Accreditation Submission to the Australian Medical Council

2021 Follow-up Assessment

Royal Australasian College of Surgeons | Australian Medical Council Limited

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List of acronyms

ACEM	Australian College for Emergency Medicine
ACSEP	Australasian College of Sport and Exercise Physicians
AIDA	Australian Indigenous Doctors' Association
AMC	Australian Medical Council
ANCA	Australian and New Zealand College of Anaesthetists
AOA	Australian Orthopaedic Association
AORA	Australian Orthopaedic Registrars Association
ASPS	Australian Society of Plastic Surgeons
ASSET	Australia and New Zealand Surgical Skills Education and Training
Au	Australia
BRIPS	Building Respect, Improving Patient Safety
BSET	Board of Surgical Education and Training
CCrISP®	Care of the Critically Ill Surgical Patient
CE	Clinical Examination
CEO	Chief Executive Officer
CICM	College of Intensive Care Medicine of Australia and New Zealand
CLEAR	Critical Literature Evaluations and Research
CPD	Continuing Professional Development
CV	Curriculum vitae
D&I	Diversity and Inclusion (Plan)
DOPS	Direct Observation of Procedural Skills
DoT	Director of Training
EB	Education Board
EGM	Executive General Manager
EMST	Early Management of Severe Trauma
EPA	Entrustable Professional Activity
EVOPP	External Validation of Professional Performance
FEX	Fellowship Examination
FSSE	Foundation Skills for Surgical Educators
FTC	Federal Training Committee
GSET	General Surgery SET
GSSE	Generic Surgical Sciences Examination
IHC	Indigenous Health Committee

IMG	International Medical Graduate
ISST	Induction for Surgical Supervisors and Trainers
KPI	Key Performance Indicator
KTOT	Keeping Trainees on Track
LMS	Learning Management System
M&E	Monitoring and Evaluation (Framework)
MCNZ	Medical Council of New Zealand
MIHI	Māori/Indigenous Health Institute
Mini-CEX	Mini Clinical Examinations
MOPS	Maintenance of Professional Standards
MSF	Multi-source Feedback
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
NZOA	New Zealand Orthopaedic Association
OHNS	Otolaryngology Head and Neck Surgery
OWR	Operating with Respect
P&RS	Plastic and Reconstructive Surgery
PBA	Procedure-based assessment
P-MEX	Professionalism Mini-Evaluation Exercise
PrASE	Promoting Advanced Surgical Education
QLD	Queensland
RACGP	Royal Australian College of General Practitioners
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainees' Association
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RANZCR	Royal Australian and New Zealand College of Radiologists
RAP	Reconciliation Action Plan
RCPA	Royal College of Pathologists of Australasia
RPL	Recognition of prior learning
RRA	Reconsideration, Review and Appeals
RSS	Rural Surgery Section

RWG	RACS Reconciliation Working Group
SA	South Australia
SATSET	The Supervisors and Trainers for SET
SET	Surgical Education and Training
SEAM	Surgical Education and Assessment Modules
SIMG	Specialist International Medical Graduate
SSE	Specialty Specific Examination
STB	Specialty Training Board
STP	Specialist Training Program
TAS	Tasmania
TIMS	Trainee Information Management System
TIPS	Training in Professional Skills
US	United States
VIC	Victoria
VLE	Virtual Learning Environment
VPNG	Victorian Perioperative Nurses Group
WBA	Workplace-based assessment
WA	Western Australia

Australian Medical Council Limited

This template sets out the information required in an accreditation submission to the Australian Medical Council (AMC) for accredited education providers[1] whose period of accreditation is due to expire and are preparing for an AMC follow-up assessment. The accreditation submission will form the basis of the assessment of the provider and its programs by the AMC.

Purpose of the assessment

The AMC conducts a follow-up assessment in response to any combination of the following:

- conditions on accreditation or reaccreditation require it
- an education provider and its programs are found to substantially meet the accreditation standards
- an education provider and its programs have been granted a limited period of accreditation
- the AMC wishes to review plans for later stages of a new program development.

The primary focus of this follow-up assessment is on the education provider's response and progress in meeting remaining conditions on accreditation. If the education provider has made or is making significant changes/developments in the way it meets any AMC standards, these developments will also need to be considered. This will allow the AMC to make a complete assessment of the education provider and its programs against the accreditation standards.

The assessment will follow the process set out in the *Procedures for Assessment and Accreditation of Specialist Medical Programs and Continuing Professional Development Programs by the Australian Medical Council 2019*.

AMC accreditation assessments are conducted against the approved accreditation standards, *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015*.

Overview of the assessment

The AMC Specialist Education Accreditation Committee appoints an assessment team, taking into account the complexity of the assessment, and required skills and expertise. The team will consider whether the education provider has demonstrated it is meeting or will meet the approved accreditation standards for specialist medical programs and continuing professional development programs. The assessment may result in new accreditation conditions if the review finds accreditation standards are not met or only substantially met.

[1] The *Health Practitioner Regulation National Law Act 2009* uses the term ***education provider*** for organisations that may be accredited to provide education and training for a health profession. The term covers universities; tertiary education institutions, other institutions/organisations that provide vocational training; or specialist medical colleges or other health profession colleges. For consistency, the AMC uses National Law terminology.

The team reviews the provider's progress reports since the last accreditation assessment as well as the information provided in this template and will undertake a program of meetings before preparing a report assessing the provider and program(s) against the approved accreditation standards. The report of the follow-up assessment builds on the report from the last accreditation assessment.

The accreditation report is considered by the Specialist Education Accreditation Committee, which makes a recommendation on accreditation to the AMC Directors. The Directors make their decision within the options described in the Procedures.

The AMC then provides the accreditation report to the Medical Board of Australia, which will then make a decision on the approval of the program of study as providing a qualification for the purposes of specialist registration in the medical profession.

Preparing the accreditation submission

The provider is asked to prepare its accreditation submission using this template and provide the submission approximately *four to five* months before the scheduled AMC assessment. The assessment team will consider the submission and then meet representatives of the education provider to provide feedback and seek clarification of detail. If necessary, the team will provide guidance on areas where further information should be presented. The education provider should ask AMC staff in the first instance if in doubt about the level of detail to be presented, who may then seek advice from the team chair.

Guide on providing requested information

Section A: Report against remaining accreditation conditions and the standards

The format of the template follows each standard in sections including:

- **The relevant AMC accreditation standards**
- **Status table**

  A status table indicating the current finding against the standard as well as the number of remaining conditions and recommendations to be addressed.

- **Remaining conditions**

  Please explicitly address each of the remaining conditions from the last accreditation assessment individually, providing:

  - a brief summary of the action(s) taken to address the condition, and details of the outcome(s) of that action
  - where applicable, a summary outlining the reasons for a particular course of action, along with any available evidence that demonstrates that the action(s) have or are likely to satisfy the accreditation standard.

  A spreadsheet is provided with this template for ease of reference. It lists all conditions and recommendations, AMC feedback provided on conditions in response to the provider's progress reports and suggestions for the type of documentation that may be useful evidence of progress on the remaining conditions.

  The education provider does not need to report on conditions the AMC has marked as satisfied since the last accreditation assessment.

- **Summary of significant developments/changes**

  Please provide a summary of significant developments completed or planned relevant to the standard. The education provider is also asked to give information on the continuing evolution of its programs.

  - Provide a brief summary of all relevant significant developments, including the rationale.
  - If the College's programs have not developed or changed significantly since the last progress report, and the College is not planning developments in the next 12 months, please indicate 'No developments'.
  - If developments planned or underway during the last accreditation assessment, or in subsequent progress reports, have now been reprioritised or stopped, please state this clearly, giving a brief description of the reasons.
  - For education providers with multiple training programs, please indicate which training programs are covered by planned or implemented developments. If policies and processes vary from program, please provide an explanation on significant variations.

  The AMC expects education providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a material change to the program. If relevant, please report on such matters under the significant developments section of this submission.

- **Documentation requested (not related to responses to conditions/recommendations)**

  Additional documentation specific to relevant standards is requested here to assist the team's understanding of the provider's current program arrangements.

- **Statistics and annual updates**

  Please provide annual data and/or an annual update as indicated under the relevant accreditation standard. The template includes suggested data tables. If required, please adjust the table to suit the provider's training and education program(s). The data should reflect both Australian and New Zealand activity for bi-national training programs. Data provided to the Medical Training Review Panel may be included if up to date.

Section B: Report on quality improvement recommendations

- **Remaining recommendations**

  Please summarise any work being undertaken on the remaining recommendations. *If the provider has decided not to accept the recommendation*, please briefly outline the reasons for this and any alternative initiatives to capture the recommended improvement.

  The provided spreadsheet summarises a list of the recommendations and AMC feedback provided in response to the provider's progress reports.

  The education provider does not need to report on recommendations the AMC has marked as satisfied since the last accreditation assessment.

Medical Council of New Zealand requirements

The AMC and the Medical Council of New Zealand (MCNZ) work collaboratively to streamline the assessment of education providers that provide specialist medical training in Australia and New Zealand. Both have endorsed the accreditation standards. In preparing their accreditation submission, education providers with branches in New Zealand should include details relating to the College's activities in New Zealand. This guide refers to the additional information required to meet criteria established by the MCNZ to address New Zealand requirements. This additional information can be found on the Council's website at: http://www.mcnz.org.nz/news-and-publications/guides-and-booklets.

Guide on format and submitting to the AMC

The submission is a standalone document with a separate, indexed folder of the appendices provided electronically by USB and by email to the AMC. The USB should contain the submission (in both PDF and Word version), appendices and the list of appendices. Appendices should *only* be provided in the electronic version.

Word length

The AMC has not specified a maximum word length for the follow-up submission, but clear, direct and succinct statements will be appreciated. This will enable useful dialogue between the team and the education provider, as well as a collegial and constructive process.

Appendices

Documents showing evidence of outcomes described in the education provider's submission, such as agreements, policies and/or training handbooks should be included as appendices. Appendices should also be used to provide information too detailed for the body of the submission, such as procedures, mapping documents and spreadsheets.

Formatting guidelines

- Provide a table of contents, a glossary, a list of appendices, and a list of the tables and figures included in the body of the submission.
- Number appendices, tables and figures according to the relevant standard. For example: Appendix 1.8.1_1 and 1.8.1_2 are the first two appendices for Standard 1.8.1; Table 1.8.1_1 is a table included in the submission at Standard 1.8.1.
- Provide an electronic link to the appendices if an appendix is referred to in the electronic version of the submission.
- Provide electronic links in the list of appendices to the relevant appendix and electronic links in the lists of tables and figures to the relevant point in the submission.
- Provide any spreadsheets as 'protected' Excel/Access sheets to improve readability.

Contact AMC staff

Please contact AMC staff for advice at any point when preparing the submission.

Ms Juliana Simon

Manager, Specialist Medical Program Assessment

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Phone : (02) 6270 9752

Education provider details

College name	Royal Australasian College of Surgeons
Address	250–290 Spring Street, East Melbourne VIC 3002
Date of last AMC accreditation decision	24 November 2017
Accreditation period granted	Four years until 31 March 2022
Reports since last AMC assessment	2017 Progress Report, 2018 Progress Report, 2019 Progress Report

Contact details

Chief Executive Officer	Mr John Biviano
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Email	John.Biviano@surgeons.org
Officer at College to contact regarding the submission	Julian Archer
Telephone number	+61 411 509 942
Email	Julian.Archer@surgeons.org

If the organisation provides training in New Zealand, please provide contact details as follows or a contact person in New Zealand if there is no branch:

Address in New Zealand	Level 3, 8 Kent Terrace, Mount Victoria, Wellington, 6011, New Zealand
Executive Officer	Justine Peterson
Telephone number	+64 4 385 8247
Email	Justine.Peterson@surgeons.org

AMC-accredited training programs subject to the follow-up assessment

Please confirm that this table includes all:

- programs offered, along with the pre-Fellowship awards and post-Fellowship awards
- fields of specialty practice, sub-specialties or similar categories in which training and education is offered
- specialist medical programs that are the joint responsibility of this education provider and another organisation, indicating which education provider awards the qualification
- countries in which each specialist medical program is provided.

College specialty program name	(Pre-/Post-) Fellowship awarded	Field of specialty practice listed by the MBA	Joint program with another organisation			Country in which program is provided
			Y/N	Organisation name	Organisation/s that award the qualification	
Surgery	FRACS	Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology, Vascular Surgery	N	N/A	N/A	Australia/New Zealand

Verify submission reviewed

The information presented to the AMC in this submission is complete, and it represents an accurate response to the relevant requirements.

