleges, medical schools, health departments, professional bodies, medical trainee groups and health consumer organisations to comment on the College's programs and future plans.
- a team meeting by teleconference in June 2011 to finalise arrangements.
- a program of site visits and meetings in the ACT, New South Wales, Queensland, Victoria and New Zealand between 14 and 27 June 2011. The ACT-based team members also attended the College's Annual Scientific Meeting in Canberra on 3 and 4 June 2011 and held meetings with trainees and supervisors of training.
- a series of meetings at the College offices from 28 to 30 June 2011. On the final day, the team presented its preliminary findings to the College.

In November 2011, having considered the report on this assessment, the AMC Directors agreed:

(i) That the College of Intensive Care Medicine's training programs in intensive care medicine and paediatric intensive care medicine, and its continuing professional development program be granted ongoing accreditation to 31 December 2015, subject to satisfactory annual progress reports to the AMC.

(ii) That the accreditation is subject to the conditions set out in the 2011 accreditation report.

Between formal accreditations, the AMC monitors developments in education and training and professional development programs through progress reports from the accredited medical education providers. The College has provided three progress reports to the AMC since its accreditation in 2011. These reports have been reviewed by a member of the AMC team that assessed the program in 2011, and the reviewer's commentary and the progress report then considered by the AMC Specialist Education Accreditation Committee.

The conditions on the 2011 accreditation required a follow-up assessment in 2015. In 2014, the AMC began the preparations for the review of the College's programs. On the Specialist Education Accreditation Committee's recommendation and after the College had an opportunity to consider the proposed membership, the AMC Directors appointed a team to complete this review. The 2015 team was chaired by Associate Professor Cameron Bennett. The membership of the 2015 team is given at Appendix 2.

In March 2015, the College provided an accreditation submission outlining progress on the conditions, recommendations and challenges facing the College. The team met in April 2015 to consider the submission, and then discussed plans for the review with College officers and staff. In May 2015, the AMC wrote to other specialist medical colleges, medical schools, health departments, intensive care medicine organisations, and health consumer organisations requesting feedback on the College's programs. A list of the organisations that made a submission to the AMC team is given at Appendix 3.

The 2015 review comprised a program of meetings with trainees, supervisors of training, fellows and other key stakeholders; and meetings with College officers, committees and staff. The team completed its review from 29 to 31 June 2015 at the College's office in Melbourne.

Australian Medical Council and Medical Council of New Zealand relationship

Since most of the specialist medical colleges span Australia and New Zealand, the Medical Council of New Zealand (MCNZ) has been an important contributor to AMC accreditation assessments.

In November 2010, the AMC and the MCNZ signed a Memorandum of Understanding to extend the collaboration between the two organisations. The two Councils are working to streamline the assessment of organisations which provide specialist medical training in Australia and New Zealand. The AMC continues to lead the accreditation process and assessment teams for bi-national training programs continue to include New Zealand members, site visits to New Zealand, and consultation with New Zealand stakeholders. While the two Councils use the same set of accreditation standards, legislative requirements in New Zealand require the bi-national colleges to provide additional New Zealand-specific information.

Appreciation

The team is grateful to the fellows and staff who prepared the accreditation submission and managed the preparations for the assessment. It acknowledges with thanks the support of fellows who met with team members during this assessment.

Summaries of the program of meetings and visits for the 2011 assessment are given at Appendix 4 and for the 2015 assessment at Appendix 5.

Report on the 2011 and the 2015 AMC assessments

This report contains the findings of both the 2011 and 2015 AMC assessments. Each section of the report begins with the relevant accreditation standards, current at July 2015. The findings of the 2015 team are provided as commentaries following the relevant sections of the 2011 report. It should be noted that the report by the 2015 team addresses progress by the College against conditions and recommendations made by the AMC in 2011. In areas where the College has made no substantial change and no recommendations were made in 2011, the 2015 team has not conducted a comprehensive assessment.

1 The context of education and training

1.1 Governance

The accreditation standards concerning the context in which education and training are delivered are as follows:

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

1.1.1 Governance in 2011

The College of Intensive Care Medicine of Australia and New Zealand (CICM) became incorporated under the Corporations Act 2001 (Cth) as a separate, independent college in November 2008 and on 1 January 2010 replaced the Joint Faculty of Intensive Care Medicine (JFICM) as the body responsible for training and certification of intensive care specialists. Established in 2002, the Joint Faculty was a collaboration of the Australian and New Zealand College of Anaesthetists (ANZCA) and the Royal Australasian College of Physicians (RACP) making a single training pathway from the separate training programs in intensive care provided by Faculties of the two Colleges.

CICM is incorporated as a body limited by guarantee. The College is governed by an eleven-member Board elected by the fellowship. One of the Board members is the New Fellows representative, who specifically represents the interests of trainees and fellows within five years of admission to fellowship. From 2011, the Board has included a trainee with observer status. There is also provision to co-opt fellows to represent those geographic regions that do not have an elected member. Board members serve a three-year term.

The Presidents of the Australian and New Zealand Intensive Care Society (ANZICS), ANZCA and RACP are official observers at Board meetings.

The Board operates within the Objects of the College as defined within the constitution. The constitution also defines the composition and election of the Board and Executive, and the election of the office-bearers – the President, Vice President and Treasurer.

The Objects of the College detail its education and training functions. The College regulations expand upon the functions of the College, detailing the duties of office-bearers, and the responsibilities and composition of the various subcommittees and the regional and national committees. The regulations also detail the requirements of the training and assessment program. The Maintenance of Professional Standards (MOPS) Program Manual outlines the College's current MOPS program.

The positions of office-bearers and chairs of the committees are permanent 'portfolios' and other portfolios are established on an ad-hoc basis. In addition to the office-bearers, the senior officers include the Censor, Education Officer and Chair of Examinations and Chair of the Hospital Accreditation Committee. Job descriptions exist for each of the senior roles.

An Executive Committee (comprising the President, Vice-President, Treasurer and Chief Executive Officer) is a standing committee of the Board with delegated authority to review urgent matters. This committee and the Finance, Audit and Risk Management subcommittee were established in 2009 in preparation for the establishment of the new College. The Finance, Audit and Risk Management committee considers the regular financial reports and the annual external audit report, monitors the College's investments and works with the Chief Executive Officer in formulating the College budget and table of fees.

The other principal committees of the Board are:

- *Education Committee*
- *Examinations Committee*
- *Fellowship Admissions Committee*
- *Hospital Accreditation Committee (HAC)*
- *Overseas Trained Specialists Committee (OTS)*
- *Fellowship Affairs Committee.*

The regulations describe the principal committees' composition and terms of reference. More detailed terms of reference have been established where required. The Chair of each committee is normally a member of the Board. These committees are described in more detail in later sections of this report.

Other subcommittees which report to the principal committees include:

- *Trainee Committee*
- *Primary Examination Committee*
- *General Fellowship Examination Committee*
- *Paediatric Fellowship Examination Committee*
- *Conjoint Rural Committee (joint committee formed in 2004 with ANZICS)*
- *Formal Projects Panel.*

The College has established regional committees in each geographic region except for the Northern Territory and Australian Capital Territory, and national committees for New Zealand and Hong Kong. These committees disseminate information from the Board, advise the Board on matters that may concern the College and matters affecting training, accreditation and the review of hospital training programs. Their structure and function are detailed in the College regulations. Members of Regional Committees are elected by fellows in that region. Board members are ex-officio members of their respective regional or national committee, and act as a conduit for communication to and from the Board. A representative of ACT fellows sits on the NSW Regional Committee. New Fellows and trainee representatives sit on the relevant regional or national committee.

There has been ongoing review of the College's governance since the AMC accreditation assessment in 2002, and in the lead up to the transition to a separate College. In addition

to the appointment of a New Fellows representative and the co-option of a trainee to the Board, other changes resulting from this review have included:

- *The responsibilities of the Chair of Examinations have increased in line with changes to the administration of the examinations.*
- *New portfolios for Rural Intensive Care, International Liaison and Continuing Professional Development and Fellowship Affairs have been established.*
- *An Assistant Education Officer has been appointed to support the supervisors of training.*
- *An Assistant Censor has been appointed to support the Censor.*

In February 2010, the Board established a Strategy Taskforce to consider the College's priorities for 2010–2012 and to evaluate its representation on external bodies both centrally and regionally. The College has identified the structure of the Board and its committees will require regular review.

1.1.2 Governance in 2015

The College's governance structure is essentially unchanged from the previous accreditation assessment in 2011 and the governance structures continue to give priority to the educational role relative to other activities.

The Board of Directors remains at 11 members, 10 of whom are elected from the general fellowship and one being elected as the New Fellows representative. The term of office continues to be three years and Board members may re-nominate for election for four consecutive terms (or 12 years in total) with the exception of the New Fellows representative, who is limited to a single three-year term. There continues to be a number of non-voting members on the Board, including the Trainee representative and representatives from the regions that do not have an elected member. The Board meets three times a year, usually in February, July and November.

The Presidents of the Australian and New Zealand College of Anaesthetists and the Australian and New Zealand Intensive Care Society (ANZICS) are official observers at Board meetings.

There have been no changes to the College's constitution, although the Board is currently considering a change to allow electronic voting in College elections.

The Board delegates responsibility for certain activities to various committees and there have been some changes to the committee structure since 2011. Each of the major committees is chaired by a Board member. Minutes of each committee meeting and a verbal report from the Chair are provided at every Board meeting.

The principal education committees in 2015 are as follows:

- Education Committee
- Assessments Committee (previously the Examination Committee)
- Fellowship Admissions Committee

- Hospital Accreditation Committee
- Fellowship Affairs Committee
- Trainee Committee
- Paediatric Intensive Care Committee (new)
- Censors Committee (new).

The subcommittees which report to the principal committees are now as follows:

- First Part Examination Committee (previously the Primary Examination Committee)
- Second Part Examination Committee (General) (previously the General Fellowship Examination Committee)
- Second Part Examination Committee (Paediatrics) (previously the Paediatric Fellowship Examination Committee)
- Formal Project Committee (previously the Formal Project Assessment Panel)
- Overseas Trained Specialists (OTS) Committee
- Trainee Selection Panel (new)
- Trainee Performance Review Committee (new)
- Continuing Professional Development Committee (new).

The Formal Project Committee now reports to the new Assessments Committee. The OTS Committee and the new Trainee Selection Panel and Trainee Performance Review Committee have become subcommittees of the Censors Committee. The new Continuing Professional Development Committee reports to the Fellowship Affairs Committee. The joint Conjoint Rural Committee with ANZICS is no longer operational. There are terms of reference for all the principal committees.

In early 2014, the College established a Community Advisory Group, which also reports to the Board.

Board members continue to be ex-officio members of their respective regional or national committee and act as a conduit for communication to and from the Board. If there is no Board member located in the region, the College will co-opt a visiting Board member to attend the regional committee meetings.

The College's committee structure as at July 2015 is shown at Appendix 6.

The College is currently in the process of developing a strategic plan for the period 2016–2020 and has identified the following four strategic priorities:

- engagement with fellows
- excellence in training
- a sustainable organisation
- external relationships.

It is anticipated that the strategic plan will be completed by the end of 2015.

1.2 Program management

The accreditation standards are as follows:

- The education provider has established a committee or committees with the responsibility, authority and capacity to direct the following key functions:
    - planning, implementing and reviewing the training program(s) and setting relevant policy and procedures
    - setting and implementing policy and procedures relating to the assessment of overseas-trained specialists
    - setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activities.
- The education provider's education and training activities are supported by appropriate resources including sufficient administrative and technical staff.

1.2.1 Program management in 2011

The College has a number of principal committees, some of which are supported by subcommittees. The committees involved in training and assessment of trainees and fellows are described below.

*The **Education Committee** is responsible for overall educational strategy. The committee implements Board policy and advises the Board on matters related to education and training. It also coordinates the College's educational activities including the following: appointment and accreditation of supervisors; curriculum development, evaluation and review; development of educational materials and courses; development of educational policy; and collaboration with relevant educational bodies. It liaises with ANZCA and RACP on educational matters. The Education Committee is supported by two subcommittees, the Trainee Committee and the Formal Projects Assessment Panel. College senior officers, the Education Officer and Assistant Education Officer, and the Administrative Officer (Education) drive the activities of this committee.*

*The **Trainee Committee** represents the interests of trainees in the affairs of the College. As a subcommittee of the Education Committee, it contributes particularly to matters concerning education and training. The committee consists of a trainee representative from each region and is chaired by the New Fellows representative on the Board.*

*The **Formal Projects Assessment Panel** is responsible for the review and approval of the formal projects which trainees must submit as part of their training requirements.*

*The **Hospital Accreditation Committee** reviews documentation and data collected from intensive care units, inspection reports and letters of accreditation to hospitals. It maintains lists of approved intensive care units, details of their status and hospitals to be inspected. It initiates hospital visits, appoints the accreditation teams and makes recommendations to the Board regarding the accreditation of intensive care units.*

*The **Examination Committee** is an overarching committee and delegates responsibility for each examination to the relevant subcommittee: the Primary Examination Committee, the General Fellowship Examination Committee, and the Paediatric Fellowship Examination Committee.*

*The **Overseas Trained Specialist Committee** administers the assessment of overseas trained specialists.*

*The **Fellowship Affairs Committee** oversees and provides direction to a number of activities for fellows including continuing professional development (CPD), the Annual Scientific Meeting, honours awards, communications and journals, health and safety, implications of recertification, workforce monitoring and external relations. It was established in 2010 to fulfil the observed need for a committee to oversee activities for fellows.*

*The **Conjoint Rural Committee of CICM and ANZICS** investigates ways to attract fellows to rural practice, ways to better support fellows and non-fellows in rural practice, ways to allow training in rural ICUs and facilitates continuing medical education in rural areas for fellows and non-fellows. This Committee's function is under review.*

In accredited units, the Supervisor of Training, a fellow appointed by the College, is the College's training representative and is key to the implementation of the intensive care medicine training program for individual trainees. The supervisor ensures there is a structured educational program for trainees, and oversees the trainee's program via assessments. The supervisor of training can refer to the Censor, who is predominately responsible for the review and approval of individual training. The Censor can refer matters to the Education Committee which handles overall educational policy and this committee can then refer to the Board.

The College's central office is located in Prahran, Melbourne. At the time of the CICM submission to the AMC, the College employed eight full-time administrative staff, two part-time staff and three part-time Directors of Professional Affairs, who are fellows of the College. In addition, the College contracts externally for technical support in areas such as IT and finance/accounting.

1.2.2 Program management in 2015

The College has made a number of changes to the committee structure since the previous assessment to enable a more streamlined approach to governance. The principal committees and subcommittees are as follows:

The **Education Committee** continues to be responsible for the implementation of Board policy and provision of advice to the Board on matters related to teaching and education of intensive care medicine trainees, and coordination of educational activities, including curriculum development, evaluation and review, appointment and accreditation of supervisors, development of educational materials and courses and development of educational policy.

The **Assessments Committee**, formerly the Examination Committee, is responsible for the oversight of the assessment modes of the College, to ensure coordinated and

continuous assessment throughout the training program. It comprises four subcommittees, including: First Part Examination Committee; Second Part Examination Committee (General); Second Part Examination Committee (Paediatrics); and Formal Project Committee.

The **Censors Committee** oversees all matters relating to trainee selection and progress through the training program and includes the following subcommittees: Overseas Trained Specialists Committee; Trainee Selection Panel; and Trainee Performance Review Committee.

The **Fellowship Admissions Committee** is responsible for assessing all applications for admission to fellowship.

The **Hospital Accreditation Committee** is responsible for ensuring that intensive care units accredited for training provide adequate facilities, case-mix, supervision and teaching.

The **Fellowship Affairs Committee** is responsible for the oversight of the College continuing professional development (CPD) program, major events including the Annual Scientific Meeting, health and welfare of fellows, management of the College scientific journal, consideration of honours and awards and external relations with bodies such as the Australian and New Zealand Intensive Care Society (ANZICS). It has a number of subcommittees including the CPD Committee.

The **Trainee Committee** was formerly a subcommittee of the Education Committee, but now reports directly to the Board. The Trainee Committee is responsible for representing trainee interests in the affairs of the College, particularly with regard to matters concerning education and training.

The **Paediatric Intensive Care Committee** was established to represent the views of the paediatric intensive care section and to make recommendations to the Board regarding all matters pertaining to paediatric intensive care medicine.

The **Community Advisory Group** provides a mechanism by which the Board can receive advice and feedback from a consumer and community stakeholder perspective. The membership includes representatives from the general community and Consumers Health Forum as well as from associations with a particular interest in intensive care. This group has met four times since it was established in 2014.

In accredited units, the Supervisor of Training continues to be the College's training representative and responsible for the implementation of the intensive care medicine training program for trainees. The Supervisor of Training can refer matters to the Censor.

At the time of the 2015 assessment, the College had 912 active fellows in total, an increase of 279 fellows from 2011. Over the past four years, the College's staffing numbers have significantly increased. The College employs a total of 14.2 FTE staff with six staff employed specifically to support education and training activity. The College has undergone an organisational restructure and has created a number of senior

positions including: Manager of Training and Education; Manager of Fellowship Affairs; Business Administrator; and Policy Officer. In addition, the College continues to outsource several support functions, such as IT support, payroll and accounting.

1.2.3 2011 team findings

Although the College began operations in January 2010, it builds on a 30-year history of evolution and maturation of the discipline of intensive care medicine and of the training program. In Australia and New Zealand, training programs in intensive care medicine have been available since 1977. The current six-year program has evolved from those begun by the Faculty of Anaesthetists of the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians, followed by the Joint Faculty of Intensive Care Medicine. The Joint Faculty made steady progress towards a stand-alone body following the formation of the Joint Specialist Advisory Committee for Intensive Care. In 2009, a review was completed of the Joint Faculty's policies, procedures and guidelines which provided a solid base for the new College.

The team recognises the College's significant investment in planning, and communication with fellows and trainees to effect a smooth transition from the Joint Faculty of Intensive Care Medicine to a new stand-alone body. The team congratulates the College on this success.

With 633 active fellows, the College remains relatively small. As is the case for all colleges, it faces a challenge in sustaining and building the number of fellows involved in its activities. As a new college, it has additional responsibilities and committees that will require the input of fellows. The College's recent strategies to engage new fellows and seek their input are commended and will need to continue.

The new College has appropriate corporate governance structures. These have evolved from the well-developed structures of the parent colleges of the Joint Faculty. It has appropriate regional and national structures and processes to manage its teaching, assessment and continuing professional development activities.

The formation of the new College has brought a great deal of enthusiasm and commitment from trainees and fellows and increased involvement in regional activities. The team noted there is variable involvement in the coordination of training between regions. Formal teaching is organised on a state, regional or local basis depending on the region. The College's website provides a link to a regional webpage for each committee, which provides information and advertises upcoming local courses. The College expects the committees will develop these pages further. It was discussed during site visits that the website is an area for further development by the committees.

In New Zealand College fellows indicated that they had good access to the Australian-based courses and good support from the College.

It is important that trainees are fully engaged in the governance structures of the College. The team commends the College's initial steps to incorporate trainees at a range of levels including the Board and looks forward to further trainee integration into governance structures.

While the College has taken steps towards trainee representation in decision making, the appropriate representation of other external stakeholder groups, such as health service managers and community members, requires consideration and review. The College's current approach to community engagement, which is based on the College website providing information and acting as a means of public enquiry, is unlikely to elicit strong interest. The College's accreditation submission indicates that the College is engaged in important discussions about matters such as the changing role of the intensivist, and the balance of clinical service requirements and training needs. There are opportunities to enrich the College's debate and ensure that the intensive care medicine curriculum adequately reflects community needs and expectations by improving the mechanisms for relevant interested groups to contribute to policy, strategy and curriculum development and review. The College will need to define its stakeholder relationships and identify a strategy or strategies to support their appropriate engagement in College activities.

The College is supported by professional and competent staff. All the employees of the Joint Faculty transferred to the new College, which has facilitated the smooth transition. Feedback from fellows and trainees indicates that their interactions with the College staff are helpful, friendly and professional. The College understands that as an independent body it will need to fund a number of professional and administrative functions which the Joint Faculty shared with ANZCA. The team was pleased to see the recognition that additional resources will be required when the new College's ongoing requirements become clear.

1.2.4 2015 team findings

The College has undertaken further work on the governance structure of the College, in particular making changes to the committee structure. The committee structure appears to be effective in supporting the functions of the Board. The team commends the College on these changes.

The College's education and training committees have appropriate terms of reference, with clear reporting lines and documented minutes. However, the team did note some inconsistencies between the College's regulations, terms of reference and organisational chart, for example the Community Advisory Group is not detailed in the regulations and the relevant subcommittees are not listed under the terms of reference for the Assessment Committee. Now that the new committee structure is agreed and is in place, the College should review the regulations, organisational chart and terms of reference to ensure consistency and currency.

The engagement and commitment of fellows who hold Board and committee responsibilities is noted and commended. Some fellows have provided significant service to the College over an extended period of time. Since 2011, the College has employed a number of strategies to increase the engagement of fellows in College affairs. This has included efforts to engage fellows with an interest in medical education, seeking wider input from the fellowship into College activities, committees and working groups. This is also addressed under standard 1.5.

The College is commended for establishing the Paediatric Intensive Care Committee which considers specific matters relating to paediatric intensive care medicine. This committee was set up in response to the issues identified by the AMC in the 2011

assessment. In stakeholder feedback as part of this assessment, the Australasian College for Emergency Medicine (ACEM) indicated that the College could consider including ACEM representation on the paediatric intensive care committee. Trainee placements in paediatric intensive care units currently contribute towards ACEM trainees' critical care training requirements and there would be value in gaining a greater understanding as to the training and assessment requirements for these placements. The Paediatric Intensive Care Committee may wish to consider ways to increase engagement with the Australasian College for Emergency Medicine.

The College is also to be commended for establishing the Community Advisory Group as a mechanism for engaging consumers and community stakeholders. To date, this group has effectively contributed to the review of various College policies, curriculum content, the definition of an intensive care medicine specialist and the publicly available information for patients and families on the College's website. This is discussed in further detail under standard 2. The progress of this group is encouraging and the AMC looks forward to updates on this work in future progress reports. Additional work is required by the College to ensure appropriate representation of other external stakeholder groups, such as health service administrators and other healthcare professionals. This is discussed under standard 1.4.

At the time of the 2011 assessment, the College acknowledged that an increase in appropriate resources and technical staff would be required to support its current and future education activities (condition 1). In 2013, the AMC agreed that the College addressed this condition by undertaking a significant organisational restructure, increasing its staffing levels and creating several senior positions. In addition, the College engaged a Project Officer to coordinate the implementation of the new CICM curriculum and contracted an IT Project Manager to oversee the development and introduction of the new learning management system and the online assessment submission system.

Feedback from key stakeholders to the team, in particular, supervisors of training and trainees, in relation to interactions with College staff was uniformly positive. College staff are committed, engaged and provide effective support to the College's education and training processes. The additional support that has been provided to supervisors of training and fellows since the 2011 assessment is acknowledged.

During the last assessment, the team noted there was variable information available on the College's website regarding formal training opportunities in the regions. The College's website has undergone significant improvements since 2011. The Regional Committees and New Zealand National Committee now provide clear information and advertise the full range of upcoming courses in each of their areas. The team commends the College on progressing this work.

1.3 Educational expertise and exchange

The accreditation standards are as follows:

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

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

1.3.1 Educational expertise and exchange in 2011

There has been a long history of incremental development of the intensive care training and assessment processes with appropriate educational input.

The first development of an intensive care medicine program in the 1970s was supported by experienced medical specialists and academics. With the establishment of the Joint Faculty in 2002, and its co-location with the Australian and New Zealand College of Anaesthetists, the development of the intensive care medicine program has been supported by the professional educational expertise of the ANZCA. CICM is continuing links with ANZCA and particularly the Director of Education and the Chair of the ANZCA Education Committee, who attends the College's Education Committee. The CICM Education Committee also has representation on the RACP College Education Committee and the ANZCA Curriculum Authoring Group.

The College has contracted educational consultants to undertake specific tasks relating to its curriculum review and to suggest improvements to the training program. The Monash University Curriculum Unit (Gippsland Medical School) has agreed to supply educational expertise, under the direction of a Curriculum Review Taskforce.

The College continues to rely on the educational expertise of its Board and committee members, fellows and trainees to refine and review the education, training and CPD activities of the College.

The College accreditation submission outlines examples of collaborations with national and overseas organisations that share an interest in intensive care medicine. Within Australia, the College works with the CPMC, as well as the RACP and ANZCA. International collaborations have included the European Society of Intensive Care on curriculum and competencies development, the Hong Kong College of Anaesthetists with regards to examinations and program development as well as the Irish Board of Intensive Care which is evolving following a similar process to that of CICM.

1.3.2 2011 team findings

The College clearly gives priority to its educational roles relative to other activities. The Censor and the Education Committee have clear responsibility for oversight of training resources. Each College committee has a program review role and each contributes to the College's overall assessment of the sustainability of developments.

In addition to the expertise of fellows, the Joint Faculty had access to additional resources and considerable additional educational expertise, particularly through ANZCA. CICM recognises the need to support educational developments with appropriate resources and expertise and has indicated that additional resources may be required including:

- *employing professional educators*
- *drawing further on fellows who have educational qualifications*

- *increasing staffing for anticipated growth in trainee and examination candidate numbers, and overseas-trained specialist applications*
- *subcontracting for development of online educational facilities.*

The College's accreditation submission identifies a number of major educational projects that require completion, all of which will require resourcing, some for a number of years. Among these are the following:

- *consideration of the evolving role of the intensivist, particularly expectations extending beyond the intensive care unit to the care of the acutely ill patient and the deteriorating patient in the general wards, and using increasingly sophisticated technology (such as echocardiography and ultrasound)*
- *the curriculum review, including issues such as introducing curriculum modules and greater College educational support for trainees*
- *the new Continuing Professional Development Program.*

The College recognises this is a significant load. The AMC will wish to be assured, through progress reports, that the College is able to continue to give priority to these important developments and that the College's operations are supported by appropriate resources.
The team commends the College's plans to engage appropriate external educational expertise to support curriculum review. There is considerable educational expertise in a number of other specialist medical colleges and the team encourages the College to review these colleges' educational processes and programs.

1.3.3 Educational expertise and exchange in 2015

During 2012 and 2013, the College undertook a major review and redevelopment of the curriculum and has developed a number of resources to support learning and assessment, including the online In-Training Evaluation Report (ITER) in addition to face-to-face courses (some of which are provided by external organisations). The team commends the College on its progress since the last AMC assessment. It has invested significantly in its educational programs and this is delivering appreciable benefits.

The College has also progressed the development of an online learning platform which is accessible to all trainees and houses a number of resources, including recorded lectures, conference presentations and e-learning courses. The content for each online course is being written by an expert working group of College fellows and reviewed by external medical specialists in each area. The development of each course is managed by College staff in conjunction with an online educational design company.

As discussed, the College increased its staffing levels to ensure appropriate priority has been given to the educational developments as identified in 2011. In its submission, the College states that it utilises specific medical education expertise by contracting fellows with an interest in medical education to assist with specific education projects, such as the curriculum review, the development of the new assessment tools. The College recently employed an experienced fellow to enhance the College's supervisor education and engagement programs.

1.3.4 2015 team findings

In 2011, the AMC recommended that the College engage additional expertise to support the review of the curriculum and the review of the role of the intensive care specialist (condition 2). The AMC agreed that the College satisfied this condition in 2013, with a significant increase in staffing levels and the appointment of a part-time medical educationalist responsible for developing and implementing the new workplace-based assessments. During the curriculum review process, the College maintained close links with the Monash University Professions Education Resource Centre for advice on educational matters.

The team was informed that the College outsources educational expertise to assist with specific projects as required. Whilst many of the fellows who have been involved with the education activities and projects are committed and engaged, the team was advised that some fellows do not have any formal education qualifications. Given the primary function of the College as an education and training provider, the College should have processes in place to ensure ongoing medical educational expertise is available for the development and implementation of programs and projects across the College.

The College is commended for its continued collaboration with organisations with an interest in intensive care medicine both nationally and internationally. The College sought input from the other specialist medical colleges including, the Royal Australasian College of Physicians (RACP), the Australian and New Zealand College of Anaesthetists and the Australasian College for Emergency Medicine on the changes to the new curriculum. The College also works closely with the Australian and New Zealand Intensive Care Society on matters relating to education and continuing professional development. The team heard during the assessment visit that the College has a number of joint policy documents and joint educational initiatives with these organisations. A working party has been formed with RACP to explore the development of an accelerated pathway to joint CICM/RACP fellowship. The AMC looks forward to updates on these initiatives in future progress reports.

1.4 Interaction with the health sector

The accreditation standards are as follows:

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

1.4.1 Relationships to promote education, training and professional development of specialists in 2011

The College's accreditation submission outlines a number of ways in which CICM contributes to health policy review and development, and communicates about specialist medical education and training. These include having representatives on national and state health bodies, and by making appropriate submissions to government.

The College is represented in Australia on the Organ and Tissue Donor and Transplantation Advisory Council and in New Zealand on the Peri-operative Mortality Review Committee, the Quality Safety Improvement Commission, the National Cardiac Surgery Network and the New Zealand Resuscitation Council.

College fellows also sit on intensive care advisory committees in most states. These committees usually review allocation and utilisation of ICU resources, but are also an avenue for College representatives to discuss issues such as specialist and registrar staffing and potential conflicts between service and educational requirements. The College accreditation submission also indicates that the hospital accreditation process is central to the way in which the College addresses potential conflict between service and educational requirements.

1.4.2 2011 team findings

In building relationships with health departments and government, non-government and community agencies to support CICM's education and training roles, the new College is able to build on those already established by the Joint Faculty. These include the Joint Faculty's existing relationship with health services through its hospital accreditation processes, the continued close relationship with the Australian and New Zealand Intensive Care Society (ANZICS), and affiliate membership of the Committee of Presidents of Medical Colleges, which became full membership in 2009.

The establishment of a separate College of Intensive Care Medicine provides excellent opportunities to develop relationships with health departments and health services to support high quality intensive care medicine training. Health departments' responses to the AMC accreditation raised no concerns about the change, and some felt it would be positive. A number were seeking greater engagement with the College. While communication from the College to its fellows was seen to be good, some health departments considered that there was inadequate formal communication directly to the jurisdictions about relevant developments in the training program, such as the recent increase in the length of the core intensive care training time. In some jurisdictions, the College's regional committee and the health department have established strong relationships to support education and training.

The College's accreditation submission indicates that it regards the discussion with hospital managers during hospital accreditation visits as an important element of its communication with the health services about education and training requirements. While the team acknowledges the value of these discussions, it encourages the College to consider a more strategic approach to communicating and engaging with health services.

1.4.3 Relationships to promote education, training and professional development of specialists in 2015

In its submission, the College outlined a number of ways in which it works with key external stakeholders, including federal, state and territory health departments and other specialist colleges, in addition to representation on a range of external committees. The majority of these arrangements have been in place since the previous assessment in 2011.

The College continues to work with the healthcare institutions through the hospital accreditation process to ensure that the teaching and supervisory roles are resourced appropriately. The College indicated that when withdrawal of accreditation of a hospital seemed inevitable due to resource or organisational issues, the College generally worked with the local authority to try and rectify the issues so that training could continue in an appropriately resourced environment.

During the assessment visit, the College informed the team that the College's external relationships are a priority area in the development of the strategic plan for the period 2016–2020. Currently the key result areas for the external relationship priority area are:

- increase the College's profile and influence with key stakeholders and government bodies
- increase interaction with the community
- support the community with a focus on local and overseas development work.

The College has started a mapping exercise to identify its key stakeholders, document the current level of engagement, define the desired level of engagement and develop a strategy for bridging the gap for each stakeholder group. The College is in discussions with the Organ and Tissue Authority and the Australian and New Zealand Intensive Care Society to define their relationships and develop formal Memoranda of Understanding.

1.4.4 2015 team findings

Key external stakeholders have significant interest in the activities of the College, evidenced by the number of submissions received by the AMC in relation to the follow-up assessment. The team recognises that stakeholder engagement can be challenging particularly for a small college. The College is commended on its progress and future direction.

The AMC received written submissions and met with state and territory health departments, the Australian Government Department of Health, Ministry of Health New Zealand and Health Workforce New Zealand during the assessment visit. Overall, the jurisdictions indicated they had positive and collegial relationships with the College and that the training program is producing safe, skilled and competent graduates.

The jurisdictions provided additional feedback to the team in the following areas.

- Consider enhancing communication with jurisdictions regarding the development of opportunities in expanded settings in rural, regional and peri-urban growth areas.
- Develop a formal process for seeking jurisdictional and employer input on issues such as proposed changes to the curriculum or selection processes.
- There is limited direct communication between the employer and College. The College communicates with employers via the local ICU Directors and supervisors of training but not directly with the employers. Some employers indicated they were not aware of the formal mechanisms for communication with the College.

In 2011, a number of the jurisdictions were seeking greater engagement with the College particularly on developments in the training program. This is highlighted as an issue again in 2014. The team recommends that the College develop formal processes for seeking input on changes to the training program.

Access to placements in clinical anaesthesia and medicine were raised as an issue by various stakeholders, including trainees and supervisors. There is a perceived lack of consistency, coordination, oversight and transparency in how these placements are organised and allocated. The College recognises that further collaboration is required with the Royal Australasian College of Physicians and the Australian and New Zealand College of Anaesthetists with regards to the medicine and anaesthesia terms. This is discussed in further detail under standard 8.2.

1.5 Continuous renewal

The accreditation standards are as follows:

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

1.5.1 Continuous renewal in 2011

The College accreditation submission lists a number of recent changes as evidence of the regular reviews occurring. These include:

- *the planned review of the training program linked to consideration of the changing nature of intensive care practice*
- *review of cultural competence and how it is addressed within the College structure*
- *provision of increased support for supervisors of training*
- *changes in committee structures including, adding trainee representation and establishing the Fellowship Affairs Committee to oversee CPD, recertification, credentialing and welfare*
- *review of policies and documentation relating to hospital accreditation.*

The submission also outlines a variety of ways in which the College reviews its structures, functions and policies.