Verified by: (*Chief Executive Officer/executive officer responsible for the program*)	John Biviano Chief Executive Officer RACS
Signature:	
Date:	

Summary of status and submission request

Standard	2019 findings	Remaining conditions	Significant developments requested	Documents requested	Statistics and annual updates requested
Overall	**Substantially met**	**25**			
1. The context of training and education	Substantially met	3	Yes	Yes	Yes
2. The outcomes of specialist training and education	Substantially met	2	Yes	Nil	Nil
3. The specialist medical training and education framework	Substantially met	6	Yes	Yes	Yes
4. Teaching and learning	Met	1	Yes	Nil	Nil
5. Assessment of learning	Substantially met	1	Yes	Yes	Yes
6. Monitoring and evaluation	Substantially met	5	Yes	Nil	Yes
7. Trainees	Substantially met	3	Yes	Yes	Yes
8. Implementing the program – delivery of education and accreditation of training sites	Substantially met	3	Yes	Nil	Yes
9. Continuing professional development, further training and remediation	Met	Nil	Yes	Nil	Yes
10. Assessment of Specialist International Medical Graduates	Substantially met	1	Yes	Nil	Yes

Section A: Report against remaining accreditation conditions and the standards

Standard 1 The context of training and education

The AMC accreditation standards are as follows:

1.1 Governance

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

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

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

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

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

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

1.2 Program management

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

- planning, implementing and evaluating the specialist medical program(s) and curriculum, and setting relevant policy and procedures
- setting and implementing policy on continuing professional development and evaluating the effectiveness of continuing professional development activities
- setting, implementing and evaluating policy and procedures relating to the assessment of Specialist International Medical Graduates
- certifying successful completion of the training and education programs.

1.3 Reconsideration, review and appeals processes

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

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

1.4 Educational expertise and exchange

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

The AMC accreditation standards are as follows:
1.4.2 The education provider collaborates with other educational institutions and compares its curriculum, specialist medical program and assessment with that of other relevant programs.
1.5 Educational resources
1.5.1 The education provider has the resources and management capacity to sustain and, where appropriate, deliver its training and education functions.
1.5.2 The education provider's training and education functions are supported by sufficient administrative and technical staff.
1.6 Interaction with the health sector
1.6.1 The education provider seeks to maintain effective relationships with health-related sectors of society and government, and relevant organisations and communities to promote the training, education and continuing professional development of medical specialists.
1.6.2 The education provider works with training sites to enable clinicians to contribute to high-quality teaching and supervision, and to foster professional development.
1.6.3 The education provider works with training sites and jurisdictions on matters of mutual interest.
1.6.4 The education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education.
1.7 Continuous renewal
1.7.1 The education provider regularly reviews its structures and functions for and resource allocation to training and education functions to meet changing needs and evolving best practice.

Status and submission request

Status: Substantially met	Number of remaining conditions = 3
	Number of remaining recommendations = 1
Significant developments requested	**Yes**
Documents requested	**Yes**
Statistics and annual updates requested	**Yes**

1.1 Remaining conditions

Please provide a summary update of the College's responses to the remaining conditions listed below from the last AMC Accreditation Report. Please detail progress made, plans for further work, and the evidence to support progress.

Condition 1	To be met by 2019	2019 Finding: Progressing
Review the relationships between Council, the Education Board, the Board of Surgical Education and Training and the specialty training boards to ensure that the governance structure enables all training programs to meet RACS policies and AMC standards. (Standard 1.2)		

Provider response

The Royal Australasian College of Surgeons (RACS) recognises the critical role that governance plays in ensuring high-quality delivery of its educational programs. In 2019, RACS initiated a series of significant structural changes to oversee, review and deliver improved governance of its obligation as a specialist medical college, including in relation to its training programs. These newly implemented initiatives have allowed RACS to address this condition by strengthening inter-board relationships to ensure that the governance structure enables all training programs to meet RACS policies and the AMC standards.

Committee oversight of the governance review

Governance and policy are areas in which RACS has significantly invested. This is evidenced through the introduction of the RACS Governance Committee, which is conducting a full review of RACS structures and relationships between Council and committees. The RACS Governance Committee has met three times (October 2019, January 2020 and October 2020) since its establishment in June 2019. Informed by the committee's deliberations, Council has rationalised governance arrangements for the global health function (i.e. establishment of the International Engagement Committee, chaired by the Vice President, the Global Health Programs Steering Group and a Global Health Section; the latter is an engagement mechanism for the wider Fellowship). Corporate committees were also rationalised, with the Resources Committee and the Risk Management and Audit Committee merged into a dedicated Finance, Audit and Risk Management Committee of Council.

Staff implementation of the governance review

A number of highly experienced staff have been appointed to orchestrate the review and revision of the relationships between the boards and committees. Head of Planning and Development and Board/Council Secretary commenced in their roles in July 2019 and March 2020, respectively; these new roles will drive progress in this vital area. A Policy Officer was also appointed in 2019 as a dedicated resource within the Education portfolio, working closely with the newly formed role of Education Governance Specialist, to which a longstanding member of the team was recruited.

With the introduction of these roles, significant inroads are being made to the governance structure and processes. The Education portfolio is reviewing all RACS regulations and policies underpinning education. The review aims to:

- address policy issues previously encountered
- align principles, standards and terminology

- remove reference to procedure and ensure procedural provisions are captured in a separate procedure document
- transfer policies to the new regulation and policy templates (once finalised).

The review aligns with broader governance requirements, and education staff are contributing to the development of the new templates and referencing system, to ensure the inclusion of the business needs where applicable. All relevant boards, committees and staff are being consulted as part of the review of their documents for quality assurance purposes, endorsement and approval. In early to mid-2021 there will be a focus primarily on preparing revised RACS SET principle-based regulations and policies drafts in consultation with the STBs. This review period will also include finalising the development or embedding of new policy principles to meet AMC accreditation requirements. Education policy and governance representatives are also working closely with other portfolio areas to review regulations and policies to ensure currency and reflect AMC accreditation requirements.

The Education governance structure

There was a substantial review of the structure and relationship between Council, the Education Board (EB) and the Board of Surgical Education and Training (BSET). After considerable engagement and feedback, all key stakeholders agreed that merging BSET and EB was not practical. It was deemed necessary, however, to implement improvements to the reporting and approval processes between the boards. Formal reporting templates encompassing key components of the training program have been introduced for each BSET meeting. These improvements to reporting are valuable in facilitating a forum designed to meet our social obligation to collaborate and learn from one another to implement the highest-quality training programs. As such, there have been marked improvements in how BSET deliberates initiatives, evaluations and implementation strategies across the surgical specialties. In addition, a more transparent, collaborative approach has been taken at EB with all relevant parties, including the Specialty Training Board (STB) Chair and Specialty Society Training Manager, where applicable, invited to contribute to discussions around revisions to selection and training regulations.

Strengthening specialty relationships

These governance enhancements will be complemented by the service agreements between RACS and the specialty societies, with the agreement renewal negotiations well underway. The focus of negotiations has been guided by feedback from the AMC requirements, KPMG audit (described against Condition 2) and a host of focused consultative discussions with stakeholders such as specialty society chief executive officers (CEOs), RACS staff and board members from both organisations.

Six service agreements have been signed with the aim to have a further seven agreements to be signed in 2021. Key features of the agreements are governance, compliance, harmonisation, reporting, roles and responsibilities, and policy and regulation development. While the agreements are an integral part of harnessing productive, robust, trusting relationships, much of the work will follow once agreements have been signed. Several components of the agreements will be operationalised to embed the strong relationships, tight governance and streamlined and collegiate processes.

RACS is progressing well on its journey to improved governance structures and processes, while also acknowledging this is an iterative process of utmost importance.

Provider documentation attached:

Condition 2	To be met by 2020	2019 Finding: Progressing
RACS must develop and implement a stronger process for ongoing evaluation as to whether each of these programs remain consistent with the education and training policies of the College. (Standard 1.2)		

Provider response

Strong and dependable processes for ongoing evaluation of the consistency of the training programs with education and training policies are central to ensuring quality program delivery. RACS is addressing this condition through commissioning an external consultancy company to audit RACS processes, facilitating an environment of collaboration with key stakeholders, and enhancing structured reporting through the governance hierarchy.

An external audit of RACS processes

The KPMG training audit commissioned by RACS has progressed. The consultation phase is an integral part of the review and revision of processes to further align the training programs to the overarching policies of RACS where necessary. Given the in-depth nature of this review, an extended timeframe for completion has been essential to ensure all relevant information and perspectives are captured. Having conducted the initial group discussions with all relevant stakeholders, a workshop with specialty society CEOs was conducted in August 2020 to finalise the review. Key outcomes point to enhanced working relationships between specialty societies and RACS, leading to improved clarity of respective roles and responsibilities. The service agreement renewal process was seen to be a positive development that continues to engage the societies as key partners.

Stronger collaboration

RACS Strategic Plan 2019–2021: Business Plan 2020 identifies the value of positive relationships and collaboration, with ‘nurturing our collaborative spirit in partnership with specialty societies and key stakeholders’ as an important focus for 2020. RACS has strengthened relationships with key stakeholders at the staff level; two initiatives have been established to deliver this strategy. First, the Specialty Society CEO Forum, chaired by the RACS CEO, was established as a valuable mechanism for information-sharing, coordination and collaboration among specialty society CEOs. Second, RACS is hosting fortnightly operational meetings with the specialty society training managers; these meetings are chaired by the Head of Training Services and have resulted in improved transparency and information-sharing. The Executive General Manager (EGM) Education attends both meetings.

Governance processes

In addition to the improvements described in Condition 1, relating to the recruitment of new staff members and the formal reporting to BSET, a formal process for the review and approval of training regulations has been introduced. When an amendment to training regulations is introduced, an initial review is conducted by the Head of Training Services to indicate if there are any inconsistencies against the principle-based policies that may need revision. This is followed by the legal team reviewing the documents for compliance. These processes occur prior to EB approval, which oversees all programs.

This journey will require a significant timeframe to comprehensively review and successfully implement improvements. It is evident that in collaboration with our key stakeholders, we are well on our way.

Provider documentation attached:

Condition 4	To be met by 2020	2019 Finding: Progressing

Provide evidence of effective implementation, monitoring and evaluation of the:

i. Reconciliation Action Plan

ii. Building Respect, Improving Patient Safety (BRIPS) Action Plan

iii. Diversity and Inclusion Plan (Standards 1.6 and 1.7)

Provider response

Targeting a diverse surgical workforce continues to be of priority to RACS, as evidenced by the time and resources invested in delivering the progress achieved to date. The program of work described below of the effective implementation, monitoring and evaluation of our action plans clearly addresses this condition.

Reconciliation Action Plan

RACS recognises that there is a public health challenge among Aboriginal and Torres Strait Islander peoples in Australia. The Reconciliation Action Plan (RAP) provides a platform for RACS to advocate and support the improvement of health inequities in Indigenous communities. Progress has been made in meeting the actions of the RAP; for example, the launch of the first course in a suite of four that provides training on developing culturally safe environments for all Aboriginal and Torres Strait Islander peoples (described further in Condition 30). We are a long way from achieving health equity for Aboriginal and Torres Strait Islander communities, and so an updated 2020–2022 Innovate RAP (Standard 1 Appendix) was developed through consultation with the RACS Indigenous Health Committee (IHC) and the RACS Reconciliation Working Group (RWG). The implementation of the RAP will continue to involve engagement with RACS Fellows, Trainees, Specialist International Medical Graduates (SIMGs), all staff across RACS and Aboriginal and Torres Strait Islander stakeholders to achieve the vision for equity in health outcomes and reconciliation.

Te Rautaki Māori (RACS Māori Health Strategy and Action Plan)

In 2019, an analysis of the RACS Māori Health Action Plan 2016–2018 took place in New Zealand to determine the next steps and ensure momentum and consistency towards developing Te Rautaki Māori 2020–2023 (Standard 1 Appendix). Significant milestones of the 2016–2018 plan were met. Māori visibility within RACS was increased through the development of the Māori motif, the Māori name for RACS (Te Whare Piki Ora o Māhutonga), recruitment of the Māori Health Project Officer, presentations on Māori health inequities in all RACS conferences and regular articles in RACS publications. These are just some of the milestones

that RACS is proud to have delivered. The analysis also identified incomplete activities, which are included in Te Rautaki Māori 2020–2023. Progress on actions in Te Rautaki Māori 2020–2023 will be reported at the IHC meetings; progress will be based on the 'measuring success' targets of each activity. These measurable targets are realistic and mostly informed by data, statistics and tangible items such as policies and Māori cultural safety and cultural competency training.

The recent publication of an Indigenous health position paper proposes the development of productive and culturally appropriate approaches to equitable health outcomes for Aboriginal and Torres Strait Islander peoples and Māori. It outlines the importance of effective partnerships with organisations that share a common vision for equitable health care.

Building Respect and Diversity and Inclusion Plans

The Building Respect, Improving Patient Safety (BRIPS) Action Plan continues to be implemented according to the actions identified, with some activities being reviewed and strengthened because of findings of the Phase 1 BRIPS Evaluation Report. Operations continue to be monitored and advanced with the oversight of the Building Respect Implementation Group on a six-weekly basis, and written progress updates are reported to every Council meeting. Activities for 2019 are documented in the fourth consecutive annual progress report published on the RACS website. Planning of implementation of the Phase 2 Evaluation commenced in the last quarter of 2020, based on the elements contained in the overall evaluation framework developed for the initiative (evaluation framework for the three phases of evaluation is attached in Standard 1 Appendix).

There have been several successful initiatives implemented as a result of the action plan. The initiatives pertaining to 2019 are summarised in the progress report. Of note is the achievement of delivery of the Operating with Respect (OWR) online module to 98 per cent of RACS Fellows, Trainees and SIMGs. Its aim of raising awareness of unacceptable behaviour in the surgical workplace and its impact on patient safety is now ensured, with the module's inclusion as a prerequisite for entry to SET. In addition, RACS has put steps in place to ensure those Fellows currently residing overseas and who make up the small number who have not completed the module will be required to do so prior to resuming work in Australasia. The OWR face-to-face course, which builds on the prerequisite online module, equips surgeons with the skills to deal with unacceptable behaviour at a peer-to-peer level. This has been delivered to 85 per cent of mandated surgeons, with delivery timelines extending into 2021. As part of its drive to evaluate the effectiveness of the OWR face-to-face course, RACS has collaborated with a PhD student at La Trobe University, Paul Gretton-Watson, to investigate whether 'Senior Surgeons participating in training on respectful workplace behaviour perceive it to be effective at improving their confidence and skill to act upon unacceptable behaviour, including bullying, and enhance surgical culture'. The pre-intervention evaluation phase is complete, and the post-intervention phase will commence imminently. This project will provide insights into the value of the OWR course.

Diversity and Inclusion Plan

The Diversity and Inclusion (D&I) Plan, derived from the Building Respect Action Plan, aims to increase diversity, including ethnic and gender diversity. One method to capture this information is monitoring the gender diversity on the RACS committees and boards regularly, with a target of 40 per cent women. Following the College Council elections in 2020, 40 per cent of RACS Councillors (directors) are female. This is a significant achievement and reflects the substantial contribution women make to our profession and to our College in particular. The Building Respect Implementation Group monitors the implementation of the D&I Plan; the 2019 progress update provides a detailed report of all actions identified in the plan. Achievement of the goals and activities in the D&I Plan will continue, given the long-term nature of the outcomes sought (Standard 1 Appendix).

Despite the advances made in several areas that support diversity, RACS understands this is a long-term goal and is dedicated to maintaining the current momentum.

Provider documentation attached:

RACS Indigenous Health Paper

Reconciliation Action Plan (RAP)

Te Rautaki Māori 2020–2023

Building Respect, Improving Patient Safety annual progress report, 2019

Diversity and Inclusion Plan, 2019 progress update

1.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 1. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs continue to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 1? *If yes, please describe below.*	☒ Yes	☐ No change

The impact of the global COVID-19 pandemic on RACS business as usual is undeniable and subsequently has altered our schedule of activities for the year; however, our commitment to ensuring the continuity of the pipeline of high-quality, competent surgeons has not diminished. The pandemic has elicited a measured and pragmatic response from RACS and, where feasible, has driven innovation. RACS has continued to position itself as a responsive organisation in delivery of educational programs, its approach to governance, and in ensuring the health and wellbeing of staff, Trainees, SIMGs and Fellows, which is evidenced by the significant developments made against Standard 1 described below.

Organisational structure

The organisational structure has evolved over the past few years and, importantly, has now stabilised following the recruitment of key roles in the Executive Leadership Team. Furthermore, the significant developments in the structure of the education portfolio are facilitating the EGM and the three Heads to effect important improvements to elevate productivity and nurture key relationships. RACS has increased the capacity of the Research and Innovation Team to broaden the program of work being performed against AMC accreditation standards, conditions and recommendations.

One College Transformation

There have been significant developments in the three pillars of the transformation program. The first has a focus on governance and policy as described in Condition 1. The second outlines initiatives that centre on people and culture. Such initiatives for staff wellbeing include the

introduction of Culture Ambassadors across RACS to lead, shape and advocate for a positive, inclusive and supportive culture that is driven by all levels of RACS staff. A learning platform has also been implemented to help all RACS staff gain knowledge on various topics, from technical expertise to professionalism and health and wellbeing. Additionally, in response to COVID-19 and the growing incidences of staff feeling higher levels of stress and isolation, RACS has partnered with Mentemia on an application that supports mental health.

The third pillar, technology, underpins the breadth of transformation across RACS. The Technology stream of the program provided a strong digital footing when the COVID-19 pandemic caused College staff to work remotely. Through the One College Transformation Program, RACS is making a substantial investment in equipping our stakeholders to collaborate seamlessly across the organisation, including our STBs. This multi-year project represents a significant change to our approach as we support a flexible and collaborative working environment, including significant improvements to business practice and investment in collaboration technology to support this initiative.

Surgeon wellbeing

The RACS Wellbeing Working Group reviewed existing support resources. The working party, with representatives from the Australian College for Emergency Medicine (ACEM), the Australian and New Zealand College of Anaesthetists (ANZCA), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Council of Presidents of Medical Colleges, shares ideas to address health and wellbeing. The working group developed a doctors' health charter and is investigating whether a unified approach to data collection for doctors' health can be achieved.

Reconsideration, review and appeals process

The RACS reconsideration, review and appeals process has been reviewed and revised with the new version now implemented. The STBs have incorporated this process into their training regulations. Further information on this process is described below in Section 1.4, Table 2. The Australian Orthopaedic Association (AOA) Federal Training Committee (FTC) has revised its Reconsideration, Review and Appeal of Training Decisions, which has now been separated from the broader organisation-wide policy. These documents provide clarity for Trainees around types of decisions in training and those which may be reconsidered, reviewed or appealed.

Response to COVID-19

As an early response to the rapidly evolving and uncertain landscape imposed by COVID-19, the RACS Education portfolio developed overarching principles to guide decisions in respect to Education programs and courses, and in providing the Fellowship Exam in 2020. These principles describe timeframes and key milestones, clarify governance and responsibilities, and confirm the overall goals to be achieved. These overarching principles have been invaluable as they allowed clear and transparent discussions with key stakeholders and underpinned the consistent, relevant and timely communication disseminated to our Trainees and Fellows.

RACS recognises this new environment imposed by COVID-19 as one of opportunity. It allows us to respond to the evolving conditions using strategy in action that comprises four stages: Stage 1 is to stop and reflect on the current program of work being undertaken, Stage 2 requires an appropriate response to the evolving landscape with Stage 3 taking on an innovative approach and Stage 4 shaping a new reality within which RACS can emerge and thrive in this changed environment. This phased approach is operationalised through a ‘go’, ‘no go’, ‘go different’ matrix that drives decision-making and identifies the areas ripe for investment. This is a significant development for RACS and continues to shape our strategic direction.

These initiatives help our governance processes, improve staff and surgeon wellbeing, and enhance relationships with key stakeholders to strengthen the delivery of our education programs.		
Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

1.3 Documentation requested

Please provide the **latest version** of the following documents either as an attachment **or** as a link to the College website as appropriate. If the College has made changes to the following document(s) since the last accreditation/progress report, please include a description of the change under significant developments.

Document	Attached	Link to document (if available)
College's governance structure with key committees and lead members indicated	☒ Yes	Standard 1 Appendix
Conflict of interest policy	☒ Yes	Standard 1 Appendix
Reconsideration, Review and Appeals Policy	☒ Yes	Standard 1 Appendix

1.4 Statistics and annual updates

Please provide data for the following tables. If required, please adjust the table to suit the College's training and education program(s).

Table 1. Categories of Fellowship and membership (Standard 1.1.1)

College membership for June 2020				
Category	**Total**	**Australia**	**New Zealand**	**Other**
Fellows	6765	5582	855	328
Retired Fellows	1175	889	162	124
Honorary Fellows	59	14	2	43
Trainees	1406	1169	234	3

Table 2. Reconsideration, reviews and appeals (Standard 1.3)

Requests for reconsideration

Reason	Number	Outcome	
		Upheld	Dismissed
Assessment decision	10 (2 in progress)	3	5
Special consideration (examinations)	1	1	0
N/A	3	1	2
Selection decision	18	17	1

Requests for review

Reason	Number	Outcome	
		Upheld	Dismissed
Assessment decision	3 (2 awaiting decision)	1	0
Selection decision	1	0	1
Dismissal	1	1	0

Requests for appeal

Reason	Number	Outcome	
		Upheld	Dismissed
Dismissal	1 (awaiting decision)	0	0

Can the College comment on the outcomes of its processes for evaluating reconsiderations, reviews and appeals to identify system issues?

Provider response

As the Reconsideration, Review, and Appeals (RRA) Regulation took effect in early January 2020, the data in the above table does not include requests submitted through the old appeals mechanism; there are two active appeals outstanding under the old policy. The reconsideration process has been successful, and the collaboration between RACS and the specialty societies has allowed for a smooth and successful transition to this improved process. The first reviews are set to take place in the second half of June 2020. RACS is committed to providing a fair and transparent process and is in regular consultation with the specialty societies to ensure that the process is consistent for all applicants. Furthermore, trends in RRA applications will be analysed to identify potential areas for improvement within RACS. The number of RRA requests is potentially lower than what might be expected, partly due to the impact of COVID-19 on RACS assessments and a subsequent reduction in the number of original decisions being made. A small number of requests have been rejected due to being either outside the 28-day timeframe or not meeting the grounds for RRA, as per the RRA Regulation.

Standard 2 The outcomes of specialist training and education

The AMC accreditation standards are as follows:

2.1 Educational purpose

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

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

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

2.2 Program outcomes

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

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

2.3 Graduate outcomes

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

Status and submission request

Status: **Substantially met**	Number of remaining conditions = **2**
	Number of remaining recommendations = **2**
Significant developments requested	**Yes**
Documents requested	No
Statistics and annual updates requested	No

2.1 Remaining conditions

Condition 6	To be met by: 2021	2019 Finding: Progressing
Broaden consultation with consumer, community, surgical and non-surgical medical, nursing and allied health stakeholders about the goals and objectives of surgical training, including a broad approach to external representation across the College. (Standard 2.1)		

Provider response

RACS will have met this condition by the AMC-delivered deadline of 2021 by embedding broad consultation in the development and review of the goals and objectives of our surgical training programs. The RACS approach to consultation is needs-based and shaped by the activity and requirements of the review.

Overarching consultation processes

RACS recognises the importance of effective community consultation and has included community representatives on its major boards and committees. RACS continues to recruit to established roles as needed and is investigating options to broaden community consultation by identifying approaches to support proactive participation. Criteria and processes for engagement through opinion polls, the use of focus or special interest groups as well as seeking feedback on personal experiences or from subject matter experts is under review. The criteria were approved at the end of 2020 for implementation in 2021. This work is also being conducted at the training board level; for example, the AOA FTC is in the process of developing a formal consultation process to collect feedback on the AOA 21 Training Program from non-surgical health professionals and healthcare administrators as well as community and consumer representatives. A list of stakeholder groups has been agreed and a question set is in development, which has been delayed due to COVID-19.

Consultation with Indigenous communities

RACS continues to work on building effective and ongoing relationships with Indigenous communities in Australia and New Zealand, as described in Condition 4. This is also evidenced across our STBs; for example, the STB in orthopaedic surgery NZ includes representation from a cultural advisor who also contributes to the selection process.