Every five years, policy documents are circulated to relevant groups including fellows, College regional and national committees and other bodies as appropriate. Feedback is assembled by the relevant committee responsible for reviewing functions and policies relating to their particular area of concern.

The New Fellows' Conference is also a forum to seek feedback from trainees and new fellows. The College holds this conference in June prior to the Annual Scientific Meeting. Its purpose is to provide new fellows and trainees with insights into how the College is run and the changing demands on trainees.

In addition to these regular reviews, the transition to the new College has been a stimulus to review governance structures and educational policies. The College recognises it will

need to keep these structures and policies under review in the early days of operation as a separate body.

1.5.2 2011 team findings

The formation of the new College is a significant milestone. This development creates a number of opportunities for the College to review how it operates and to build its profile as the body that sets standards for medical practice and patient care in intensive care medicine.

This may require an expansion of the College's role to take responsibility for functions previously managed in collaboration with the Joint Faculty's parent colleges. Such roles include public education; contributing to debates about healthcare, and wider health and social issues; collaborating with other professional bodies nationally and internationally; and promoting health policy that supports good care and responsible decisions. The College acknowledges these opportunities and recognises that it will need to keep its capacity to support them under review.

As noted earlier, the College plans to progress several important initiatives, including the reviews of the role of the intensivist and the curriculum. The College will need the time of staff and College officers, beyond the demands of day-to-day operational issues, to progress these issues.

1.5.3 2015 team findings

The College has undertaken significant work in this area since the previous assessment, in particular on the curriculum review and the role of the intensive care medicine specialist. The College has mechanisms in place to regularly review governance structures, policies and processes as well as education activities and there is evidence of an effective response to feedback gathered through these review processes.

The College indicated that ongoing review of the curriculum will involve gathering and reviewing information from a number of sources. These sources include feedback from trainees and supervisors via online surveys, at College meetings, through the Trainee Committee and review of performance of the various assessment components. Areas of concern will be considered by the Education Committee and recommendations for change will be forwarded to the Board. Formal review of the curriculum is planned to occur after five years, notwithstanding the changes that may need to be implemented in the intervening period. The College intends to use external educational expertise for the comprehensive review process.

It is noted that a number of fellows have given significant service to the College, particularly during the period of its establishment. Whilst these fellows are to be commended for their commitment and engagement, the team was concerned that much of the work has fallen to a relatively small group of fellows and questions the sustainability of this over time. Discussions with the College during the assessment visit revealed that the College is aware of these issues. As discussed under standard 1.1 and 1.4, the College is in the process of developing a strategic plan with key priority areas (particularly (i) engagement of fellows and (ii) a sustainable organisation) that may address this.

The College has undertaken significant work as it has been established and now requires a period of consolidation. It is noted that the engagement of fellows is a key component of the strategic plan and the team looks forward to seeing a wider representation of the fellowship in the governance of the College in the future.

In its accreditation submission, the College identifies a number of challenges it will need to address from 2015 onwards including:

- addressing the issue of the mismatch between the number of trainees entering the program (and the number of graduates) and the demand for intensive care medical specialists
- increasing the level of interaction with other health service organisations, and external stakeholders
- closely monitoring trainee progress with certain aspects of the new curriculum, for example when trainees start to reach the Transition Year of training
- continuing the debate with hospitals and jurisdictions on the most desirable 'model' for an intensive care service, and the implications for training and its ongoing development
- continuing to address the high rate of burn-out in fellows due to the requirement for 24-hour care, as well as the current lack of gender balance at both fellow and trainee level.

2011 Accreditation Conditions and Recommendations

2011 Commendations

A The College's smooth and successful transition to an independent training organisation.

B The recent strategies developed by the College to engage new fellows and seek their input in its teaching, assessment and continuing professional development.

C The College's plans to engage appropriate external educational expertise to support the curriculum review.

2011 Conditions to satisfy accreditation standards

1 In recognition of the College's recent expansion and continued growth, in progress reports provide evidence of appropriate resources and technical staff to support current and future educational activities. (Standard 1.2)

2 Develop a strategy to engage additional educational expertise particularly to support the review of the curriculum and the review of the role of the intensive care medicine specialist. (Standard 1.3)

2011 Recommendations for improvement

AA Develop and implement strategies to continue to expand the number of fellows engaged in its activities. (Standard 1.1)

BB Define the College's stakeholders and identify a strategy or strategies to

	support their appropriate engagement in College activities. (Standard 1.4)
CC	Put in place structures to support constructive working relationships with health departments and health services at the strategic and senior level to support high quality education and training in intensive care medicine. (Standard 1.4)

The 2015 team considers conditions 1 and 2 from 2011 have been met.

2015 Accreditation Conditions and Recommendations

2015 Commendations

A	The engagement and commitment of fellows who hold Board and committee responsibilities, and in particular the significant service some fellows have provided to the College over an extended period of time.
B	The establishment of the Community Advisory Group as a mechanism for engaging consumers and community stakeholders.

2015 Conditions to satisfy accreditation standards

1	Demonstrate that there are processes in place to ensure ongoing medical educational expertise is available for the development and implementation of programs and projects across the College. (Standard 1.3.1)

2015 Recommendations for improvement

AA	Review the regulations, organisational chart and terms of reference to ensure consistency and currency in line with the recent committee changes. (Standard 1.2.1)
BB	Increase collaboration with the Royal Australasian College of Physicians and the Australian and New Zealand College of Anaesthetists to address how the anaesthesia and medicine terms are organised and allocated in order to achieve the learning objectives of the intensive care medicine training program. (Standard 1.3.2)
CC	Increase engagement with jurisdictions regarding educational changes and the resulting impact on workforce and clinical service delivery. (Standard 1.4.1)

2 Purpose of the College and outcomes of the training programs

2.1 Organisational purpose

The accreditation standards are as follows:

- The purpose of the education provider includes setting and promoting high standards of medical practice, training, research, continuing professional development, and social and community responsibilities.
- In defining its purpose, the education provider has consulted fellows and trainees, and relevant groups of interest.

2.1.1 Purpose of the College of Intensive Care Medicine in 2011

The College of Intensive Care Medicine of Australia and New Zealand is the body that oversees training of intensive care specialists and sets and promotes high standards of medical practice in the specialty of Intensive Care Medicine in this region.

The Objects of the College are contained in the constitution. There are nineteen characteristics of a generic nature, which would be relevant to all good colleges.

The College defines intensive care medicine as follows: 'Intensive Care Medicine encompasses the early detection, assessment, resuscitation and ongoing management of critically ill patients with life-threatening single and multiple organ failure, and monitoring of those at high risk of developing life-threatening complications. It also involves management of end-of-life care, organ donation and provision of palliative care. Clinical responsibilities are not confined to the Intensive Care Unit since intensive care specialists are also frequently required to manage medical emergency teams for the wards and attend seriously ill patients outside of the ICU for assessment and treatment, including their safe transport within and between facilities. They are also involved in the practice and teaching of out-of-hospital resuscitation and transport. Quality improvement activities, research and the active practice of evidence-based medicine are important in the intensive care specialist's practice, to maintain the highest level of care.'

The description of Paediatric Intensive Care Medicine is identical to the above, except that it applies to children of less than 16 years. Paediatric Intensive Care Medicine is generally practised in specialised paediatric hospitals. Although the principles are very similar to those of Intensive Care Medicine for adult patients, the subspecialty acknowledges there are illnesses, clinical conditions and problems unique to critically ill children.

The College website, www.cicm.org.au, and particularly the 'About Us' page explains the role of the College as the peak body for intensive care medicine specialist training and education in Australia and New Zealand. There is also a short history of intensive care training in Australia and New Zealand, and descriptions of the role of an intensive care specialist and the specialty of intensive care medicine.

The College's accreditation submission outlines a number of ways in which the College's purpose and role are communicated. These include:

- *policy documents and annual reports*

- *communication by the President including committee reports and regional visits to meet trainees and fellows*
- *through the regional committees*
- *by the College's six-weekly electronic newsletter to all fellows and trainees*
- *through the Annual Scientific Meeting.*

As noted in section 1 of the report, the College has no formal, organised means of dialogue with the community at large. The College website explains the role of the College to the public and is a potential avenue for community enquiry.

2.1.2 Purpose of the College of Intensive Care Medicine in 2015

The College has made no changes to its purpose or mission since 2010 when it became the body responsible for training and certification of intensive care specialists. The Objects of the College form the preamble to the constitution and are publicly available on the College's website.

In 2012, the College completed the review of the statement of the role of the intensive care medicine specialist. The draft statement was circulated broadly for consultation to College fellows and trainees, and a wide range of external stakeholder groups, including health and regulatory authorities, medical and nursing training institutions, a variety of patient advocacy groups, and medical associations.

As discussed under standard 1, the College formed the Community Advisory Group in 2014 whose role is to facilitate engagement with consumers and the community on the broad issues relating to training of intensive care specialists and the practice of intensive care medicine. This group provided advice on the content of the 'For Patients & Families' section of the website. It was also tasked with reflecting on the statement of purpose and definition of graduate outcomes and at the time of the 2015 review had produced a statement, 'What is an Intensive Care Specialist?' which has recently been ratified by the Board. That statement is as follows:

> An intensive care specialist is the leader of the clinical care team and the person ultimately responsible for the care of the patient whilst that person is in an intensive care unit. An intensive care specialist is a medical specialist trained and assessed to be proficient in the comprehensive clinical management of critically ill patients as part of a multidisciplinary team. Critically ill patients include patients with life-threatening single and multiple organ system failure, those at risk of clinical deterioration as well as those requiring resuscitation and/or management in an intensive care unit or a high dependency unit. The intensive care specialist has clinical skills that include the ability to recognise and manage the disturbances associated with severe, medical, surgical, obstetric and paediatric illness and to diagnose and treat the conditions that cause them. This usually involves invasive and non-invasive diagnostic techniques, monitoring, and treatment modalities designed to support vital organs. The intensive care specialist is an expert in end of life care, the diagnosis of brain death, and care and support of the organ donor. Intensive care specialists are also frequently involved in the transport and retrieval of critically ill patients as well as in the management of seriously ill patients outside the intensive care unit.To facilitate their practice the intensive care specialist has advanced communication skills that enable appropriate and effective interaction

with patients, families, other team members and referring clinicians, and that enable collaborative, multidisciplinary practice. The intensive care specialist continues to learn throughout professional life and acknowledges that involvement in teaching, research, quality improvement and administration are integral to the role.

2.2 Graduate outcomes

The accreditation standards are as follows:

- The education provider has defined graduate outcomes for each training program including any sub-specialty programs. These outcomes are based on the nature of the discipline and the practitioners' role in the delivery of health care. The outcomes are related to community need.
- The outcomes address the broad roles of practitioners in the discipline as well as technical and clinical expertise.
- The education provider makes information on graduate outcomes publicly available.

2.2.1 Graduate outcomes in 2011

The Objectives of Training documents are statements of the knowledge, skills and attributes that the College expects a trainee to have achieved by the end of a component of training. These documents are posted on the College website.

Since the 2002 AMC accreditation of the Joint Faculty of Intensive Care Medicine, the Objectives of Training documents have been comprehensively revised and expanded to include:

- *Objectives of Training and Competencies for Basic Training in General Intensive Care Medicine document T-5*
- *Objectives of Training and Competencies for Advanced Training in General Intensive Care Medicine document T-6*
- *Objectives of Training and Competencies for Advanced Training in Paediatric Intensive Care Medicine) document T-15*
- *Objectives of Training - The Medical Term document T-7*
- *Objectives of Training - The Anaesthesia Term document T-8.*

The Objectives of Advanced Training and Competencies describe the outcomes expected for a graduate of the general intensive care medicine training program of the College. The Objectives of Paediatric Intensive Care Training and Competencies was first promulgated in 2010 and describes the outcomes expected of Trainees taking the paediatric pathway to fellowship of the College. Achievement of the objectives is intended to ensure that the new graduate has advanced knowledge, skills and highly developed communication skills and other personal attributes necessary to function as a competent intensive care specialist and thus to serve the community. They are considered to be the minimum standards for a graduate to be a safe independent specialist.

These objectives include clinical competencies, such as the approach to acute illness, therapy, monitoring, measurement and interpretation of data; technical skills; and broad

roles of practitioners according to accepted (CanMEDS) categories such as communicator, manager and educator.

These documents were reviewed in 2004, 2007 and 2010. The College made changes following the introduction of a program model of Basic Training and Advanced Training in 2003, to specify the skills to be developed during each of the two stages. A new paediatric document followed in 2010. Other changes respond to the trainees' request for clarification of the rationale for mandating anaesthesia and internal medicine terms.

2.2.2 Graduate outcomes in 2015

As part of the review of the curriculum, the College also revised the Objectives of Training documents taking into account the expanding role for specialists in intensive care medicine. The Objectives of Training documents have been revised as follows:

- Competencies, Learning Opportunities, Teaching and Assessments for Training in General Intensive Care Medicine 2011 (combines three documents into one document, previously titled the Objectives of Training)
- Objectives of Training for the Transition Year 2013 (new document outlining the objectives for the final year of training)
- Objectives of Training for the Anaesthesia Term 2014 (not substantially altered)
- Objectives of Training for the Medical Term 2014 (updated to reflect the requirement for trainees to now complete six months in an acute medicine placement).

All documents are available on the College's website.

As discussed under standard 1.2, a paediatric intensive care medicine section has now been formed within the College. The Paediatric Intensive Care Medicine Committee will be reviewing the competencies, learning opportunities, teaching and assessments for training in paediatric intensive care medicine. This document will be completed and available on the College's website by the end of 2015.

The College's revised In-Training Evaluation Report (ITER) has been developed in line with the CanMEDS roles of medical practice. The competencies fall under seven domains which are:

- Medical (Clinical) expert
- Communicator
- Collaborator (Team worker)
- Manager (Leader)
- Health advocate
- Scholar (Educator)
- Professional.

The ITER rates trainee performance in 23 items across the seven domains of medical practice. The required competencies are described by a key competency (broad

statement of skills to be acquired by the trainee) and then the route to its acquisition is detailed in two stages, novice trainee and expert trainee.

2.2.3 2011 team findings

The College's purpose, as the training organisation and standards setting body for intensive care medicine, is well defined and appropriate. There is ample information about the College's role on its website.

Of the stakeholders consulted during this accreditation assessment, a majority viewed the establishment of a separate College of Intensive Care Medicine positively, and considered that it had the potential to promote a stronger identity for the specialty. Currently, the College focuses its efforts in communicating its role and purpose to its fellows and trainees. It has a more passive approach to making information available to other stakeholder groups. The team encourages the College to engage with a wider range of stakeholders to enhance its capacity to promote high standards of medical practice, training, research, and continuing professional development.

The AMC accreditation standards require that the education provider has defined graduate outcomes for its training program and that these outcomes are based on the nature of the discipline and the practitioners' role in the delivery of health care, and are related to community need.

The team noted the College's definition of intensive care medicine, and that there were limited international definitions the College could use for comparative purposes. Internationally, there is a small number of countries which have training programs for the specialty of intensive care medicine, including Canada, the USA, Hong Kong, Ireland and elsewhere in Europe. Some of these are modelled on the Australian/New Zealand program. In other countries, intensive care medicine is usually a subspecialty of anaesthesia or internal medicine, and if internal medicine it is most commonly placed in respiratory medicine.

During the assessment, the team has had considerable discussion with College committees, fellows and trainees about the role of the intensivist. The College regards the document, Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine, as the current statement of this role. However, there is a clear recognition that the role is evolving in response to factors such as:

- *the changing characteristics of hospital patients in terms of acuity, age and presence of co-morbidities*
- *heightened expectations by jurisdictions, consumer groups and families leading to demand for the skills of intensive care specialists in caring for very ill patients in the general wards*
- *technological changes and new practical and procedural skills*
- *location of practice, with a significant number of future consultant positions in some Australian states being available in rural and regional intensive care units, which require a broader range of skills than tertiary referral units.*

The team considers the intensive care medicine program and the paediatric intensive care medicine program produce high quality, technically skilled graduates. This was supported by feedback from new fellows and their employers. While the specialist nature of intensive care practice and its value in the health services is recognised, so too is the possibility of future graduates being ill-prepared for specialist practice as the role continues to change.

The College intends to make the review of its current statement a priority. The team supports this intention. The statement needs to relate the outcomes of the College's training program to the community's diverse needs. As is the case for all colleges, CICM needs to strengthen its processes for understanding community need with opportunities for appropriate community and/or consumer engagement. The challenge for the College is to lead the debate about the changing role of the intensive care medicine specialist, engaging not only its fellows and trainees in this review, but also external stakeholders.

As employers of the College's fellows, the health services have a clear interest in this review. The team's consultations with health department officers indicated they have considerable interest in the way in which the role is developing, and the ability to provide useful information about relevant workforce challenges.

The evolution of the role of the intensive care specialist will effect the roles of other related specialties. The team encourages the College to provide other specialist medical colleges with opportunities for formal input into the review of the role statement so the important differences between the role, skills and knowledge of the intensive care specialist and those of other specialists, and the implications of this for future training are understood.

The College also intends to review its curriculum. The team sees the review of the role statement, as critical to the College's development of its objectives of training and graduate outcome statements and to defining the curriculum. The team supports the view that these discussions are a high priority for the College.

2.2.4 2015 team findings

During the 2015 assessment, both internal and external stakeholders indicated to the team that the College's intensive care medicine program and the paediatric intensive care medicine program continue to produce high quality and competent graduates.

In 2011, the AMC applied three conditions on accreditation regarding the College's purpose and graduate outcomes, including reviewing the role of the intensive care medicine specialist statement (condition 3); reviewing the objectives of training (condition 4), and implementing processes for regularly reviewing the statement of graduate outcomes in relation to community need (condition 5).

The College satisfied condition 3 in 2012 with the completion of the review of the statement of the role of the intensive care medicine specialist. A broad range of internal and external stakeholders were consulted as part of the review. Condition 4 was addressed in 2013 by finalising the review of the Objectives of Training documents which reflect the changing role of the intensive care medicine specialist. The 2015 team considered condition 5 as part of this assessment.

The 2011 team findings on the purpose of College and graduate outcomes remain relevant. As a result of the 2011 review, the AMC recommended that the College review its statement concerning the role of the intensive care medicine specialist seeking wide stakeholder input. As part of the 2015 assessment there was a significant level of interest in the College as measured by the number of stakeholder responses. These responses came largely from health departments, other specialist colleges and peak consumer groups. There is opportunity for the College to develop a mechanism for seeking and incorporating input from stakeholders such as the jurisdictions, health service providers, consumer organisations and other specialist medical colleges in defining the purpose of the College and reviewing the statement of graduate outcomes in relation to community need. A useful reference is the Australian Commission on Safety and Quality in Health Care document, Standard 2 – Partnering with Consumers.

The team commends the College on the formation of the Paediatric Intensive Care Medicine section and the work being completed on the competencies, learning opportunities, teaching and assessments for training in paediatric intensive care medicine. The team recognises efforts thus far to address the needs of children in relation to graduate outcomes.

In 2013, the College introduced an annual survey of new fellows seeking their views on how well the training program prepared them for specialist practice. The 2014 survey results indicated that 81% of new fellows thought their training prepared them adequately for taking on the role of consultant particularly around the 'medical expert' role. Some new fellows indicated that they were not well prepared for other aspects of becoming a consultant, for example the 'manager' role. The College indicates that once the new curriculum has been in place for a few years and the new graduates have undertaken the Transition Year of training and the College Management Skills course, it will assess whether this has had an impact on the results of the survey. The AMC looks forward to updates on progress in future progress reports.

The College accepts the Royal Australasian College of Physicians- and the Australian and New Zealand College Anaesthetists-accredited medicine and anaesthesia terms for intensive care medicine training. The team heard during the assessment visit that this process is working well for the College. The team considers however that accreditation of a term for training in another specialist organisation may not always be appropriate in the context of the specific graduate outcomes of intensive care medicine. The team recommends careful monitoring of such terms by the College.

The College regards the practice of intensive care medicine as evolving and recognises that changes in available technology, research findings, and health service organisation will impact on the requirements of training. Even though the curriculum has been recently reviewed, the College recognises there will be further developments which need to be taken into account. An example is the gradual formalisation within health services of 'Rapid Response' or 'Medical Emergency' Teams, which are often sourced from the intensive care unit. Currently, there is no formal requirement for trainees to spend time training as part of a Rapid Response Team, but the College indicated it will continue to monitor the situation and may possibly in future change the training requirements to include this. The AMC looks forward to updates from the College on any developments.

2011 Accreditation Conditions and Recommendations

2011 Commendations

Nil.

2011 Conditions to satisfy accreditation standards

3 Review the College's statement concerning the role of the intensive care medicine specialist seeking wide stakeholder input including community consultation. This review should result in a statement that articulates clearly the requirements for comprehensive, safe and high quality intensive care medicine practice, including in the general roles and multifaceted competencies inherent in all medical practice. The statement should also identify the competences that distinguish the intensive care medicine specialist from other health professionals. (Standard 2.1.1)

4 Following the review of the statement of the role of the intensive care medicine specialist, review the objectives of training to ensure they articulate the knowledge, skills and professional attributes necessary for comprehensive intensive care medicine practice, including practice in tertiary, rural and regional centres. These statements should be the basis for developing the intensive care medicine curriculum. (Standard 2.1)

5 Provide evidence of processes for regularly reviewing the statement of graduate outcomes in relation to community need. (Standard 2.2.1)

2011 Recommendations for improvement

DD Engage with a wider range of stakeholders to enhance the College's capacity to promote high standards of medical practice, training, research, and continuing professional development. (Standard 2.1.2)

The 2015 team considers condition 3 and 4 from 2011 has been met. Condition 5 from 2011 is progressing and is replaced with condition 2 in 2015.

2015 Accreditation Conditions and Recommendations

2015 Commendations

C The work of the Community Advisory Group in reviewing the definition of the intensive care medicine specialist and the content in the 'For Patient & Families' section of the College's website.

D The formation of the Paediatric Intensive Care Medicine section, the work being completed on the competencies, learning opportunities, teaching and assessments for training in paediatric intensive care medicine and the efforts thus far to address the needs of children in relation to graduate outcomes.

2015 Conditions to satisfy accreditation standards

2 Develop a mechanism for seeking and incorporating input from stakeholders

such as the jurisdictions, health service providers, consumer organisations and other specialist medical colleges in defining the purpose of the College and reviewing the statement of graduate outcomes in relation to community need. (Standard 2.1.2)

2015 Recommendations for improvement

DD Implement a process for the College to be informed of changes to the criteria for accreditation of the medicine and anaesthesia terms accredited by the Royal Australasian College of Physicians and the Australian and New Zealand College of Anaesthetists so CICM is assured the terms continue to meet the graduate outcomes of the intensive care medicine training program. (Standard 2.2)

3 The education and training program – curriculum content

3.1 The curriculum framework, structure and content

The accreditation standards are as follows:

- For each of its education and training programs, the education provider has a framework for the curriculum organised according to the overall graduate outcomes. The framework is publicly available.
- 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.
- Successful completion of the training program must be certified by a diploma or other formal award.

3.1.1 Curriculum framework, structure and content in 2011

The Intensive Care Medicine Training Program consists of six years of structured supervised training divided into three years of Basic Training and three years of Advanced Training.

As noted in section 2 of the report, a number of documents outline the key objectives of Basic and Advanced Training including the objectives of the medicine and anaesthesia components of the training program, and a separate document covering the objectives of Advanced Training in Paediatric Intensive Care.

In addition, the College has a syllabus for the Basic Sciences in Intensive Care Medicine document T-4 which describes the learning objectives for trainees, tutors and examiners.

The Objectives of Training documents list the skills and competencies to be achieved prior to completing Basic or Advanced Training and those required to be completed prior to the award of fellowship.

The Objectives of Basic Training identify 14 curriculum areas, with the content expressed as general instructional objectives and required skills and abilities. The Objectives of Advanced Training are structured in the same way, with 17 curriculum areas. Common to both basic training and advanced training are:

- *The Approach to Acute Illness*
- *System(s) Failure*
- *Medical, Surgical and Obstetric Conditions*
- *Therapy*
- *Supportive Care of the Critically Ill Patient*
- *Monitoring, Measurement, Investigations and Interpretation of Data*
- *Cardiopulmonary Resuscitation*
- *Transportation of Critically Ill Patients*

- *Technical Skills*
- *Ethics*
- *Communication*
- *Education.*

The Basic Training objectives also encompass The Basic Sciences, and Clinical Audit and Quality Improvement. The Advanced Training objectives also encompass Paediatrics; End of Life Care; Organ Donation; Administration and Quality Assurance; and Research in Intensive Care.

Both Objectives documents include a Representative List of Treatments Undertaken in the Intensive Care Unit that the trainee should understand and a Representative List of Procedures relevant to the Intensive Care Specialist that the trainee should be able to perform safely. The Advanced Training objectives include an expanded Representative List of Medical, Surgical and Obstetric Conditions which the trainee should recognise, understand the pathophysiology, manage and work to prevent the associated complications.

Trainees can apply for entry into the CICM training program after successfully completing the internship (postgraduate year 1).

The six years of structured supervised training includes a defined minimum period of core intensive care training recently increased from 24 to 36 months. Of this, a minimum of 24 months' core intensive care training must be undertaken during the three years of Advanced Training. At least 12 months of core Intensive Care training must be undertaken in a unit designated as a C-24 Unit and at least 12 months of core ICU must be in one intensive care unit.

Trainees are required to gain experience and knowledge in a 12-month anaesthesia term and a 12-month internal medicine term in addition to the 36 months of core intensive care medicine. The aims for each term are documented in the relevant statement of term training objectives.

The College offers specific training in paediatric intensive care medicine, in addition to the general pathway to Fellowship. Separate training in Paediatric Intensive Care has been available since 1997.

The paediatric training program uses the framework of the general training program but it is aimed at training and assessing specific skills necessary for the care of critically ill children of less than 16 years. The outcomes expected of the paediatric pathway to Fellowship are described in the Objectives of Paediatric Intensive Care Training and Competencies document.

The Paediatric Intensive Care Medicine pathway is the same length and structure overall but has the following specific requirements:

- *24 months of core intensive care medicine training in Advanced Training:*
    - *18 months must be in an approved paediatric intensive care unit*

- *12 months must be in a major paediatric intensive care unit in a tertiary referral hospital, designated by the College as a C24, which means it provides unrestricted core training*

- *completion of the Fellowship Examination in paediatric intensive care medicine.*

Trainees admitted to fellowship of the College who have satisfied the training and examination requirements in Paediatric Intensive Care are issued a certificate indicating successful completion of the requirements of the Paediatric Intensive Care Medicine examination.

Instead of the 12-month internal medicine term, Paediatric Intensive Care Medicine trainees complete a 12-month paediatric internal medicine term. The College recommends they complete some or all of the 12-month anaesthesia term in paediatric anaesthesia.

All trainees must complete the following:

- *Basic Training covers the fundamentals of the practice of intensive care medicine. College regulations state that two of the three years of Basic Training will be spent in any combination of: intensive care medicine; clinical anaesthesia; general medicine; specialist medicine; emergency medicine; surgery; pain medicine; research; and/or other disciplines related to intensive care medicine.*
- *A formal project which exposes trainees to clinical research or evidence-based medicine and the requirements for this project are set out in the document Formal Project Requirements document T-9.*
- *The Basic Sciences Examination must be completed or recognition of prior learning granted.*
- *The medical Australasian Donor Awareness Program (ADAPT) course is also compulsory as is obtaining a pass in the fellowship examinations.*

3.1.2 2011 team findings

The curriculum is a critical component of any training program. The curriculum allows the blueprinting of many educational and training functions. In particular a well-constructed and clearly defined curriculum defines the course objectives expressed as learning outcomes, the clinical experience necessary, the assessment standard, and the strategy for assessment. It also provides the basis for decisions about credit for prior learning. The curriculum should also describe the infrastructure required and the resources including the educators and supervisors.

The College makes its current curriculum documentation, the statements of objectives, publically available via the College website. There is also a syllabus for the Basic Sciences examination in Basic Training. The College acknowledges the urgent need to combine and refine these documents into a single curriculum for training in intensive care medicine. The Joint Faculty began work on a curriculum review in 2006, but the work did not progress while the organisation concentrated on the establishment of the new College.

The Board and the Education Committee of the College both support the urgent need for a curriculum review. The team agrees that this review is the critical educational priority for

the College. In the short term, the AMC will expect a well-developed plan and clear timetable for completion of this work.

The team identified the following areas of curriculum as requiring attention.

The curriculum review will need to clarify the objectives of training in core Intensive Care Medicine as well as in the medicine and anaesthesia terms. At present, trainees may complete the medicine attachment in many subspecialty areas including those with only a limited or no acute component. Clarification of the objectives of the medicine attachment will in turn aid the College in directing trainees to only those attachments considered to offer the breadth and depth of medical experience required for intensive care medicine training.

The team recommends the curriculum review address the question of the length of both the medicine and anaesthesia attachments. Given the historical development of the specialty, the requirements for lengthy training in these two specialty areas is not surprising. However, as the practice of intensive care medicine has evolved, questions have arisen about the length of these terms. Greater clarity around the training objectives and the structured educational approaches available may lead to an alteration in the requirement for 12-month terms. In addition, the team believes the curriculum review should explore the potential training value of an attachment in an approved emergency department setting.

The positioning of the medicine and anaesthesia attachments within the six years of the training program should also be examined. In view of the importance of airway management in core intensive care practice, the team suggests the curriculum review consider whether achievement of the anaesthetic learning outcomes and anaesthesia term should be a requirement of Basic Training.

The team explored the preparedness of trainees to enter specialist practice when they complete their training. Most trainees felt well prepared, but a number of common themes emerged. One of these was the timing of the medicine term, which is frequently completed near the end of training. The team suggests that trainees may benefit most from spending the last 12 months of training in a core intensive care setting to optimise preparation to begin specialist practice. Another theme was the training settings, and the potential mismatch between the completion of a majority of training in a tertiary unit and the availability of consultant positions largely outside these centres. By developing a comprehensive curriculum that identifies important and common conditions, the College would have a sound basis to determine the training experience appropriate to satisfy the curriculum requirements.

CICM has taken account of the broad curriculum frameworks, such as CanMEDS, that describe the roles of medical specialists beyond that of medical expert and also consider the social context of medical practice. The graduates of the College's programs are seen as highly skilled, but gaps were identified in their preparation for the administrative, leadership and management role of a consultant. Some health departments suggested that communication and teamwork skills required further attention. Although the College's current statement does take account of these roles and competencies, the team encourages

further consideration of these frameworks and the incorporation of this broader context in the curriculum review.

The College has given considerable thought to the question of paediatric experience for all trainees, not just those entering the Paediatric Intensive Care Medicine training pathway. The College believes the flexibility offered by the general intensive care medicine training program allows those trainees who expect to care for children to gain appropriate paediatric intensive care experience. The team acknowledges the Education Committee regularly reviews this issue but recommends the College determine if management of the critically ill child is core knowledge for all trainees and therefore must be addressed in the curriculum. At present the greatest barrier to a compulsory paediatric attachment is a severe limitation on paediatric ICU rotation positions.

The supervised clinical experiences will be variously augmented by a number of courses, skills workshops and opportunities for self-directed learning. These are described in section 4.

The College Board has recently approved a proposal to accredit a three-month rotation to rural or regional ICUs approved for Basic Training during the non-continuous year of Advanced Training. It has rigorously debated the role of a rural rotation as a compulsory training requirement. This has predictably raised tensions for trainees about the potential dislocation and the perceived training advantages of experiencing rural practice. Whilst most trainees do not support a mandatory attachment, the idea is supported by the vast majority of fellows who see benefits in the opportunities for trainees to see patients of all ages, undertake more procedures, develop non-clinical skills such as management skills, and extend their experience in the management of critically ill patients who may require transfer to a tertiary centre for further care.

The important differences between metropolitan and rural practice are well recognised by the College. The team encourages the College to articulate clearly its educational reasons for proposing such a rotation and to link this to the learning outcomes. This may mean the medicine or anaesthesia terms will meet the requirements as well as in intensive care.

The Education Committee is exploring the concept of training modules. Modules could address such areas as rural training, experience in the management of significant neurological disorders, burns, major trauma, cardiothoracic surgery and so forth. If the College develops such a framework, these modules will need to be fully defined in the curriculum with the competencies to be acquired, training resources available, assessment methods, and learning opportunities and methods described. Trainees did express concern that a modular curriculum structure may create additional limitations and barriers to the completion of training. These concerns should be considered by the Education Committee.

As noted earlier the College is reviewing its statement describing intensive care medicine practice. In discussions with the team, College representatives described the changing role of the Intensive Care Specialist in recent years with many specialists developing roles in clinical decision-making and management of patients outside the physical intensive care environment. Such roles include ICU 'outreach services' for deteriorating patients defined as 'at risk' on wards and in emergency departments. At present there is no specified component of the curriculum to prepare trainees for these aspects of intensive care

practice. The College has highlighted this as an area of rapid change in intensive care work. Again, the team expects further definition and development of the curriculum covering such activity.

As a provider of specialist training in New Zealand, CICM must meet specific requirements in relation to education and training and professional development in cultural competence. The College clearly recognises the need for trainees and specialists to be able to interact effectively with the broad range of cultures encountered in the practice of intensive care medicine. The College specifically lists cultural competence in its Guide to Advanced Training. The In-training Assessment (ITA) forms used at the completion of each six-month rotation require assessment of the trainee in two domains relevant to cultural competence. The College intends to create an electronic link on its website for trainees and fellows to access the Medical Council of New Zealand statement on cultural competence.

The College has introduced specific training in communication skills and the fellowship examination contains a specific communication component. All trainees must attend the Australasian Donor Awareness Program (ADAPT) course. Communication and cultural issues concerning brain death and potential organ donation are key aspects of the course.

The College clearly defines the requirements for the award of fellowship. There is, however, no time limit on when trainees need to meet all requirements in relation to the successful completion other components of the training pathway. The team recommends the College examine this issue.