Examples illustrating the RACS approach to consultation

RACS recognises the value of broad consultation from non-surgical health professionals and community representatives. In December 2019, RACS was involved in discussions with the accreditation team at ACEM to provide feedback on their accreditation practices. These discussions evolved into a forum that facilitated the sharing of learnings across specialist medical colleges. This forum was then formalised as the inter-College accreditation managers meeting and introduced on a regular, biannual basis. In February 2020, RACS attended the inaugural meeting, hosted by ACEM, alongside the Royal Australian and New Zealand College of Psychiatrists (RANZCP), RANZCOG, the Royal Australian and New Zealand College of Radiologists (RANZCR), the Royal Australian College of General Practitioners (RACGP), ANZCA, the Australasian College of Sport and Exercise Physicians (ACSEP), and the Royal College of Pathologists of Australasia (RCPA). This forum will be fundamental for the review of the revised RACS Hospital Training Post Accreditation. RACS will also consult with patients in

the community, the Victorian Perioperative Nurses Group (VPNG) and a selection of hospitals as part of this process.

A further example is the broad consultation being undertaken by the STBs for review of their curricula. One such curriculum is that of the STB in urology, which was distributed for external review to a number of relevant community organisations and non-surgical medical organisations such as RANZCOG, RANZCR and the College of Intensive Care Medicine (CICM) of Australia and New Zealand. The consultation has identified useful opportunities to engage with other organisations to deliver reciprocal teaching and learning.

RACS is proud of its approach to broad consultation and the work it has done to embed feedback from stakeholders. Further strategies are being considered to formalise processes to seek feedback on our Trainees, supervisors and training programs. We envisage implementation of a standardised questionnaire that would facilitate a robust and beneficial appraisal of the training program.

Provider documentation attached:

Condition 7	To be met by: 2021	2019 Finding: Progressing
Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available, reflect community needs and which map to the nine RACS competencies. (Standard 2.2 and 2.3)		

Provider response

RACS has addressed this condition as both the program and graduate outcomes are articulated in the STB Selection or Training Regulations and are publicly available.

Overarching program and graduate outcomes

The Regulations for STBs in paediatric surgery, vascular surgery, urology, otolaryngology head and neck surgery (OHNS), plastic and reconstructive surgery (P&RS) NZ, orthopaedic surgery NZ, neurosurgery, cardiothoracic surgery and the AOA FTC articulate that the program outcome is to ensure surgeons serve their communities and health systems with the highest standard of safe, ethical and comprehensive care and leadership. These STBs describe the graduate outcome as the production of competent and independent surgeons with the experience, knowledge, skills and attributes that align with the RACS competencies. The STBs in general surgery Au and NZ similarly describe the graduate outcomes of a competent, independent surgeon in relation to achieving competence against the RACS-defined competencies in their new GSET curriculum.

Program outcomes

Our program outcomes are a direct response to the needs of the community, which are identified through workforce planning. RACS is working closely with the Australian Government Department of Health to achieve the goal of improving workforce planning through the collection of regular, in-depth data on the medical workforce that, in combination with statistical modelling, will drive decision-making on the future needs of the community. In turn, this will shape the successful aspirants of the training programs. In response to work being conducted by the Federal Department of Health, RACS has reflected on the needs of the community and committed to ameliorating the maldistribution of the surgical workforce, particularly in relation to needs of rural communities. A strategic discussion was held at October Council 2020 to outline the approach that RACS will take to improve the health outcomes of rural communities.

Competency-level graduate outcomes

The defined competencies of a surgeon, that describe the expected abilities of a training program graduate and the ongoing standard against which Fellows are held, were recently reviewed and revised to further reflect the needs and expectations of the community.

Following broad consultation with key stakeholders, including members from various committees and boards, RACS recognised that the significance of health inequities on poor health outcomes within the community, particularly Indigenous peoples in Australia and Māori in New Zealand, was not adequately reflected within the competency framework. Subsequently, the RACS Surgical Competence and Performance Guide was revised and a 10th competency, Cultural Competence and Cultural Safety, was introduced. The Cultural Competence and Cultural Safety competency requires surgeons to demonstrate a willingness to embrace diversity among all patients, families, carers and the healthcare team, and to respect the values, beliefs and traditions of individual cultural backgrounds that are different to their own. The ten competencies are further explained with the description of behavioural markers associated with each competency and example behaviours that do and do not fulfil the requirements.

Curriculum-level graduate outcomes

Revision of the curricula is allowing for community needs to be evidenced stronger through the graduate outcomes aligned to each of the surgical competencies. The patient-centred professional skills curriculum currently under development will clearly reflect community needs. Curriculum development is further described in Condition 8.

Clearly, the program and graduate outcomes described above have the needs of the community at their centre. Now that we have the revised competency framework, RACS is working with surgical specialties to achieve the required uniformity.

Provider documentation attached:

Surgical Competence and Performance

2.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 2. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs are continuing to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 2? *If yes, please describe below.*	☒ Yes	☐ No change
There have been significant developments made against Standard 2 in regard to graduate outcomes. The emergence of COVID-19 has delayed some timelines for drafting graduate outcomes as part of curricula reviews; for example, the STBs in general surgery Au and NZ delayed the launch of the new General Surgery Education and Training (GSET) program to the 2022 training year. The GSET program specifies the program outcomes for each GSET level and therefore specifies the progression requirements. The graduate outcomes are currently being embedded into the curriculum with competencies, sub-competencies and milestones across GSET1, GSET2–3 and GSET4–5. The STB in neurosurgery commenced a comprehensive review of its curriculum in early 2020. While progress has been slowed as a result of COVID-19, several working parties have been established and modules finalised. The full revision of the curriculum, which includes graduate outcomes over the three levels of training being Basic, Intermediate and Advanced, will be released in 2021. The STB in P&RS Au plans to implement competency-based training using a phased approach, commencing in 2022. Presently, Trainees use newer competency-based assessment tools. Direct Observation of Procedural Skills in Surgery has been substituted with the Operative Feedback Form, and the Mini Clinical Examination has been substituted with the Clinical Feedback Form and a new Case-Based Discussion Form. The implementation of competency-based training will complement the earlier comprehensive development of the 2019 Curriculum.		
Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

2.3 Documentation requested

Nil

2.4 Statistics and annual updates

Nil

Standard 3 The specialist medical training and education framework

The AMC accreditation standards are as follows:

3.1 Curriculum framework

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

3.2 The content of the curriculum

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

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

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

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

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

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

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

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

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

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

3.3 Continuum of training, education and practice

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

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

3.4 Structure of the curriculum

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

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

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

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

Status and submission request

Status: **Substantially met**	Number of remaining conditions = **6** Number of remaining recommendations = **Nil**
Significant developments requested	**Yes**
Documents requested	**Yes**
Statistics and annual updates requested	**Yes**

3.1 Remaining conditions

Please provide a summary update of the College's responses to the remaining conditions (listed below) from the last AMC Accreditation Report. Please detail progress made, plans for further work, and the evidence to support progress.

Condition 8	To be met by: 2021	2019 Finding: Progressing
Enhance and align the non-technical competencies across all surgical specialties including a consideration of the broader patient context. (Standard 3.2)		

Provider response

RACS will have addressed this condition within the proposed deadline of 2021.

Professional skills curriculum

Non-technical skills support high-quality, safe, effective and efficient delivery of patient care. RACS is cognisant of the important role of these skills and has altered the terminology from non-technical skills to professional skills to remove any perceived hierarchy of competencies.

RACS has commenced the Professional Skills Curriculum Development Project. It is intended that a generic curriculum will be developed to drive alignment across specialties and provide opportunities for tailoring, where applicable. In September 2019, a working group for this project was established, comprising Fellows from a cross-section of surgical specialties, the Training In Professional Skills (TIPS) Committee and a Trainee representative. Workshops were convened in November 2019 and March 2020 and monthly meetings have been held (May, June, July, August and September 2020) to progress this vital piece of work. This project has been underpinned by strong collaboration across the specialties, with a mapping exercise of the professional skills graduate outcomes conducted to build on the excellent work already completed by some of the STBs (AOA FTC, the STB in P&RS Au and the STB in urology). This exercise has identified the areas of alignment and those that require some level of divergence. The graduate outcomes from other STBs will be incorporated as they complete their curriculum reviews; for example, the STB in general surgery Au has made substantial progress in the development of their curriculum. The working party is currently developing the curriculum graduate outcomes across the three stages of the Surgical Education and Training (SET) Program – early, mid and late – in line with the specialty specific curricula.

Learning opportunities for professional skills

As a key learning opportunity in professional skills for Trainees, the TIPS course has been mandated for Trainees in a number of specialties and encouraged in others. This course provides an opportunity to practise and develop professional skills relevant in a surgical setting, including patient-centred communication and teamwork.

Development of the curriculum for the 10th competency

The IHC has led the development of graduate outcomes for the new 10th RACS competency: Cultural Competency and Cultural Safety. Consultations were held with the Aboriginal, Torres Strait Islander and Māori educators and community members early in 2020 to ensure the graduate outcomes met community needs.

Once drafted, a thorough consultation process will occur to ensure the generic professional skills curriculum meets the expectations of a number of stakeholders and the needs of health consumers. The significant work undertaken in this space is testament to RACS' recognition of the importance of professional skills in supporting high-quality patient care.

Provider documentation attached:

Condition 9	To be met by: 2021	2019 Finding: Progressing

As it applies to the specialty training program, expand the curricula to ensure trainees contribute to the effectiveness and efficiency of the healthcare system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of settings within the Australian and/or New Zealand health systems. (Standard 3.2.6)

Provider response

RACS will have completed this by the 2021 deadline. The recent revision of the Surgical Competence and Performance Guide has further embedded the requirement for a competent surgeon to contribute to an effective and efficient healthcare system. Of particular note is the health advocacy competency. This competency comprises behavioural markers that address the delivery of effective and efficient health care, outlining that a competent surgeon must be able to:

1. respond to the social determinants of health and understand how they may impact on the health outcomes of patients.
2. demonstrate a commitment to the sustainability of the healthcare system, giving consideration to financial and environmental effects relating to healthcare sustainability.
3. care for the wellbeing of colleagues and recognise the potential impact wellbeing may have on colleagues and patient outcomes.

Another example can be found within the competency for collaboration and teamwork where the expectation is for competent surgeons to foster an environment where patient safety measures are the team's responsibility, contributing to high-quality healthcare delivery.

The revised competencies were recently finalised, and work is ongoing to develop the graduate outcomes and stages of Trainee progression within the curricula. The STBs in P&RS NZ and Au completed their curricula review in 2019; graduate outcomes are now included in the curricula. The STBs in general surgery Au and NZ, neurosurgery, OHNS, orthopaedic surgery NZ, urology and vascular surgery are all reviewing their curricula to further detail competencies that relate to the delivery of effective and efficient health care across a range of settings in Australia and New Zealand. Once these reviews are complete, learning opportunities will be developed to support Trainees in achieving these graduate outcomes. The AOA FTC is already developing additional learning resources for Trainees, with a working group recently formed to develop a module on Ethics and Professionalism.

Provider documentation attached:

Condition 10	To be met by: 2021	2019 Finding: Progressing
Document the management of perioperative medical conditions and complications in the curricula of all specialty training programs. (Standard 3.2.3, 3.2.4 and 3.2.6)		

Provider response

RACS recognises the importance of a clear, informative and comprehensive curriculum in the training of surgeons. The curriculum covers the breadth of the competencies required to become a surgeon and includes detail on the management of perioperative medical conditions and complications. Documenting the management of perioperative medical conditions and complications continues to be addressed in the staggered reviews and revisions of the specialty curricula, with this condition expected to be addressed in its entirety by the end of 2021.

As previously described in the RACS 2019 progress report, this condition has already been addressed by the STBs in cardiothoracic surgery, neurosurgery, OHNS, paediatric surgery, general surgery within the Surgical Education and Assessment Modules (SEAM) and the AOA FTC.

The STBs in orthopaedic surgery NZ, P&RS NZ and Au and urology have since addressed this issue in their new curricula.

The curriculum continues to be under review for the STB in vascular surgery, and it is expected this issue will be addressed when their review is finalised in mid-2021.

Provider documentation attached:

Condition 11	To be met by: 2021	2019 Finding: Progressing
Include the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori, along with cultural competence training, in the curricula of all specialty training programs. (Standard 3.2.10)		

Provider response

RACS will have met this condition within the defined deadline. RACS demonstrated its commitment to the specific health needs of Aboriginal and Torres Strait Islanders and Māori in the revision of the competencies, which led to the introduction of Cultural Competency and Cultural Safety as a 10th competency. This competency will be incorporated into the professional skills curriculum, with the graduate outcomes and milestones for the three stages of training currently being developed as described in Condition 8.

RACS is presently developing learning opportunities for Trainees to meet the 10th competency in Aboriginal and Torres Strait Islander and Māori Health and Cultural Safety. It is expected that RACS will complete the Aboriginal and Torres Strait Islander cultural competence eLearning modules by the end of 2021. These modules will relate to:

- promoting the special status of Aboriginal and Torres Strait Islander peoples in Australia to achieve optimal health outcomes
- developing cultural safety, incorporating cultural competency and cultural safety into patient care
- promoting cultural competency and cultural safety in the health care environment.

In addition, the RACS Māori Health Advisory Group is working with the Māori/Indigenous Health Institute at the University of Otago to develop online and face-to-face cultural training. It is planned that this will be rolled out to all supervisors across New Zealand. This will also be supported by implementation across the specialty training board space including SET entry and curriculum development and training delivery.

All STBs recognise the importance of providing educational opportunities in cultural competence; for example, the AOA FTC recently mandated that Trainees complete the RACS Aboriginal and Torres Strait Islander Health and Cultural Safety curriculum modules as they progressively become available.

Provider documentation attached:

Condition 12	To be met by: 2020	2019 Finding: Progressing

In conjunction with the specialty training boards, develop a standard definition across all training programs of ‘competency-based training’ and how ‘time in training’ and number of procedures required complement specific observations of satisfactory performance in determining ‘competency’. (Standard 3.4.2)

Provider response

RACS is in the process of addressing this condition. Across the specialties, there is agreement on the importance of a hybrid approach of competency-based and time-based training in surgery. This centres on the reliance on experiential learning for developing competence in performing surgical procedures along with the flexibility to meet professional skills competencies with no requisite timeframe.

RACS is continuing to gather information to fully understand and synthesise the evidence that exists as well as the position of relevant surgical colleges globally on competency-based training and the number of procedures required in achieving competence. RACS is also cognisant that the AMC is conducting a review of competency-based medical education to improve the uniformity of the definition. We eagerly await the results of that review, which will inform our work in this area.

Several RACS specialties have progressed on plans to implement competency-based assessment tools where appropriate. A number of STBs are introducing workplace-based assessments (WBAs), some of which will be required evidence to contribute towards achieving entrustable professional activities (EPAs); for example, Trainees on the new program delivered by the STB in general surgery Au and NZ will be required to complete 16 EPAs covering a range of professional activities and 17 different procedure-based assessments (PBAs) covering key general surgery procedures. There will be minimum requirements for each EPA and PBA to be completed. The STB in urology and the AOA FTC are reviewing the requirement of a defined number of procedures to reach competence. The AOA FTC’s online Trainee Information Management System (TIMS) captures significant quantities of data on Trainee eLogs and WBAs. This data is scrutinised, and it is hoped that ongoing review as the data continues to accumulate may help to identify the approximate caseload that is required for a Trainee to achieve competence. A key component of the neurosurgery training program is Direct Observation of Procedural Skills (DOPS) assessments with milestones to be reached to progress between Basic, Intermediate and Advanced Training levels. DOPS are designed to assess both knowledge and technical proficiency in discrete procedural skills. During training, 4 DOPS must be completed to progress from Basic to Intermediate Training, 24 DOPS to progress from Intermediate to Advanced Training and 5 DOPS to complete Advanced Training.

Provider documentation attached:

Condition 13	To be met by: 2018	2019 Finding: Progressing
RACS has a policy that is applicable to all specialty training programs to remove the overt and hidden barriers to flexible forms of training. RACS must build on the existing policy and processes and liaise with hospitals to implement flexible training. (Standard 3.4.3)		

Provider response

RACS has made significant progress against this condition, in regard to both the overarching policy and how this is implemented.

Trainee Registration and Variation Regulation

RACS has an overarching regulation, the Trainee Registration and Variation Regulation, that facilitates Trainees in undertaking flexible training posts. This regulation outlines the requirement for eligible Trainees to be assisted in pursuing such posts, and the potential for Trainees to request that decisions on flexible training be reviewed or appealed as part of the RRA Regulation.

Implementation of flexible training

All STBs endorse the RACS Trainee Registration and Variation Regulation, which defines flexible training as training in an accredited post with a time commitment greater than 50 per cent but less than 100 per cent full-time equivalent being suitable for an assessment of competence. The STBs have worked hard to facilitate flexible training posts where possible as described below:

- The AOA FTC accredited seven sites in 2019 after satisfactorily demonstrating compliance with the requirement of the accreditation standards for any training site with three or more posts to have a plan in place for how they would facilitate a part-time training post. While requests for part-time training are not frequent, all recent requests have been facilitated.
- The STB in neurosurgery has revised the regulations to include flexible training. Each year, Trainees are invited to submit requests for flexible training and the Board then works with Trainees to accommodate these requests. The Training Post Accreditation Regulations for Neurosurgery also require larger units to facilitate flexible training. Flexible training posts have been identified in all regions where accredited training posts are located, which can be activated if required.
- The STB in general surgery Au approved a new rule whereby Trainees can combine time undertaken across two rotations to allow them to meet the requirements of one term. There are currently 15 Trainees undertaking flexible training.
- The training regulations for paediatric surgery have further defined flexible training; there is one Trainee in a flexible post.
- The STB in general surgery NZ allows part-time terms to be considered for Trainees on parental or sick leave that cannot be taken within the confines of the standard rotations. This initiative enables Trainees to retrospectively seek approval to train for a minimum of two months from one rotation and a further four months from another rotation.
- The STB in urology remains committed to providing flexible training posts; three Trainees undertook training in less than full-time capacities in 2019 and two Trainees are undertaking flexible training in 2020 by job-sharing one training post for the duration of the year.
- The STB in OHNS currently has three Trainees in flexible training, with a few Trainees (9.5 per cent) in OHNS NZ.

- The STB in P&RS NZ has flexible posts available in two of four units.
- The STB in P&RS Au remains committed to providing flexible training posts; one Trainee has completed a flexible term (split over two separate terms as three months).
- The STB in vascular surgery has one post available but currently no uptake.

The progress already achieved will be complemented by the review of the hospital training post accreditation standards that will ensure those standards align with the RACS regulation on flexible training. RACS will work with a select group of hospitals to pilot the implementation of the standards, including flexible training, once the standards are agreed to and published.

Trainees' perspective on flexible training

RACS surveyed Trainees as part of the RACS Trainees' Association (RACSTA) survey to identify appropriate mechanisms to assess Trainees' knowledge of flexible training pathway options and identify the factors contributing to the gap between Trainee interest and initiation of flexible training. Of the 392 respondents, 98.5 per cent were on full-time rotation compared to 1.5 per cent who were on part-time rotation. Just over a quarter (26.5 per cent) of respondents indicated an interest in completing some of their training on a part-time basis compared to 73.5 per cent who stated that they had no interest in doing so. Of the respondents who indicated an interest in part-time training, 14.5 per cent supported a job share model, 16 per cent preferred a 0.5 FTE standalone model, 12 per cent preferred 0.5 FTE research/clinical and 2.5 per cent preferred a 0.5 FTE private model. Only 3.5 per cent of respondents confirmed that they had applied for part-time training, with 23 per cent of respondents never having applied and just over 73 per cent of respondents not answering this question. Importantly, all respondents who applied were successful in gaining a part-time rotation.

RACS recognises the importance of promoting the option of flexible training, and so a Trainee Engagement Working Group is also working to raise awareness of the option among Trainees. This work will include identifying a pool of volunteers who have undertaken flexible training and can be referred to for advice, promotion and advocacy. Information on flexible training will also be shared across multiple avenues for Trainees and surgical directors/supervisors, including insights from both male and female Trainees who have undergone flexible training.

RACS will continue to encourage and support those Trainees with an interest in pursuing a flexible training post.

Provider documentation attached:

RACS policy on Trainee registration and variation

3.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 3. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs are continuing to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 3? *If yes, please describe below.*	☒ Yes	☐ No change

Significant developments have been made against Standard 3. The progress made on each of the specialty specific curriculum is staggered.

Evaluating the implementation of current curricula

To fully understand the outcomes of implementing a new curriculum, it takes a requisite length of time to allow for Trainees to have experienced the journey through the training program; for example, most AOA FTC Trainees are now progressing through the AOA 21 Training Program. Trainees who commenced in the Introduction to Orthopaedics from the 2018 intake have now progressed into Core Orthopaedics along with Trainees from the 2017 intakes. The first Trainees are expected to be able to progress into Transition to Practice (the third and final stage of the AOA 21 Training Program) from mid-2021. Between each stage of training, a stage review panel assesses the Trainee's portfolio to ascertain if there is sufficient evidence to demonstrate that the expectations of performance for the stage have been met. The AOA FTC Transition to Practice stage of training has been designed to refine and cultivate the foundation competencies, particularly around professionalism, leadership, teaching and collaboration, in preparation for work as a specialist orthopaedic surgeon. The time also could potentially allow Trainees to pursue more focused development in a sub-speciality area of interest.

Revising current curricula

There are STBs with curricula requiring comprehensive review and revision. The STBs in general surgery Au and NZ's curriculum was initially developed in 2008 and has been reviewed continually on a three-year rotation since 2010. In 2018, recommended changes to the SET program were approved. The changes will lead to the move to competency-based training and the introduction of EPAs, PBAs and development of competencies aligned to the various SET levels. Workshops have been held in 2019 and 2020, and the competencies and sub-competencies have been finalised. The Curriculum Working Party is now in the process of developing the milestones across the following levels GSET1, GSET2–3 and GSET4–5. The new GSET program and curriculum will articulate what is required at each stage of training (i.e. GSET level). The STB in neurosurgery is currently undergoing a review of its curriculum with rollout to take place in 2021.

Introduction of new curriculum

Newly developed curricula have been implemented recently for some STBs. The STB in orthopaedic surgery NZ published its curriculum following consultation with all specialities and with the support of the AOA FTC. This covers all RACS competencies including what is expected of Trainees throughout their training. The curriculum weaves cultural competence throughout to take into account the needs of Māori.

Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

3.3 Documents requested

Please provide the **latest version** of the following documents either as an attachment or as a link to the College website as appropriate. If the College has made changes to the following document(s) since the last accreditation/progress report, please include a description of the change under significant developments

Document	Attached	Link to document (if available)
Curriculum map	☒ Yes	Standard 3 Appendix

3.4 Statistics and annual updates

Please provide data for the following tables. If required, please adjust the table to suit the College's training and education program(s).

A. Recognition of prior learning (Standard 3.3.2)

Provide data on the number and percentage of Trainees who sought and were granted recognition of prior learning (RPL), and the periods of RPL granted by year since the last accreditation assessment.

Table 3. Requests for recognition of prior learning, 2017 to date

Year	Number	% granted	Period granted	Comments (if required)
2017	31	90		RPL is for the research requirement, not time
2017	16	100	12 months	
2018	23	83		RPL is for the research requirement, not time
2018	3	100	6 months	
2018	2	100	12 months	
2018	2	100	24 months	
2019	13	92		RPL is for the research requirement, not time
2019	23	100	6 months	
2019	3	100	12 months	
2020 (to date)	22	91		RPL is for the research requirement, not time
2020 (to date)	1	100	6 months	
2020 (to date)	2	100	12 months	1 dependent on satisfactory performance throughout rest of 2020

B. Part-time and Interrupted training (Standard 3.4.3)

Provide data on the number of Trainees by year that have sought and the number that have been granted part-time or interrupted training since the last accreditation assessment.