3.1.3 Curriculum framework, structure, content and cultural competence in 2015

In 2013, the College completed the review of the intensive care medicine curriculum framework. The new training program was implemented for all trainees registering with the College from 1 January 2014. Trainees who commenced training prior to 2014 will complete their program under the requirements of the old curriculum. The Guide to CICM Training: Trainees, available on the College's website covers the requirements of both training programs.

As noted under standard 2, the document Competencies, Learning Opportunities, Teaching and Assessments for Training in General Intensive *Care* published in 2011, outlines 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. The Competencies, Learning Opportunities, Teaching and Assessments for Training in Paediatric Intensive Care, is being developed and should be finalised by the end of 2015.

The required competencies are described by a key competency (broad statement of skills to be acquired by the trainee) and then the route to its acquisition is detailed in two stages, novice trainee and expert trainee. As discussed under standard 2, the competencies fall under seven domains of medical practice. Acquisition of the knowledge, skills and attitudes required to meet these competencies occurs through mandatory teaching terms and specified courses, both online and face-to-face. Further information on the College's courses is provided under standard 4.

Training to fellowship of the College continues to be a minimum of six years of structured supervised training with prescribed terms in intensive care units, anaesthesia and medicine. Each trainee's requirements vary depending on prior experience and qualifications.

The main changes to the training program from 2014 are:

- the increase of specific intensive care training time from 36 months to 42 months, while keeping the overall length of training to six years
- the introduction of a 'Transition Year' of training, which must be undertaken in intensive care
- a requirement to complete a minimum of three months of the overall training time in a rural or regional placement
- the introduction of mandatory courses as part of the program
- changes to the in-training assessment process.

The 42 months of intensive care medicine training time consists of:

- 6 months of foundation training in intensive care medicine (pre-registration) which must be undertaken prior to selection into the training program in a unit approved by the College.
- 24 months of core intensive care medicine training. For trainees on the Paediatric Pathway, 18 months of this training must be undertaken in paediatric intensive care. Of these 24 months, at least 12 months must be continuous and undertaken in one unit. Entry into core training is dependent upon satisfactory completion of the CICM First Part Examination.
- 12 months of transition training in final year, which must be continuous and undertaken in one intensive care unit. Entry into the Transition Year requires successful completion of the CICM Second Part Examination and all other required assessment tasks.

General Pathway

General Pathway trainees must complete the terms in units that are accredited for and provide adequate experience in each of the following:

- cardiothoracic surgery intensive care
- neurological/neurosurgery intensive care
- trauma intensive care.

Additional training includes the following:

- 12 months of anaesthesia training
- 12 months of medicine training (including 6 months of emergency or acute medicine and 6 months with responsibility for longitudinal care of medical patients)
- 6 months of elective training in a position approved by the College for training in one of the following disciplines: intensive care medicine, clinical anaesthesia; general medicine (adult and paediatric); specialist medicine; emergency medicine;

surgery; pain medicine; research; or other disciplines related to intensive care medicine.

General Pathway trainees are also required to complete:

- 3 months in a rural hospital and
- a term (6 to 12 months) in paediatrics in a unit approved for paediatric training.

Paediatric Pathway

Paediatric Pathway trainees must complete the terms in units that are accredited for and provide adequate experience in each of the following:

- paediatric cardiothoracic surgery intensive care
- paediatric neurological/neurosurgery intensive care
- paediatric trauma intensive care.

Additional training includes the following:

- 12 months of anaesthesia training
- 12 months of paediatric medicine training (including 6 months of emergency or acute medicine)
- 6 months of elective training in a position approved by the College for training in one of the following disciplines: intensive care medicine, clinical anaesthesia; general medicine (adult and paediatric); specialist medicine; emergency medicine; surgery; pain medicine; research; or other disciplines related to intensive care medicine.

Paediatric Pathway trainees are also required to complete three months in a rural hospital.

As described under standard 2, the revised objectives of training for the anaesthesia term, the medicine term and the Transition Year are available on the College's website.

Assessment of acquisition of knowledge is through the First Part and Second Part Examinations, In-Training Evaluation Reports, workplace competency assessments, observed clinical encounters and a formal project.

The College refers to the Syllabus for the Basic Sciences in Intensive Care Medicine, second edition 2011. This document is a guide for the First Part Examination for trainees, tutors and examiners.

The old curriculum is running in conjunction with the new curriculum and will continue to do so for such time as trainees who entered under the old regulations require training. The resources of the new curriculum are available to trainees training under the old regulations. Trainees informed the team that they are prevailing themselves of the opportunity to use the new training program resources.

Cultural competence

As part of the curriculum review, the College has standardised the formal learning opportunities for cultural competence. From 2014, trainees must complete an online course in cultural competence: in Australia, the Intercultural Competency Course; and in New Zealand, the Foundation Course in Cultural Competence. Trainees in New Zealand must also complete an externally run course, the Mauriora Foundation Course in Cultural Competency. The College has also developed an educational DVD which covers communication, consent and other cultural issues with Aboriginal and Torres Strait Islander peoples.

Trainees are assessed in cultural competence via the In-Training Evaluation Report under the 'Professional' category. The performance indicators for demonstrating culturally sensitive practice are as follows:

- Understands and respects cultural and individual diversity
- Establishes rapport and communicates effectively with members of other cultures
- Demonstrates ability to research unfamiliar cultures or issues
- Understands the impact of cultural background on communication, comprehension of therapy and end of life care.

3.1.4 2015 team findings

The College is to be commended on the significant work it has undertaken on the review and implementation of the new curriculum which relates to condition 6 from the 2011 assessment. The team found that the course objectives expressed as learning outcomes, the clinical experience necessary, the assessment standard, and the strategy for assessment is appropriate. The curriculum is divided into clear domains. There is a clear experiential component to the training and specific term requirements are outlined. There are written learning objectives for each of the different terms.

As discussed, the Competencies, Learning Opportunities, Teaching and Assessments for Training in Paediatric Intensive Care document is in the final stages of development. The College informed the team that this document will be finalised at the end of 2015. The AMC will expect an update on progress in the College's next progress report.

The team notes that the Syllabus for the Basic Sciences in Intensive Care Medicine has not been reviewed as part of the curriculum review. The team recommends that the College undertake a review of this document to align with and reflect the changes in the new curriculum.

In response to the AMC findings in 2011, the College has undertaken the following as part of the curriculum review:

- Developed a comprehensive curriculum that identifies important and common conditions, which has determined the training experience appropriate to satisfy the curriculum requirements.
- Clarified the objectives of training and length of core intensive care medicine as well as the medicine and anaesthesia terms. The 12-month medicine term now includes six months of emergency or acute medicine training.

- Examined the positioning of the medicine and anaesthesia terms within the six years of the training program.
- Explored the preparedness of trainees to enter specialist practice when they complete their training. Trainees are now required to spend 12 months in transition training in the final year to assist in preparing to begin specialist practice.

There is now a requirement for trainees on the General Pathway to complete a term which includes paediatric experience. The team commends the College on this development. During the assessment visit, the College reported that there did not appear to be any barriers for trainees in obtaining this experience. The new curriculum includes a section which outlines core competencies required by a general intensive care physician in the care of the critically ill child. The team notes however, that these requirements are part of the new curriculum and that a large number of trainees who are completing the old curriculum are not required to gain this paediatric experience prior to obtaining fellowship. The College may wish to consider developing resources accessible to all trainees in caring for the critically ill child.

The team acknowledges the inclusion of the three-month rural term in the new curriculum and recommends that the College develops specific objectives for this experience for inclusion in the curriculum documents.

The team commends the College on the inclusion of a section on extramural care and cultural competence in the new curriculum. The team also commends the College on requiring completion of an online cultural competency course prior to fellowship.

The work the College is undertaking on making use of existing online courses and where needed, developing new courses has a clear and structured approach. The team recommends that as the courses are developed they are mapped to learning objectives in the curriculum. This is discussed in further detail under standard 4.

The team notes that the College is in the process of implementing a new, more sophisticated online trainee dashboard which will provide a personalised training portfolio for each trainee to keep them updated about their training requirements and also contain all submitted assessment material. The team commends the College on the work being done on the dashboard and recommends that any new resources added are also mapped to the curriculum.

The College takes the view that no trainee will be disadvantaged by changes to training regulations that take place during their training. As the new curriculum has additional requirements that are not part of the old curriculum, it was decided that existing trainees will complete their training under the regulations in place at the time they registered. The fact that there will be two programs running in conjunction will need careful management and additional administrative support by the College. The team heard that trainees in the old training program were allowed access to the new program and were actively participating in extra courses as they found them to be relevant and useful.

Feedback received through the AMC assessment also highlighted some areas that the College may consider in its cycle of ongoing curriculum development and renewal. The team recommends that the College consider strategies for providing training in:

- palliative care
- managing a deteriorating patient outside of the intensive care unit
- additional skills and knowledge required to work in smaller intensive care units or rural/regional units.

In the 2011, the AMC recommended that the College place a time-limit on when trainees need to successfully complete all requirements of the training program. The 2015 team recommends that the College document this in its regulations.

3.2 Research in the training program

The accreditation standards are as follows:

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

3.2.1 Research in the training program in 2011

AMC accreditation standards require that specialist medical training include formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, and opportunities for trainees to participate in research.

Trainees must complete a formal research project to complete the training program. The College's formal project requirements indicate that the ability to plan, undertake, write and present a research project is an important part of training. The College indicates that the completion of the project is intended to encourage the trainees' development of an understanding of research methods, an ability to critically analyse scientific literature and a questioning attitude to their own clinical practice.

The formal research project can take a number of forms, including a prospective scientific study, an evidence-based, systematic review, a retrospective study or a case series. The project must be reported in the style of a paper for a peer-reviewed journal.

The College will accept a scientific paper already accepted for publication in a journal which referees all manuscripts and will consider accepting a project report completed in conjunction with training toward another college fellowship.

The trainee must be the first author of the project report and should present the project, ideally at a regional or national scientific meeting.

The training program allows for formal periods of research to be credited toward the completion of training. This is clearly specified in the College documentation.

3.2.2 2011 team findings

The team commends the College's clear commitment to engaging trainees in research.

The College's formal project requirements are explained in the publicly available CICM documentation. The processes for assessing the projects are fair and transparent.

Among trainees and fellows there is a considerable difference of opinion as to how well the project achieves its objectives of assessing research literacy. Trainees raised concerns about the selection of achievable and appropriate projects. While the College's Guidelines for ICUs seeking Accreditation of Training in Intensive Care Medicine require accredited training sites to have a program of research in which trainees can participate, trainees were concerned about the variation in the support and research supervision available to them. This variation affected the time trainees require to complete the project and their learning opportunities.

The team recommends the College's curriculum review consider the educational support necessary for trainees to meet the research learning outcomes. In addition, it encourages the College to consider other ways in which trainees might meet these learning objectives, such as by completion of an appropriate module or formal course.

The team was aware of some trainees not having satisfied the research requirement even some years after completing all other requirements, including successfully passing the Part II examination. This anomaly could be rectified by establishing time limits for the successful completion of various components of training. The team recommends the College examine the timing of the research requirement.

3.2.3 2015 team findings

The College continues to have a clear research focus and during the course of the training program trainees have to conduct a research project. This research needs to be presented at the level of a paper suitable for a peer review journal. Trainees can present a proposal for consideration to the College. The Formal Project is assessed through the Assessment Committee.

As part of the curriculum review, the College considered the overall learning objectives for the Formal Project. The College acknowledged that there was a lack of clarity about the requirements of the project and trainees were often leaving the completion of the project until after the Second Part Examination. In many cases, the project was the last outstanding aspect of the program and sometimes delaying a trainee's admission to fellowship. As previously discussed, under the new training program the College changed the requirements for fellowship to include a Transition Year of training. All trainees must complete the requirements of the Formal Project prior to commencing the Transition Year. In addition, the Formal Project Requirements T-9 document has been revised and makes more explicit the scope of activities that will be acceptable.

The College also commenced a review of the requirements of the Formal Project. The College agreed that the overall scope of the project could be broadened to allow for more flexibility in its completion. The team heard during the assessment visit, that the

College is considering developing a research course. Some early discussions have taken place with the University of Sydney regarding these requirements.

The College acknowledges that the research project can be challenging for some of its trainees. However, it was noted that all fellows should have had some hands on experience with the research process and academic writing. The supervisors of training are encouraging trainees to start the process early and the College is implementing a mentoring system for trainees.

The Trainee Committee has proactively addressed a number of questions regarding the research project via the 'Training FAQ' section of the website. This section of the website indicates that acceptance of a formal project depends on several factors and examples of possible projects include (but are not limited to):

- a quality assurance audit or a quality improvement project with a 'before and after' evaluation as for a typical 'Plan, Do, Study, Act' iterative quality cycle
- an observational study reviewing an aspect of practice or the management of a group of patients. Such case series could be conducted prospectively or retrospectively
- a prospective scientific study. This might entail a randomised or pseudo randomised evaluation of a treatment or a process. Other possibilities include a before and after evaluation of the introduction of a new treatment or process
- a study of a particular aspect of management of patients involved in a multi-centred trial. This will likely require the assent of the principal investigator for the study
- a systematic review of the literature pertaining to a clinically relevant subject.

3.3 Flexible training

The accreditation standards are as follows:

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

3.3.1 Flexible training in 2011

Within the College's basic and advanced program structure, trainees have a great deal of flexibility in how they structure their training. This is compounded by the high proportion of trainees completing dual fellowships. Progress reports to the AMC by the Joint Faculty and subsequently the College indicate that about 37% of trainees are completing intensive care medicine training only, 24% dual training with anaesthesia (with an additional 14% having completed anaesthesia training), 15% dual training with emergency medicine and 10% dual training with internal medicine. Dual training may be undertaken sequentially or concurrently.

The College allows part-time training and some interruption to training. The regulations indicate that requests for part-time training are considered on an individual basis, and must be prospectively approved by the Censor and supported by the head of the unit. Part-time training must result in the same total training time and training content as is required for full-time trainees.

The College recognises prior learning in a number of areas. Trainees may be exempted part or all of the Basic Training requirements including the Primary Examination of Basic Sciences depending on prior learning.

The College usually exempts trainees who have completed most or all of the basic training requirements for either the Royal Australasian College of Physicians or the Australian and New Zealand College of Anaesthetists from most or all the requirements of CICM Basic Training. The team regarded the College's recent decision to increase the period of required core intensive care training to 36 months as a strength, since it had required many trainees to reconfigure training to include at least six months of intensive care medicine in Basic Training. This would allow those trainees without prior anaesthesia experience in particular to achieve many of the current objectives of basic training as outlined in College document T5.

Trainees who have passed the Royal Australasian College of Surgeons' Part I examination or the Australasian College for Emergency Medicine Part I examination will usually be exempt from the CICM Basic Sciences Examination. This is another strength of the CICM program.

3.3.2 2011 team findings

The team acknowledges the flexibility inherent in the College training requirements. It recommends that the requirement for two years of uninterrupted training in advanced training be reviewed. At the time of the AMC assessment, it was not clear how the regulation would be interpreted for part-time trainees and this should be made explicit.

The College has identified considerable areas of commonality between its training requirements and those of a number of other specialty training programs. The team commends the College on its mature approach to the issue of prior learning.

Trainees granted recognition of prior clinical experience and learning in internal medicine or anaesthesia are generally exempt from some or all of the CICM requirements in these attachments. As indicated above, the team is recommending the College review the learning outcomes for these terms as part of the curriculum review. This may require the College to reconsider its approach to exemption of trainees from these terms. In particular, the CICM approach that allows trainees to satisfy the medicine term requirement in almost any branch of internal medicine may need review once the College has defined the knowledge and skills the trainee is expected to acquire during these attachments.

3.3.3 2015 team findings

The College continues to provide flexibility in how trainees structure their training.

Provision is made for trainees to undertake part-time training. The regulations also make provision for both deferred training (5.8) and interrupted training (5.9). Part-time

training continues to be considered by the College on an individual basis and must be prospectively approved by the Censor as per regulation 5.6.

The number of trainees in part-time training from 2012 to 2015 according to training pathway and gender is as follows.

Training Pathway / Gender	2011	2012	2013	2014	2015
Total	4	6	4	7	4
Female	1	2	0	3	3
Male	3	4	4	4	1
Paediatric pathway	0	1	1	2	1
General pathway	4	5	3	5	3

In the 2011 assessment, it was recommended that the College review the requirement for two years of uninterrupted training in advanced training and make explicit how the regulation would be interpreted for part-time trainees. The College has clarified in the regulations that if training is interrupted for between one and two years, there must be a minimum of one training year (i.e. at least the Transition Year) as part of subsequent training. If training is interrupted for more than two years, a total of at least one Core Training Year and the Transition Year must be completed as part of subsequent training. The 2015 team recommends that the College document in its regulations how interrupted training is interpreted for part-time trainees.

Trainees may apply for retrospective approval of prior training in anaesthesia, medicine and rural experience as detailed in regulation 5. Advanced Training, Core Intensive Care Training and the Transition Year training must be prospectively approved. From 2011 to 2014 the College had a total of 764 applications for recognition of prior learning (RPL). The following table shows completed assessments.

Year	Number of applications	RPL granted for previous training (minimum 3 months)	RPL granted for exemption from First Part Exam
2011	148	138 (93.2%)	89 (60.1%)
2012	226	213 (94.2%)	117 (51.8%)
2013	364	344 (94.5%)	133 (36.5%)
2014	26*	26 (100%)	1 (3.8%)

The College indicated that it has commenced work on a document for RPL that will provide more detailed information on the process in a simple format for trainees and supervisors. The College is encouraged to finalise and publish this document. This is discussed in further detail under Standard 7.3.

The College no longer accepts the primary examinations from the Australasian College for Emergency Medicine (ACEM), Australian and New Zealand College of Anaesthetists (ANZCA), Royal Australasian College of Surgeons (RACS) and Royal Australasian College

of Physicians (RACP) as exemptions for the CICM First Part Examination. It is now a requirement to pass the CICM First Part Examination in order to enter intensive care training.

The College undertook a review of the other colleges' primary examinations and determined that the syllabus did not sufficiently cover the CICM primary examination syllabus and therefore did not warrant ongoing recognition of them as an alternative. The College does not consider that abolishing the exemption policy for those who have successfully completed the primary examinations of other colleges is a backward step. The College considers that the exemption policy attracted applicants to the program because their qualifications were being recognised and this in turn lead to a previously high entry rate into the program.

Individuals who have been admitted to fellowship of ANZCA, ACEM or RACP may be granted exemption from the First Part Examination.

3.4 The continuum of learning

The accreditation standards are as follows:

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

3.4.1 The continuum of learning in 2011

The College builds on the basic medical education phase particularly in relation to physiology and pathology learning. An attachment in Intensive Care Medicine is not regarded as desirable for doctors in their first postgraduate year (PGY1) although many doctors experience aspects of Intensive Care Medicine as part of their normal PGY1 attachments given the wide range of patients who require ICU care.

The expanding roles of Intensive Care doctors outside the ICU offer greater opportunities for interactions between ICU staff and junior medical colleagues and medical students. This creates an opportunity for Intensive Care Medicine to integrate even more with the wider medical faculty.

3.4.2 2015 team findings

Currently the College does not have a formal process for engagement at the prevocational and entry to practice stages of medical training, but a number of College representatives have academic appointments that allow direct input into guiding curriculum development for these processes at the university level.

A number of College fellows have recently contributed to the formal review process of the prevocational stage of medical training commissioned by the COAG Health Council. Their contribution to this process has been via their individual involvement given jurisdiction-based educational roles or as members of the various state-based Postgraduate Medical Councils.

Fellows of the College have also been involved with medical careers 'expos' for both medical students and prevocational trainees to provide them with an exposure to the realities of a career in intensive care medicine.

The College is also a member of the Committee of Presidents of Medical Colleges, where regular discussions are held with representatives of Medical Deans Australia and New Zealand (undergraduate component) and the Confederation of Postgraduate Medical Education Councils (prevocational component).

2011 Accreditation Conditions and Recommendations

2011 Commendations

D The College's clear commitment to engaging trainees in research.

E CICM's support of flexible training.

2011 Conditions to satisfy accreditation standards

6 Complete the curriculum review, taking account of the recommendations in this accreditation report regarding the framework and content as well as other stakeholder feedback. The AMC would expect to see a plan for the review with clear timelines by the College's next progress report. (Standard 3.1) (met in 2014)

2011 Recommendations for improvement

EE Consider ways in which trainees might meet the research learning objectives, other than completion of a formal project, such as completion of an appropriate module or formal course, and consider the educational support available to trainees to meet this requirement. (Standard 3.3)

The 2015 team considers condition 6 from 2011 has been met.

2015 Accreditation Conditions and Recommendations

2015 Commendations

E The completion of the curriculum review and the implementation of the new training program in 2014.

F The College's comprehensive review of the objectives of training for core intensive care, anaesthesia and medicine terms.

G The introduction of the Transition Year, which aims to address the gaps in the previous curriculum, by allowing time to acquire non-clinical skills such as expertise in administration, teaching and quality assurance and prepare trainees for entry into specialist practice.

H The development of cultural competence outcomes and associated training resources for trainees.

2015 Conditions to satisfy accreditation standards

3 Finalise and implement the document, *Competencies, Learning Opportunities, Teaching and Assessments for Training in Paediatric Intensive Care*. (Standard 3.1 and 3.2)

4 Develop and publish specific learning objectives for the three-month rural term. (Standard 3.2)

2015 Recommendations for improvement

EE Develop a mechanism to ensure as new training resources are developed they are mapped to learning objectives in the curriculum. (Standard 3.2)

4 Teaching and learning methods

4.1 Teaching and learning methods

The accreditation standard is as follows:

- The training is practice-based involving the trainees' personal participation in relevant aspects of the health services and, for clinical specialties, direct patient care.

4.1.1 Practice-based teaching and learning in 2011

The intensive care medicine training requirements are described in section 3 of this report.

The training program is broad-based and aims to provide the trainee with an understanding of the scientific basis of intensive care and the opportunity to learn through a mixture of training, self-directed learning and exposure to a wide range of clinical experience. There are no requirements for completion of university or other formal programs.

The training includes periodic assessment intended to test whether the trainee has acquired the requisite knowledge, skills and attitudes to progress at each stage and finally to practise in the specialty at an appropriate standard.

The College training program is hospital-based with the trainee involved in all aspects of patient care in intensive care departments. These departments are accredited by the College on a seven-year cycle. Further information the accreditation process is detailed under Standard 8. The College accredits intensive care units rather than training posts and the accreditation process classifies each unit as suitable for 6, 12 or 24 months training for an individual trainee.

The College's Accreditation Guidelines require units to offer trainees a wide spectrum of experience, a comprehensive range of medical and surgical specialities, access to a wide spectrum of investigations and therapeutic procedures. Rosters must also ensure that adequate clinical management is available to trainees. A program of education, quality assurance and research must be offered as well as formal teaching.

The training program is largely coordinated by the supervisors of training (SOTs), who are guided by documents which focus on clinical aspects of intensive care management and the CanMEDS framework which describes dimensions of professional behaviour.

4.1.2 Practice-based teaching and learning in 2015

The College training program remains hospital-based with trainees exposed to a broad range of clinical experiences. As described under standard 3, there is now a requirement to spend a minimum of three months in a rural placement, a clinical setting with adequate paediatric caseload, as well as working in units with adequate exposure to cardiothoracic surgery, neurological/neurosurgery and trauma patients.

The College has introduced a 'Transition Year', that has a major focus on the acquisition of non-technical and management skills, including expertise in administration, teaching and quality assurance. In the Quality of Training and New Fellow surveys, trainees

undertaking the old program indicated a lack of opportunities to gain skills in these domains.

The accreditation process has been reduced from a seven-year cycle to a five-year cycle, to more closely monitor the quality of training at sites. The Hospital Accreditation Committee retains the option to grant a further two years of accreditation before site inspection, on receipt of satisfactory paper-based accreditation documents. The College continues to accredit intensive care units as suitable for 6, 12 or 24 months of training for an individual trainee.

The College has begun using data from the Australian and New Zealand Intensive Care Society's Centre for Outcome and Resource Evaluation to strengthen the accreditation process. This provides detailed annual data regarding the quantity and quality of training opportunities at each accredited site, with information provided to the College on a yearly basis. This allows monitoring of unit staffing, patient numbers, infrastructure, outcomes and case-mix. The data is reviewed by the Chair of the Hospital Accreditation Committee to ensure ongoing compliance with minimum requirements for accreditation.

The Quality of Training survey was first conducted in 2011, and has been sent out six-monthly since 2013. Areas covered include clinical experience, teaching and supervision provided, and trainee administration and resources. Until 2015, this survey had been anonymous. The survey circulated in February 2015 underwent a number of changes, including asking the trainee to identify themselves and their training rotation. The results of each survey are analysed and considered by the College Education Committee.

4.2 Practical and theoretical instruction

The accreditation standards are as follows:

- The training program includes appropriately integrated practical and theoretical instruction.

4.2.1 Practical and theoretical instruction in 2011

Practical and theoretical instruction is overseen by the SOT in each unit. This role is discussed further in section 8 of this report. Guidelines for the SOT are set out in document T-10, The Role of Supervisors of Training in Intensive Care Medicine. SOTs are responsible for ensuring there is a structured educational program for trainees including external programs.

Each accredited unit must have a formal documented and demonstrable program of teaching including tutorials, daily review of patients with the on-duty intensive care specialist, case reviews and presentations, and mortality and morbidity sessions.

The In-Training Assessment (ITA) is the tool that facilitates the ongoing education of the trainees. It is the means by which the trainees receive formative feedback to inform their choices of experience and the College provides modifying and remediating activities. ITAs are mandatory every six months in the Advanced Training years and recommended in the Basic Training years.

The College and the Australian and New Zealand Intensive Care Society coordinate a number of symposia and courses that present aspects of intensive care practice. Training is organised on a state, regional and local basis depending on the particular needs of trainees. In Queensland, the major teaching hospitals organise a weekly program of lectures and tutorials for all trainees. In New South Wales, these educational activities are organised according to regional responsibilities. For example, Royal North Shore Hospital provides a topic review lecture program to the northern region of Sydney and the state.

The College has indicated it provides materials to support mentoring, examination preparation and communication training. The Education Officer has developed printed and electronic materials that use scenarios to allow trainees to practise communication situations common in intensive care practice. The College has recently piloted a formal one-day course to develop communication skills.

All trainees must satisfactorily complete the Australian Donor Awareness Program (ADAPT). This course has a strong emphasis on communication as well the clinical science and the ethics of brain death and organ transplantation. ADAPT courses are regularly held throughout Australia. Trainees, including those in New Zealand, report no difficulty in gaining registration for the course. The team acknowledges the strong contribution of College fellows to the success of this course.

The College indicated it was considering the development of a formal requirement for training in echocardiography as this has become a routine investigation in intensive care units. Suitable courses have been developed but not yet mandated as part of the program.

In 2007, the College introduced the requirement for all trainees to complete satisfactorily at least four clinical 'hot cases' within six months of intending to sit the written section of the fellowship examination. This was introduced as an attempt to reduce the number of candidates who are inadequately prepared for the clinical part of the examination. Four satisfactory assessments must be completed in the workplace and signed off by the supervisor or nominated assessor.

The College detailed in its accreditation submission the following additional formal courses available for trainees:

- *The Canberra ICU Course - focuses on the written examination, vivas and hot cases.*
- *Data Interpretation in Acute Medicine, Brisbane - focuses on blood gas interpretation, approach to biochemistry, haematology, coagulation, microbiology, pulmonary function, ventilator waveforms, etc.*
- *Procedure and Communication Course in Intensive Care - focuses on communication through procedural and simulation exercises and interacting with professional actors in clinical situations.*
- *Australian Intensive Care Medicine Clinical Refresher Course - focuses on the fellowship examination process.*

- *The Australian Short Course on Intensive Care Medicine Annual Course - aimed at trainees registered to sit the fellowship examination, includes tutorials, vivas and hot cases.*
- *Sydney Intensive Care Equipment Course - focuses on the basic and advanced knowledge of IC equipment and insertion procedures, with lectures and 12 station displays.*
- *The Sydney Written Course - focuses on the written component of the fellowship examination.*

4.2.2 Practical and theoretical instruction in 2015

Practical and theoretical instruction continues to be overseen by the supervisor of training in each unit. The College requires all accredited intensive care units to have an educational program that involves theoretical instruction. Activities should include research, data collection, a quality improvement program, morbidity and mortality meetings, tutorials, bedside review, case presentations and review sessions. The educational program is assessed during College accreditation visits and through the Quality of Training survey.

The new curriculum has added the requirement to successfully complete a number of online courses. These are intended to cover aspects of the curriculum to which some trainees may not be adequately exposed during training. Currently they are:

- Intercultural Competency Course (Australia) and Foundation Course in Cultural Competency (New Zealand)
- Brain Death and Organ Donation
- Burns and Inhalational Injury
- Neuro Intensive Care
- Spinal Cord Injury.

The following online courses are planned or under development:

- Evidence Based Medicine
- Focused Cardiac Ultrasound in Intensive Care
- Haemodynamics
- Safe Patient Transport
- Tracheostomy.

The College intends to develop several more courses over the next year, specifically to address possible gaps in the hospital-based teaching.

Additionally, the College has mandated six face-to-face courses. These include:

- an Introductory Intensive Care Medicine course
- the College Communication Skills course
- an Advanced Airway Skills course

- an Introductory Echocardiography and Ultrasound course
- either the Medical Introductory Donation Awareness Training (IDAT) (previously called ADAPT) course or the Organ and Tissue Authority Family Donation Conversation workshop
- the College Introduction to Management Skills course.

Some of these courses are provided locally by accredited intensive care training units, some by the College and others by external providers. Locally run courses must first be approved by the College Education Committee. A list of approved courses is published on the College website.

4.3 Increasing degree of independence

The accreditation standard is as follows:

- The training process ensures an increasing degree of independent responsibility as skills, knowledge and experience grow.

4.3.1 Increasing degree of independence in 2011

Trainees are expected to work increasingly independently under supervision of the intensive care specialists and with assistance from the SOT. The ITA forms are graded for the stage and year of training and the forms detail the aspects for professional growth that are required from the trainees. The trainees are assessed against a standard of increasing responsibility. There are separate ITA forms for each term and each increasingly senior period of training.

A six-month term as a senior registrar is mandatory for all trainees. This involves increased responsibility close to the end of specialist training.

4.3.2 Increasing degree of independence in 2015

As described under standard 2, the Competencies, Learning Opportunities, Teaching and Assessments for Training in Intensive Care Medicine document was developed as part of the curriculum review. This document presents in detail the expectations for the specific competencies and skills required of trainees as they progress from a 'novice trainee' to 'expert trainee'. These are grouped and listed under the CanMEDS domains, and include the expectations for both clinical and non-clinical skills.

The six-monthly In-training Evaluation Report (ITER) is based on achieving the expected levels of increased skill acquisition, independence and responsibility related to each level of training, and provides feedback on the trainee's stage of development and progression through the training program. The marking scale is devised to evaluate the progress of the trainee in each area across time.

The College has introduced the Transition Year as the final year of training. It is intended that the Transition Year will allow greater clinical autonomy and also promote development of the non-clinical characteristics of a medical specialist, including administration, teaching and management skills.

4.4 2011 team findings

There is strong practice-based training in intensive care medicine with a well-developed apprenticeship-based model characterised by a high level of interaction between consultants and their trainees.

The practice-based teaching is delivered to a very high standard although the team found that the protected teaching time available to trainees varies significantly. Consultants are enthusiastic and committed teachers. During site visits, most trainees spoke very highly of their support from their SOT. The team recognised that close working relationships between trainees and consultants enables the consultants to observe both clinical and professional skills and provide regular feedback to the trainee.

The College has a very heterogeneous trainee cohort. Historically the trainees have pursued dual fellowships. The trainee group also has included a large number of international medical graduates and more recently the College has been accepting doctors in their second postgraduate year (PGY2) directly into the program. The heterogeneous nature of the cohort and the flexibility inherent in intensive care medicine training means that trainees' individual training requirements are very variable. In this situation, the College needs to give more specific guidance to supervisors and trainees about its expectations and requirements across each stage of training. As discussed in section 3, the team would expect this specification to be one outcome of the College's curriculum review. In particular, the College needs to define the standards and learning outcomes it expects trainees to achieve prior to entering advanced training, and the objectives of the medicine and anaesthesia terms.

While the structure of the training program aims to support the trainees progressively building their clinical and procedural skills, the curriculum documents do not provide sufficient guidance on the level of understanding and experience which would be expected of a successful trainee at successive training stages. This should be considered as part of the curriculum review, and needs to be reflected in tools such as the in-training assessment forms that are reviewed by both the trainee and supervisor. The College indicates that there is no current requirement for trainees to keep a logbook or for specific assessment of competence in each individual skill, although this and modular training are being considered by the Education Committee.

Many supervisors of training and intensive care units devote considerable effort to the provision of education and teaching activities. The teaching program is reviewed through the College's accreditation process and there is monitoring of the ITA assessments by the Censor. As would be expected in a dispersed training program, the team observed there was some variability in the standard of didactic teaching across the sites. The team encourages the College to consider other methods for continuous monitoring of the quality of the teaching program on a more frequent basis than the seven-year cycle.

In addition to regular teaching activities, some intensive care units offer formal courses. While the College promotes relevant activities, it appears to give relatively little guidance or oversight. The team recognises these are independent activities, largely conducted by College fellows. However, the team encourages the College to consider how it monitors their educational relevance, particularly as the curriculum changes and to consider how it would supplement these courses.

In the College survey of trainees and the feedback to the team, the majority of trainees indicated that they would welcome more educational support from the College, identifying topics such as preparation for the examination, communication skills, research methods, medico-legal topics and skills courses, utilising methods such as modules and online learning. The College has already begun to introduce some additional courses.

The College is piloting a communications skills course because of concern that this skill needs more formal attention. In addition, the CICM journal is available on the College website and the College intends to increase the use of this educational tool by adding further core journals to the site. The team looks forward to feedback on the College's plans.

As in any geographically dispersed training program, there are challenges relating to variability in the access to educational activities from site to site. These would be addressed by the development of College resources to supplement the onsite education and training activities.
The College is exploring the role simulators can play in training. Simulators offer an opportunity to examine critical decision-making in a structured educational environment especially in situations such as crisis management where other suitable modalities of learning are not possible. The team encourages further consideration of this learning method.