Table 4. Requests for part-time and interrupted training, 2017

Part-time training	Number requested	Number granted	% granted	Comments (if required)
Total	**7**	**7**	**100**	
Male	1	1	100	
Female	6	6	100	
NSW/ACT	1	1	100	
NT	0	0	0	
QLD	5	5	100	
SA	1	1	100	
TAS	0	0	0	
VIC	0	0	0	
WA	0	0	0	
NZ	0	0	0	
Interrupted training	**Number requested**	**Number granted**	**% granted**	**Comments (if required)**
Total	**82**	**80**	**98**	
Male	31	29	94	
Female	48	48	100	
NSW/ACT	28	27	96	
NT	0	0	0	
QLD	8	8	100	
SA	4	4	100	
VIC	17	17	100	
TAS	1	1	100	
WA	0	0	0	
NZ	19	18	95	

Table 5. Requests for part-time and interrupted training, 2018

Part-time training	Number requested	Number granted	% granted	Comments (if required)
Total	11	11	100	
Male	0	0	0	
Female	11	11	100	
NSW/ACT	2	2	100	
NT	0	0	0	
QLD	4	4	100	
SA	0	0	0	
VIC	1	1	100	
TAS	1	1	100	
WA	0	0	0	
NZ	3	3	100	
Interrupted training	**Number requested**	**Number granted**	**% granted**	**Comments (if required)**
Total	94	93	99	
Male	30	30	100	
Female	64	63	100	
NSW/ACT	28	28	100	
NT	0	0	0	
QLD	10	10	100	
SA	4	4	100	
TAS	2	2	100	
VIC	21	21	100	
WA	8	8	100	
NZ	18	18	100	

Table 6. Requests for part-time and interrupted training, 2019

Part-time training	Number requested	Number granted	% granted	Comments (if required)
Total	24	24	100	
Male	11	11	100	
Female	12	12	100	
NSW/ACT	2	2	100	
NT	0	0	0	
QLD	3	3	100	
SA	4	4	100	
TAS	1	1	100	
VIC	4	4	100	
WA	1	1	100	
NZ	3	3	100	
Interrupted training	**Number requested**	**Number granted**	**% granted**	**Comments (if required)**
Total	79	79	100	
Male	29	29	100	
Female	50	50	100	
NSW/ACT	22	22	100	
NT	0	0	0	
QLD	9	9	100	
SA	4	4	100	
VIC	18	18	100	
TAS	1	1	100	
WA	12	12	100	
NZ	11	11	100	

Table 7. Requests for part-time and interrupted training, 2020 (May 31)

Part-time training	Number requested	Number granted	% granted	Comments (if required)
Total	23	23	100	
Male	7	7	100	
Female	15	15	100	
NSW/ACT	6	6	100	
NT	0	0	0	
QLD	3	3	100	
SA	6	6	100	
TAS	0	0	0	
VIC	5	5	100	
WA	1	1	100	
NZ	2	2	100	
Interrupted training	**Number requested**	**Number granted**	**% granted**	**Comments (if required)**
Total	64	64	100	
Male	24	24	100	
Female	40	40	100	
NSW/ACT	12	12	100	
NT	1	1	100	
QLD	9	9	100	
SA	4	4	100	
VIC	19	19	100	
TAS	1	1	100	
WA	8	8	100	
NZ	8	8	100	

Standard 4 Teaching and learning

The AMC accreditation standards are as follows:

4.1 Teaching and learning approach

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

4.2 Teaching and learning methods

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

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

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

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

Status and submission request

Status: **Met**	Number of remaining conditions = **1**
	Number of remaining recommendations = **1**
Significant developments requested	**Yes**
Documents requested	No
Statistics and annual updates requested	No

4.1 Remaining conditions

Please provide a summary update of the College's responses to the remaining conditions (listed below) from the last AMC Accreditation Report. Please detail progress made, plans for further work, and the evidence to support progress.

Condition 14	To be met by: 2021	2019 Finding: Progressing
For all specialty training programs, develop curriculum maps to show the alignment of learning activities and compulsory requirements with the outcomes at each stage of training and with the graduate outcomes. This could be undertaken in conjunction with the curricular reviews that are currently planned or underway. (Standard 4.1.1)		
Provider response RACS is currently developing the professional skills curriculum and with it the associated curriculum map. The current review of RACS educational courses will provide up-to-date information on the compulsory learning activities aligned to the graduate outcomes for each of the eight professional skills competencies. Several specialty training programs are advancing in this area. In 2020 the AOA FTC scheduled work on mapping learning opportunities to the outcomes of the curriculum in an explicit matrix. The work was not completed due to the COVID 19 restrictions. This work will continue in 2021. The AOA FTC TIMS maps Trainee learning activities and performance against each competency in the curriculum graphically. The new OHNS curriculum states specific activities and requirements for each stage of training. The STBs in general surgery Au and NZ are moving forward with a new curriculum and program that will include requirements for learning activities and assessments to be linked to the competencies at each stage of training. The STB in urology incorporated this into the reviewed curriculum, with clearly defined learning outcomes linked to three stages of training. A teaching and learning strategy is currently under development and will be mapped to the sections of the curriculum. The existing curriculum of the STB in neurosurgery already had learning outcomes at the three levels of training, being Basic, Intermediate and Advanced. Neurosurgery commenced a comprehensive review of its curriculum in early 2020, which will be released in 2021.		
Provider documentation attached:		

4.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 4. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs are continuing to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 4? *If yes, please describe below.*	☒ Yes	☐ No change
Significant developments have been made with learning and teaching approaches and methods; for example, the STB in orthopaedic surgery NZ is introducing online teaching nationally to address challenges posed by COVID-19. Weekly/fortnightly virtual learning environment (VLE) sessions will be delivered to Trainees via Zoom. These VLE sessions will be based on the curriculum and will cover all topics in an approximately 12- to 18-month cycle. All VLE sessions will be recorded and made available for four weeks for those unable to attend. The STB in vascular surgery has introduced online Trainee tutorials via Zoom for SET 1–4 Trainees via Zoom. These online tutorials were introduced into training program regulations at the end of 2020. The STB in neurosurgery has transitioned its face-to-face training seminars to videoconferences. Three videoconferences were held in the second half of 2020 (July, August and September), and a further three are scheduled for the first half of 2021. Face-to-face training seminars will recommence when it is safe and logistically possible to do so.		
Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

4.3 Documentation requested

Nil

4.4 Statistics and annual updates

Nil

Standard 5 Assessment of learning

The AMC accreditation standards are as follows:	
5.1	**Assessment approach**
5.1.1	The education provider has a program of assessment aligned to the outcomes and curriculum of the specialist medical program which enables progressive judgements to be made about trainees' preparedness for specialist practice.
5.1.2	The education provider clearly documents its assessment and completion requirements. All documents explaining these requirements are accessible to all staff, supervisors and trainees.
5.1.3	The education provider has policies relating to special consideration in assessment.
5.2	**Assessment methods**
5.2.1	The assessment program contains a range of methods that are fit for purpose and include assessment of trainee performance in the workplace.
5.2.2	The education provider has a blueprint to guide assessment through each stage of the specialist medical program.
5.2.3	The education provider uses valid methods of standard setting for determining passing scores.
5.3	**Performance feedback**
5.3.1	The education provider facilitates regular and timely feedback to trainees on performance to guide learning.
5.3.2	The education provider informs its supervisors of the assessment performance of the trainees for whom they are responsible.
5.3.3	The education provider has processes for early identification of trainees who are not meeting the outcomes of the specialist medical program and implements appropriate measures in response.
5.3.4	The education provider has procedures to inform employers and, where appropriate, the regulators, where patient safety concerns arise in assessment.
5.4	**Assessment quality**
5.4.1	The education provider regularly reviews the quality, consistency and fairness of assessment methods, their educational impact and their feasibility. The provider introduces new methods where required.
5.4.2	The education provider maintains comparability in the scope and application of the assessment practices and standards across its training sites.

Status and submission request

Status: **Substantially met**	Number of remaining conditions = **1** Number of remaining recommendations = **3**
Significant developments requested	**Yes**
Documents requested	**Yes**
Statistics and annual updates requested	**Yes**

5.1 Remaining conditions

Please provide a summary update of the College's responses to the remaining conditions (listed below) from the last AMC Accreditation Report. Please detail progress made, plans for further work, and the evidence to support progress.

Condition 16	To be met by: 2019	2019 Finding: Progressing
Implement appropriate standard-setting methods for all specialty-specific examinations (the AMC recognises that at least three specialties are already compliant in this respect). (Standard 5.2.3)		

Provider response

RACS will have addressed this condition for all applicable examinations by mid-2021. RACS has achieved significant progress in implementing appropriate standard-setting methods for specialty-specific examinations despite the cancellation of these examinations where necessary in 2020 due to the challenges presented by the COVID-19 pandemic.

The STBs in urology and P&RS have trialled and implemented the Modified Angoff Method for their specialty-specific examinations. The STBs in OHNS and vascular surgery have conducted successful trials of their respective specialty examinations again using the Modified Angoff Method, with the implementation delayed due to COVID-19 affected examination postponements. The AOA FTC has adopted the Bookmark Method, which has been trialled and will be implemented with the running of the next examination. The STB in cardiothoracic surgery has trialled several standard-setting methods and will be finalising its decision by 2021 for implementation. The STB in paediatric surgery conducted a substantive review of its exam. Standard setting remains a challenge due to a very small number of candidates per year (1–3) with validated standard-setting methods being reviewed.

The STBs in general surgery Au and NZ use Surgical Education and Assessment Modules (SEAM) in place of Specialty Specific Examinations, with the Modified Angoff Method standard setting used for these modules. The STB in neurosurgery continues to implement the Neurosurgery Anatomy Examination as part of a selection tool onto the SET program. The questions are set by a committee of neurosurgeons who also predict the response probability of candidates for each question used. The process has been very consistent with the average candidate score for the past four years being 80.66 per cent (2020), 80.00 per cent (2019), 79.01 per cent (2018) and 80.35 per cent (2017). The cut-off score for suitability is 70 per cent. The highest score in each year has also been consistent with the highest score in all four years being within a range of 3.93 per cent.

RACS is proud of the progress made in this space and will continue to implement these standard-setting methods to improve the quality of these examinations.

Provider documentation attached:

5.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 5. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs are continuing to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 5? *If yes, please describe below.*	☒ Yes	☐ No change
Significant developments have been made against Standard 5 and are referred to in Condition 12 when describing the implementation of competency-based assessment tools. Additional progress is being made on assessment methods and approaches at the specialty level; for example, implementation of any new assessments is delayed until the 2022 training year due to COVID-19. Trainees on the new GSET program will be required to complete 16 EPAs covering a range of professional activities, and 17 different PBAs covering key general surgery procedures. There will be minimum requirements for each EPA and PBA to be successfully completed. The in-training assessment will also alter to be aligned to the milestones in the curriculum for all 10 competency domains. For Trainees who are underperforming, the current and new program utilises various assessment types depending on the nature of the area where the Trainee is underperforming. This includes DOPs, Mini-CEX, P-MEX and MSF. Under the new GSET program, goal setting is a component at the beginning of the term. Trainees will be required to set their goals and have these reviewed by their supervisor. This will assist in the learning and development of the Trainee throughout their training		
Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

College to note

In the 2019 AMC response to the College's progress report, the College was asked to provide reporting in Standard 5 to identify any potential issues related to the change to the Clinical Examination being a prerequisite to selection into training. The College is asked to report if outcomes of the change has led to a higher pass rate, the feasibility of applicants going through the Clinical Examination on selection and if the College has sufficient resources to deliver the exam reliably. This response is related to Standard 7 (7.1 – Admission Policy and Selection).

5.3 Documentation requested

Please provide the **latest version** of the following documents either as an attachment or as a link to the College website as appropriate. If the College has made changes to the following document(s) since the last accreditation/progress report, please include a description of the change under significant developments.

Document	Attached	Link to document (if available)
Assessment map or blueprint (showing how formative and summative assessments relate to curriculum and progression point decisions/hurdles though the program)	☒ Yes	Standard 5 Appendix

5.4 Statistics and annual updates

Please provide data for the following tables. If required, please adjust the table to suit the College's training and education program(s).

A. Summative assessment data (Standard 5.4) – TBC

Provide data on the College's various summative assessments by region and gender on the number and percentage of Trainees who passed various their first, second, third and subsequent attempts in each year since the last accreditation. *Separate tables can be added for each summative assessment.*

Table 8. Summative assessment – Generic Surgical Sciences Examination, 2017

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	**No. passed**	**% passed**	**No. sitting**	**No. passed**	**% passed**	**No. sitting**	**No. passed**	**% passed**
Total	**709**	**508**	**71.6**	**189**	**82**	**44.5**	**102**	**43**	**42.1**
Male	467	355	76.0	114	49	43.0	67	26	38.8
Female	233	150	64.3	70	33	47.1	34	17	50.0
Chose not to identify gender	9	3	33.3	5	0	0	1	0	0
ACT	11	10	90.9	4	1	25.0	3	0	0
NSW	189	133	70.3	53	24	45.2	36	13	36.1
NT	5	3	60.0	0	0	0	1	1	100
QLD	132	97	73.4	34	17	50.0	15	10	66.7
SA	41	25	60.9	9	3	33.3	6	5	83.3
TAS	7	4	57.1	2	1	50.0	0	0	0
VIC	144	99	68.7	42	16	38.1	19	7	36.8
WA	63	37	58.7	28	12	42.8	10	2	20.0
NZ	114	100	87.8	15	6	40.0	11	3	27.2
O/S	1	0	0	1	1	100	0	0	0

Table 9. Summative assessment – Generic Surgical Sciences Examination, 2018

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**654**	**471**	**72.1**	**143**	**69**	**49.2**	**80**	**27**	**36.0**
Male	435	330	75.8	80	48	60.0	46	13	28.2
Female	215	139	64.6	60	21	35.0	29	14	48.2
Chose not to identify gender	4	2	50	3	0	0	5	0	0
ACT	10	7	70.0	2	2	100	0	0	0
NSW	171	114	66.7	43	24	55.8	24	5	20.8
NT	3	2	66.7	3	1	33.3	0	0	0
QLD	122	92	75.4	24	9	37.5	14	4	28.5
SA	37	23	62.1	14	8	57.1	5	2	40.0
TAS	6	5	83.3	2	0	0	2	1	50.0
SA	37	23	62.1	14	8	57.1	5	2	40.0
TAS	6	5	83.3	2	0	0	2	1	50.0
VIC	145	105	72.4	30	14	46.6	14	5	35.7
WA	62	43	69.3	12	5	41.6	10	5	50.0
NZ	98	80	81.6	13	6	46.1	6	3	50.0

Table 10. Summative assessment – Generic Surgical Sciences Examination, 2019

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**685**	**443**	**64.8**	**168**	**57**	**34.3**	**79**	**18**	**22.1**
Male	427	285	66.7	89	35	39.3	36	11	30.6
Female	255	157	61.6	77	22	28.6	41	6	14.6
Chose not to identify	3	1	33	2	0	0	2	1	50
ACT	6	5	83.3	3	0	0	1	1	100
NSW	161	94	58.3	49	20	40.8	19	2	10.5
NT	8	4	50	0	0	0	0	0	0
QLD	136	86	63.2	31	9	29.0	15	5	33.3
SA	48	29	60.4	15	6	40.0	4	1	25.0
TAS	11	6	54.6	1	1	100	0	0	0
VIC	156	104	66.7	38	8	21.0	27	6	22.2
WA	59	38	64.4	18	7	38.9	6	1	16.7
NZ	98	75	76.6	11	6	54.6	3	0	0

Table 11. Summative assessment – Clinical Examination, 2017

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**235**	**181**	**77.0**	**37**	**34**	**91.9**	**3**	**3**	**100**
Male	187	144	77.0	31	28	90.3	2	2	100
Female	48	37	77.0	6	6	100	1	1	100
ACT	3	1	33	1	1	100	0	0	0
NSW	58	44	75.6	11	11	100	0	0	0
NT	0	0	0	0	0	0	0	0	0
QLD	45	38	84.4	5	5	100	1	1	100
SA	11	14	78.5	2	1	50.0	0	0	0
TAS	2	2	100	0	0	0	0	0	0
VIC	54	39	72.2	11	11	100	0	0	0
WA	16	12	75.0	2	2	100	0	0	0
NZ	39	31	79.4	5	3	60.0	2	2	10

Table 12. Summative assessment – Clinical Examination, 2018

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**158**	**107**	**67.7**	**55**	**39**	**70.9**	**13**	**9**	**69.2**
Male	102	67	65.7	41	28	68.3	12	8	66.7
Female	56	40	71.4	14	11	78.6	1	1	100
ACT	2	2	100	1	0	0	1	1	100
NSW	44	28	63.6	14	7	50.0	3	3	100
NT	0	0	0	0	0	0	0	0	0
QLD	25	16	64.0	7	6	85.7	0	0	0
SA	8	6	75.0	3	3	100	2	1	50.0
TAS	1	1	100	0	0	0	0	0	0
VIC	32	27	84.3	13	9	69.2	3	2	66.7
WA	12	10	83.3	3	2	66.7	1	1	100
NZ	33	16	48.4	14	12	85.7	3	1	33.3
O/S	1	1	100	0	0	0	0	0	0

Table 13. Summative assessment – Clinical Examination, 2019

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**82**	**51**	**62.2**	**25**	**17**	**68.0**	**12**	**5**	**41.7**
Male	56	36	64.3	14	9	64.3	9	3	33.3
Female	26	15	57.7	11	8	72.7	3	2	66.7
ACT	2	1	50	0	0	0	0	0	0
NSW	24	14	58.3	11	10	90.9	6	3	50.0
NT	0	0	0	0	0	0	0	0	0
QLD	14	7	50.0	5	3	60.0	2	0	0
SA	6	5	83.3	1	0	0	1	1	100
TAS	1	1	100	0	0	0	0	0	0
VIC	25	14	56.0	3	1	33.3	1	1	100
WA	4	4	100	1	1	100	0	0	0
NZ	6	5	83.3	4	2	50.0	2	0	0

Table 14. Summative assessment – Fellowship Examination, 2017

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	224	157	70.0	59	34	57.6	19	7	36.8
Male	159	115	72.3	41	21	51.2	12	2	16.7
Female	65	42	64.6	18	13	72.2	7	5	71.4
ACT	2	1	50.0	0	0	0	0	0	0
NSW	57	37	64.9	20	8	40.0	5	2	40.0
NT	2	1	50.0	1	0	0	0	0	0
QLD	36	26	72.2	6	6	100	2	0	0
O/S	32	24	75.0	8	6	75.0	1	0	0
SA	13	13	100	3	3	100	0	0	0
TAS	2	1	50.0	2	1	50.0	0	0	0
VIC	43	31	72.1	11	6	54.4	6	3	50.0
WA	16	12	75.0	5	3	60.0	2	0	0
NZ	131	116	88.5	26	11	42.3	6	2	33.3

Table 15. Summative assessment - Fellowship Examination, 2018

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**254**	**176**	**69.2**	**70**	**46**	**65.7**	**27**	**15**	**55.6**
Male	189	128	67.7	55	36	65.4	22	10	45.4
Female	65	48	73.8	15	10	66.7	5	5	100
ACT	5	3	60.0	2	1	50.0	0	0	0
NSW	63	45	71.4	15	9	60.0	10	6	60.0
NT	2	0	0	1	1	100	0	0	0
QLD	45	28	62.2	13	7	53.8	1	1	100
O/S	20	13	65.0	6	5	83.3	3	2	66.7
SA	13	10	76.9	3	3	100	1	0	0
TAS	4	3	75.0	3	1	33.3	0	0	0
VIC	68	50	73.5	15	11	73.3	7	4	57.1
WA	15	10	66.7	7	4	57.1	2	1	50.0
NZ	19	15	78.9	5	4	80.0	3	1	33.3

Table 16. Summative assessment – Fellowship Examination, 2019

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**259**	**189**	**72.9**	**74**	**49**	**66.2**	**21**	**11**	**52.3**
Male	188	142	75.5	47	28	59.6	15	8	53.3
Female	71	47	66.1	27	21	77.8	6	3	50.0
ACT	3	3	100	1	1	100	1	1	100
NSW	74	49	66.2	23	13	56.5	7	4	57.1
NT	2	0	0	2	1	50.0	1	0	0
QLD	38	27	71.0	15	12	80.0	6	3	50.0
SA	11	8	72.7	4	4	100	0	0	0
TAS	4	3	75.0	1	1	100	2	1	50.0
VIC	67	48	71.6	18	13	72.2	2	2	100
WA	18	15	83.3	2	0	0	2	0	0
NZ	34	28	82.3	6	2	33.3	0	0	0

Table 17. Summative assessment – Specialty Specific Examination, 2017

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**143**	**122**	**85.3**	**22**	**19**	**86.3**	**4**	**4**	**100**
Male	120	103	85.8	16	14	87.5	3	3	100
Female	23	19	82.6	6	5	83.3	1	1	100
ACT	0	0	0	0	0	0	0	0	0
NSW	36	27	75.0	11	9	81.8	3	3	100
NT	0	0	0	0	0	0	0	0	0
QLD	30	27	90.0	3	3	100	0	0	0
SA	15	13	88.5	3	3	100	0	0	0
TAS	0	0	0	0	0	0	0	0	0
VIC	35	31	88.5	3	3	100	0	0	0
WA	5	2	40.0	0	0	0	1	0	0
NZ	22	22	100	1	1	100	0	0	0

Table 18. Summative assessment – Specialty Specific Examination, 2018

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**135**	**115**	**85.1**	**21**	**15**	**71.4**	**5**	**5**	**100**
Male	97	87	89.6	18	12	66.7	5	5	100
Female	38	28	73.6	3	3	100	0	0	0
ACT	0	0	0	0	0	0	0	0	0
NSW	37	34	91.8	6	4	66.7	2	2	100
NT	0	0	0	0	0	0	0	0	0
QLD	25	21	84.0	3	3	100	1	1	100
SA	11	8	72.7	3	3	100	0	0	0
TAS	0	0	0	0	0	0	0	0	0
VIC	28	23	82.1	3	1	33.3	1	1	100
WA	12	9	75.0	6	4	66.7	1	1	100
NZ	37	34	91.8	0	0	0	0	0	0

Table 19. Summative assessment – Specialty Specific Examination, 2019

	1st attempt			2nd attempt			3rd attempt		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	**120**	**103**	**85.8**	**12**	**7**	**58.3**	**6**	**5**	**83.3**
Male	83	71	85.5	7	5	71.4	3	3	100
Female	37	32	86.4	5	2	40.0	3	2	66.7
ACT	0	0	0	0	0	0	0	0	0
NSW	26	22	84.6	2	1	50.0	0	0	0
NT	0	0	0	0	0	0	0	0	0
QLD	13	10	76.9	2	2	100	0	0	0
SA	13	11	84.6	1	1	100	0	0	0
TAS	0	0	0	0	0	0	0	0	0
VIC	28	25	89.2	5	2	40.0	5	5	100
WA	12	10	83.3	1	1	100	1	1	100
NZ	28	25	89.2	1	0	0	0	0	0

B. Withdrawal from training program (Standard 5.4.1)

Provide data on the number of Trainees who withdrew from the program before completion and a summary of the reasons for withdrawal in each year since the last accreditation.

Table 20. Trainees withdrawing from program, 2017 – to date.

Year	Number	%	Reason for withdrawal
2017	16	0.01%	Mental health reasons, family and personal reasons, change of specialty training program
2018	8	0.01%	Dismissed (maximum time expired), resigned (was underperforming), Trainee failed third consecutive term
2019	7	0.01%	Dismissed (continued unsatisfactory performance), failure to complete exam
2020 (as of May 31)	3	0.01%	No reason provided

C. Performance feedback (Standard 5.3)

Provide data on the number of Trainees who remediated or who were provided additional support and a summary of the outcomes in each year since the last accreditation.

Table 21. Trainees remediated, 2017 to date.

Year	Number	% remediated	Summary of outcomes
2017	29	69	Satisfactory final assessments, performance review was elevated to 6-month probation in next rotation, Trainee dismissed, Trainee suspension pending review, mental health issues – trainee resigned, failed probationary term, passed probationary term
2018	29	76	Withdrew for multiple failed assessments, proceeded to further probation, Trainee dismissed, Trainee withdrew, Trainees still being remediated currently, remediated but failed clinical exam, failed probationary term, passed probationary term, Trainee completed a 6-month rotation unsatisfactorily, was supported by a Performance Management Plan in the following 6 months and completed those 6 months satisfactorily
2019	17	82	Unsatisfactory final assessments, placed on probation in next rotation, Trainee dismissed, Trainee still being remediated, Trainees continue to be on track, Trainee completed a 6-month rotation unsatisfactorily, Trainee supported by a Performance Management Plan in the following 6 months and completed those 6 months satisfactorily
2020 (as of May 31)	7	N/A	Probation still in progress

Table 22. Trainees provided additional support, 2017 to date

Year	Number	% supported	Summary of outcomes
2017	17	0.01%	Exam pending, Learning Action Plans were implemented to support progress of competencies in which they were struggling, succeeded in improving their practice and passed the 6-month run.
2018	17	0.01%	Two exam pending Trainee, one flexible training with 9-month interruption following childbirth, learning action plans – successfully reintegrated, Trainee was struggling. A Learning Action Plan was implemented to support progress of those competencies in which that Trainee was struggling. That Trainee succeeded in improving practice and passed the 6-month run, Trainee was supported in a return to work after parental leave by implementing a Learning Action Plan. That Trainee succeeded in returning to work and passed the 6-month run.
2019	23	0.02%	Exam pending, Trainee back on track, learning action plans – successfully reintegrated, Trainee was struggling. A Learning Action Plan was implemented to support progress of those competencies in which that Trainee was struggling. That Trainee succeeded in improving practice and passed the 6-month run.
2020 (as of May 31)	5	0.01%	Exam pending, Learning Action Plan – successfully reintegrated, Learning Action Plan is ongoing, Trainee completed successfully.