The intensive care medicine training program aims to facilitate increasing levels of responsibility and independence. The supervisor of training and the trainees are expected to set goals and objectives in an initial interview at the start of each term. Trainees' increasing independence and their achievement of their goals is reported through the in-training assessment process.

The team had considerable discussion with the College about the rationale for and value of the introduction of the 'hot cases'. This as a pragmatic approach to assessing candidates' readiness for the clinical examination, but the team suggests that the College consider whether the original concern about the candidates' capacity to undertake a medical examination might identify a gap in training and experience. The team's findings are further discussed in section 5.

4.5 2015 team findings

The training program remains strongly practice-based, with a well-developed clinically-based model. Committed and enthusiastic supervisors of training, alongside other consultants, work closely with trainees, allowing regular teaching and feedback, both formal and informal.

The College has invested substantial resources in identifying and developing resources that complement the teaching that occurs at a local level. The team commends the College for this significant work. Feedback from the 2011 accreditation, as well as the New Fellow and Quality of Training surveys, had identified areas of learning that were deficient. The College has targeted these areas in the development of both online and face-to-face courses. Trainees have reported these courses as being useful and of a high quality. Many trainees on the old training program have elected to voluntarily undertake these courses, as they are perceived as being useful. For example, 53 completed the communications course in 2014, and in 2015, 47 had completed the

course at the time of the accreditation assessment. It is believed that trainees are also utilising the recommended external courses, but the College has no data on this. These educational resources are helping the training program move from one which was very reliant on local resources to provide adequate training, to one where the training program and learning experiences are much more consistent.

The College will need to monitor the availability of mandatory courses. Locally provided mandated courses are listed on the College website, but some jurisdictions do not yet provide them. Hopefully this will change as the number of trainees on the new program increases, but the College will need to monitor this to ensure equitable access to training for all trainees. Similarly, access to externally provided courses will need to be watched closely. The College believes that there is adequate capacity to accommodate all trainees, but this will need to be monitored.

The provision of mandated courses by external providers, while convenient, requires the College to monitor these courses to ensure that they achieve their aims and learning objectives. A document is being trialled to assess the suitability of external courses, but has not yet been finalised. The team encourages the College to finalise the development of this process, to ensure the educational relevance and quality of external courses. Stakeholders met during the assessment visit, commended the College on the quality of the training course provided for organ donation.

The online learning portal is still under development. A number of courses have been completed, but others remain in development. The College has assured the team that it is investing time and resources to ensure that these courses are of the highest quality, which has meant that their development is taking some time. The College is to be commended for this development of high-quality online resources. The team would encourage the College to continue to develop more online resources for trainees, as they are rated as useful and therefore valued by trainees. In addition, the team also encourages the College to develop processes for evaluating the College's online courses to ensure they are of the highest quality.

The Transition Year, involving 12 months of mandatory intensive care medicine training at the end of training, has been introduced as a component of the new curriculum. The aims of the Transition Year include the acquiring of non-clinical skills, such as expertise in administration, teaching and quality assurance. These domains have been repeatedly identified as gaps in training under the previous curriculum, so it is pleasing to see the College addressing this deficiency. The Transition Year was well supported by trainees and fellows with whom the team spoke.

The College has gone some way to addressing the need for monitoring the quality of the teaching program on a more frequent basis than the previous seven-year cycle. The College has reduced the accreditation cycle to five years. Full accreditations more often than five yearly are constrained by the resources required to perform this process. To more closely monitor the quality of teaching in between accreditations, the College is in the process of developing mechanisms to monitor training sites more frequently. The use of the Australian and New Zealand Intensive Care Society's Centre for Outcome and Resource Evaluation (ANZICS CORE) data is a sensible way of using existing data to monitor training sites. The College now has access to this data, and states that the Chair

of the Hospital Accreditation Committee reviews this data. It was not clear to the team how this data had been used to date, and the processes to do this appeared to be in their infancy. The College is in discussions about designing an online dashboard that would contain this information for each unit. The College expects this data will allow it to closely monitor any changes in the clinical experience that trainees encounter.

The College is also starting to use the Quality of Training survey to monitor training sites. Overall, the results of these surveys are positive, with 91% of respondents stating they would recommend the term to a colleague. However, the anonymous nature of the survey has meant that it has been difficult for the College to identify which training site was generating negative responses. This was compounded by the fact that even when trainees identified themselves, they were usually unwilling to progress the complaint. This has resulted in the College now asking trainees to identify themselves and the training site as part of the survey. It would appear that this has had some impact on the response rate, with a drop in the response rate from generally in the order of 40%, to 23% in February 2015 according to the College. The College is considering making the survey mandatory. Given these changes to the survey only occurred in February 2015, a process for utilising this site-identified data has not yet been developed by the College. The information gleaned from these surveys has great potential to assist in identifying both excellent and poor training sites, as well as providing useful feedback to supervisors of training. This process will need to be managed carefully to ensure that trainees are comfortable in providing honest feedback, and that they cannot be individually identified, and therefore disadvantaged, in providing that feedback. The team encourages the College to develop more rigorous and mature processes in managing the data of both the ANZICS CORE and Quality of Training survey. This is also discussed under standard 6.

The Competencies, Learning Opportunities, Teaching and Assessments for Training in Intensive Care Medicine document is a significant piece of work and articulates the expectations of a trainee from novice to expert trainee. It provides trainees and supervisors with the learning outcomes expected during training, including in non-medical domains. The In-Training Evaluation Report (ITER) uses the framework of this document to monitor the trainee's progress over time. It was not clear to the team if this document was being widely used by trainees and supervisors. Given that the ITER aims to monitor a trainee's progress over time against the competencies, it may be beneficial to provide a graphical representation of this achievement to both trainee and supervisor.

2011 Accreditation Conditions and Recommendations

2011 Commendations

F The training program is a well-developed apprenticeship-based model with committed and enthusiastic supervisors of training.

2011 Conditions to satisfy accreditation standards

Nil.

2011 Recommendations for improvement

FF Develop methods for continuous monitoring of the quality of the teaching program on a more frequent basis than the seven year accreditation cycle. (Standard 4.1.1)

GG Increase the College's role as a provider of educational courses and resources for its trainees. (Standard 4.1.2)

HH Monitor the educational relevance of formal courses delivered by intensive care units, particularly as the curriculum changes and how the College can supplement these courses. (Standard 4.1.2)

II As part of the curriculum review, improve the College's guidance to trainees and supervisors about the learning outcomes expected at each stage of training. (Standard 4.1.3)

There were no conditions regarding standard 4 from 2011.

2015 Accreditation Conditions and Recommendations

2015 Commendations

I The College's significant investment of resources in developing and identifying courses and online resources that complement the training program and that are considered useful by trainees, in particular by targeting the skills that were previously identified as deficient.

J The development of the Quality in Training and New Fellow surveys and accessing of the Australian and New Zealand Intensive Care Society's Centre for Outcome and Resource Evaluation data to provide information that illuminates the quality and quantity of teaching and learning at training sites.

K The development of the *Competencies, Learning Opportunities, Teaching and Assessments for Training in Intensive Care Medicine* document which lists expectations as trainees progress through training from novice to expert trainee.

2015 Conditions to satisfy accreditation standards

Nil.

2015 Recommendations for improvement

FF Finalise and implement a process for assessing the educational relevance and quality of external courses. (Standard 4.1.2)

5 The curriculum – assessment of learning

5.1 Assessment approach

The accreditation standards are as follows:

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

5.1.1 Assessment approach in 2011

The College employs both summative and formative assessments. The In-Training Assessments (ITAs) in Basic and Advanced Training are formative, and the final In-Training Assessment is summative. Five of the six ITAs during Advanced Training must be rated as 'satisfactory'. The Primary Examination is summative. The Final (General) and Final (Paediatric) Written and Viva Examinations are summative assessments for their respective training programs. The Formal Project (research requirement) is a summative assessment. The subject areas for all of the examinations are blueprinted and matched with the relevant objectives and competencies documents.

The Primary Examination can be sat at any time during Basic Training as long as the candidate has completed at least 12 months of general hospital experience. Trainees must complete Basic Training and the Primary Examination before proceeding to Advanced Training. To be eligible to sit the Final Examination, trainees are required to complete Basic Training and a minimum of 12 months of Advanced Training in core intensive medicine. While completion of the formal project is a training requirement, trainees may present for the Final Examination before it is completed.

Interviews with trainees and supervisors of training during the site visits demonstrated that there is wide support for the transparency, fairness and rigour of the College's overall assessment approach. It was generally felt that the formal examinations adequately assessed the required capabilities to be a competent intensive care clinician, with the ITAs providing the opportunity to assess those capabilities not easily measured in formal examinations. The ITAs also provided ongoing feedback to trainees during the course of their training.

5.1.2 Assessment formats in 2011

In-Training Assessment (ITA)

The ITA is the College's predominant formative assessment tool. The formal requirements and the process of in-training assessment are detailed in the Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine T-12 document.

The process begins with an initial interview, in which the trainee and supervisor set goals for the training term. Previously completed assessments, retained in the trainee's training portfolio can also be used at this time. The definitive assessment is completed at the end of each training term. Assessments are completed according to the length of the term (as little as three months for the rural rotation), but at a minimum must be completed every six months. Trainees complete a self-assessment using Section C of the ITA form, before each ITA interview. Assessments are completed by the supervisor of training based on the consensus views of the majority of senior staff in the department. Participating staff must have a personal knowledge of the trainee.

When a trainee consistently performs at a level below that considered acceptable for a developing specialist in intensive care medicine, notwithstanding repeated documented attempts at correction, the provisions outlined in the document T-13 (2010) Guidelines for Assisting Trainees with Difficulty are invoked.

The College indicated that the principles of the ITA have remained unchanged since the AMC's 2002 assessment. The ITA forms, however, have been amended to reflect changes to the training program. Progressive modifications include:

- *amendment of the forms to reflect the introduction of Basic and Advanced Training (2003)*
- *development of a separate assessment form for Basic Training (2004)*
- *development of the generic ITA form for Advanced Training into separate ITA forms for each component and stage of Advanced Training (2007), which enabled a more relevant assessment targeted at each term, recognising increasing responsibilities. The revised forms apply to core intensive care, anaesthesia, medicine and elective training. An additional form was developed as a Final In-Training Assessment (FITA), which requires the trainee's last supervisor to give a global assessment confirming the trainee is suitable to commence intensive care specialist practice. All assessment forms are reviewed prior to admission to fellowship.*
- *amendment of forms to specify and document required trainee exposure to subspecialty areas such as cardiac surgery, neurosurgery, burns, major trauma and paediatrics (2007).*

The College indicated it has been focusing on improving the consistency of trainee assessment during training through supervisor support and education. It is considering diversifying simulations and courses, combined with pre-tests and post-tests proposed.

Primary Examination

The Primary Examination tests the basic sciences relevant to intensive care medicine with an emphasis on integration of knowledge across disciplines. It comprises written and oral sections. The written section has two 150-minute papers of short answer and short fact questions, and the oral section involves eight 10-minute stations.

In 2003, the policy permitting exemption from the Primary Examination requirement was revised to include trainees who had passed the ACEM and RACS Primary Examinations.

In practice, the introduction of a Primary Examination has initially been relevant to a minority of trainees, namely those who are not undertaking joint training with another college, and those who have undertaken training overseas that is not approved by the Censor. However, this number is continuing to grow.

The Board continues to support a multi-disciplinary approach to intensive care training, and there are no plans to cease recognition of the basic training and primary exams of related specialty training programs. The College is also engaging with ANZCA and ACEM to consider reciprocal recognition of the CICM Primary Examination as a means to facilitate dual training in the spectrum of acute care medicine.

Fellowship Examination

The Fellowship Examination is held twice yearly. It consists of three sections; the written section, the clinical section, and the cross table viva section. Some candidates may be exempted from the written section of the examination (e.g. carrying a previous pass in that section, and some overseas trained specialist candidates). Marks are structured as follows:

Both the total mark and the mark in each section are considered when determining a pass/fail decision. To pass the examination, a candidate must:

- *achieve a total score of at least 50% (in those sections not exempted)*
- *not fail more than one section*
- *perform adequately in the clinical section. A mark of less than twelve out of thirty (12/30) in the clinical section is regarded as a poor fail and will result in failure of the whole examination.*

Information about the structure of the examinations is detailed in the Candidates Notes for Final Exam Document Ex-2.

The subject areas for the Fellowship Examination are drawn from the Objectives of Advanced Training and Competencies in Intensive Care Medicine or the Objectives of Training and Competencies in Paediatric Intensive Care Medicine. The Paediatric Fellowship Examination has the same structure as the general Fellowship Examination.

The College has conducted a number of reviews of the fellowship examination process since the last AMC review including:

- *expansion to incorporate assessment of CanMeds skills (including communication, procedures and professional qualities)*
- *increasing the number of exposures to examiners to ensure reliability*
- *quarantining candidates to allow the provision of a similar examination for each candidate*
- *increasing emphasis on examiner training and standard setting*
- *increasing feedback to candidates to improve the educational experience and guide examination preparation*
- *blueprinting questions to maintain validity*

- *logistic revision to ensure feasibility for a rapidly growing number of candidates and refinement to apply modern standard setting and quality control.*

Formal Research Project

The training program includes the requirement for all trainees to complete a formal research project, to submit the report for publication and to present the findings at an appropriate scientific meeting. The program for the College's Annual Scientific Meeting (ASM) allocates one session for presentation of trainees' formal projects and awards a prize to the best presentation. Trainees are also encouraged to provide a poster presentation at the ASM.

The requirements of the formal project are detailed in the Formal Project Requirements document T-9. The Guidelines for ICUs seeking Accreditation of Training in Intensive Care Medicine document IC-3 details the requirements for accredited training sites to have a program of research in which trainees can participate.

The Queensland Regional Committee is monitoring project 'uptake' by Queensland trainees and the Committee also conducts a one-day course on research to aid trainees in the completion of their projects.

5.1.3 Policies for special consideration during assessment

The College regulation 5.16.4 and document Ex-3 Examination Candidates suffering illness, accident or disability, detail the policy for examination candidates. The regulations allow for interrupted training in the event of disadvantage or sickness, and all requests are considered on an individual basis by the Censor. Allowance is made in training time for sickness, annual and all other forms of leave, so that a minimum of 44 weeks full-time equivalent training time must be completed in order for the 12 months of training to be approved.

5.1.4 2011 team findings

Both supervisors of training and trainees felt the ITA was a useful process. However, the trainees felt that much of the value of the process lies in the supervisor of training's verbal feedback, and that much of the depth and richness of this feedback was lost in the written ITA document. This also hinders the portability of the feedback given during the ITA meeting.

Whilst the College has developed specific ITA forms for each stage of training with a view to reflecting more accurately the increase in skills and responsibilities of the trainees, there is actually very little difference between the ITA forms used at each stage of advanced training. The area within the ITA form for providing free-text feedback to the trainee is small and requires handwritten entry. Examples of de-identified completed ITAs were provided to the team, and in most cases the information entered into this area was rudimentary and often difficult to read.

The College clearly states that supervisors of training have access to a trainee's previously completed ITA forms, but there is considerable confusion on this issue at both a local and a College level. All supervisors interviewed stated that they would find it useful to see a trainee's previous assessments at the commencement of each post, in order to more

effectively identify training needs and devise an appropriate learning plan. The supervisors interviewed did not seem aware that this option was available. This confusion seems to reflect the conflicting views expressed by College officials regarding the privacy issues around the provision of such information to supervisors. All supervisors felt that an electronic system of completing the ITA form and sending it to the College would enhance its effectiveness.

The Final In-Training Assessment seems to be applied variably, depending upon the trainee and the supervisor of training. Because of the structure of the training program, it is possible for a trainee to require completion of their FITA by a supervisor who has not directly worked with them for up to a year. This would apply to trainees who undertake their medicine or anaesthesia year during their final year of training. Supervisors who were interviewed adopted differing approaches to this problem. Some automatically signed off the trainee as satisfactory, based on their successful performance in the formal examination. This clearly subverts the purpose of the FITA as a complementary assessment process to the examination. Other supervisors felt that they could not honestly complete the FITA without requiring that the trainee undertake an additional period of supervised training in their department.

The College acknowledges these issues and is exploring other mechanisms to improve the ITA, such as the introduction of more formal workplace-based assessment tools. This would provide more detailed and accurate feedback to trainees undertaking formative ITAs, but might also aid the application of the FITA in the circumstances described above.

Trainees who were interviewed felt the Primary Examination was fair, transparent and rigorous. Several expressed the view that it was more relevant to their intensive care training than those primaries offered by other colleges, and which are accepted as equivalent by CICM. Nevertheless, many trainees interviewed were reluctant to take the CICM Primary Examination. This was partly because it is relatively new with fewer opportunities therefore to access past papers etc., but mainly because of a perception that taking either the ACEM or ANZCA primary examination would give them a wider range of options in terms of pursuing their future career.

The College invests considerable time and effort in the planning of the formal examinations. A variety of examination methods are used, each of which is subject to rigorous evaluation by examiners at workshops prior to the examination, and subsequently reviewed after each examination. Examiner selection and training is robust. The examination processes and requirements are communicated clearly to candidates. Both trainees and examiners felt that the formal examinations were appropriate measures for assessing the candidates' required capabilities.

Candidates are given support in the preparation for the examination in a number of ways. As noted in section 4 of the report, each candidate has to pass four 'hot cases' in their training institution before each attempt at the Fellowship Examination. There are also a number of excellent examination preparation courses, which although not coordinated or overseen by the College, are widely advertised through the College website, and delivered by College fellows and examiners.

While the introduction of hot cases addresses an identified need, the team was concerned that their introduction may suggest the College's ITA process and the accreditation process are not ensuring that trainees are progressing in independence and clinical skill throughout the continuum of the training program. The College is encouraged to examine ways in which the training program can be monitored and improved to address the gap filled by the introduction of the hot cases.

5.1.5 Assessment approach in 2015

As discussed under standard 1, following the curriculum review process the College established a new standing committee of the Board, the Assessment Committee. This committee is responsible for coordinating all aspects of the College's assessment program.

The College has strengthened its processes of formative and summative assessments, including a more robust system of in-training evaluations and the introduction of workplace-based assessments. The new curriculum includes a requirement for all trainees from 2014 to complete a number of specific workplace-based assessments. Trainees continue to be required to successfully complete the College's major summative assessments, the CICM First Part (Primary) Examination and the CICM Second Part (Fellowship) Examination.

In-Training Evaluation Reports

The new In-Training Evaluation Report (ITER) replaces the previous In-Training Assessment. The ITER is a formative tool used to drive learning, but a summative ITER is submitted to the College at the completion of each six months of training. The ITER is divided into seven categories of medical practice and based on the CanMEDS domains of practice. A total of 23 items are assessed. The trainee's performance is assessed on a sliding scale from novice trainee to an intensive care medicine fellow. It is expected that trainees will demonstrate progress along the scale for each item with each subsequent ITER. The ITER also contains a 'Global Rating Scale', which allows the supervisor to provide an overall assessment of the trainee's performance relative to their stage of training. Different ITERs are used for the anaesthetic, medicine and elective terms of training.

Under the new curriculum the College has introduced the Transition Year as the final year of training which must be completed in a CICM-accredited intensive care unit. The CICM supervisor will complete an ITER at the mid-point in the Transition Year and a Final ITER at the conclusion of the year. Under the old curriculum trainees were completing their final year of training in disciplines other than intensive care, and seeking sign-off of their Final ITER by Supervisors who may not have seen the trainee for some time. The College has made this change to the new curriculum in response to this issue.

Workplace Competency Assessments

Under the new curriculum, trainees are required to satisfactorily complete a total of seven Workplace Competency Assessments (WCA) prior to entry into the Transition Year. The required WCAs are:

- Inserting a central venous catheter

- Performing advanced life support
- Testing and certifying brain death
- Setting up and administering mechanical ventilation
- Demonstrating advanced communication skills
- Performing and inserting a tracheostomy.

Trainees must demonstrate adequate knowledge, skills and behaviour in all performance indicators to be assessed as competent. The College does not record information on how many attempts a trainee may take to complete a WCA. Trainees are required to only submit the satisfactory WCA.

Observed Clinical Encounters

Under the new curriculum the College has replaced the requirement for the completion of 'hot cases' with a more structured requirement for Observed Clinical Encounters (OCEs) to be successfully completed at specific intervals during core training. Trainees are required to complete a minimum of eight OCEs under the supervision of a CICM fellow. Two are required during each six months of core intensive care training. The OCE takes around 20 minutes to complete, plus time for discussion and feedback. The OCE provides trainees with a structured assessment and feedback format which covers the skills and behaviours required for the clinical assessment of a critically ill patient. Trainees are encouraged to complete OCEs that focus on a variety of clinical presentations and organ systems including:

- Cardiovascular
- Extra-mural care
- Gastrointestinal
- Haematological
- Neurological
- Renal
- Respiratory
- Trauma.

The College suggests that the requirement for a minimum of eight OCEs to be completed as part of the new curriculum should result in candidates being better prepared for the clinical part of the First and Second Part Examinations.

Formal Project

All trainees must satisfactorily complete the requirements of the Formal Project. Under the new curriculum, the project must be submitted for assessment prior to commencing the Transition Year. The *Formal Project Requirements* document has been revised to make explicit the scope of activities that are acceptable for the research project.

First Part and Second Part Examinations

Trainees are required to successfully complete the First Part (Primary) Examination and the Second Part (Fellowship) Examination. Under the new program, the First Part Examination may be attempted at any time after completion of Foundation Training. Trainees do not commence core intensive care training until after satisfactory completion of the First Part Examination. However trainees can undertake the required anaesthetic, medicine, paediatric and rural components of training before commencing core intensive care training. The Second Part Examination must be completed before entering the Transition Year.

The College has limited the number of attempts a trainee can make at an examination to five attempts. This was previously unrestricted. The document *Guidelines for Assisting Trainees with Difficulties* outlines the College's process for providing support to trainees who sit two examinations without success.

As previously discussed, the College no longer grants an exemption from the CICM First Part Examination for trainees who have completed a primary examination from the Australian and New Zealand College of Anaesthetists (ANZCA), the Royal Australasian College of Surgeons (RACS), the Australasian College for Emergency Medicine (ACEM) and the Royal Australasian College of Physicians (RACP). Trainees must successfully complete a fellowship with ANZCA, RACS, ACEM or RACP to be exempt.

The College continues to offer examination preparation courses for its trainees across the various jurisdictions.

5.1.6 2015 team findings

The College is commended for the substantial amount of work it has undertaken in meeting the recommendations made in 2011. The College is working hard, and successfully, to ensure the formal summative assessment processes are sound. The First Part Examination has considerable rigour in the setting of the questions and the expected standards for the candidates. The team observed the examiners meet, discuss each question and confirm its alignment to the curriculum, and then make decisions on the expected standard.

The Second Part Examination consists of eight interactive vivas and two separate clinical 'hot cases'. The hot cases use authentic cases in the real-world setting of an intensive care unit. For the vivas, candidates will be allowed two minutes to read the introductory questions and then spend 10 minutes at the station. The time provided for candidates for the hot cases is 10 minutes which is considered what is required on a busy clinical service. In relation to the hot cases in the Second Part Examination, examiners make an initial assessment of the case, so calibrating themselves against the case and the expected standard.

The College overall is moving from reliance solely on examinations to a graduated process of workplace-based assessments. Philosophically, it appeared to the team, that there is still an emphasis on the examinations which is where much of the effort is directed, with the workplace-based assessments really being about a trainee's preparation for the summative examinations. It is hoped that, with time, there is a

greater sense of the continuum of assessment throughout the training program, with the workplace-based assessments mattering in themselves as critical learning and feedback points, and the summative assessments being adjuncts to this process. The College's workplace-based assessments are discussed under standard 5.2 and 5.3.

The team observed that one aspect of the curriculum that did not appear to be well covered in the summative assessments was the domain of professionalism and medical humanities. The CanMeds domains are in the curriculum, but unless adequately assessed, their utility is not fully expressed. Poor professional behaviour should be considered as unsatisfactory performance. Poor performance in the domain of professionalism should be escalated and invoke a remediation plan. The trainee should demonstrate improvement before being allowed to progress through the training program. The team recommends that the College review the assessment of professionalism across the training program to ensure that it is adequately assessed and there is appropriate remediation for unprofessional behaviours.

Trainees have advised that there is a lack of clarity as to what constitutes a 'pass' or 'fail' in the Workplace Competency Assessments and Observed Clinical Encounters. If the workplace-based assessments are formative only, so a pass or fail is irrelevant, then rules around progression through the training program based on the cumulative data from the workplace-based assessments needs to be made explicit and clear. The College should make explicit to trainees the criteria for all workplace-based assessments.

5.2 Performance feedback

The accreditation standards are as follows:

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

5.2.1 Performance feedback in 2011

The College's In-Training Assessment (ITA) process incorporates the requirement for feedback to the trainee and the College on the trainee's progress. It is the main avenue for early identification of trainees who are under-performing. Any score of 1 or 2 (rated out of 5, with 5 being excellent) is identified by the College's Training Department and forwarded to the Censor for attention. The Censor will contact the relevant supervisor and offer advice or assistance. Should problems remain during the training term, an interview involving the supervisor and relevant staff of the Training Department is held. After this meeting a documented plan of remedial action is determined. This may include external courses or supervised tailored activities. Advice or formal counselling (possibly by a mentor), and monitoring by the supervisor is required. This process is outlined in the Guidelines for Assisting Trainees with Difficulties T-13 document. An educational module, Trainees Experiencing Difficulty' T-33 document, is also available as a training exercise for supervisors. Outcomes may include extension of training time and the trainee and mentor may be called to the College for discussion of unresolved issues.

The College indicates that should a problem remain unresolved, it may require an independent review of training. Document T-14, The Trainee Performance Review provides an independent process for review which may result in dismissal of a trainee from the training program.

The College provides ongoing performance feedback to trainees through the ITA process. The College also provides detailed feedback to trainees regarding examination performance. Individual trainees who fail the formal examinations receive detailed written feedback about their performance in order to help them address areas of deficiency. Candidates who fail the formal project are also given specific and detailed feedback as to which areas of the project need redressing before resubmission. All trainees can access feedback as to overall trainee performance in the formal examinations, via the examination reports.

The College indicated it gives supervisors the option of viewing a trainee's previous completed ITAs. The College also provides detailed feedback to a supervisor whose trainee has failed a formal examination or the formal project.

5.2.2 2011 team findings

The supervisors of training and the College Censor felt confident that the processes in place would accurately identify a trainee who was experiencing difficulty whilst in an accredited intensive care unit. The processes for identifying trainees who experience difficulty in the medicine and anaesthesia terms need to be improved.

The team noted supervisors rarely accessed trainees' previous ITAs and would welcome a more formal and robust process to ensure that this is the norm.

However, the team considered the College's processes for evaluation and review of trainee progress require review. The training program is flexible, with many trainees undertaking dual fellowship training. This can result in trainees moving in and out of the College training program. Tracking of these trainees is difficult, although the College is taking steps to improve this. Evaluation of the progress of the borderline or under-performing trainee appears inadequate. Supervisors of training reported not being aware of trainees who have had problems in prior terms. The College needs to consider ways to improve tracking and support for under-performing and borderline trainees, such as an online system.

5.2.3 Performance feedback in 2015

As discussed previously, as part of the curriculum review process the College revised the structure and function of the In-training Assessments. The In-Training Evaluation Report (ITER) provides feedback to the trainee on their performance at their stage of training and identifies any areas that may require remediation. If a trainee performs below expectations and the issues cannot be resolved during the term the supervisor will reflect the unsatisfactory performance in the ITER.

The ITER is submitted electronically as part of the online trainee portfolio. Completed ITERs are reviewed by the College and any unsatisfactory ITERs are referred to the College Censor for review. The 'triggers' that will cause an ITER to be referred to the College Censor are:

- The supervisor selects 'did not demonstrate safe practice' on any section of the ITER.
- The supervisor selects that the ITER has been unsatisfactory.
- The supervisor answers yes to the question, 'Is there a need to refer the trainee to the College for additional support?'
- The supervisor answers no to the question, 'Has the trainee made sufficient progress during this term?'

The College uses the *Guidelines for Assisting Trainees with Difficulties* which outline the steps that will be taken if a trainee performs below expectations.

5.2.4 2015 team findings

Since 2014, the College has improved its processes by ensuring supervisors are able to access their trainees' previous In-Training Evaluation Reports (ITERs). The online Education Portal enables greater interaction with supervisors from non-intensive care medicine specialties and identification of trainees who may be experiencing difficulties in the medicine and anaesthesia terms.

The College has also put considerable effort into the feedback processes used by supervisors to inform trainees of their progress.

There has been considerable consultation on the ITER. The College explained that a lot of work went into the design of the rating scale of the ITER. Trainees however informed the team that they were not satisfied with the rating scales. For trainees early in their training, if they are performing at less than expected standard the scale does not allow this to be shown. As a minimum the College needs to consider a communication process to trainees and supervisors on the purpose of the ITER and how trainees can use it to understand their deficiencies and where they need to improve.

The College is commended on the introduction of a range of workplace-based assessments, however further work is still required to integrate these into the training program. The College is encouraged to clearly articulate how such assessments are intended to guide trainee learning, and how the attainment of competence in various domains of the curriculum, where relevant, are measured through workplace-based assessments.

Clear feedback paths to the trainees from such formative assessments, with recommendations on further work required, will greatly complement the summative examinations.

The College continues to provide comprehensive feedback to unsuccessful candidates on their examination performance. Trainees are advised to use the feedback to develop an action plan for remedial training and development in consultation with their supervisor or mentor. During site visits, some fellows suggested that the College could also consider providing feedback to successful candidates on their performance in the examinations.

5.3 Assessment quality

The accreditation standards are as follows:

- The education provider has a policy on the evaluation of 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.

5.3.1 Assessment quality in 2011

The College indicated the validity of the examination has been assessed in terms of how it appears on inspection to assess relevant knowledge (face validity), how test items are blueprinted to the Objectives of Training (content validity) and whether it predicts a sustainable career in intensive care medicine (predictive validity). On a regular basis, data are collected and analysed for measurement error and bias, and measures have been introduced to minimise them.

According to the College's submission, it has introduced a number of measures to assist in ensuring fairness and maintaining quality in various stages of the examinations:

- *Inclusion of multiple formats – written, vivas and clinical. Each component carries a significant part of the overall mark, thus providing an opportunity for candidates to make up for a particular case or weak performance in one section.*
- *Inclusion of multiple stations, with exposures to multiple examiners in the oral (vivas and clinical) sections. The examiners are blinded to the candidate's marks in other stations and sections of the examination. The dependability coefficient of the clinical cases is currently being used to maintain reliability of this section of the examination.*
- *Allocation of two examiners, who mark the candidate independently, for each question in the written section, the hot case assessment and some stations in the viva examination.*
- *Mandatory attendance of examiners at regular examiner calibration workshops. During these workshops, questions and marking grids are reviewed and practiced between a 'surrogate candidate' (usually an examiner) and an examiner, and video calibration of examiners is utilised.*
- *Examiners are assigned to candidates in a random, blinded fashion.*
- *An independent assessor reviews the performance of examiners on a regular basis whilst they are examining and assesses the conduct of the examination.*

Appointments to the panel of examiners are based on qualifications, experience and competence, but also on referee reports that testify to the applicant's skills and ability to examine without bias.

The College holds examiner workshops immediately following each examination to compile and consider marks. This is the first point at which trends in marking and examiner calibration are observed and discussed. Following each examination a statistical report is compiled and circulated to the relevant examination committee, the overarching Examinations Committee, the Board, supervisors of training and trainees. It provides an analysis of each component of the relevant examination. The Chair of each examination

and the Board Chair of Examinations are both responsible for oversight of pass rates and other causes for investigation.

Reasons for variations in pass rates are explored by the relevant committee, and if necessary the Board, following which appropriate action is taken.

The reliability of the ITA process is dependent on the assessment by intensive care specialists working within the team environment. The College provides training in this process through supervisor of training workshops.

The College details that supervisors are provided with a number of training opportunities in relation to the College's assessment processes:

- *The Supervisor of Training Support Kit (T-11) details all the forms of assessment. It provides two Educational Modules and lists other resources.*
- *Workshops, covering topics relating to the ITA and the examination processes, are held either at the time of the Annual Scientific Meeting or can be held independently.*
- *Supervisors are encouraged to attend examinations as observers, and examination reports are circulated to all supervisors to help them understand the examination process and help their trainees prepare.*

5.3.2 2011 team findings

The College puts considerable effort into ongoing quality assurance of the formal examinations, with robust examiner selection and training, and rigorous review of each examination both prior and subsequent to each sitting. Supervisors are expected to attend regular workshops, which include training in the use of the ITA, giving feedback, and identifying and remediating the trainee in difficulty. Whilst the College attempts to ensure the examinations cover the entirety of the curriculum, with questions in the clinical examinations complementing those in the written, a formal blueprinting process is not yet in place.

5.3.3 Assessment quality in 2015

According to the College's accreditation submission, since 2011, the College's examination process has undergone a number of developments.

- The College has created an online short answer question (SAQ) database that gives access to all examiners to previously used questions.
- Each SAQ has a detailed answer template to assist with marking concordance.
- The College conducts in depth analysis of SAQs and feedback from each examiner regarding the performance of the question and the candidates which may result in changes for future questions.
- Examiners practise vivas and role play with a good and bad candidates which teaches the examiner how to deal with a wide variety of candidates.
- Candidates who fail an examination are given detailed feedback letters which provide a mark range.
- Detailed examination reports are produced and made available to all trainees and fellows.

The major developments for the First Part Examination have been:

- The College runs a day-and-a-half face-to-face workshop for every examination (totalling three days per year).
- The College has implemented a Viva Assessment Record (VAR) that is used by senior examiners to analyse the performance of all examiners and provide immediate feedback.
- The College runs workshops for trainees, supervisors and educators at the Annual Scientific Meeting providing information on the format and process of the examinations.

The major developments for the Second Part Examination have been:

- Three face-to-face examination workshops are held per year and include video analysis of candidate and examiner performance.
- The College has implemented a Viva Assessment Record (VAR) to analyse the performance of the examiner.
- The Chair and Deputy Chair of the Second Part Examination Committee observed the Royal Australasian College of Physicians' clinical examination to learn more about other Colleges' examinations.
- To allow candidates additional preparation for the hot cases, the College has implemented a two-minute period for candidates to read an introduction prior to each case.

The major developments in the Paediatric Second Part Examination have been:

- The Paediatric Examination Committee now holds an annual face-to-face meeting in July to workshop the examination questions in addition to the workshop held in November at the time of the examination.

5.4.4 2015 team findings

The College uses a broad range of assessment instruments. Much attention is given to the construction of the examination questions, with standard setting, relevance and links to the curriculum carefully examined and considered. These processes are robust and reliable.

The College is commended on the introduction of a range of workplace-based assessments, however further work is still required to integrate these into the training program. The College is encouraged to clearly articulate how such assessments are intended to guide trainee learning, and how the attainment of competence in various domains of the curriculum, where relevant, are measured through workplace-based assessments.

In 2011, the AMC recommended that the College complete the blueprinting of its assessments as part of the development of the new curriculum (condition 7). The College indicated during the assessment visit that this work is yet to be completed. The newly formed Assessment Committee will be undertaking the coordination and

blueprinting of the assessment processes to the new curriculum. The AMC expects the College to progress this work and asks for an update in the next progress report.

2011 Accreditation Conditions and Recommendations

2011 Commendations

G The range of assessment methods used, encompassing both formative and summative assessments.

H The rigour with which the formal examinations are developed, conducted and evaluated.

I The transparency and fairness of the assessment methods used.

J The quality of the feedback given to candidates regarding the formal examinations.

K The College's commitment to the ongoing review and quality improvement of its assessment processes.

2011 Conditions to satisfy accreditation standards

7 Undertake blueprinting of all assessments as part of the development of the new curriculum. (Standard 5.3.1)

2011 Recommendations for improvement

JJ Introduce a suite of workplace-based assessment tools to provide more robust and detailed feedback to trainees, and to increase the rigour of the formative assessments. (Standard 5.1.1)

KK Consider ways in which the College can address through the curriculum the gap filled by the introduction of the clinical 'hot cases' requirement. (Standard 5.1.2)

LL Review the role and utility of the Final In-Training Assessment addressing the problems of variable use of the tool and completion by non-current supervisors. (Standard 5.1.2)

MM Improve the quality of the In-Training Assessments (ITA), including more specific mapping of progress against the curriculum, the provision of trainees' previous ITAs to supervisors, and electronic entry of data. (Standard 5.2)

The 2015 team considers condition 7 from 2011 is progressing and is replaced with condition 6 in 2015.

2015 Accreditation Conditions and Recommendations

2015 Commendations

L The College's summative examinations, the First and Second Part Examinations, are comprehensive and each incorporate a variety of assessment formats.

M The development and introduction of a comprehensive suite of workplace-based assessments as part of the new curriculum.

2015 Conditions to satisfy accreditation standards

5 Develop clear criteria for workplace-based assessments to ensure trainees understand what constitutes successful completion of each of these assessments. (Standard 5.1.1)

6 Finalise the blueprinting of all assessments to align with the new curriculum. (Standard 5.3.1)

2015 Recommendations for improvement

GG Review the assessment of professionalism to ensure that it is adequately assessed and there is appropriate remediation for unprofessional behaviours. (Standard 5.1)

HH Communicate to trainees and supervisors how the In-Training Evaluation Report (ITER) works and how it can be used by trainees to understand their deficiencies and to identify areas for improvement. (Standard 5.2)

II Improve feedback provided to trainees on their performance in workplace-based assessments to ensure these assessments become critical learning points. (Standard 5.2)

5.4 Assessment of specialists trained overseas

The accreditation standard is as follows:

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

5.4.1 Assessment of specialists trained overseas in 2011

The College's document IC-11 Assessment of Overseas Trained Intensive Care Specialists is publicly available on the College website.

The policy outlines the criteria and processes for assessment, explains how the OTS Committee and Interview Panel reach their assessments, details what is required at interview and what possible outcomes can be expected. The document also incorporates processes for overseas-trained specialist applications in New Zealand.

The OTS process is managed by the College secretariat under the supervision of the OTS Committee. Overseas-trained specialists may contact the Censor (Chair of the OTS Committee) via the secretariat for advice on appropriate positions and the process. Once a position is approved, an assessor is appointed, who provides the main avenue for immediate support and feedback.

According to the College, a majority of assessments require a period of supervised practice in a pre-approved position. The level of the position may vary depending upon the training and experience of the applicant. Requirements usually include one or more aspects of the OTS Performance Assessment, which uses components of the fellowship examination (general or paediatric) as its assessment tool. Detailed feedback is provided to OTS on their performance at the examination.

The College's criteria for assessment of specialists trained overseas are based on:

- *training in intensive care medicine. This must be equivalent with the CICM training program in its duration, structure and content, assessments and supervision.*
- *experience as a specialist. There should be evidence of past management of patients with adequate case mix and severity of illness, use of equipment and procedures, and compliance with standards of good practice in intensive care medicine equivalent to those promoted in College policy documents.*
- *participation in continuing education and quality assurance activities must be similar to the College Maintenance of Professional Standards (MOPS) Program. A continuous involvement in recent years is important.*

The process entails a paper review of the application to determine whether the applicant has a specialist qualification and has practised intensive care medicine as a specialist in their country of origin. The applicant must document medical registration, specialist qualifications in intensive care medicine and details of specialist practice in intensive care medicine. Consideration is given to the curriculum vitae, references, and any other documents that portray the applicant's previous practice as an intensive care medicine specialist. Stated experience and qualifications must be substantiated by statements of training and original or certified copies of diplomas from relevant bodies.

Applicants who meet these criteria are invited to an interview enquiring about previous training and experience, using a proforma based on the criteria detailed above. There have been no specific changes to these criteria for assessment since 2002.

The College has indicated that there have been no formal appeals against decisions regarding overseas-trained specialists. The appeals process of the College is detailed in regulation 13.

In New Zealand, the College acts as the Branch Advisory Board to the Medical Council of New Zealand (MCNZ). The New Zealand Committee of the College provides much of this function, but all recommendations of the assessment committee are sent to the College Board for approval. The College confirms it undertakes the following steps in the recognition and assessment of overseas-trained specialists.

- *Assessing the applicant's qualifications, training and experience against the standard, as equivalent to, or as satisfactory as, that of an Australasian-trained specialist holding the fellowship qualification. This process involves review of the candidate's curriculum vitae, reference checking and face-to-face interview. The interview is attended by three fellows (one of whom is the Censor – possibly by telephone link) and a lay person.*

- *Notifying the MCNZ in writing if any significant concerns about competence become apparent during the assessment and thereafter.*
- *Identifying differences between the applicant's qualifications, training and experience, and the prescribed qualification (fellowship), whether there are any deficiencies or gaps in training, and whether subsequent experience has addressed these, and if not, what type of experience, supervised practice and assessment would address the deficiencies or gaps in training, to inform MCNZ in making a decision.*
- *Advising the MCNZ of any requirements the doctor needs to complete to obtain vocational registration, together with comprehensive reasons.*
- *Ensuring reports meet administrative law obligations and principles by providing well-reasoned advice directly supported by the paper documentation and information obtained at interview.*

The College has established a list of comparable countries and their qualifications for assessment purposes.

Table 1: List of comparable countries and their intensive care medicine programs

Canada	*Fellowship of the College of Physicians and Surgeons of Canada with completion of a recognised fellowship program in Intensive Care Medicine and training and experience in Intensive Care totalling at least 2 years full-time equivalent.*
Hong Kong	*A training program is in its infancy, modelled on the JFICM program. The major difference is the final summative assessment based on the previous JFICM exam format.*
USA	*Intensive Care Medicine or Critical Care Medicine, as it is called, is a sub-specialty of surgery, anaesthesia or internal medicine.*
Europe	*In Europe the most common intensive care specialist qualification is the European Diploma of Intensive Care supervised by the European Society of Intensive Care Medicine.* *United Kingdom: fellow of the Royal College of Anaesthetists, Surgeons or Physicians – FRCA, FRCS or FRCP with CCST in Intensive Care and with the European Diploma of Intensive Care.* *Ireland: Diploma of the Irish Board of Intensive Care Medicine with full registration as an Intensive Care Specialist in Ireland.*
Republic of South Africa	*The College of Anaesthetists of South Africa within the College of Medicine supervises a Critical Care program.*
India	*India has had an organised training program under the auspices of the Indian Society of Critical Care Medicine for 4 years.*

The College assesses the training and experience of applicants from other countries with more than one intensive care program on a case-by-case basis.

The policy for recognition of prior learning is included in the College regulations and relevant policy documents and, for the purposes of OTS, candidates are questioned about

their prior learning using a structured interview proforma, and are given credit in the assessment.

The College submission indicates that a great majority of the overseas-trained specialists being assessed have less than two years of specialist experience in intensive care medicine.

The College submission details the number of specialists completing the OTS Program by Year and Region of Origin, 2006–2010 as follows:

Table 2: Number of specialists completing the CICM OTS program by year and region of origin

	India	Asia	UK/ Ireland	Europe	N America	Other	Total
2006	0	0	1	0	0	0	1
2007	0	0	2	8	0	1	11
2008	0	0	3	2	2	0	7
2009	0	0	4	2	1	1	8
2010	1	0	0	1	0	1	3

The College has a separate policy Intensive Care Services for Areas of Need document IC-12, which is available on the College website. Since 2005, the College has assessed eight individuals for AON positions. The College submission provided the information on Area of Need assessments by region of origin per year 2006–2010.

Table 3: Number of Area of need applications by year and region of origin

	India	Asia	UK/ Ireland	Europe	N America	Total
2006	0	0	1	2	0	3
2007	1	0	0	1	0	2
2008	0	0	1	0	0	1
2009	0	0	1	0	1	2
2010	0	0	0	0	0	0

5.4.2 2011 team findings

The College faces challenges in the assessment of overseas-trained specialists as there are no clear international comparators to CICM training and qualification. The processes used by the College are transparent and rigorous. Applicants interviewed during site visits considered them to be fair. The growth of intensive care medicine internationally will provide the College with future opportunities to explore equivalency with identified Competent Authorities.

5.4.3 Assessment of specialists trained overseas in 2015

Overseas-trained specialists (OTSs) are assessed according to the standards applicable in Australia and New Zealand and according to the curriculum requirements of the College.

From February 2011 to the end of 2014, the College received 53 applications for the Overseas Trained Specialist Pathway. At the time of the College's submission in March 2015, no applications had been received for 2015.

Year	Number of Overseas-Trained Specialist Applications	Outcomes recorded	CICM Fellowship obtained
2011	10	6 Partially comparable	2
		4 Non-comparable	
2012	15	9 Partially comparable	4
		3 Withdrawn	
		2 Non-comparable	
		1 Pending	
2013	16	8 Partially comparable	1
		4 Pending	
		3 Non-comparable	
		1 Withdrawn	
2014	12	6 Pending	1
		5 Partially comparable	
		1 Withdrawn	

Since 2011, the College has reviewed its procedures in relation to the Overseas Trained Specialist and Area of Need (AON) Pathways in line with the 2013 Medical Board of Australia's consultation on proposed changes to the competent authority pathway and specialist pathway for international medical graduates. The College has:

- developed a new application form and checklist for overseas-trained specialists.
- developed comprehensive internal procedures for processing overseas-trained specialist applications, Steps and Procedures for Receiving and Processing Applications.
- reviewed its interview process and structure and made no changes to the process.
- reviewed its communication with overseas-trained specialists, AHPRA and the AMC. The College continues to have a designated staff member who oversees all matters. In line with the changes, the College has endeavoured to improve its assistance to overseas-trained specialists when completing their application for specialist recognition. Overseas-trained specialists are encouraged to contact the College for advice on the suitability of their documentation and with any other questions they may have. They can visit the College office for further assistance. Staff and a senior fellow representing the College attended the Specialist Pathway Forum presented by AHPRA and the AMC on 21 February 2014. Feedback on the Report 1 templates and the working paper, Guidelines on Good Practice in the Specialist IMG Process was also submitted. The College has also continued to participate in the network of college international medical graduate managers group.

- reviewed the redefined comparability definitions, as per the recommendations, , and adopted these into the assessment process. The definitions provide a reference point for the College when determining the suitability of an overseas-trained specialist applying for the specialist pathway. To accommodate these changes (and the new administration processes), the College has included the comparability definitions in its revised document T-27. The College has also included these definitions on its website so that overseas-trained specialists are better informed of the different assessment outcomes.
- reviewed the fees charged for assessments as per the recommendations. Although the College has not made an adjustment to its fee structure to coincide with administration changeovers, fees may be reviewed in the event of a sizeable increase in the number of applications.
- published information on its website regarding the new assessment process since June 2014.

2011 Accreditation Conditions and Recommendations

2011 Commendations

L The College's transparent and rigorous process for assessment of specialists trained overseas.

2011 Conditions to satisfy accreditation standards

Nil.

2011 Recommendations for improvement

Nil.

There were no conditions regarding standard 5.4 from 2011.

2015 Accreditation Conditions and Recommendations

2015 Commendations

N The College's comprehensive review of its procedures and processes associated with the Overseas Trained Specialist and Area of Need Pathways in accordance with the Medical Board of Australia's review of the specialist pathway for international medical graduates.

2015 Conditions to satisfy accreditation standards

Nil.

2015 Recommendations for improvement

Nil.

6 The curriculum – monitoring and evaluation

6.1 Monitoring

The accreditation standards are as follows:

- The education provider regularly evaluates and reviews its training programs. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.
- Supervisors and trainers contribute to monitoring and to program development. Their feedback is systematically sought, analysed and used as part of the monitoring process.
- 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.

6.1.1 Monitoring in 2011

The College's Education Committee is responsible for monitoring, evaluation and improvement of the training program and also the assessment and appointment of supervisors of training (SOT) for each accredited unit. The College developed a plan in 2005 for the ongoing development of the program, and since then a number of significant changes have been made. These include:

- *development of the intensive care Primary Examination in 2007*
- *redesign of the format of the Fellowship Examination in 2008*
- *increasing the core intensive care training time from 24 to 36 months for all new trainees from 1 January 2011*
- *option of a three-month rotation to a rural unit during Advanced Training*
- *introduction of hot cases in response to poor trainee performance in the clinical examination.*

The College indicates that proposals for change are disseminated to the regional and national committees to allow input from SOTs and other fellows. The College invites all SOTs to twice-yearly workshops held during the Australasian annual scientific meetings. These workshops provide opportunities to discuss aspects of the program with office-bearers and to give feedback on issues concerning training and supervision. The College has gathered formal feedback from SOTs in 2002 and 2004. In May 2011, in preparation for the accreditation assessment the AMC sent a survey of SOTs to 115 supervisors and 39 responded.

Trainees provide feedback on training issues and proposed program changes through the Trainee Committee, SOT workshops and the hospital accreditation process.

In the last 12 to 18 months, the College has introduced a number of new ways of obtaining trainee feedback. In 2010, the College surveyed trainees to gather feedback on supervision, assessment and other training issues. The trainee survey was sent to over 600 trainees and

233 trainees responded. Having attended the AMC workshop on confidential trainee feedback in November 2010, the College Board appointed trainee representatives to a number of CICM committee, including the Board and also the hospital review teams.

6.1.2 2011 team findings

The team found good evidence of ongoing review and evaluation of its training program.

There are also clear plans for future review, which are listed in the College's 2010 Strategic Plan. These build on the plans for curriculum review that began in 2006 but stalled as the College directed its energies to the formation of the new college. It is pleasing to see that the College is once again starting to focus on this important review. There is good evidence of internal debate and reflection within the College, which bodes well for the future direction of the curriculum and the College.

While the College does make opportunities for SOTs and other fellows to be involved in review processes, through the regional and national committees, these opportunities could be expanded. Some SOTs met by the team felt there were limited opportunities to provide feedback and contribute to monitoring and program development. This was supported by the AMC survey of supervisors of training, in which a majority of those responding were either neutral or disagreed with the statement "the College uses supervisors' experience and skills in program development". The team supports the College's intentions to consider further processes to allow supervisors to contribute to training program development.

The College's supervisor workshops have enabled supervisors to provide feedback on issues concerning training and supervision. The College has also introduced a one-day interactive forum, which may provide another avenue for SOT involvement in monitoring and program development. There appear to be few other opportunities for feedback for those unable to attend these workshops.

Supervisors also indicated that where feedback was provided, such as on the final ITA sign off, the College's response to the feedback was not always clear. In the AMC survey of SOTs, only a third of SOTs agreed with the statement "Supervisors receive adequate feedback on how the College responds to issues of concern to supervisors." Supervisors met by the team wanted to be more involved in the monitoring of the training program, and it would be useful if the College explored ways to facilitate this. Methods may include regular SOT surveys or SOT regional meetings to encourage collegiality, training and feedback.

The College assesses the quality of supervision well during hospital accreditations. However, between accreditation visits, supervision is not regularly monitored or evaluated. The College currently has few mechanisms to identify poorly supervised terms, in particular in the medicine and anaesthesia terms, which account for two of the six years of training. The SOT plays a critical role in the training program. A committed and enthusiastic SOT can add significantly to a trainee's progress, while a SOT experiencing difficulties could be of great detriment to the training program. In the recent trainee survey, 18.4% of trainees did not find the SOT role useful, and some reported behaviour that they regarded as bullying. The team noted the College's current monitoring mechanisms had not identified these problems.

The AMC survey of SOTs found only 10% of those who responded agreed with the statement, "I receive helpful feedback to improve my performance as a supervisor." Overall, the supervisors interviewed by the team expressed a willingness to have more structured performance feedback to assist their professional development. De-identified 360-degree feedback, particularly from trainees, may provide a useful method for this purpose. It would not only allow constructive feedback to SOTs, but also help identify excellent trainers, as well as where conflicts or poor performance are occurring.

The College's approach to instituting changes, with a long lead time, does enable trainees to comment on proposed change. The team recommends that the College extend the formal opportunities for involvement of trainees in discussion of program change. The Trainee Committee would seem to represent a suitable avenue for this purpose, particularly as it matures and becomes more independent.

The team commends the College on the recent survey of trainees. Trainees valued this opportunity to contribute to monitoring and program development. At a unit and regional level, trainees reported that it was not always easy to provide feedback that can effect change without the trainee feeling vulnerable. The College canvasses trainees during the accreditation of training sites, but these can occur as infrequently as every seven years. A regular systematic system for obtaining de-identified feedback from trainees regarding their training and clinical experiences and quality of supervision would be useful. It is pleasing to see that the College is supportive of adopting such a policy. There are opportunities for the College to work with the Trainee Committee to support trainee feedback systems that are well supported by the trainees.

6.1.3 Monitoring in 2015

The College's Education Committee continues to be responsible for the monitoring, evaluation and improvements of the training program.

As discussed, the College implemented a new curriculum in January 2014. As part of the curriculum review, trainees and supervisors were consulted at various stages to provide input and feedback on the old training program and proposals for change. The College intends to undertake a comprehensive review of the curriculum after five years using external educational expertise. In the interim, feedback on the curriculum will be sought from:

- trainees and supervisors via email, online surveys and at College meetings
- the Trainee Committee
- College staff.

The College has identified several components of the new curriculum which will be reviewed, including:

- the trainee selection process
- In-Training Evaluation Reports
- Workplace Competency Assessments
- Observed Clinical Encounters

- access to the various specialised training modules including trauma, cardiac, neuro, rural, paediatric workload implications of the assessments (via feedback from supervisors)
- First Part and Second Part Examinations
- implementation of the Transition Year.

The College is currently reviewing data from the first 12 months of In-Training Evaluation Reports (ITER). Approximately 1,000 completed ITER forms have been submitted to date and this data will be reviewed by the Assessment Committee and reported to the Board. The College indicates this data will assist in analysing trainee progress through the program and compare results between different training units, At this stage, there has been insufficient data obtained from the workplace competency assessments and observed clinical encounters to facilitate meaningful analysis.

There have been some changes to the trainee feedback processes since 2011. The College has adapted the twice-yearly Quality of Training survey to enable the trainee and their training location to be identified. Trainees are asked questions regarding their clinical experience, formal teaching, involvement in research, quality of supervision and trainee administration and resources provided by each training unit. The Education Committee receives this information for analysis and consideration. The College has plans to collate and analyse data for each training unit. Once a number of responses have been received the College intends to de-identify the information so that it can be fed back to individual units. The College also proposes to allow units to view the de-identified data of similarly sized units so that relevant comparisons can be made.

Trainees are also invited to provide feedback on assessments as part of the ITER process. Although several trainees have voiced concerns, no trainee has wished to put these comments in writing. Given that an individual staff member has responsibility for managing trainee feedback the College considers that trends regarding individual units could be detected. To date no trainee has made a formal complaint about a supervisor and if this was to occur the College policy would be for the Censor and Censors Committee to manage the issue.

Trainees are encouraged to provide feedback on training issues through the trainee representatives on College committees, the Trainee Committee and through confidential discussions during the hospital accreditation visits which now occur every five years.

All supervisors of training were asked to comment on the changes to the curriculum, in particular whether to reduce the anaesthesia training requirement to six months, and to increase the amount of training in intensive care by an additional six months. This feedback was taken into consideration and resulted in the anaesthesia training time remaining at 12 months.

In 2013, the College implemented an annual Supervisor of Training survey. A total of 153 supervisors were invited to participate in the 2015 survey with a 33% response rate. Supervisors are also asked to provide feedback on the training program at supervisor workshops where there is a direct link to the College due to the presence of College staff and Board members. The College introduced a supervisor of training e-

newsletter, SOT Newsletter to assist in increasing communication from the College to its supervisors.

Other evaluations processes have also been put in place including:

- surveying examination candidates after each examination
- surveying new fellows via the New Fellow survey, introduced in 2013
- surveying participants following completion of each of the College Communication and Management Skills Courses.

6.1.4 2015 team findings

As stated previously, the College clearly takes the matter of monitoring the training program seriously. The team congratulates the College on its extensive program of evaluation. The team notes that the College is undertaking a number of evaluation activities and the team recommends that the College implement an overarching framework to ensure systematic program monitoring and evaluation.

In 2011, the AMC recommended that the College implement methods for systematic and confidential feedback on the quality of their supervision, training and clinical experience and for analysing and using this feedback in program monitoring (condition 9). The team commends the College on the implementation of the Quality of Training survey. The College's plans to monitor and analyse training at different training units is seen as a positive development.

Feedback to the team indicated that trainees are satisfied with their training. The only issue of concern is that some trainees have been reluctant to provide negative feedback on their terms as doing so may result in being required to repeat a term. A no disadvantage policy may create more transparency for the College with regard to obtaining information from trainees on the educational quality of these terms. The team recommends that the College implement mechanisms for analysing and using trainee feedback in program monitoring and develop policies on how the College will respond to issues raised by trainees.

The AMC recommended in 2011 that the College implement structured methods for supervisors, including those supervising the medicine and anaesthesia terms, to contribute to monitoring (condition 8). The team commends the College on processes introduced for supervisors to contribute to monitoring of the training program since the last assessment. In January 2014, the College launched the online Training Portal which can be accessed by all supervisors including those supervising the medicine and anaesthesia terms. The portal allows all supervisors to access information on individual trainees and to provide comments on the training term that is fed back to the College. The College reported to the team that the online portal has been successful in enabling greater interaction with supervisors from non-intensive care medicine terms.

As noted earlier, the College receives feedback from supervisors on the training program via the supervisor workshops. The College is currently changing the scheduling of workshops which has resulted in no sessions being held at the College Annual Scientific Meeting in 2015. In feedback to the team, supervisors in rural and regional locations indicated they were unable to attend the other scheduled workshops

due to their location or time. For example they may be held on a New Zealand bank holiday. The team considers that this may result in reduced feedback being provided by fellows from rural and regional locations which would otherwise contribute to the monitoring of the program.

The team commends the College on the number of ways in which feedback is sought from supervisors, however the team suggests that the College could benefit from adopting a more formal and consolidated approach to ensure that the supervisor feedback is used effectively in the monitoring and evaluation of the program.

6.2 Outcome evaluation

The accreditation standards are as follows:

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

6.2.1 Outcome evaluation in 2011

The College maintains records on the outputs of its training programs. The College submission contains detailed records of the number of general and paediatric fellowships awarded between 2005 and 2010 and these are as follows:

Year	***General***	***Paediatric***
2005	*29*	*0*
2006	*23*	*0*
2007	*36*	*2*
2008	*62*	*5*
2009	*63*	*3*
2010	*53*	*4*

In addition, the College maintains records of all Primary and Fellowship Examinations and analyses the examination results.

In August 2010, the College conducted a workforce survey of its fellows to gather information on the working environment of intensive care specialists. It planned to use the information to inform proposed changes to the training program.

6.2.2 2011 team findings

The AMC accreditation standards refer to developing methods of collecting qualitative information on outcomes. The College currently does not achieve this. On site visits, supervisors, College fellows, hospital administration, health department officers, nurses and allied health professionals who met team members all overwhelmingly viewed newly graduated College fellows as being of a high standard. However, the College has no systematic way of assessing whether or not the standard of its output, the new fellows, is

commensurate with community expectation, or if there are deficiencies relating to shortcomings in the training program and assessment of learning. Many new fellows and SOTs as well as some submissions by health departments, suggested new fellows were not prepared for the administrative, leadership and management role of a consultant. A de-identified survey of newly graduated fellows, seeking self-assessment of their preparedness, is one way in which such qualitative information may be obtained.

Many groups in the health services have close contact with intensivists, including other health professionals, health service managers and patients, their families and carers. All these groups may be able to provide important feedback on the performance of the workforce as a whole, especially of new fellows, and thus contribute to the evaluation of the College's outputs. For example, nursing and allied health staff that the team met identified communication with patients and families as a common weakness for new fellows. Health department officers interviewed by the team were concerned about the need to train specialists for rural and regional areas, not just the major tertiary centres. The team encourages the College to develop specific plans for engaging these stakeholders in program evaluation.

The team recognises matching the outputs of a training program to workforce needs is difficult. Nevertheless, trainees identified this as an issue of major concern. The number of fellowships awarded has increased significantly over the past few years, from 29 and 23 in 2005 and 2006 respectively, to 62 and 63 in 2008 and 2009. Trainees expressed significant concerns regarding the availability of consultant positions for future graduates during site visits as well as in the College trainee survey.

The team commends the College for its recent formal workforce survey of its fellows. The identification of workforce needs is important not only to ensure that enough new specialists are being trained, but also not to waste time and resources on training too many specialists. As outlined earlier in the report, the College considers the role of the intensive care medicine specialist is changing significantly and is likely to expand. The team encourages the College to make this review a priority, to consult stakeholders in the review, and to consider the matching of training outputs to workforce needs.

6.2.3 Outcome evaluation in 2015

The College provided details of the number of general and paediatric fellowships awarded between January 2011 and October 2015. These are as follows:

Year	General	Paediatric
2011	56	2
2012	56	4
2013	63	5
2014	44	3
2015	29	0 (so far)

As noted under 6.1.3, the College introduced the New Fellow survey in 2013 to begin evaluating the outcomes of the training program. This survey collects information on

the graduate's capabilities for becoming a consultant, their reflections on how well the training program prepares them, and the various roles and employment they obtain.

In November 2014, the College along with the Australian and New Zealand Intensive Care Society hosted a workforce summit meeting to discuss projections for the supply and demand for intensive care specialists over future decades. There was clear agreement from the group that at the present time the opportunities for new fellows at the consultant level are limited. This summit began the discussion on workforce issues and highlighted this as an area requiring ongoing attention by the College.

As discussed under standard 1, the College's Community Advisory Group has met four times since it was formed in 2014. The Group provides a mechanism by which the Board can receive advice and feedback from a consumer and community stakeholder perspective. It includes members from the Australian College of Critical Care Nurses, the Australian Association of Social Workers and the Consumers Health Forum of Australia, as well as two community members with experience in roles within health-related organisations. The Community Advisory Group has contributed to evaluation and monitoring activities as well as the evolution of the College's evaluation processes.

6.2.4 2015 team findings

In 2011, the AMC recommended that the College collect qualitative data on the newly graduated fellows' preparedness for the role of consultant (condition 10). The team commends the College on the introduction of the survey for new graduates of the program, the New Fellow survey. The draft survey questions were reviewed by the Trainee Committee to ensure appropriateness of content. The results from the survey since its introduction has indicated that the training program prepares new graduates for the clinical and technical aspects of their role as a consultant, but many felt less well prepared for other aspects, for example, management, administration and quality improvement. As part of the curriculum review, the College has introduced the Transition Year in the final year of training. As previously described under standard 3, this year is intended to better prepare the trainee for taking on a consultant role.

All key stakeholders interviewed by the team, indicated that the training program produces high quality graduates. As discussed under standard 2, the definition of an intensivist is still being reviewed by the College. Once this has been finalised, the team considers that a formal evaluation of stakeholders in relation to the outcome of the training program, and the new consultant in intensive care, would be an important formal evaluation to undertake.

The AMC recommended in 2011 that the College engage healthcare administrators, other healthcare professionals and consumers in the evaluation process (condition 11). In response, the College formed the Community Advisory Group in 2014. The team noted that the Community Advisory Group is very positive about its role within the College and the contribution that it will be able to make across all areas including monitoring and evaluation. The team looks forward to seeing evidence of the contributions to change which are initiated by this group. Additionally, the team recommends that the College seeks feedback from healthcare administrators and other healthcare professionals as part of the College's regular program evaluation activities.

2011 Accreditation Conditions and Recommendations

2011 Commendations

M The ongoing development and review of the intensive care medicine training program, combined with evidence of debate and reflection within the College committees and the fellowship.

N The recent formal surveys of College trainees and fellows.

O The College's graduates are viewed by supervisors, fellows, health service managers, health departments, nurses and other health professionals as being of a high standard.

2011 Conditions to satisfy accreditation standards

8 Implement structured methods for supervisors of training, including those supervising the medicine and anaesthesia terms, to contribute to the monitoring of the training program. (Standard 6.1.1)

9 Implement methods for systematic, confidential trainee feedback on the quality of supervision, training and clinical experience, and for analysing and using this feedback in program monitoring. (Standard 6.1.1)

10 Develop ways to collect qualitative information on outcomes including the newly graduated fellows' preparedness for the role of consultant. (Standard 6.2.1)

11 Implement processes for engaging health care administrators, other health care professionals and consumers in the evaluation process. (Standard 6.2.2)

2011 Recommendations for improvement

NN Develop better methods of feedback to supervisors of training, and provide further opportunities for them to be involved in monitoring and program development. (Standard 6.1.2)

The 2015 team considers conditions 8 and 10 from 2011 have been met. Condition 9 and condition 11 from 2011 are progressing. Condition 9 from 2011 is replaced with condition 7 in 2015. Condition 11 from 2011 is replaced with condition 8 in 2015.

2015 Accreditation Conditions and Recommendations

2015 Commendations

O The College's ongoing efforts to monitor and evaluate all aspects of the intensive care medicine training program.

P The implementation of the six-monthly Quality of Training survey and annual Supervisor of Training survey which allows for systematic collection of feedback on training supervision and clinical experiences.

Q The College's plans for collating and analysing feedback gathered from the Quality of Training survey and feeding de-identified information back to the training units.

R The introduction of the online Training Portal which enables greater interaction and opportunities for feedback with all supervisors including those supervising the medicine and anaesthesia terms.

2015 Conditions to satisfy accreditation standards

7 Implement methods for analysing and using trainee feedback in program monitoring and for responding to issues raised by trainees. (Standard 6.1)

8 Seek feedback from healthcare administrators and other healthcare professionals as part of the College's regular program evaluation activities. (Standard 6.2.2)

2015 Recommendations for improvement

JJ Implement an overarching evaluation framework to ensure systematic monitoring and evaluation including how feedback is analysed and used in program monitoring. (Standard 6.1 and 6.2)

KK Develop a formal and more rigorous process for the management and use of data obtained from the Quality of Training survey and the Australian and New Zealand Intensive Care Society's Centre for Outcome and Resource Evaluation data, including closing the feedback loop, whilst protecting trainee confidentiality. (Standard 6.1.3)

7 Implementing the curriculum - trainees

7.1 Admission policy and selection

The accreditation standards relating to selection into the training program are as follows:

- A clear statement of principles underpins the selection process, including the principle of merit-based selection.
- The processes for selection into the training program:
  - are based on the published criteria and the principles of the education provider concerned
  - are evaluated with respect to validity, reliability and feasibility
  - are transparent, rigorous and fair
  - are capable of standing up to external scrutiny
  - include a formal process for review of decisions in relation to selection, and information on this process is outlined to candidates prior to the selection process.
- The education provider documents and publishes its selection criteria. Its recommended weighting for various elements of the selection process, including previous experience in the discipline, is described. The marking system for the elements of the process is also described.
- The education provider publishes its requirements for mandatory experience, such as periods of rural training, and/or or rotation through a range of training sites. The criteria and process for seeking exemption from such requirements are made clear.
- The education provider monitors the consistent application of selection policies across training sites and/or regions.

7.1.1 College selection processes in 2011

The College's accreditation submission provided the following information on the numbers of trainees entering the training program in the last four years and their educational background.

Number of trainees entering Intensive Care Medicine training 2007–2010 are as follows:

	Australia/ NZ	***India***	***Asia***	***UK/ Ireland***	***Europe***	***North America***	***Other***	***Total***
2007	*66 (33%)*	*59*	*15*	*31*	*15*	*2*	*10*	*198*
2008	*52 (30%)*	*38*	*31*	*25*	*10*	*4*	*10*	*170*
2009	*63 (31%)*	*45*	*24*	*28*	*22*	*3*	*18*	*203*
2010	*57 (34%)*	*24*	*26*	*25*	*10*	*5*	*20*	*167*

The College's submission states that the College does not administer selection or appointment of its trainees centrally or locally. Rather, the College's involvement in

selection processes has been limited to accreditation of training sites (in which the number of positions available at the particular training site is determined by the employer) and to the involvement of College fellows on the selection panels.

The College has published Guidelines for the Selection of Trainees document T-1 that aim to guide fair and transparent selection. The guidelines include:

- *a statement of principles that underpins the selection process*
- *the eligibility criteria that apply to candidates*
- *the selection criteria that address academic achievements and capacity, previous and potential clinical performance, and desirable personal attributes that relate to the practice of intensive care medicine*
- *the processes for the selection that outline steps to be taken in selecting trainees.*

A weighting and marking system is suggested but not prescribed. Regulation 13 details the appeals process for candidates wishing to review the decision on admission to the training program. In the first instance, the appeals process of the employing authority would be applied. Trainee selection guidelines and details of the appeals process are published on the College website and provided with the Trainee and Supervisor Support Kits.

The College acknowledges that there is regional variation in the selection and appointment of trainees. In 2009, a centralised appointment process was developed for Queensland intensive care trainees and resourced by Queensland Health. The College has indicated that the coordinated nature of training rotations militates against a centralised appointment process in each region. The College does not monitor the consistent application of selection policies.

The College considers as eligible candidates for selection into its vocational training program, any medical practitioner:

- *who is registrable with the medical licensing authority of the region in which the accredited College training will be undertaken*
- *who has completed 12 months of general hospital experience after graduation, according to the College regulation 5.2*
- *who is free from alcohol and chemical abuse*
- *who is willing to comply with the rules and procedures of the College.*

7.1.2 2011 team findings

The criteria for selection set a minimum level for candidates to be considered eligible for entry to intensive care training, including provision for candidates to enter at postgraduate year 2 level. It was not clear how satisfaction of these criteria, particularly the identification of who is free from alcohol and chemical abuse, was assessed.

As noted earlier in this report, doctors entering the training program have very diverse experience and include a significant number who are also completing anaesthesia, emergency medicine or physician training as well as a significant number whose primary medical qualifications were obtained outside Australia and New Zealand.

In the AMC survey of supervisors and the College survey of trainees, the desirability of more defined and tighter entry requirements was frequently raised, with concerns expressed about the selection of trainees who are motivated to complete training and are suited to the specialty.

The number of local (Australian and New Zealand) medical school graduates continues to increase, which is likely to increase competition for training places in all medical specialties. The College indicated that, to date, increases in the number of registering trainees has been more than matched by the increase in the number of positions available. As a result, competition for places has not acted to increase the standard required for entry. Should the expansion in the number of places no longer match the number of applicants, the College will require more discriminating/selective selection processes, but which continue to be fair and transparent.

Given the likelihood of increasing demand on training positions, the heterogeneous nature of the trainees, and the multiple entry pathways to training, the team considers the College should review the eligibility and selection criteria, so that they align well with the selection of trainees who are suited to intensive care medicine and who are likely to succeed in the training program.

While the College's guidelines for accreditation of intensive care units do require the unit's selection process to conform to College guidelines, the College's guidelines to its accreditation teams and the report form completed by teams do not require these processes to be reviewed during unit accreditations. No evidence was presented to the team of other review processes.

The exception to the College's limited involvement in selection and appointment processes is in Queensland. In this state, a centralised appointment process operates. The regional committee, working in partnership with Queensland Health, has streamlined the appointment process in addition to managing potential bottlenecks in relation to access to medicine and anaesthesia terms.

In its accreditation submission, the College acknowledges the potential benefits of a centralised selection process, but lists a number of factors that have contributed to the difficulties in establishing a College-run process. These include the relative under-subscription for intensive care positions; hospital-based training; a large number of trainees from outside Australia and New Zealand; a proportion of trainees completing dual training and moving in and out of the intensive care program; and the movement of a significant number of trainees to different geographical locations to gain experience.

Whilst the team acknowledges the significance of these factors, and that there is no single process and method of selecting the most appropriate trainees, it has formed the view that demand is likely to rise as the numbers of medical graduates produced by the Australian and New Zealand medical schools continues to increase. In this situation, limited College involvement in, and governance of, the selection of trainees is likely to significantly constrain the College's capacity to fulfil its stated goal of supporting a selection process that will result in enrolling the best possible candidates into its training program.

The team recognises that the College is not the employer of the trainees but believes that some procedural changes are required to meet the accreditation standards for selection. The processes of selection must be transparent, rigorous and fair. The College should take a leadership role in the development of the criteria for selection of entrants into training for the specialty. The team recommends that the College engage with employers to ensure that its guidelines are known and that it institute processes to monitor compliance with its guidelines. One avenue of engagement with employers could be through the Regional Training Committees.

7.1.3 College selection processes in 2015

In its accreditation submission, the College provided the number of trainees entering the training program from 2011 to 2014.

Trainees	**2011**	**2012**	**2013**	**2014**
New Trainees	149	208	334	65
Basic Trainees	152	192	199	208
Advanced Trainees	312	302	281	336

The College reported that the change in the requirements of the new curriculum drove an increase in trainees entering the program in 2013 which also resulted in a smaller number of trainees entering the program in 2014.

A new selection into training policy was developed in 2013 and applied to all trainees registering for training with the College from 1 January 2014. It is outlined in the Trainee Selection Policy, T-1 (2013) document and detailed in regulation 5.1. A statement of the principles underpinning this process and the selection criteria are included in the document, which is published on the College website. An online application pack is available from the College for prospective trainees.

The College's statement of principles for the selection of intensive care medicine trainees is as follows:

- The aim of the selection process is to recruit the best available trainees for the training program, with the objective of producing intensive care specialists who possess the values, attitudes and aptitude and the characteristics defined in the CICM curriculum.
- All candidates who satisfy the eligibility criteria and apply through the College application process will be considered. The final selection of candidates will be based solely on merit. In the initial stages of least selection will be based on the achievement of minimum entry criteria, rather than a ranking with an arbitrary cut off.
- The selection process will be documented, transparent and objective, with applicants having access to eligibility criteria, information on the selection process, selection criteria and appropriate appeals processes.
- The selection process will be subject to ongoing review to ensure its validity and effectiveness.

- Full details on the application process will be disseminated to all accredited Intensive Care Units, through the College's website and other mechanisms.

The selection process involves attaining a minimum standard, with the number of training positions uncapped. There is no weighting of elements and no marking system. All applicants must complete a six-month introductory term in an accredited intensive care unit (Foundation Training) with satisfactory references from two fellows of the College to be eligible for selection. The College provides a standard reference form to complete. A satisfactory reference is one in which no area (core ability) is marked 'falls short of expected standard' and the referee endorses the candidate's suitability for intensive care training. Trainees who are unable to provide structured references from College fellows are interviewed. The files of all applicants are reviewed by the Trainee Selection Panel according to the requirements set out in the Training Selection Policy. The College reported to date that 63 trainees had been deemed 'successful' and two 'unsuccessful'.

Regulations 15 and 16 outline the College review, reconsideration and appeals processes. These processes cover all applicants, including prospective trainees. There have been no appeals to date.

The selection policy was reviewed by the Censor's Committee in February 2015, and deemed to be operating satisfactorily such that no changes were considered necessary at present, but that it would be reviewed in 12 months after collection of another year of data to ensure that entry criteria remain appropriate.

7.1.4 2015 team findings

It is early in the implementation of the selection policy and it is being reviewed by the College. The College gave a number of reassurances that the policy is working well in the current circumstances. The team has concerns regarding the reliability, rigor and transparency of the policy especially should other training policies change and affect the available number of positions. The policy will require ongoing evaluation by the College to ensure that it continues to meet its statement of principles.

As recommended by the AMC in 2011, the College has developed a selection process (condition 12) which entails assessment of prior experience in the discipline. The references of two College fellows to support the selection of a trainee into the program are considered by the Trainee Selection Panel, using the Recommendation to Trainee Selection Panel form. Where the trainee does not have access to two fellows of the College, for example due to working in a unit staffed by fellows of another specialty, an interview process is also used. The College stated there was much flexibility in the logistics of the interview process, although one health jurisdiction complained of the additional cost imposed on a trainee as a result of working in a rural unit not staffed by College fellows, and the implication this has had on recruitment to that unit. It would be concerning if the selection policy dissuaded trainees from working in certain rural units during their period of Foundation Training.

The team observed a number of potential benefits of the selection policy. Firstly, it provides the opportunity for potential trainees to be mentored and to maturely reflect on their experience of working in an intensive care unit prior to applying to become a

trainee. Secondly, it allows an assessment of a trainee over six months by fellows of the College, thus identifying trainees who are unsuitable to training, and unlikely to graduate from the training program, and for whom another specialty may be more appropriate. There is no data on the number of trainees dissuaded from applying for training, or who would have applied for training under the old system but have not done so under the new system, so it is not possible to know if this is indeed occurring. On paper, the process itself appears to provide little barrier to selection, with only two applicants refused in the first 18 months. Presumably these trainees were deemed unlikely to make suitable specialists. As the College itself notes, the selection process represents a minimum standard, rather than selection on the basis of merit. Trainees and supervisors who were interviewed saw the process as a formality rather than a barrier.

The team acknowledges that there is indeed a selection process but it considers the process warrants further review and provides the following comments for consideration in this review. The first concern relates to who is ultimately responsible for the selection decision. The College states that trainees are selected centrally, not by hospitals or regions, and the application of the selection process is consequentially consistent. However, the team saw the Trainee Selection Panel as administrative in nature, ensuring the minimum requirements have been met, and the references are acceptable. In deeming acceptability, the College states an applicant is selected if both referees state that an applicant is suitable for admission into the CICM training program and if neither has scored the applicant's performance as falling short of the expected standard in any domain. This marking scheme is not documented in either the Training Selection Policy or on the College website. Given this process, the barrier to selection is the acceptability of the structured references, and it is therefore the two fellows completing these that perform the selection process, with the exception of those trainees who require an interview.

The second concern is the rigor and transparency of the process. The College states that the Trainee Selection Panel aims to ensure an independent, fair and consistent approach to reviewing each application. The College also states that because selection is occurring centrally, there is no need to monitor the consistent application of selection policies across training sites and regions (condition 13). However, the AMC team questions this assertion based on its view on the role of the fellows who provide the structured references. The team was not made aware of any processes to ensure the standardisation of the assessment by the fellows undertaking the structured references.

The College argues that selection into training involves attaining a 'minimum entry standard' with the number of training positions uncapped. There is a need for large numbers of junior doctors within intensive care units to meet the clinical service delivery requirements. All of these are potential training positions. Thus entry into the College is not a competitive process and weighting of elements unnecessary. It could be argued that all elements have equal weighting, as failure to achieve the standard in any one domain results in refusal of trainee status. In reality, virtually no one fails.

The College is considering the development of training rotations, although this is at a very early stage. As the number of positions on training rotations is finite, a merit-based selection process will need to be developed if this system is introduced. The College

recognises that it would need to review other colleges' processes before developing its own.

Importantly the selection policy does provide a clear statement of principles that underpin the selection process. The processes for selection into the training program are based on the published criteria. The selection criteria are published in the Trainee Selection Policy, which is available on the website under the 'Becoming a Trainee' tab. Unsuccessful applicants have access to the review and appeals processes of the College.

7.2 Trainee participation in education provider governance

The accreditation standards are as follows:

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

7.2.1 Trainee participation in the governance of their training in 2011

The Trainee Committee was established in 2004. The terms of reference describe the Committee's purpose as representing trainee interests in the governance and affairs of the College and, particularly, contributing to matters concerning education and training. The Committee meets by teleconference three times per year prior to Education Committee meetings.

Each of the Australian states and New Zealand have a representative on the Trainee Committee. Representatives need to be either an Advanced Trainee or registered with the College for at least two years. Once approved, the representative can remain in their position for three years, without the need for re-election. If more than one representative is nominated from a region, an election is held in that region. Normally each representative on the Trainee Committee also takes the role of the trainee representative on each regional committee and the New Zealand National Committee.

Since 2007, when the position of New Fellows representative on the College Board was created, the New Fellows representative has chaired the Trainee Committee. The New Fellow provides a conduit for communication between the Trainee Committee and the Board, representing trainees' and new fellows' interests at Board level.

In November 2010, the College Board resolved to co-opt a trainee to the Board as an invited observer, as well as the Education Committee and hospital accreditation review teams. It also resolved to include a trainee on the Hospital Accreditation Committee although this position has not been filled.

The College accreditation submission indicates that the Joint Faculty had some difficulty engaging the Trainee Committee due to the diversity of trainee origins and changing terms however the level of engagement has improved since the new College was formed. It lists a number of ways in which trainees have been engaged, including:

- *a survey of trainees in 2004 required trainees to rate their satisfaction with aspects of training and suggest improvements*
- *the establishment of an Annual Scientific Meeting in 2005 has increased the ability for trainees to meet and share experiences*

- *seeking opinions of trainees as part of the hospital accreditation review process, with assurances of confidentiality and encouragement to comment on all aspects of training*
- *trainee forums at CICM and ANZICS Annual Scientific Meetings, chaired by the New Fellows representative.*

7.2.2 2011 team findings

The Trainee Committee's terms of reference refer to a systematic procedure of requesting nominations for membership and an election occurring if there is more than one nomination. The reality appears to be different and varies from region to region. In one region, the Committee vacancy was advertised in only one hospital. In another there was a vetting process, and then the position was decided by a vote of the College regional committee, rather than by the trainee body.

In order to be seen as truly representative of their constituency, trainee representatives should be appointed through open processes supported and funded by the training organisation. Appointment by election by the body of trainees is the most open process possible. The College regulations provide a structure for this to occur. The team encourages the College to ensure formal processes for selection are implemented. College fellows, especially SOTs, can encourage trainee involvement in College affairs by indicating their support for such positions.

So far, the arrangement whereby the New Fellows representative on the College Board chairs the Trainee Committee has worked well for both trainees and the College. Although practical, the team identified several limitations to this arrangement. Firstly fellows, not trainees, elect the person and therefore their mandate comes from a different group to the trainee body. Secondly, the appointee is expected to represent both trainees and new fellows. New fellows are no longer trainees, and their interests may differ from those of trainees, thus creating conflict and making it difficult for the New Fellows representative to truly represent trainees.

Recently, the College has invited a trainee member of the Trainee Committee to participate in Board meetings. The College is to be congratulated on this initiative. This person, however, is not elected to the Board, and is unable to vote. The team encourages the College to continue to support trainee involvement at the Board level, and to consider creating a position for an elected trainee Board Member.

Trainee representatives on regional and national committees have full voting rights. Otherwise, trainee involvement in the governance of their training has been minimal to date, with much of this function fulfilled by the New Fellow Board member. Recently the College has increased their involvement. A trainee representative has been added to the Education Committee, although at the time of the team's assessment, that trainee was yet to attend a meeting of the Committee. In addition, a trainee is now part of all hospital accreditation visits, although there was not yet a trainee on the Hospital Accreditation Committee. The team encourages the College to continue to expand the opportunities for trainee involvement in the governance of their training, and to consider establishing a trainee position on every training-related committee. Such participation brings significant benefits. It enhances the training organisation's understanding of how training and

assessment policies work in practice. It also assists the committees that manage the training program to identify and respond early to problems, and to recognise and expand successful strategies. Finally, it promotes the trainee's understanding of and engagement in their training program, to encourage them to be active contributors when they become fellows, and to enable decision-making to be informed by the user's perspective of the training program.

The College has recently introduced a President's Medal, which is awarded to the trainee who is judged to have made the best contribution to the College. Initiatives such as these, that reward and encourage trainee participation in College affairs, are to be commended.

The team noted that ensuring appropriate trainee representation across many geographical regions is difficult. Many intensive care medicine trainees spend a significant amount of their training time in a single hospital or rotation and, with perhaps the exception of Queensland, may have little interaction with trainees in different sites in their region. Many of the trainees met by the team did not know their trainee representative, or how they would nominate for this position. The College should consider how these different sites could be better represented. Trainee committees at a regional level may be one way of achieving this, although the current trainee representatives were unsure if there was enough trainee interest to achieve this. Confidential meetings of trainees at suitable local and regional education and training events may be another way to allow state representatives better to represent their trainee body.

Engagement with individual trainees is also important, and it is satisfying to see the College has several approaches. Trainee opinion is sought at hospital accreditation visits, trainee forums at the CICM and ANZICS Annual Scientific Meetings, and recently through a trainee survey. These are to be commended, and the team encourages continuing support by the College to allow in-depth exploration of concerns and ideas.

Despite these approaches, few trainees had any significant involvement in College affairs. Most are unaware of the College's investment in the development and management of the training program and, because of their limited involvement, cannot influence College requirements and College decisions that can have broad consequences for their training. It is pleasing to see the College making improvements to encourage greater trainee involvement. The team encourages the College to make further advances in this key area, as these initiatives will require considerable College support to develop to their full potential.

7.2.3 Trainee participation in the governance of their training in 2015

The College has strengthened the election process for the Trainee Committee, with the College regulations now covering this matter. Eligible trainees are those registered for training with the College for a minimum of two years, and current Advanced Trainees of the College. Where more than one trainee applies for a vacancy, an election is conducted by email within that region. Additionally, the Trainee Committee has been expanded to include a representative of the trainees undertaking paediatric intensive care medicine.

The New Fellow representative remains the Chair of the Trainee Committee. There is a trainee on most College committees and a member of the Trainee Committee is invited to attend CICM Board meetings. As noted in the 2011 report, this person is not elected

to the Board and is unable to vote. Trainees are represented on the Education and Assessments committees by the New Fellow representative.

The contact details of Trainee Committee members are available on the College website, and the trainee newsletter, *Trainee e-news* regularly features information on committee members. The Trainee Committee now meets annually at a face-to-face workshop immediately before the February Board meeting. This enables the committee members to visit the College, meet the staff and engage with Board members.

7.2.4 2015 team findings

The Trainee Committee's role within the governance of the College continues to strengthen. Members of the committee considered that they are well represented throughout the College, including on the Board, with the trainee who attends Board meetings stating they were able to actively participate in meetings. There did not seem to be strong support for a voting member of the Board amongst the committee, with most satisfied with the current arrangement. Trainees are now participating in some, but not all, hospital accreditation teams. There is, however, no trainee on the Education Committee, with trainees represented by the New Fellow representative. Given this is the principal education committee of the College, the team encourages the College to create a trainee position on this committee, so that trainee opinions and concerns can be properly represented.

The New Fellow representative remains the Chair of the Trainee Committee. The trainees on the committee did not report any concerns in relation to this arrangement. It was felt that the arrangement allowed the New Fellow representative to act informally as a mentor to the committee. The team considers, however, that this role could be achieved without the New Fellow being the chair of the committee, and that this arrangement should be reviewed.

The committee continues to receive excellent support from College staff. The committee meets annually at a face-to-face workshop immediately before the first Board meeting of the year. This is a useful way to engage the Trainee Committee, and to effectively communicate both within the committee, and with the College. There is no induction for trainees who join College committees, and the Trainee Committee was of the view that this would be beneficial. The team encourages the College to develop such a resource.

The committee reports ongoing difficulties in trying to interact with the trainee body as a whole. The committee produces newsletters that are distributed to all trainees by email, as well as published on the College website. The email addresses of the committee members are listed on the College website, to allow easy contact. Despite this, engagement with trainees remains difficult. Stakeholder feedback suggests communication from the Trainee Committee and contact with state representatives is viewed as infrequent. The team encourages the College to help the Trainee Committee to find innovative ways to represent and communicate with all trainees. For example, the Trainee Committee would value mechanisms to allow contact between the regional representatives and their region by email.

Trainees undertaking the new curriculum risk being underrepresented as trainees must be registered for training with the College for at least two years, or be an advanced

trainee, to apply for a vacancy on the committee. In addition, representatives can remain on the committee for a period of up to three years without re-election. These factors may mean that there is little or no direct representation of this cohort for some time. The team encourages the College to address this lack of representation.

The College engages individual trainees through the Quality of Training survey, held twice per year. This survey allows trainees to feed back both strengths and weaknesses, to the College. There is evidence that the College follows up, where possible, on issues identified by this survey. This is commendable, and the team encourages the College to further develop this tool as a mechanism to further strengthen the training program.

7.3 Communication with trainees

The accreditation standards are as follows:

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

7.3.1 Communication with trainees in 2011

The College has several formal processes for informing trainees. Emails, the College e-newsletter and the website are primary channels for communication with trainees. There is also an online forum for trainees, although this is currently not well utilised.

The College e-newsletter is sent to fellows and trainees approximately every six weeks and, in addition, is freely available on the College website. Within the newsletter, there is a dedicated section that particularly addresses issues of special interest to trainees.

The website itself provides access to detailed information regarding selection, the training program, including policies, regulations, forms, training resources, journals and publications. Information is also available on the design, requirements and costs of the training program as well as proposed changes to the design, requirements and costs of the training program.

The New Fellows representative also communicates with trainees, principally by email. The New Fellows representative emails trainees prior to Board meetings inviting them to nominate any particular issues they would like raised or discussed by the Board and then communicates the results of the Board's deliberations on the issue in an individual reply to the trainee. In addition, following each Board meeting, a report is circulated to supervisors and trainees highlighting important changes in training, as well as general news regarding the College.

7.3.2 2011 team findings

Overall, the team noted that trainees are happy with the quantity and quality of communication from the College. The College communicates with its trainees in an open and transparent way.

During site visits and in the College survey of trainees, the majority of trainees commented on the quality of the website as satisfactory or better. It certainly represents a commendable effort for a College in its infancy. Most of the website is transparent and openly available to people without the requirement for a login, an initiative the team commends.

The recent survey of trainees also indicated that a majority thought communication from the College was either satisfactory or better. Comments from trainees were mostly positive. Trainees stated they received regular emails from the College, and that direct communication with the College was usually helpful, timely, and efficient. A few trainees wanted better communication regarding requirements for dual fellow trainees, and the approval of prior learning.

Although the team was satisfied with the College's communication strategy, it has several suggestions for improvement. Information regarding mechanisms for the recognition of prior learning and flexible training options on the website is limited. For recognition of prior learning, prospective trainees are advised to call the College. There is little information available, and inconsistency in decisions relating to this issue was highlighted in the recent trainee survey, and in some of the team's site visits. This perception may be improved by more open and transparent information regarding this issue, ideally on the website.
Information regarding options such as part-time and interrupted training is not readily available, outside that provided in the regulations. The team would encourage the College to develop easily accessible resources regarding this issue.

The team noted there was minimal information regarding trainee support systems and career guidance. Supervisors of Training provide much of this support and guidance, but this is not necessarily available for prospective trainees or for trainees who do not want to approach their SOT. Currently prospective trainees would need to contact the College directly. A handbook was previously available and is being updated. This updated resource will potentially fill this void and ideally would be available on the College website. Information for trainees experiencing difficulties would also be a useful addition to the website, in case local support systems are unable to address their requirements.

The College has given lengthy lead-in times when making significant changes to the program and only applied the changes in regulations to new trainees, ensuring existing trainees are not disadvantaged. This strategy was used for the recent increase in the core intensive care training time from 24 months to 36 months. The team commends this approach.

The College appears to provide timely and correct information to trainees about their training status. Trainees are able to access details of their previous accredited terms, status of fees, level of training and In-Training Assessments through the member login section of the College website. This also lists the successful completion of the examinations,

ADAPT and formal project components. Accessing this portal allows trainees to identify whether the information the College holds is correct, and to contact the College if details are incorrect. The recent trainee survey did, however, highlight the introduction of this system as being problematic, although trainees did not identify this as an issue during site visits.

7.3.3 Communication with trainees in 2015

Since 2011, a specific trainee edition of the regular College newsletter called Trainee e-news has been published. This includes contact details for each regional trainee representative and communication of College developments relevant to training.

The College provides an online training portfolio for each trainee that keeps trainees updated about training requirements, both completed and yet to be undertaken. The online Training Portal was upgraded in early 2015. As discussed under standard 3, the College plans to develop a more sophisticated online trainee dashboard, which will give trainees much greater detail about their progress through the training program and also contain all submitted assessment material.

7.3.4 2015 team findings

The College continues to communicate with trainees in an open and transparent manner. Overall trainees reported satisfaction with the quality and quantity of communication received from the College.

The College communicates in a number of formats. Email and newsletters remain the preferred method, but social media is also being used, though it was not clear what the uptake of this method is.

The website is well laid out and easy to navigate. Trainees reported that they were satisfied with the information provided on the website, with information on trainee selection processes, educational objectives, program structure and assessment requirements being clear and transparent. In particular they commented on the very clear information the College provided on the curriculum transition arrangements. The College continues to ensure existing trainees are not disadvantaged, by providing clear and early communication regarding changes to the curriculum, and by only applying changes to new trainees.

The team, however, has some minor concerns regarding the amount of information provided on the website. For some aspects of training, such as flexible training options, the website simply refers trainees to the College. During the assessment visit, some of these issues had already been rectified by the College. The website, however, may still benefit from more detail regarding processes for options such as recognition of prior learning, and flexible training options.

The 2011 assessment also identified information on career guidance as lacking. The handbook and website provides some information to fulfil these requirements. However, a jurisdictional health department stated it would like to see the College do more in this space. The standard advises that "to assist trainees to choose their training program and locations in an informed way, information on career pathways, addressing workforce distribution issues and training opportunities in different regions, should be

available. Additionally, education providers are encouraged to collaborate with health departments and other stakeholders to ensure that career guidance systems are in place". The team heard trainees' concerns regarding job prospects in intensive care medicine and encourages the College to collaborate with the jurisdictions and other stakeholders to provide information on career pathways, addressing workforce distribution issues and training opportunities in different regions.

The College continues to provide timely and correct information to trainees regarding their training status. Trainees are satisfied with the online Training Portal, which allows access to up-to-date training information, online learning modules, paper-based Workplace Competency Assessments and Observed Clinical Encounters, as well as other resources such as medical search databases and online journals.

Trainees reported satisfaction with the assistance they received when making contact with the College. Trainees said they found staff to be very helpful, and responsive with fast turnaround times to email queries.

7.4 Resolution of training problems and disputes

The accreditation standards are as follows:

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

7.4.1 Resolution of training problems and disputes in 2011

In 2009, the College introduced regulations 12 and 13 relating to reconsideration, review and appeals. It also has Guidelines for Assisting Trainees with Difficulties document T-13 and Trainee Performance Review document T-14. These documents are freely available on the College's website. They are detailed and outline the processes that will be followed in the event of a trainee dispute.

The College indicates the Trainee Performance Review process may commence when local measures have failed to resolve the problem. A report prepared by the supervisor or trainees is considered by the Censor. An independent review team will be established, interviews conducted, and the report will be considered by the Education Committee and ultimately by the Board. If the matter is not satisfactorily resolved, the trainee may access regulation 12 and regulation 13 pertaining to the review, reconsideration and appeals processes.

7.4.2 2011 team findings

Overall, trainees appeared happy with their interactions with the College, and none of the trainees who met the team had experienced a training problem or dispute which needed resolution.

Despite this, there seemed to be a lack of knowledge of College processes for dispute resolution amongst trainees, including the Trainee Committee. The Trainee Committee is planning to develop a simple flow chart to aid trainees experiencing problems in finding the required dispute resolution pathway.

While the formal appeal process is clear, the team was concerned that trainees may not be permitted the support of an advocate or legal representative even at the final appeal stage, as per regulation 13.4.3. The regulation allows for an accompanying person, but no representation without prior agreement of the Appeals Committee. The team questions whether these restrictions on representation accord with the requirement of regulation 13.4.4 that the Appeals Committee act fairly within the wider ambit of natural justice.

In the recent College trainee survey, the majority of trainees reported satisfaction with their supervisor. There were, however, some trainees who expressed dissatisfaction, with 14.7% of trainees disagreeing with the statement, "the SOT role is helpful". Free text responses indicated perceptions of some SOTs lacking motivation and some of bullying behaviour. The College reported that these concerns are not communicated formally or informally to them. The College relies on trainees or fellows to approach independently with their problem and it currently has no mechanism to seek information regularly and systematically from trainees or other health professionals, to identify problems with training supervision. The hospital accreditation process may identify such problems, but it only occurs every seven years. The recent trainee survey is an excellent initiative, but is not performed on a regular basis, and due to its anonymous nature, is unlikely to identify specific problems. More systematic seeking of structured anonymous trainee feedback may help to solve this problem. The team was encouraged to hear that the College is considering implementing such a system.

To the team's knowledge, the College does not have a process for evaluating de-identified appeals and complaints to determine if there is a system problem. As the College had not yet had a formal appeal, this is understandable. However, the evaluation of reviews and reconsiderations, as well as complaints may be of greater use in helping to identify system problems. The team encourages the College to develop such an internal review mechanism.

7.4.3 Resolution of training problems and disputes in 2015

Reconsideration and review processes are covered by regulation 15, and the appeals process by regulation 16. Since 2011, the provision for a trainee to be advised or accompanied by a support person during the appeals process has been added. This person can advise the trainee, but cannot represent them.

There have been no appeals by trainees or overseas-trained specialists from 2011 to 2015. Documents T-13 Guidelines for Assisting Trainees with Difficulties, and T-14 The Training Performance Review, were updated in 2014. Both these documents are available on the College's website.

7.4.4 2015 team findings

The College has made progress in this area since 2011. The regulations relating to reviews, reconsiderations and appeals have been updated, and now allow for a trainee to be advised or accompanied by a legal representative or support person in the case of an appeal. The team welcomes this decision.

The College reports that there were no appeals between 2011 and June 2015. Data provided detailing reviews and reconsiderations appears to contain only requests for approval, and the team could not identify any reconsiderations or reviews during this time. This may reflect the fact that most requests were approved. In general the trainees who interacted with the assessment team did not raise concerns regarding College decisions.

Trainees, however, displayed a lack of knowledge regarding these dispute processes, the details of which may be found in the regulations. The College reported to the AMC in its 2013 progress report that it would add a new tab labelled 'Disputes and Appeals' under Training, on the College website. To date this has not occurred. Nor is there anywhere on the website that provides easily accessible information regarding these processes. The team strongly encourages the College to provide information to trainees regarding dispute resolution that is both easy to find and understand.

The College has implemented the Quality of Training survey, which may identify training problems at training sites. The power of this tool has been further strengthened by the move in 2015 to identify the site of the trainee completing the survey. In particular, the College has introduced a question relating to bullying which, in April 2015, identified that 13 (20%) trainees had observed bullying during their rotation, and 6 (9.2%) identified themselves as being the target. The College has followed up with those that requested it but no trainee wished to make a formal complaint. The College is to be commended for this initiative. As more surveys are completed over time, problematic supervisors or training sites may be recurrently identified. The team encourages the College to take action to address these problems where they occur, as individual trainees are often reluctant to speak up.

The College has detailed and quality information on its website regarding managing a trainee in difficulty. There does not, however, appear to be any information regarding processes or options for trainees that are having difficulty with their supervisor. This was supported by trainee feedback, indicating they were unaware of an easily identifiable and confidential option to raise concerns in this instance. The Quality of Training survey is a commendable initiative to identify such problems. However, this mechanism is provided twice per year, and occurs at the end of a rotation. The College should develop transparent processes to assist trainees having difficulty with their supervisors, providing easily accessible information on the website explaining these processes and who to contact.

Given the College has had no appeals, it is difficult to assess the College's processes for evaluating de-identified appeals and complaints (condition 15). This could be evaluated in future progress reports to the AMC, if and when the College has collected a reasonable number of complaints.

2011 Accreditation Conditions and Recommendations

2011 Commendations

P The College's support for trainee representation, through increasing the trainees' role in governance and the introduction of the President's Medal.

Q The College's approach to engagement of individual trainees through such initiatives as the trainee forum and the trainee survey.

R The multiple methods used to achieve open and transparent communication.

S The notice given of changes proposed to the training program, and the College's approach to ensuring that changes do not disadvantage existing trainees.

2011 Conditions to satisfy accreditation standards

12 Increase the College's involvement in the selection of trainees, working in partnership with employers to ensure that the College's role in appointing trainees is clear, and selection processes follow College principles. (Standard 7.1.2 and Standard 7.1.3)

13 Monitor the application of the College's published selection criteria to ensure that they are fairly and consistently applied across all training sites. (Standard 7.1.5)

15 Develop a process for evaluating de-identified appeals and complaints. (Standard 7.4.4)

2011 Recommendations for improvement

OO Review the eligibility and selection criteria with the aim of developing criteria that are assessable and align well with suitability for intensive care medicine training and with success in the program. (Standard 7.1.1)

PP Strengthen the College's developing processes for formal involvement of trainees in the governance of their training, including:

- continue to expand trainee involvement in College governance
- review the processes for appointment of trainee representatives, to ensure that the trainees chosen are truly able to represent the trainees
- consider the election of a Trainee Board Member
- in collaboration with the Trainee Committee, develop mechanisms to help trainee representatives better represent their diverse geographical regions. (Standard 7.2)

QQ Improve its communication with trainees on the following issues: recognition of prior learning, flexible training options, support systems for trainees, and career guidance. (Standard 7.3.2)

RR Consider ways in which information concerning the dispute processes can be clearer and more easily accessible to trainees. (Standard 7.4.2)

SS Reconsider regulation 13 regarding advocacy and representation at appeals. (Standard 7.4.3)

The 2015 team considers conditions 12 and 15 from 2011 have been met. Condition 13 from 2011 is progressing. Condition 13 from 2011 is replaced with condition 9 in 2015.

2015 Accreditation Conditions and Recommendations

2015 Commendations

S The College's commitment to open and transparent communication with trainees and its commitment, through its processes, to ensuring existing trainees are not disadvantaged by changes to the training program.

T The implementation and modification of the Quality of Training survey, which now allows the identification of training issues at specific training sites.

U The College's plans for the development of a more sophisticated Trainee Dashboard which will give trainees greater detail about their progress through the training program.

2015 Conditions to satisfy accreditation standards

9 Review the processes for selection into the training program to ensure they are rigorous, transparent and fair. (Standard 7.1.2)

10 Document and publish the weighting for the various elements of the selection process, in particular the marking criteria, including that applied to the structured references used by the Trainee Selection Panel to deem suitability for training. (Standard 7.1.3)

2015 Recommendations for improvement

LL Strengthen trainee involvement in the governance of their training by:

- Creating a position for a trainee on the Education Committee
- Giving consideration to having a trainee as the Chair of the Trainee Committee
- Creating an induction package for trainee representatives on College committees
- Ensuring trainees of both the new and old curriculum are adequately represented on the Trainee Committee
- Collaborating with the Trainee Committee to develop mechanisms to improve representation and communication with all trainees. (Standard 7.2)

MM Provide additional information on the processes for recognition of prior learning and flexible training options for trainees on the website. (Standard 7.3.2)

NN In response to trainees' concerns about job prospects in intensive care medicine, collaborate with the jurisdictions and other stakeholders to provide information on career pathways, addressing workforce distribution issues and training opportunities in different regions. (Standard 7.3.2)

OO	Make information concerning dispute and appeals processes clearer and more easily accessible to trainees. (Standard 7.4.3)
PP	Develop transparent processes to assist trainees having difficulty with their supervisors, providing easily accessible information on the website explaining these processes and who to contact. (Standard 7.4.1 and 7.4.2)

8 Implementing the training program – delivery of educational resources

8.1 Supervisors, assessors, trainers and mentors

The accreditation standards are as follows:

- The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the training program and the responsibilities of the College to these practitioners.
- The education provider has processes for selecting supervisors who have demonstrated appropriate capability for this role. It facilitates the training of supervisors and trainers.
- The education provider routinely evaluates supervisor and trainer effectiveness including feedback from trainees and offers guidance in their professional development in these roles
- The education provider has processes for selecting assessors in written, oral and performance-based assessments who have demonstrated relevant capabilities.
- The education provider has processes to evaluate the effectiveness of its assessors/examiners including feedback from trainees, and to assist them in their professional development in this role.

8.1.1 College roles in supervising training in 2011

The College's key roles are as follows:

*The **Education Officer** is the Chair of the Education Committee and oversees supervisors of training and In-Training Assessment matters. The Education Officer is responsible for supervising the Trainee Committee, overseeing the Training Committee and contributing to the Hospital Accreditation Committee. The Education Officer reports to supervisors and trainees on educational matters following Board meetings. They prepare educational documents and contribute to training program development.*

*The **Censor** oversees training of the College's trainees, supervises the assessment of overseas-trained specialists and supervises the assessment of applications for Area of Need. The Censor reports to the Board or Education Committee on all matters pertaining to these roles. The Censor makes recommendations on the College training program and regularly reviews the College regulations. The Censor's specific tasks include:*

- *overseeing prospective approval of each individual trainee's advanced training by the Training Committee*
- *providing individual assessment of a trainee's training requirements*
- *ruling on trainee queries*
- *assessing OTS for referral to the OTS Committee*
- *assessing specialists for Area of Need by paper assessment and then interview, making recommendations to the Board*
- *responsibility for the performance of Formal Project Assessment Panel.*

*The hospital **Director of Intensive Care** is primarily responsible for ensuring the intensive care service functions effectively and efficiently. Their training-related roles include nominating supervisors of training and notifying the Board of the recommendation.*

*The **Intensive Care Specialists** provide and participate in educational activities for trainees. The College has defined expectations with respect to supervision of trainees within the intensive care units in addition to provision and participation of appropriate education activities for trainees. All intensive care specialists are involved in the supervision and teaching of trainees and are usually consulted on trainee performance when the Final In-Training Assessment is completed.*

*The **Supervisor of Training** is the College's representative on training in accredited units. The supervisor provides the liaison between trainees and both the hospital authorities and the College. Their primary role is formative assessment of the trainee. The supervisor is required to have regular meetings with the trainee and organise assessments based on observation of the trainee's clinical practice. The supervisor provides summative assessment using the in-training assessment form and at the completion of six months of training. The College indicates that the supervisor will often also have a mentor role which may include discussion with the trainee regarding their future training and employment. Each accredited intensive care unit must have one or more dedicated supervisors of training.*

Selection and evaluation of supervisors

The College has a defined process for selecting and appointing fellows who have demonstrated capability to perform the SOT role, which is also detailed in document T-10. The supervisor of training will be nominated by the Director of the Intensive Care Unit who will then, in turn, notify the College Board of the recommendation. The supervisor of training is subsequently appointed by the Board and both the Director and the hospital administration are advised of the appointment. Supervisors of training are required to hold the Diploma of Fellowship of CICM or an equivalent qualification.

The College evaluates supervisor and teaching effectiveness by formally seeking feedback during hospital accreditation reviews. The review focuses on receiving feedback from the SOT and trainee on matters relating to the training, supervision and education of trainees. The College expects SOTs to participate in the MOPS program and attend regular workshops on topics related to teachers, trainers and mentors.

Selection and evaluating of examiners

The College has established processes for the selection and training of examiners set out in Guidelines for Appointment, Training and Duties of Examiners Document Ex-4. One of the roles of the Examination Committee is the oversight of the selection, professional development and performance of the College Examiners. Nominations for College Examiners are made to the Training and Examination Coordinator, who in turn, refers the nomination to the Examinations Committee. The Committee makes a recommendation to the Board based on the explicit criteria in Document Ex-4 which is publicly available. Examiners are appointed for a three-year period which can be renewed to a maximum term of 12 years.

An examiner must be at least five years post-fellowship of CICM and have evidence of current MOPS certification The College requires examiners to be active clinicians and teachers, to be clinically competent and of high professional standing. It also sets requirements regarding capacity to examine without bias, and fairness as an interrogator and skill as an evaluator.

Examiners are required to attend an examination workshop at least one a year. The workshop includes a number of activities aimed at calibrating examiner performance and improving the reliability of the examination process itself. In addition, the Chair of the Examination Committee observes and monitors the performance of the examiners during both the workshop and examinations, and provides performance feedback to the examiners.

8.1.2 2011 team findings

The role of the supervisor of training is critical to the success of the College's training program. This role is defined well, and the College has published clear information regarding the roles and responsibilities of supervisors. The guidelines for the supervisor of training are detailed in The Role of Supervisors in Training of Intensive Care Medicine document T-10. Information is also detailed in Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine document IC-2 and The Supervision of Vocational Trainees in Intensive Care Medicine document IC-4. During the anaesthesia and internal medicine terms, the trainees are supervised by specialists in those fields and the aims of those terms are set out in documents T-7 Aims of the Medical Term and T-8 Aims of the Anaesthesia Term.

As intensive care medicine is a consultant-led service, trainees have a high level of exposure to consultant staff during their training, including their supervisors of training and examiners, mentors, teachers and role models. The high level of contact between trainees and intensive care specialists is one of the great strengths of intensive care medicine training.

During the site visits the team was impressed by the obvious engagement and commitment of supervisors of training who generally appeared well aware of their responsibilities. Trainees largely reported that the supervisors of training are very accessible, supportive and helpful.

The College is recognising the critical importance of the role of supervisors of training by increasingly developing resources dedicated to their training and professional development. These include a published Supervisor of Training Support Kit, which covers a comprehensive range of topics and resources. More recently, the College has introduced supervisor of training workshops and courses. The supervisors consider these to be of high quality. The annual meeting of supervisors of training is held as a part of the College's Annual Scientific Meeting and provides attending supervisors opportunities to meet peers to discuss issues of common interest. As noted in section 6.1, supervisors would also like the College to provide more opportunities for active feedback on the program as well as opportunities for peer discussion and professional development.

A challenge with the increased number of trainees, particularly in the larger units, is that a single supervisor of training may be responsible for a large number of trainees. Some

supervisors of training reported that their workload had increased as a result, especially in tracking the progress of individual trainees. Some units have dealt with this by appointing a Deputy Supervisor of Training. There is currently no stipulated policy or guidelines on the numbers of trainees that a single supervisor of training should supervise. The team encourages the College to consider the development of such guidelines to assist units and supervisors of training to manage the expanded load.

In many units, the supervisor of training is a relatively junior consultant. The College recognises these enthusiastic supervisors of training, who are often very committed to trainees, need support. It encourages mentoring by more senior consultants. The team encourages the College to continue to develop this largely informal support process.

As noted earlier in the report, intensive care medicine trainees undertake lengthy anaesthesia and medicine terms. The College's relationship with the supervisors of these terms is less formal. While it made available the documented Term Objectives, the College did not communicate routinely with these supervisors about other College support or requirements. The team encourages the College to expand the guidance and support to the supervisors in the non-intensive care terms to ensure this training meets College requirements.

The College evaluates supervisor and teacher effectiveness during the seven-yearly unit accreditation. Despite a stated intent to seek feedback from trainees regarding their supervision and other aspects of the training program at other stages, this is largely informal and relies on information collected at the time of the In-Training Assessment. The College recognises that seeking trainee feedback via the ITA might constrain the nature of the feedback, given its primary purpose of trainee assessment. It outlined plans to establish more regular and robust feedback mechanisms, which the team supported.

The role of mentor is less well defined by the College. College fellows and trainees reported that in most cases mentor relationships develop informally and there was clearly an awareness of the potential issues involved in blurring the roles of supervisor and mentor. The College recognises that this is an area of potential future development.

8.1.3 College roles in supervising training in 2015

The key roles of those involved in the supervision and training as articulated in the 2011 assessment are essentially unchanged, although some changes to the governance structure have changed the emphasis of key responsibilities.

The **Education Officer** continues to be the Chair of the Education Committee and oversees supervisors of training and in-training assessment matters.

The **Censor** oversees all matters relating to training selection and progress through the training program. The Censor's specific responsibilities include making decisions about:

- approval of training
- recognition of prior learning
- unsatisfactory trainee progress
- assessment for recognition as an overseas-trained specialist.

The Censor chairs the Censor's Committee and is assisted by Deputy Censors (including one for Paediatrics).

The hospital **Director of Intensive Care** is primarily responsible for ensuring the intensive care service functions effectively and efficiently. The Director of Intensive Care is responsible for nominating supervisors of training within their unit and notifying the Education Committee of the recommendation.

As a consultant-led service, all **Intensive Care Specialists** provide and participate in clinical supervision and educational activities for trainees. The College has clearly articulated the expectations with respect to supervision of trainees within the intensive care setting in addition to provision and participation of appropriate education activities for trainees.

The **Supervisor of Training** has the primary responsibility for the formative assessment of trainees. The role of the supervisor is clearly articulated within the College training document T-10 The Role of Supervisors of Training in Intensive Care Medicine. There are clear and established processes for the selection of supervisors. Applications are assessed by the College Education Committee, which is also responsible for monitoring the performance of supervisors of training. It was noted that with the implementation of the new curriculum the responsibilities of supervisors of training have expanded. The Education Committee is also responsible for monitoring the proposed number of trainees being supervised by each supervisor and ensuring that an appropriate amount of time is quarantined to perform this function. The team was advised that the current maximum number of trainees that each supervisor of training can supervise is 10.

In its accreditation submission, the College indicated that supervisor performance is assessed using the Quality of Training survey in addition to information obtained during the accreditation site visits. As discussed under standard 6, this survey is no longer anonymous which will allow the College to aggregate information obtained from multiple trainees from a single unit to provide feedback to supervisors.

8.1.4 2015 team findings

The team was impressed by the sustained high level of engagement of fellows with regard to the support, supervision and monitoring of trainees.

The team noted that with the implementation of the new curriculum, the roles and responsibilities of supervisors of training and other fellows involved in training are expanding, particularly with respect to the requirements for formative and summative assessment processes. Whilst the College is aware of the increased workload on supervisors and has to some extent addressed this through stipulating a ratio of trainees to supervisors, it is encouraged to continue to monitor this issue.

In its submission, the College indicated that the annual supervisor workshop has been reviewed and that the content of the workshop has been changed to include a series of workshops with a focus on relevant themes. It is encouraging to see the development of supervisor workshops. However, feedback received from some supervisors, particularly those from regional and rural locations, indicated limited access to professional

development opportunities. This is particularly relevant in light of the implementation of and transition to the new curriculum.

In addition to supervisor workshops, the College has continued to develop online resources and plans to expand this to include podcasts. The College indicated in its submission that it plans to make supervisor engagement a permanent responsibility for a staff member of the College and that the responsibilities of this individual will be to further improve resources and materials distributed to supervisors in addition to the development of a supervisor network. The team looks forward to seeing the continued development of resources and support for all fellows who are involved in supervision and training.

As was identified at the previous assessment, a number of supervisors of training are relatively junior consultants. The 2015 team heard that the College is in the process of developing a "champions" mentoring program to provide support and professional development opportunities for new supervisors. The team commends the College on initiating this program.

In 2011, the AMC recommended that the College strengthen links with and support available to supervisors in the medicine and anaesthesia terms to ensure that the training undertaken in those terms meets college requirements (condition 16). As discussed under standard 6, in 2014 the College introduced the online education portal which is available to all supervisors including those who are not fellows of the College but are supervising trainees in medicine and anaesthesia terms. The portal allows supervisors to access and complete the In-training Evaluation Report (ITER) and also provides access to documents and information relevant to the training program such as:

- Guide to CICM Training: Supervisors document
- Guide to completing the In-training Evaluation Report for Supervisors of Training (Intensive Care)
- Formal Project Requirements document which includes information on the requirements for the Formal Project including examples of acceptable submissions
- information on the College's activities
- contact details for College staff including a direct email address for the Training Department for any enquiries.

The AMC recommended in 2011 that the College implement more regular feedback processes with regard to the role and performance of supervisors of training (condition 17). As discussed under standard 6, the College has introduced the Quality of Training survey and annual Supervisor survey. The College anticipates this information will identify supervisors who are underperforming and may require additional guidance to meet the requirements of the role. In addition, the feedback will allow the College to identify supervisors who are performing well in the role. In 2015, the College indicated that the Quality of Training survey has brought to light the issue of some trainees experiencing an inadequate rapport and relationship with supervisors. The team notes that these processes are in the early stages of development and the College is asked to develop formal and systematic processes for feeding back information to supervisors on their performance which will assist them in their role.

The College has established processes and criteria for the selection and professional development of examiners. During the assessment visit, some team members had the opportunity to observe examination activities, including calibration and professional support of examiners by more senior examiners. An experienced examiner is paired with a less experienced examiner during the examination. The team was impressed with the approach and support provided with respect to the development of examiners in their role.

The College indicated that the Assessments Committee has been given the specific task of monitoring the workplace-based assessments and ensuring that fellows who conduct the assessments are appropriately trained. A specific Assessments Committee member has been given the task of developing a series of workshops based on the workplace-based assessments. The AMC looks forward to updates on the development of these workshops.

2011 Accreditation Conditions and Recommendations

2011 Commendations

T The high level of engagement and commitment by the supervisors of training.

2011 Conditions to satisfy accreditation standards

16 Strengthen links with and support available to supervisors in the medicine and anaesthesia terms to ensure that the training undertaken in those terms meets College requirements. (Standard 8.1.1)

17 Implement more regular and formal feedback processes with regards to the role and performance of supervisors of training. (Standard 8.1.3)

2011 Recommendations for improvement

TT In recognition of the considerable responsibilities the supervisor of training has to their trainees, consider specifying the number of trainees able to be supervised by one supervisor. (Standard 8.1.1)

UU Make a clear distinction between the roles and responsibilities of supervisors of training and the role of mentor with respect to trainees. (Standard 8.1.1)

VV Consider increasing the number of opportunities for supervisors of training to meet to discuss areas of common interest. (Standard 8.1.2)

WW Make a clear distinction between the roles and responsibilities of supervisors of training and those of a trainee mentor. (Standard 8.1.1)

The 2015 team considers condition 16 from 2011 has been met. Condition 17 from 2011 is progressing and is replaced with condition 12 in 2015.

2015 Accreditation Conditions and Recommendations

2015 Commendations

V The significant contribution and engagement of fellows in supporting, supervising and monitoring of trainees.

W The development of robust processes for the professional development of examiners.

2015 Conditions to satisfy accreditation standards

11 Implement a strategic approach to the development of a program to support and train supervisors of training. (Standard 8.1.2)

12 Implement formal and systematic processes to provide feedback to all supervisors of training on their performance in the role. (Standard 8.1.3)

2015 Recommendations for improvement

QQ Implement workshops to assist and support fellows in undertaking workplace-based assessments. (Standard 8.1.2)

RR Provide access to professional development for all supervisors, in particular those from regional and rural locations. (Standard 8.1.2)

8.2 Clinical and other educational resources

The AMC accreditation standards are as follows:

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

8.2.1 Clinical and other educational resources in 2011

The College accredits intensive care units for training rather than individual training posts. There are 109 accredited units: Australia (83), New Zealand (12), Hong Kong (7) and other overseas countries (7). Eight of these units are in rural centres, 15 in private hospitals and 13 are accredited only for Basic Training.

The College process and criteria to select and recognise intensive care units for training processes are defined in the following documents:

- *Minimum Standards for Intensive Care Units Document IC-1*
- *Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine Document IC-3*
- *Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine Document IC-13*
- *The Supervision of Vocational Trainees in Intensive Care Medicine Document IC-4.*

Supplementary documents provide guidance for particular situations:

- *Minimum Criteria for Accreditation of Units for Basic Training*
- *Accreditation of Units Overseas for Core Training*
- *Guide for Hospitals Seeking Accreditation of Training*
- *Guide for College Accreditation Team.*

The process of hospital accreditation is overseen by the Hospital Accreditation Committee. Its roles include: accreditation and review of training sites; appointment of accreditation teams; collation and analysis of data obtained from sites; and review of accreditation documentation.

The College routinely reviews accredited training units every seven years. In addition, intensive care units can apply for accreditation and this is referred to the Hospital Accreditation Committee for consideration. If the intensive care unit meets the criteria for accreditation, an inspection will be arranged.

Training sites seeking accreditation must complete and submit a detailed proforma for consideration by the Hospital Accreditation Committee before an accreditation visit is arranged. Hospital site visits are generally conducted over a half-day. Interviews are held with representatives of hospital administration, the ICU Director, the Supervisor of Training, ICU specialists and trainees. The three-member accreditation team includes an experienced reviewer who is a member of the Board from another state or region, and two other reviewers who are members of the relevant national or regional committee who do not work at the hospital under review. The Board has recently approved the appointment of a trainee representative to the accreditation team. The accreditation team provides a report to the Hospital Accreditation Committee which makes recommendations to the Board. Where criteria are not satisfied, follow-up visits will check standards are being met.

The College may conduct an unscheduled review when there is a change in a unit's staffing or educational program, or a reduction in resources. This may be after notice from the

SOT, who is expected to advise the College of any significant change that would affect the training offered in the unit.

According to the College submission, from 2006 to 2010 the College conducted the following number and types of accreditations:

Number and type of College accreditations 2006 to 2010 are as follows:

	Number of new applications received	***Number of ICUs inspected***	***New applications approved***	***Total number of accredited units***
2006	*16*	*14*	*14*	*77*
2007	*19*	*15*	*12*	*89*
2008	*14*	*14*	*10*	*99*
2009	*8*	*18*	*5*	*104*
2010	*9*	*13*	*5*	*109*

Currently, intensive care units are designated for purposes of accreditation for training as: basic training; C6; C12; and C24. The number refers to the number of months that is accredited for intensive care training within a given unit.

The duration of core training is determined by the College's classification of the unit. The guidelines for accreditation of units set general requirements and specific criteria for each level of accreditation (24, 12 or 6 months). These requirements cover the following: unit level; total number of cases; case mix; and involvement in the unit of intensive care medicine specialists who are fellows of the College.

The C6 classification - *six months' core training is granted to Level II, Level III or Paediatric units where the case load, case mix, supervision or facilities are limited. Normally, trainees cannot complete more than one period of C6 training in a unit during core intensive care training. A second period of C6 training in another unit requires prior approval of the Censor.*

The C12 classification - *12 months' core training is granted to Level III units and Paediatric units, and occasionally to Level II units.*

The C24 classification - *unrestricted core training is granted only to Level III units and Paediatric Units. C24 accredited units are major intensive care units in tertiary referral hospitals. Trainees are required to spend at least one year of core intensive care training in a unit with a C24 classification.*

The College regulations indicate trainees are required to gain a broad experience. The caseload, casemix and patient outcomes are assessed at each accreditation visit, ensuring trainees are exposed to sufficient numbers and diversity of patients.

Historically, the College has accepted the accreditation status of the RACP and ANZCA with regards to the medicine and anaesthesia terms. More recently, largely in response to increased demand and difficulty accessing ANZCA-accredited anaesthesia terms in

particular, the College has approved some terms in regional settings for the anaesthesia components of training, which are not currently accredited with ANZCA. Trainees need to seek prospective approval of the term from the College.

8.2.2 2011 team findings

The College has a well-defined process and criteria to select and recognise intensive care units for training and these are publicly available on the College website. The process appears to be collegial, allowing the College to work with health services when concerns are identified so that training can continue in an appropriately resourced environment.

The team noted the College's accreditation requirements cover the facilities, teaching support and clinical experience requirements mandated in the AMC accreditation standards, except for orientation.

The College's criteria allow for accreditation of sites across a spectrum of clinical settings including tertiary metropolitan, private, regional and rural intensive care units in addition to clinical settings outside of hospitals (for example, retrieval services). In practice, some health departments felt that the College's approach could be more flexible, to allow trainees better opportunities to experience the breadth of intensive care medicine. The team recognises recent moves by the College to increase flexibility and encourage the College to extend the opportunities for registrars to experience a range of practice locations.

The College emphasises the role the hospital accreditation visit plays in monitoring the formal teaching, the trainee's experience and the supervision. While the process appears to be thorough, and provides for good involvement of trainees in the assessment, in the absence of other formalised feedback processes, the seven-year accreditation cycle may be too long. The team has made recommendations in earlier sections of the report concerning other mechanisms for regular and robust monitoring of the local delivery of the training.

The team has identified a number of issues concerning the College's designation of units as C6, C12 and C24. As the College reviews its curriculum, it will be important for the designations of training experience relevant to the curriculum requirements to also be reviewed. While the College does not encourage it, under the current arrangements a trainee may complete all the mandatory 24 months of intensive care training in a C24 unit. The guidelines for accreditation of intensive care units support this. Discussion with trainees and supervisors confirmed that this can limit the trainees' breadth of training and their preparation to work outside tertiary referral hospitals. The College has indicated that these guidelines are a high priority for review.

The College accepts the accreditation status granted by the RACP and ANZCA for the medicine and anaesthesia terms of the intensive care medicine training program. The College has recently agreed to accept anaesthesia terms in regional settings, which do not have accreditation for ANZCA training of specialist anaesthetists, as meeting the requirements of intensive care medicine training. The team applauded the College's plans to consider flexibly the needs of trainees preparing to become specialist intensivists. The College indicated an intention to review the anaesthesia and medicine terms as part of the curriculum review. The team encourages the development of clear accreditation

requirements for the medicine and anaesthesia terms to ensure that the learning objectives of the non-intensive care components of training are met.

As noted earlier, the links and communication between the College and supervisors in non-intensive care terms can be weak, which may lead to the College not being informed of changes in the teaching program, the training or the supervision. The College will need to ensure robust accreditation processes are in place for these terms.

8.2.3 Clinical and other educational resources in 2015

The College continues to accredit intensive care units for training rather than individual training posts.

The College process and criteria to select and recognise intensive care units for training processes are defined in the following documents:

- IC-1 Minimum Standards for Intensive Care Units
- IC-3 Minimum Standards for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine
- IC-13 Recommendations on Standards for High Dependency Units Seeking Accreditation in Intensive Care Medicine
- IC-4 The Supervision of Vocational Trainees in Intensive Care Medicine.

Supplementary documents provide guidance in particular situations:

- Minimum Criteria for Accreditation of Units for Basic Training
- Guide for Hospitals seeking Accreditation for Intensive Care Training
- Guide for the College Accreditation Team
- Application for Accreditation for Foundation Training.

As noted in the College's accreditation submission, a number of changes have been made to the College accreditation processes since the 2011 assessment:

- The accreditation cycle has been shortened to five years from the original seven.
- Data on ICU activity is being sourced on an annual basis from the Australian and New Zealand Intensive Care Society (ANZICS) and the requirement for units to submit data has been enhanced.
- IC-3 Minimum Standards for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine has been modified in response to the new curriculum and is available in two versions to reflect the changes to the curriculum with a plan to phase out the original versions once trainees training under the old curriculum complete training.
- All accredited ICUs have received notification of their classification under the new curriculum. This includes suitability of ICUs for subspecialty experience.
- Criteria for accreditation for Foundation Training have been approved and a process for accreditation of Foundation Training has been implemented.

- Criteria have been established and a process has been implemented for the accreditation of sites for anaesthesia training in hospitals that are not accredited for training by ANZCA.

In its accreditation submission the College indicated its plan to develop a specific document outlining the accreditation requirements for the Transition Year.
The process of hospital accreditation is overseen by the Hospital Accreditation Committee which is responsible for ensuring that intensive care units accredited for training provide adequate facilities, casemix, supervision and teaching. Training sites seeking accreditation must complete and submit a detailed Hospital Data Sheet for consideration by the Hospital Accreditation Committee which upon reviewing the information makes a recommendation to the Board whether or not to consider accreditation. An inspection visit is subsequently arranged for those units recommended for consideration.

The inspection team comprises a Board member from out of state and two nominees from the College's Regional Committee. Since the previous assessment, the College has also made provision for the inclusion of a trainee representative on the inspection team. The inspection team generally consists of a College Board Member (or recent member within the last three years), a local fellow and a local trainee nominated by the relevant Regional Committee.

The inspection visit is generally conducted over a half day. During the inspection visit, the reviewers conduct a number of interviews with representatives of hospital administration, the ICU Director, the Supervisor of Training, ICU fellows and trainees, in addition to conducting an inspection of the intensive care unit, department, library and other relevant hospital areas.

Following the inspection, a report is prepared by the inspection team for consideration by the Hospital Accreditation Committee and a recommendation is made to the Board which ultimately decides on approval for accreditation and accreditation status.
In its submission, the College provided the following information regarding its accreditation activities since the 2011 AMC assessment:

Year	Re-accreditation applications	New applications received	ICUs inspected	Applications approved	Total units accredited
2011	17	9	20	26	107
2012	9	9	16	17	115
2013	15	12	20	21	128
2014	16	8	20	16	131

In addition to the above, 15 intensive care units have applied for Foundation Training and all have achieved accreditation. Six units have applied for accreditation for the anaesthesia training and all were successful. The latter units are in addition to those already accredited by the Australian and New Zealand College of Anaesthetists for anaesthesia training.

8.2.4 2015 team findings

The College has a well-defined process for accreditation of intensive care units with clearly articulated requirements, documented in policies and guidelines which are accessible on the College's website.

The team noted the College's efforts to further strengthen its accreditation processes and requirements since the 2011 AMC assessment, including the shortening of the accreditation cycle to five years, changes to the designation of units in line with the new curriculum, and commencing the development of standards for the accreditation of units for anaesthesia training which are not currently accredited by the Australian and New Zealand College of Anaesthetists.

Stakeholder feedback referred to the Accreditation of Specialist Medical Training Sites Project commissioned by the Australian Health Ministers' Advisory Council and noted that the College has not currently implemented these standards. The team encourages the College to map its accreditation standards against the accreditation domains as outlined in the Project's Final Report.

The College's plan to develop a specific document outlining the accreditation requirements for units for the Transition Year is encouraged.

In 2011, the AMC recommended that the College review its processes for monitoring and assessing non-intensive care terms against the College's requirements (condition 18). Whilst the accreditation standards for intensive care units are well articulated, there is very limited information on the standards for medicine and anaesthesia units and these are not articulated in the IC-3 Minimum Standards for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine document. Whilst it is understood that some work has progressed on accreditation of units for anaesthesia training, (in addition to those accredited by ANZCA), further work on the development of the accreditation standards for both medicine and anaesthesia training is now required. The College should finalise, incorporate and publish the accreditation standards which are relevant to intensive care medicine training outcomes, for the medicine and anaesthesia terms in the relevant College accreditation documentation.

The AMC recommended in 2011 that the College include a requirement for orientation in the College's accreditation guidelines (condition 19). The College provided evidence that this requirement is addressed, not in the Guide for Hospitals Seeking Accreditation of Intensive Care Training, but in the document, Minimum Standards for Intensive Care Units. The AMC indicated that while the intent of the recommendation was addressed, it would be helpful to include this requirement explicitly in the accreditation guide, when these are updated.

In 2011, the AMC also recommended that the College review the C6, C12 and C24 accreditation designations to ensure trainees' clinical experience meets the College's learning objectives (condition 20). In its 2013 progress report to the AMC, the College reviewed the classifications assigned to units and determined they would remain in place, with a classification being added which is based on the unit's capacity to provide the requisite exposure to a particular clinical area of practice. In April 2013, the College wrote to all units to advise on their new additional classification (e.g. trauma,

cardiothoracic surgery, neurology, paediatrics, etc.) based on data collected and analysed by the College.

2011 Accreditation Conditions and Recommendations

2011 Commendations

Nil.

2011 Conditions to satisfy accreditation standards

18 Review its processes for monitoring and assessing non-intensive care terms against College's requirements. It is acknowledged that the learning objectives of the medicine and anaesthesia terms may change as a result of the curriculum review planned by the College. (Standard 8.2.2)

19 Include a requirement for orientation within the Guidelines for accreditation of intensive care units seeking accreditation for training in intensive care medicine. (Standard 8.2.3)

20 Review the current C6, C12, and C24 accreditation designations to ensure that the trainees' clinical experience will meet the College's learning objectives. (Standard 8.2.4)

2011 Recommendations for improvement

Nil.

The 2015 team considers conditions 19 and 20 from 2011 have been met. Condition 18 from 2011 is progressing and is replaced with condition 13 in 2015.

2015 Accreditation Conditions and Recommendations

2015 Commendations

X The well-defined process for accreditation of intensive care units with clearly articulated requirements, documented in policies and guidelines which are accessible on the College's website.

2015 Conditions to satisfy accreditation standards

13 Finalise, incorporate and publish the accreditation standards which are relevant to intensive care medicine training outcomes, for the medicine and anaesthesia terms in the relevant College accreditation documentation. (Standard 8.2.1)

2015 Recommendations for improvement

SS Finalise the requirements for the accreditation of intensive care units for the Transition Year and publish these once finalised. (Standard 8.2.1)

TT Map the College's accreditation standards against the accreditation domains as outlined in the Accreditation of Specialist Medical Training Sites Project Final Report. (Standard 8.2.1)

9 Continuing professional development

9.1 Continuing professional development programs

The accreditation standards concerning continuing professional development (CPD) are as follows:

- The education provider's professional development programs are based on self-directed learning. The programs assist participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine as well as changing societal expectations.
- The education provider determines the formal structure of the CPD program in consultation with stakeholders, taking account of the requirements of relevant authorities such as the Medical Board of Australia and the Medical Council of New Zealand.
- 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.
- The education provider documents the recognised CPD activities of participants in a systematic and transparent way, and monitors participation.
- The education provider has mechanisms to allow doctors who are not its fellows to access relevant continuing professional development and other educational opportunities.
- The education provider has processes to counsel fellows who do not participate in ongoing professional development programs.

9.1.1 The College's Maintenance of Professional Standards Program in 2011

The College's continuing professional development program has evolved from the Maintenance of Professional Standards Program which was introduced by the Faculty of Intensive Care, ANZCA in 1996. In 2000, the program underwent a major revision. Minor revisions were made subsequently, taking account of developments in the Joint Faculty's parent colleges, including the major review of the ANZCA program in 2008.

The College Fellowship Affairs Committee oversees general aspects of the program, such as its development and evaluation. The MOPS Officer is a College Board member who is elected to the MOPS portfolio. This fellow oversees all MOPS activities.

The College's principal objective of the MOPS program is to foster continuing scholarship and quality improvement in order to maintain a high standard of clinical practice. The principal role is educational and the program validates continuous medical activities, quality assurance and other self-improvement educational activities.

The College credits MOPS program points according to the participants' educational activities. It places emphasis on continuing medical education and quality assurance, by requiring participants to obtain at least 50 points for Continuing Medical Education/Training, Teaching and Research activities and 25 points for Quality

Assurance activities every year. Apart from this requirement, the program is not points driven.

The MOPS Framework is based on the following categories:

- ***Continuing medical education:*** *The minimum requirement is 50 points every year, which may include teaching training and research points. A wide range of educational activities relevant to intensive care and related disciplines can be credited including national and international conferences, local activities, remote group learning, self-directed learning, and learning projects including formal skills courses such as Early Management of Severe Trauma (EMST).*
- ***Quality assurance activities:*** *The minimum requirement is 25 points every year. This can be achieved from points compiled from activities such as participation in quality assurance meetings, quality assurance planning, hospital accreditation visits for CICM, short hospital attachments, or from a single activity such as a clinical audit project, a professional practice review, or a one-week hospital attachment.*
- ***Training, teaching and research:*** *While credit points from these activities are not mandatory, the College indicates that these activities contribute significantly to continuing scholarship, and participants, as medical professionals, should uphold a commitment to these activities.*
- ***Professional practice review:*** *This is a one-day review of a participant's practice, on-site at the practice, by a peer nominated by the regional/national committee and endorsed by the College MOPS Officer. Both the participant under review and the reviewer may claim points for these activities.*
- ***Hospital attachment:*** *This is a period of attachment at a hospital accredited for intensive care training, where a participant can observe and engage in hands-on clinical practice.*
- ***Simulator and skills laboratory courses:*** *Participants can receive credit for these courses if the course is approved and completed at an accredited simulator centre.*
- ***Other activities:*** *Other activities considered suitable for MOPS require a detailed submission to the MOPS Officer for evaluation. The College gives examples of sabbaticals, attending courses on subjects outside intensive care, and overseas aid trips.*

The categories are detailed in a comprehensive manual that is regularly updated and available on the College's website.

Most educational activities are assigned points per hour, with points weighted in value according to the nature of the activities. For self-directed learning, such as journal reading, one point per hour is awarded. Formal learning activities are awarded set points depending on the activity. Participation in a simulator or skills laboratory course for example is awarded 25 points under the continuing medical education category and 25 under the quality assurance category, and a learning project such as completion of an ADAPT course is 100 points. Set points are awarded for some activities and examples of these are: 25 points for participation in clinical audit; and 30 points per day for acting as a College examiner.

The College provides a MOPS Diary, both online and in hard copy, for participants to record their involvement in educational activities. Participants use the diary record to self-target areas for improvement. Participants are required to submit an annual return of their activities from 1 January to 31 December of each year. Returns can be submitted by paper forms or via the web. When it receives the Annual Return, the College issues the participants with a Statement of Participation for the past year.

The College has a process for pre-approving certain recognised activities and providers for the continuing professional development program. This means that participants do not have to seek approval from the MOPS Officer, as long as the documentation is provided. These activities include the annual scientific meetings of internationally recognised intensive care medicine organisations and other relevant colleges, local continuing medical education meetings such as hospital grand rounds, self-directed learning, continuing medical education committee work, preapproved courses such the Australasian Donor Awareness Program (ADAPT), College or ANZICS organised remote group learning activities, and all quality assurance activities, as well as most teaching, training and research activities.

The College MOPS Officer applies the following principles and criteria in considering requests from participants for approval of other activities:

- *relevance of learning objectives of the activity to the clinical, administrative or managerial practice of intensive care medicine*
- *qualifications and track record of activity providers*
- *modality of learning used in the activity*
- *assessment of the level of participation undertaken during the activity*
- *formative and/or summative assessment processes*
- *time spent completing the activity.*

The College reviews and has increased the range of courses accepted as meeting MOPS requirements in response to the evolving role of the intensive care specialists. Courses in communication, teamwork and resuscitating skills are now accepted in recognition of the intensivist's involvement in patient care outside the intensive care unit. In response to technological advances, the College now accepts courses to develop skills in bronchoscopy, laryngoscopy, echocardiography, ultrasound-guided cannulation and extracorporeal membrane oxygenation. Advanced mechanical ventilation courses have also been accredited.

The College encourages all fellows to participate. Non-fellows may do so for a fee. There are no differences in policy or procedures for fellows and non-fellows. The participation of SOT, examiners and Board members in the program is mandatory.

The College maintains a record of CPD participation for fellows and non-fellows. In the College submission, participation rates for fellows in 2005–2010 are as follows:

	Total number of fellows	*Number of fellows submitting returns in that year*	*%*
2005	*521*	*150*	*28*
2006	*540*	*140*	*25*
2007	*613*	*132*	*21*
2008	*630*	*126*	*20*
2009	*688*	*152*	*22*

In the period 2005 to 2010, four to five non-fellows have participated in the MOPS program each year.

The College has processes for reminding and contacting fellows who do not stay up-to-date in recording their CPD online.

The College's continuing professional development program in 2011

The Joint Faculty had planned to complete a review of the MOPS program in 2007, but this was delayed by the work required to establish the new College. Under the supervision of the Fellowship Affairs Committee, the College has recently completed a comprehensive review, with stakeholder input. The new CPD program will commence in January 2012.

The new program requires participants to obtain at least 100 points for activities in every two-year cycle. The College has listed three categories of activity as mandatory: Self Learning; Group Learning; and Quality Assurance and Patient Safety Activities. Participants must acquire 20 points in each of these categories. The two other categories of activity are: activities that enhance education and research and non-clinical professional and personal advancement activities.

The College's documentation concerning the new program emphasises self-motivated education and the promotion of life-long learning. Each participant is expected to record a personal CPD plan and, to encourage this, activity points can be claimed for time taken to develop the plan. Once activities have been completed, participants can appraise the value and impact of the activities to assist them to establish if they achieved their original educational targets, and to decide on any further activities. An online activity appraisal tool will be included in the CPD diary.

The College's process for assessing and recognising CPD providers will not change although in future providers will be accredited for a fixed term, followed by re-application, to ensure a high standard is maintained.

Several aspects of the new program are being trialled before introduction, including a new online diary which the College expects will be simpler and more user-friendly. The College website contains an open letter to fellows outlining the changes that will take place as the College moves towards introducing the new CPD program in 2012. An online certificate and a list of approved activities will also be available on the College website.

The existing system of random reviews of up to 5% of participants will be retained. Those participants who complete a random review will not be exempt from any future reviews.

As is presently the case, non-fellow participants will have full access to the online diary and receive statements of participation yearly for an annual fee. The program will be the same for fellows and non-fellows.

The CPD program will be compulsory for fellows. The College has developed procedures to remind fellows who have not entered any activities in the online diary mid-way through the cycle. Those who have not entered any activities for a full cycle will be contacted, initially by the College staff, and then the CPD Officer to discuss reasons for non-participation.

9.1.2 2011 team findings

The College's MOPS program is based on self-directed learning, and the framework to support self-reflection and identification of learning needs will be improved by the introduction of the new CPD program in January 2012.

The College has demonstrated that its program supports participants to maintain and develop knowledge, skills and attitudes essential for practice. The recent review, and the College's recognition of new courses and programs demonstrate the College's commitment to a CPD program that meets the changing needs of patients and the changing environment in which intensive care medicine is practised and responds to scientific developments in medicine.

The available activities are varied and the program offers flexibility and diversity in crediting educational activities to meet the varied needs of individual participants.

The College is congratulated for the inclusive nature of its current program, which allows non-fellows to participate in the program.

The College is to be commended on the intended content of the 2012 program. As well as the revised mandatory categories, the category of activities for non-clinical professional and personal advancement provides incentives for fellows to become involved in the governance of the College and will thereby advance the development and strength of the specialty. This category of the new CPD program will also encourage fellows to consider issues such as work-life balance, which are important for the long-term welfare of the College community.

There was little evidence of trainee involvement in the development of the new CPD program and the team encourages the College to seek input from these future CPD program participants. It was also unclear how the College would evaluate the success of the new program and the team encourages the College to provide mechanisms for fellows to evaluate the program to ensure it continues to improve.

The College has transparent, defined principles and criteria for evaluating and approving activities for CPD purposes. The College assesses the quality and relevance of the content and the qualifications. It tracks the performance of the activity providers. The method of delivery also forms part of the assessment process. The introduction of a time limit for approval of providers is supported. The team recommends the College specify how feedback from fellows regarding specific CPD activities will be used to renew accreditation or review accreditation of such activities.

The College has invested significant effort and human resources in the evolution of its CPD program since 2008. The new CPD program will benefit fellows through significant improvements in content and emphasis. The intention to improve the delivery of the program via the website is commended and, in the long run, should improve the compliance rates and decrease the College's administration load. The team congratulates the College on these initiatives and looks forward to updates in progress reports.

The introduction of the new CPD program also sees the introduction of mandatory participation for fellows. This is in line with the developments in other specialist medical colleges and is now supported by the continuing professional development registration standard of the Medical Board of Australia. While the College has strengthened policy and processes to support this decision, it was not clear whether the College would apply sanctions should fellows remain non-compliant. The College has indicated that it has processes for reminding and contacting fellows who do not maintain an up-to-date online diary. The team encourages the College to develop structured guidelines for counselling fellows once that contact is made.

The records of participation provided in the College submission indicate low levels of participation by fellows in the College's CPD program. These rates of participation may have improved since the submission. Reasons for low participation rates may include fellows completing other CPD programs and/or non-electronic recording. As part of the introduction of the new CPD program, the team encourages the College to consider ways in which it will develop a more accurate indication of fellows' CPD participation, including the participation of those completing other colleges' programs.

Because of the College's historical development, it has a significant number of fellows who hold dual fellowships. The College indicated that approximately 50% of its fellows are also fellows of other colleges. Currently, activities of other colleges and specialties are recognised, if they are relevant to the CICM program participant's intensive care practice. As noted above, the College has processes to recognise automatically a number of these activities for credit in the CICM MOPS program. In view of the new Australian continuing professional development registration standard, the team recommends the College clarify with the Medical Board the CPD requirements to maintain specialist registration in multiple disciplines and whether participants will be able to meet requirements for registration as intensive care medicine specialists by completing other specialist colleges' CPD programs.

9.1.3 2015 team findings

The College's new CPD program commenced on 1 January 2012. The team congratulates the College on the successful implementation of the new program. The CPD program, which uses reflection and consideration of learning needs through a learning cycle, has close to 100% participation by fellows. An online process is used, which is able to capture and record outcomes.

In the College submission, participation rates for fellows during the period 2011–2015 are as follows:

2011 – MOPS

	Total	Australia	New Zealand	Rest of the world
Number of fellows	798	625	71	102
Number of MOPS participants	324	275	41	8
Percentage of fellows	40%	44%	58%	8%

2012/2013 – CPD

	Total	Australia	New Zealand	Rest of the world
Number of fellows by end of 2013	931	725	83	123
Number of CPD participants	861	680	76	105
Percentage of fellows	92%	93%	91%	85%

2014/2015 – CPD (mid-way through the cycle)

	Total	Australia	New Zealand	Rest of the world
Number of fellows by end of 2014	978	776	88	114
Number of CPD participants	565	453	64	48
Percentage of fellows	57%	58%	73%	42%

The principles and criteria used for evaluation of CPD activities remain the same as in 2011. The College provides a comprehensive CPD manual which gives details of the online diary, activity framework, and regulatory documents.

The College's Fellowship Affairs Committee continues to oversee the general aspects of the CPD program. As described under standard 1, the College established a CPD Committee to provide oversight of the process and assist with ensuring fellows participate in the program. The CPD Committee is chaired by the CPD Officer. The CPD Committee includes the trainee representative to the CICM Board and provides a link with the Trainee Committee and the trainee body. The team commends the College on this development as a way of seeking trainee input into the CPD program.

Intensive care units in Australia and New Zealand are quite diverse. Some are relatively small with a mix of patients, including paediatrics. Hence there is a need for fellows to keep up to date with this diverse patient mix. In addition, there are emergent technologies which are affecting the practice of intensive care medicine. The College may wish to consider developing or linking to a range of modules that would cover such domains of practice, perhaps over a five-yearly cycle.

As discussed under standard 4, the College mandates cultural competency online courses for both Australian and New Zealand trainees. The College makes these courses available to all fellows and they are encouraged to participate.

The College indicates it seeks feedback on the effectiveness and usability of the CPD program through College meetings such as the annual scientific meeting, workshops and conferences and directly through the online system. In the lead up to the CPD online diary enhancements, to assess the areas that need improvement the College indicated that it will conduct a survey of fellows.

Since 2011, the College's process for assessing and recognising CPD providers and individual CPD activities has been standardised (condition 21). Accreditation of providers is for a fixed term of five years, followed by re-application, to ensure standards are maintained. All educational activities are assessed for suitability by the CPD Officer. The College does not specify the standards required for providers wishing to deliver CPD activities. The team recommends that the College consider developing and publishing standards to assist education providers.

The College audits 5% of participants every cycle. Audited participants are required to submit proof of participation for all activities listed in their online diary. The most recent audit saw 100% compliance.

In 2011, the AMC recommended that the College develop clear guidelines for counselling fellows who do not participate in CPD (condition 22). The College addressed this condition in 2012 with the implementation of the Policy for Compliance with the Continuing Professional Development Program. The policy stipulates the process to be followed to ensure participation in the program and the extent of the follow-up and counselling that the College will undertake at various stages throughout the CPD cycle to those not participating.

Participation is compulsory for all CICM fellows. As discussed in 2011, a significant number of fellows hold dual fellowships. The 2011 team recommended that the College clarify with the Medical Board whether participants can meet the requirements for registration as intensive care medicine specialists by completing other specialist colleges' CPD programs. Following advice from the Medical Board, the College determined that the CPD programs of the Australian and New Zealand College of Anaesthetists, the Australasian College for Emergency Medicine and the Royal Australasian College of Physicians are comparable to the CICM CPD program. It is now necessary for fellows to provide a certificate of compliance from the respective college in order to fulfil the CICM requirements.

The processes used by the College to ensure compliance with the New Zealand requirements (for the New Zealand fellows) are still in their infancy. The College is currently planning improvements to the CPD online diary to be implemented in 2016. Part of these improvements will include the introduction of the requirement and the mechanism for New Zealand fellows to indicate that they have completed the specific Medical Council of New Zealand requirements for recertification, including conducting at least one medical audit per year and to submit that audit to the College.

The College has processes in place for remediation of fellows who are not compliant with the College's CPD program or do not fulfil the College's own audit of their CPD. At present, this does not include a mechanism for routinely informing the Medical Council of New Zealand when fellows are not compliant. The College indicated to the team that the CPD Committee will revise its CPD compliance policy to include this reporting mechanism. This work is a priority for the College. The College indicated that documentation demonstrating such compliance will be finalised by the end of 2015.

9.2 Retraining

The accreditation standard is as follows:

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

9.2.1 Retraining in 2011

The College has a well-documented process for responding to requests for retraining from its fellows who have been absent from practice for a period of time. In broad terms, one month under supervision in an approved department is required for each year out of practice. The program is tailored to the specific needs of the individual fellow, and a supervisor is appointed who provides progress reports to the College. The retraining program requires prospective approval by the Censor.

9.2.2 Retraining in 2015

In 2012, the College's policy document IC-15, Recommendations for Practice re-Entry for an Intensive Care Specialist was expanded and renamed Recommendations for Practice-Entry, Retraining and Remediation of Intensive Care Specialists.

Retraining processes are clearly documented and available, and appear realistic and appropriate.

The Chair of the Fellowship Affairs Committee oversees the process and determines whether the retraining program is appropriate. The duration of supervised practice continues to be four weeks for every year of absence from intensive care medicine clinical practice. The fellow undergoing retraining is encouraged to seek the support of a mentor.

The College reports that there has been only one retraining request since 2012 from a New Zealand fellow who returned from maternity leave.

9.3 Remediation

The accreditation standard is as follows:

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

9.3.1 Remediation in 2011

A strength of intensive care practice is the requirement for collegial interaction, through handing over care from one specialist to another often on a daily basis. This practice and the interaction of individual intensivists with other hospital departments are considered to provide avenues through which poor performance can be identified.

While these mechanisms exist in hospitals and intensive care units, there is no formal College process for remediation of the underperforming specialist.

The College acknowledges the requirement for such a process particularly as recertification through national registration develops. In New Zealand, the College, generally via the New Zealand Committee, will work with the Medical Council of New

Zealand on the assessment of performance and any subsequent educational program or review ordered by the Medical Council. It would also inform the Medical Council if it became aware of any significant performance or conduct issues relating to specialists registered with the Medical Council.

The Fellowship Affairs Committee indicated it intends to develop a defined process.

9.3.2 Remediation in 2015

The 2012 policy document, Recommendations for Practice-Entry, Retraining and Remediation of Intensive Care Specialists, details how the College responds to fellows who have identified themselves, or who have been identified by the regulators as requiring retraining (condition 23).

The remediation processes are documented and available, and appear realistic and appropriate.

Fellows who identify themselves as requiring retraining are directed to the College's CPD program to guide their learning activities. When a request for retraining or remediation comes from a regional health authority, medical board, medical council or other regulatory body a formal retraining program is developed. This process is overseen by the Chair of the Fellowship Affairs Committee. The Chair will consider the nature and seriousness of the unsatisfactory performance identified and the length of time since the fellow has been in active practice. Key areas of concern and/or deficiencies will be identified from the performance assessment.

If retraining is appropriate, the Chair will select an appropriate supervisor to coordinate a period of supervised clinical practice. The retraining program will include: set goals specific for the area of concern; expected outcomes; clear timeframes; allocate time for feedback; and methods of assessment. At the completion of the program, the supervisor will prepare a report which will be considered by the Fellowship Affairs Committee and the CICM Board.

The College reports there have been no requests for remediation to date.

2011 Accreditation Conditions and Recommendations

2011 Commendations

U The plans for a new continuing professional development program from 2012, including the following features: new educational categories; mandatory participation for fellows, streamlined reporting requirements; and plans for monitoring of the quality of courses provided.

V The inclusive nature of the College's continuing professional development program, with opportunities for non-fellows to participate.

W The College's well-documented process for responding to requests for retraining of its fellows.

2011 Conditions to satisfy accreditation standards

21 Develop mechanisms to assess and recognise the continuing professional development activities of all fellows, including those who are not undertaking the CICM CPD program. (Standard 9.1.4)

22 Develop guidelines for counselling fellows who do not participate in continuing professional development. (Standard 9.1.6)

23 Develop a structured process to respond to requests for remediation of fellows who have been identified as under-performing. (Standard 9.3)

2011 Recommendations for improvement

XX Provide opportunities for trainees, as future participants, to contribute to ongoing development of the continuing professional development program. (Standard 9.1.1)

YY Clarify with the Medical Board of Australia the continuing professional development requirements to maintain specialist registration in multiple disciplines and whether participants will be able to meet requirements for registration as intensive care medicine specialists by completing continuing professional development programs with other specialist colleges. (Standard 9.1.2)

The 2015 team considers conditions 21, 22 and 23 from 2011 have been met.

2015 Accreditation Conditions and Recommendations

2015 Commendations

Y The introduction of the College's new continuing professional development program which effectively uses an online process and that requires reflection and consideration of learning needs through a 'learning cycle' approach.

Z The formation of the College's Continuing Professional Development Committee to provide increased oversight, and the inclusion of a trainee representative as a way of seeking trainee feedback into the program.

2015 Conditions to satisfy accreditation standards

14 Develop and implement processes to comply with specific New Zealand requirements regarding monitoring of continuing professional development and reporting of non-compliance to the Medical Council of New Zealand. (Standard 9.1)

2015 Recommendations for improvement

UU Given the changing nature of intensive care medicine, develop or link to, a range of modules that would cover a limited scope curriculum for continuing professional development which would ensure all fellows undertake training in such critical domains. (Standard 9.1)

VV Develop standards for education providers wishing to deliver continuing professional development activities. (Standard 9.1)

Appendix One Membership of the 2011 AMC Assessment Team

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Final Year Anaesthetics Trainee, Westmead Hospital Rotational Scheme

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Appendix Two Membership of the 2015 AMC Assessment Team

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Dr Simon Martel BSc (Med), MBBS, FANZCA, Postgrad Certificate in Clinical Ultrasound
VMO Anaesthetist, Liverpool/Fairfield and Blacktown/Mt Druitt Hospitals

Ms Jane Porter
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Appendix Three List of Submissions on the Programs of CICM in 2011 and 2015

2011

Australasian College for Emergency Medicine

Australasian College of Sports Physicians

Australian and New Zealand College of Anaesthetists

Department of Health and Human Services, Tasmania

Department of Health, Northern Territory

Department of Health, Victoria

NSW Department of Health

Queensland Health

SA Health

The Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian College of General Practitioners

The University of Adelaide

The University of Sydney

University of Newcastle and University of New England Joint Medical Program

University of Otago

2015

Australasian College for Emergency Medicine

Australian and New Zealand College of Anaesthetists

Australian Medical Association

Deakin University

Department of Health and Human Services, Victoria

Health Consumers' Council WA

NSW Ministry of Health

NZ Health and Disability Commissioner

Royal Australasian College of Surgeons

Royal Australian College of General Practitioners

Royal College of Pathologists of Australasia

SA Health

University of Adelaide

University of Auckland

Appendix Four Summary of the Team's Program of Meetings 2011

Location	Meeting
CANBERRA, ACT	
Friday 3 June – Dr David Hughes, Ms Theanne Walters (AMC staff), Ms Jane Porter (AMC staff)	
Annual Scientific Meeting	AMC Briefing – Fellows and Trainees
	New Fellows and Trainees
Saturday 4 June – Dr Jo Burnand, Dr David Hughes, Ms Jane Porter (AMC staff)	
Annual Scientific Meeting	Supervisor of Training Workshop
Tuesday 14 June – Ms Darlene Cox, Dr David Hughes, Ms Jane Porter (AMC staff)	
Canberra Hospital	Director of Intensive Care
	Senior Hospital Staff
	Trainees and Overseas Trained Intensivists
	Critical Care Nursing and Allied Health
	Supervisors
	Trainees from other disciplines
AUCKLAND, NEW ZEALAND	
Tuesday 21 June – Dr Andrew Connolly, Ms Liz Hird, Professor John Collins	
Starship Children's Hospital	Supervisors of Training
	Paediatric Intensive Care Trainees
	Clinical Director and Intensivists
Auckland City Hospital	CICM Representatives
	Intensive Care Medicine Trainees
	Chief Medical Officer and Director of Child Health
	Supervisors of Training, Training Committee Chair and other senior medical staff
	Non-Intensive Care Supervisors
	Overseas Trained Intensivists
	New Zealand Regional Committee Chair
SYDNEY, NSW	
Tuesday 21 June – Associate Professor Terry Brown, Dr Simon Martel, Ms Jane Porter (AMC staff)	
Royal Prince Alfred Hospital	Director of Intensive Care Unit

Location	Meeting
	Intensive Care Medicine Trainees
	Intensive Care Staff Specialists and Supervisors of Training
	Director of Medical Services
	Representatives of critical care nursing and related allied health disciplines
	Supervisors of Intensive Care Trainees (anaesthesia and general medicine terms) Supervisors from Bankstown, Orange and Mater Hospitals via teleconference
St George Hospital	Senior Hospital Executives
	Intensive Care Medicine Trainees
	Supervisors of Training
	Senior Medical Staff
Wednesday 22 June – Associate Professor Terry Brown, Dr Jo Burnand, Dr Simon Martel, Professor Jung Yul Park (Observer), Ms Jane Porter (AMC staff)	
NSW Health	Medical Adviser Director Workforce Development and Innovation Associate Director State-wide Education Policy
Sydney Children's Hospital	Paediatric Intensive Care Medicine Trainees
	Assistant Director of Clinical Operations
	Intensive Care Unit Supervisors
St Vincent's Hospital (Public and Private)	Chair of NSW Regional Committee
	Intensive Care Medicine Trainees
	Supervisors of Training
	Overseas Trained Intensivists
	NSW Regional Committee
BRISBANE, QLD	
Thursday 23 June – Associate Professor Cameron Bennett, Dr Jo Burnand, Ms Charlotte Nash-Stewart (AMC staff), Ms Jane Porter (AMC staff)	
The Redcliffe Hospital	Acting Director Medical Services
	Intensive Care Medicine Trainees from Redcliffe Hospital and Nambour Hospital via videoconference
	Supervisors of Training
	Overseas Trained Intensivists

Location	Meeting
	Intensive Care Medicine Trainees
The Prince Charles Hospital	Executive Director of Medical Services
	Supervisors
	Nursing Staff
Friday 24 June – Associate Professor Cameron Bennett, Dr Jo Burnand, Ms Jane Porter (AMC staff)	
Queensland Health	Director, QMET
Mater Children's Hospital	Directors of Paediatric Intensive Care Unit and Adult Intensive Care Unit
	Trainees and Overseas Trained Intensivists
	Supervisors of Training
	Directors of Allied Units
	Emergency Department Services Director of Nursing
	Supervisors of Training Intensive Care Unit Directors
Princess Alexandra Hospital	Director of Intensive Care Unit
	Supervisor of Training
	Executive Director Director Medical Services
	Intensive Care Medicine Trainees
	Supervisor of Training, Emergency Department
MELBOURNE, VIC	
Monday 27 June – Associate Professor Terry Brown, Dr David Hughes, Professor Jung Yul Park (Observer), Ms Jane Porter (AMC staff)	
St Vincent's Hospital	Supervisor of Training
	Director of Intensive Care Unit
	Chief Medical Officer and Director of Anaesthesia
	Intensive Care Medicine Trainees
The Epworth Hospital	Intensive Care Medicine Trainee
	Director of Medical Services
	Supervisor of Training

Location	Meeting
Monday 27 June – Associate Professor Cameron Bennett, Ms Liz Hird, Ms Anthea Kerrison (AMC staff)	
The Alfred Hospital	Intensive Care Medicine Trainees
	Supervisors of Training
	Critical Care Nurses and representatives of related allied health disciplines
	Director and Executive Director of Medical Services
	Supervisors of Intensive Care Trainees in anaesthesia, emergency medicine and general medicine
Cabrini Hospital	Director of Intensive Care Unit
	Deputy Director Intensive Care Unit Supervisor of Training
	Intensive Care Medicine Trainees
Monday 27 June – Dr Jo Burnand, Dr Simon Martel, Ms Theanne Walters (AMC staff)	
Department of Health, Victoria	Department of Health representatives

Meetings with the College of Intensive Care Medicine of Australia and New Zealand Committees and Staff

Tuesday 28 June – Thursday 30 June 2011
Associate Professor Cameron Bennett, Associate Professor Terry Brown , Dr Jo Burnand, Dr Andrew Connolly, Ms Liz Hird, Dr David Hughes, Dr Simon Martel, Professor Jung Yul Park (Observer), Ms Theanne Walters (AMC staff), Ms Jane Porter (AMC staff)

Meeting	Attendees
Tuesday 28 June 2011	
College governance, decision-making structures, challenges, strategic directions, communication	President Vice President Chair, Examination Committee Chair, Hospital Accreditation Committee Chair, Paediatrics Examination Committee Acting Chair, Education Committee and Deputy Chair, Hospital Accreditation Committee CPD Officer New Fellows Representative and Annual Scientific Meeting Officer Assistant Education Officer and Regional Representative Censor and Research Officer Co-opted South Australian Representative and Assistant CPD Officer Chief Executive Officer Director, Professional Affairs Project Officer
Structure, duration and sequencing of training; Recognition and approval of training in non-ICU terms; Selection of trainees, College guidelines on trainee selection	President Vice President and former Censor Censor Director, Professional Affairs
Overall assessment and examination policies; In-training assessment and formative assessment; Examinations - standards setting, training of examiners; Function of the Primary Examination and the Fellowship Examination; Procedures re unsatisfactory performance: performance feedback, remediation	President Censor Chair, Examinations Committee Member, Examinations Committee and Chair, Primary Exam Committee Paediatrics Representative, Examinations Committee Director, Professional Affairs and Former Dean

Meeting	Attendees
The College's vocational education and training programs - Management of education and training including Joint training programs; Review and reform of education and training; Structure, duration and sequencing of training; The content of education and training Additional issues: rural training and/or training to meet rural needs; research in training; recognition of prior learning; flexible training Teaching and learning methods and College provision of teaching and learning aids/courses Monitoring and evaluation, quality assurance processes Supervisors and trainers - Appointment, training, review of performance; College role in supporting supervisors, clarity of roles	President Vice President Deputy Chair, Education Committee Censor Acting Education Officer Chair, Formal Projects Panel New Fellows Representative Director, Professional Affairs and former Chair, Education Committee Director, Professional Affairs
Wednesday 29 June 2011	
Issues relating to trainees - Selection of trainees, College guidelines on trainee selection; Trainees' involvement in College affairs; Mechanisms to provide support, counselling, and ongoing monitoring of trainees' wellbeing; Trainees' involvement in decision-making about their training; Dispute resolution	Censor Deputy Chair, Education Committee Chair, Trainee Committee Trainee Representative (VIC), Education Committee Director, Professional Affairs
	Chair, Trainee Committee VIC Representative, Trainee Committee NSW Representative, Trainee Committee SA Representative, Trainee Committee TAS Representative, Trainee Committee

Meeting	Attendees
Assessment of overseas-trained specialists	President Censor Representative, Overseas Trained Specialists Committee Community Representative, Overseas Trained Specialists Committee Director, Professional Affairs
Environment for training - Accreditation of intensive care units for training; Interactions with hospitals and health departments about training requirements; Monitoring quality of training over a wide range of clinical sites/ settings; Rural training; Accreditation of posts outside Australia and New Zealand	Chair, Hospital Accreditation Committee Director, Professional Affairs Communications Officer, Hospital Accreditation Committee
Rural training	Censor Regional/Rural Representative on Board Former Member, Conjoint Rural Committee Former Member and Australian and New Zealand Intensive Care Society Representative, Conjoint Rural Committee President, Australian and New Zealand Intensive Care Society Director, Professional Affairs and Former Rural Representative on Board
Continuing professional development programs; College process for retraining fellows after absence from practice, remediation of under-performing fellows	President Rural Representative, Fellowship Affairs Committee New Fellow Representative New Zealand Member, Fellowship Affairs Committee Director, Professional Affairs Continuing Professional Development Officer Communications Officer

Meeting	Attendees
College staff to discuss roles and responsibilities in supporting education and training	Chief Executive Officer Director, Professional Affairs Co-ordinator, Training and Examinations Administrative Officer, Education Executive Assistant, Continuing Professional Development/Communications Administrative Officer, Training Project Officer
Thursday 30 June 2011	
Team presents preliminary statement of findings	President Chair, Paediatrics Examination Committee Chair, Hospital Accreditation Committee New Fellows Representative Chief Executive Officer Director, Professional Affairs Project Officer Continuing Professional Development Officer AMC team

Appendix Five Summary of the Team's Program of Meetings 2015

Location	Meeting
MELBOURNE, VIC	
Wednesday 25 February – Dr Christopher Duncan	
Teleconference	CICM Trainee Committee meeting
Wednesday 22 April – Associate Professor Cameron Bennett, Professor Kevin Forsyth	
Intercontinental Melbourne The Rialto	Observation of CICM First Part Examination Workshop
Thursday 14 May – Professor Kevin Forsyth	
The Alfred Hospital	Observation of CICM Second Part Examination
BRISBANE, QLD	
Tuesday 7 April – Associate Professor Cameron Bennett	
Australian Medical Association office	CICM Queensland Regional Committee meeting
DARWIN, NT	
Friday 29 and Saturday 30 May – Dr Jo Burnand, Dr Liza Lack, Dr Simon Martel, Ms Jane Porter (AMC staff)	
State Peak Consumer Groups via teleconference	Representative, Health Care Consumers' Association of the ACT Senior Project Officer, Consumer Participation Capacity Development, Health Issues Centre VIC Executive Director, Health Consumers NSW
2015 CICM Annual Scientific Meeting	Community Advisory Group
	Intensive Care Medicine Trainees and Trainee Committee members
	Supervisors of Training
	Overseas trained specialists
	New Zealand Committee members
MELBOURNE, VIC	
Wednesday 29 July 2015 - Associate Professor Cameron Bennett, Professor Kevin Forsyth, Dr Simon Martel, Ms Jane Porter (AMC staff), Ms Ellana Rietdyk (AMC staff)	
Teleconferences held at College office	Supervisors of Training
	Intensive Care Medicine Trainees

Location	Meeting
	State and Territory Health Department representatives from: Department of Health and Human Services, Victoria Queensland Health Department of Health, Western Australia SA Health NSW Ministry of Health Department of Health and Human Services, Tasmania Commonwealth Department of Health
	New Zealand Ministry of Health and Health Workforce New Zealand representatives: Acting Director of Public Health, New Zealand Ministry of Health Director, Health Workforce New Zealand
	Overseas trained specialists

Meetings with the College of Intensive Care Medicine of Australia and New Zealand Committees and Staff

Wednesday 29 July – Friday 31 July 2015
Associate Professor Cameron Bennett (Chair), Dr Jo Burnand, Professor Kevin Forsyth, Dr Simon Martel, Ms Jane Porter (AMC staff), Ms Ellana Rietdyk (AMC staff)

Meeting	**Attendees**
Wednesday 29 July 2015	
College governance, decision-making structures, challenges, strategic directions, communication Graduate outcomes	President Vice President Treasurer Board Member New Fellows Representative Co-Opted Board Member Director, Professional Affairs Trainee Representative Chief Executive Officer Policy Officer
30 July 2015	
The College's vocational education and training programs - Management of education and training including Joint training programs; Review and reform of education and training; Structure, duration and sequencing of training; The content of education and training Additional issues: rural training and/or training to meet rural needs; research in training; recognition of prior learning; flexible training Teaching and learning methods and College provision of teaching and learning aids/courses Monitoring and evaluation, quality assurance processes Supervisors and trainers - Appointment, training, review of performance; College role in supporting supervisors, clarity of roles	President Chair, Education Committee and Education Officer Deputy Education Officer Censor Deputy Censor Chair, Assessment Committee New Fellow Representative Chair, Paediatric Committee and Paediatric Deputy Censor Victorian Member, Paediatric Committee New Zealand Member, Paediatric Committee Director, Professional Affairs Manager, Education and Training

Meeting	Attendees
Issues relating to trainees - Selection of trainees, College guidelines on trainee selection; Trainees' involvement in College affairs; Mechanisms to provide support, counselling, and ongoing monitoring of trainees' wellbeing; Trainees' involvement in decision-making about their training; Dispute resolution	President Chair, Education Committee and Education Officer Deputy Education Officer Censor Deputy Censor Paediatric Deputy Censor Chair, Assessment Committee New Fellow Representative Director, Professional Affairs Manager, Education and Training
Assessment and examination	Chair, Assessment Committee Members, First Part Examination Committee Chair, Second Part Examination Committee (General) Members, Second Part Examination Committee (General) Members, Second Part Examination Committee (Paediatrics) Chair, Formal Project Assessment Panel, NSW Member, Formal Project Assessment Panel, NSW Member, Formal Project Assessment Panel, NT Manager, Education and Training
Environment for training - Accreditation of intensive care units for training; Interactions with hospitals and health departments about training requirements; Monitoring quality of training over a wide range of clinical sites/ settings; Rural training; Accreditation of posts outside Australia and New Zealand	President Censor Deputy Censor Paediatric Deputy Censor Chair, Second Part Examination Committee Chair, Hospital Accreditation Committee Trainee Representative, Hospital Accreditation Committee Education Officer, Hospital Accreditation Committee Director, Professional Affairs Manager, Education and Training
Assessment of overseas-trained specialists	Chair, Overseas Trained Specialists Committee and Censor Deputy Censor Chair, Assessment Committee

Meeting	Attendees
	New Zealand Board Member Community Representative Director, Professional Affairs
College staff to discuss roles and responsibilities in supporting education and training	Education Director, Professional Affairs Manager, Education and Training Administrative Officer, Education Administrative Officer, Training Administrative Officer, Online Education and Assessment Administrative Officer, Examinations Administrative Assistant, Training
Continuing professional development programs; College process for retraining under-performing fellows	Chair, Fellowship Affairs Committee and Vice President New Fellows Representative Director, Professional Affairs Member, Fellowship Affairs Committee Manager, Fellowship Affairs CPD Officer and CME Events Officer
31 July 2015	
AMC team prepares preliminary statement of findings	AMC team
Team presents preliminary statement of findings	President Chief Executive Officer Paediatric Deputy Censor Director, Professional Affairs Policy Officer

Appendix Six CICM Education Governance Structure July 2015