Standard 6 Monitoring and evaluation

The AMC accreditation standards are as follows:

6.1 Monitoring

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

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

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

6.2 Evaluation

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

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

6.2.3 Stakeholders contribute to evaluation of program and graduate outcomes.

6.3 Feedback, reporting and action

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

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

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

Status and submission request

Status: **Substantially met**	Number of remaining conditions = **6**
	Number of remaining recommendations = **1**
Significant developments requested	**Yes**
Documents requested	No
Statistics and annual updates requested	**Yes**

6.1 Remaining conditions

Please provide a summary update of the College's responses to the remaining conditions (listed below) from the last AMC Accreditation Report. Please detail progress made, plans for further work, and the evidence to support progress.

Condition 17	To be met by: 2019	2019 Finding: Progressing
Develop an overarching framework for monitoring and evaluation, which includes all training and educational processes as well as program and graduate outcomes. (Standard 6.1, 6.2 and 6.3)		

Provider response

RACS has made significant progress in addressing this condition. An overarching Monitoring and Evaluation (M&E) Framework for the SET program is being developed in conjunction with the STBs. It is intended to help enhance the quality of SET monitoring and evaluation practices by ensuring a unified language, understanding and agreement on the M&E components across RACS, the STBs and key stakeholders. Additionally, the M&E Framework provides a series of steps and guidelines to facilitate the implementation of the M&E activities. A theory-based, results-driven approach was used in developing the M&E Framework. The SET program theory is the centrepiece of the M&E Framework and the Results Logic Model (the Logic Model) is used to measure progress against the program theory.

The monitoring component of the M&E Framework is concerned with tracking the delivery of influencing activities of the SET program to the intended targets (Trainees, supervisors, faculty) and the outputs of these activities. The monitoring plan outlines the data sources, which include both Trainee and supervisor feedback, and the data collection tools that will be used for reporting. It clearly explains the indicators and processes for obtaining and reporting data. The evaluation component of the M&E Framework includes both process and summative evaluations. Process evaluations will assess the extent to which the SET program is being implemented as intended and will provide recommendations to improve program implementation. Summative evaluations will assess the achievement of graduate and program outcomes identified in the M&E Framework as the intermediate and long-term outcomes, respectively.

As part of the One College Transformation Project, RACS is currently developing a data lake to enable more efficient monitoring and evaluation across the specialties. The data lake will be a single store of all raw data from RACS and its specialties. We will be able to apply machine learning to this raw data to look for insights and patterns in our program evaluations. RACS will be able to derive meaning from raw data which will be dynamic and facilitate the generation of real-time progress reports for monitoring. This will also align the approach to evaluation of the SET program across specialties. The data lake will be rolled out mid-2021.

Following the finalisation of the M&E Framework, the next step will be to ensure successful implementation. This will facilitate greater understanding of the training programs; ensuring quality assurance and identifying areas in need of quality improvement.

Provider documentation attached:

Condition 19	To be met by: 2019	2019 Finding: Progressing
Establish methods to seek confidential feedback from supervisors of training, across the surgical specialties, to contribute to the monitoring and development of the training program. (Standard 6.1.2)		

Provider response

RACS continues to make progress against this condition.

Supervisor feedback on the training programs is critical to both monitoring the training program and developing recommendations to further improve the programs. The Supervision Project conducted by RACS recently surveyed supervisors in collaboration with the STBs regarding the supervisor framework. As part of this survey, feedback was sought from supervisors on the challenges they faced in implementing the training programs. The results from that survey will be released at the end of 2020 and will inform future support for supervisors and the M&E Framework.

RACS continues to develop methods to capture confidential feedback from supervisors at the specialty level. The STB in general surgery Au seeks feedback from supervisors via email and at focus meetings as part of the implementation of the revised GSET program. The STB in urology circulated the curriculum to supervisors for confidential feedback this year and plans to undertake annual confidential surveys (augmented by face-to-face discussions) to be distributed at the end of the clinical training year. The STB in orthopaedic surgery NZ uses the newly implemented TIMS to collect feedback from supervisors regarding Trainees and the training program. The STB in P&RS Au conducts six-monthly training post evaluations and annual program evaluations that are confidential; individual responses cannot be accessed. The information system used only provides de-identified summary data for areas flagged as problems. The AOA FTC circulated the refreshed Supervisor Survey early in 2020. The first round will be treated as a pilot, with responses followed up in late 2020. The completion of the survey is not mandatory; however, the response rate for the Director of Training Survey was 41 per cent. The AOA FTC reviewed the results and the intention is to run the supervisor survey on a regular basis. Neurosurgery conducts face-to-face supervisor meetings. The 2020 meeting was cancelled due to COVID-19 and a videoconference of supervisors was held in June 2020. Feedback from previous supervisor meetings have directly resulted in changes to the assessment processes used in the training program. Due to the size of P&RS NZ, all supervisors are members of the STB in NZ plastics and contribute to and provide feedback on the training program through board meetings. Supervisors have an annual end-of-year supervisor handover meeting to discuss Trainee progress prior to Trainees moving to new training units.

Further work is required to align supervisor feedback into a streamlined, centralised process that can be embedded into the M&E Framework and allow for cross-specialty analysis.

Provider documentation attached:

Condition 20	To be met by: 2019	2019 Finding: Not Progressing
Develop and implement completely confidential and safe processes for obtaining and acting on regular, systematic feedback from trainees on the quality of supervision, training and clinical experience. (Standard 6.1.3 and 8.1.3)		

Provider response

RACS has made significant progress against this condition. Trainees provide invaluable insight into the training program and their feedback can help enhance both learning and teaching practices and support the continued delivery of high-quality training programs as well as improve graduate and program outcomes. RACS is working towards developing a single system of feedback that integrates existing mechanisms including the RACSTA Trainee survey, STB surveys and the Medical Board of Australia Medical Training Survey.

The RACSTA Trainee survey

The RACSTA survey is conducted biennially as a generic survey for all SET Trainees in Australia and New Zealand and publicly reports in 5-year aggregation, with time delay for protection of Trainees in current posts. Individual dataset reports are provided in confidence to BSET after each survey. The key themes addressed in this survey are demographic profile, flexible training, accommodation, rotation setting, team structure, workload, hours, acute/elective operating exposure, ward and outpatient exposure, administrative support, objectives/assessment, bullying and harassment, and an overall evaluation. The RACSTA Survey Working Group, comprising RACSTA Committee members, and RACS staff oversee the survey, identify areas requiring change, refine questions and identify processes for more regular reporting to stakeholders while maintaining appropriate Trainee safeguards. In February 2020, the RACSTA Committee resolved to complete several action items relating to the collection of Trainee feedback and the interrelatedness between the RACSTA survey, the Medical Board Training Survey and specialty-level surveys. The RACSTA committee continues to make progress on the following items:

- The RACSTA Survey was revised during 2020 and a new foreword incorporated to make explicit the secure handling, confidentiality and de-identification of collected data. Given the new alignment of term dates from February 2021, the Australian and New Zealand surveys are now distributed simultaneously.
- The RACSTA Survey reporting frequency has been modified to biennial reporting on a rolling 5-year dataset, balancing timely feedback on contemporary issues with protection of respondents through sufficient data aggregation and de-identification.
- Analysis of trainee survey question sets is pending the submission of complete data from Specialty Training Boards. Preliminary analysis of the RACSTA Survey and Medical Training Survey has been conducted.
- The Hospital Training Post Accreditation Working Group has produced a second draft Accreditation Standards for stakeholder feedback and is expected to be completed in 2021. The final Standards will guide the revision of trainee surveys that more closely align with accreditation criteria.

Next actions include follow-up of STBs for outstanding trainee survey data and commencement of the planned trainee survey mapping exercise.

The Medical Training Survey

The Medical Training Survey is conducted annually by the Medical Board of Australia as a generic survey for all Australia-based medical Trainees. Topics covered in this survey include

demographic profile, curriculum, orientation, assessment, supervision, access to teaching, workplace culture, patient safety, overall satisfaction and future career intentions. While reports are generated for RACS' consideration, a clear limitation to RACS' integration of the Medical Training Survey into its Trainee feedback systems is that it exclusively surveys Australian Trainees.

STB surveys

STBs deliver the trainee surveys at the specialty level. Several STBs have made progress in enacting protocols to enhance the confidentiality and safety of Trainee feedback processes. This area, however, remains challenging for the STBs in the smaller specialties.

The STB in P&RS Au replaced its post evaluation form with an anonymised evaluation process and developed a new form which excluded free-form text options resulting in increased anonymity for respondents. Data points relate to training post accreditation standards that naturally include supervision metrics. These include questions regarding the frequency of supervisor feedback, the frequency of surgical trainer feedback, the level of support and the number of consultant-led ward rounds. Also, individual responses are not provided to STB members or hospital inspection teams, in accordance with anonymity.

The STB in general surgery Au has regulations about hospital post feedback from Trainees. The regulations detail the feedback de-identification process and the question set, which covers the themes of registrar workload, education and training, professional development and hospital supervisors/unit supervisors/hub supervisors. The periodicity (which is annual) and the reporting process are also detailed in the regulations. Similarly, the STB in general surgery NZ has revised its Trainee feedback process; feedback is now only sought after the end of term when most Trainees have moved on to another training post. OHNS Trainees are now required to complete an anonymous feedback questionnaire following each rotation to gauge the quality of training, supervision and clinical experience as part of the online learning management system (LMS). Trainees are also surveyed during the annual Trainees meeting, and the survey findings are reported to the Convenor of the next meeting. The STB in neurosurgery has been conducting six-monthly confidential evaluation surveys of Trainees for more than 10 years. As a small specialty, confidentiality is a key issue. The data is combined over a five-year period into a rolling report that is used as part of the training post accreditation process. In addition, where a survey flags a significant issue, the Trainee is contacted, and discussions occur about how best to address the issue. For example, in both 2019 and 2020 Trainee evaluations have triggered two out-of-cycle hospital post accreditation reviews, both initiated with the support of the Trainees providing the feedback. The AOA FTC routinely collects Trainee feedback for each rotation via their Trainee Evaluation survey. Raw data is only accessible to the Education and Training team. The de-identified data is presented to the AOA FTC and accreditation review teams. Individual Trainee comments are collated and reported over an extended period to ensure anonymity. The survey question topics include supervision, assessment, teaching and learning, technology, and AOA administration and support.

Other STBs regularly conduct person-to-person interviews with Trainees. The number of people in the interview room is limited for confidentiality purposes. The STB in orthopaedic surgery NZ collects Trainee feedback during accreditation hospital inspections and yearly formal individual Trainee meetings during a training weekend with the Education Committee Chair. The STB of vascular surgery interviews every Trainee annually at the skills course to seek confidential feedback on all aspects of their surgical training. The question set includes Trainee views on the training program, satisfaction with training to date, satisfaction with current hospital allocation, current supervisors, logbook numbers, and feedback on whether they believe they are lacking any experience at their current training level. The interviewers take notes throughout, but only make recommendations to the STB based on overall comments. Access to raw data is limited and only a summary report is provided to the STB. In terms of reporting, information about any areas that the STB has had to act on goes to BSET via the STB report or hospital accreditation report. Feedback sometimes gets introduced into training program processes, procedures or policy. For OHNS NZ, the Training Education and Accreditation Committee meets individually

with each Trainee at the annual NZ Registrars Conference. A Trainee's Supervisor of Training exits the meeting to allow that Trainee to provide feedback about the unit and supervision within that unit.

The value of the data collected from Trainees on different aspects of the training program will be fully realised once the data is integrated into the overarching M&E Framework.

Provider documentation attached:

Condition 21	To be met by: 2019	2019 Finding: Progressing

Develop formal consultation methods and regularly collect feedback on the surgical training program from non-surgical health professionals, healthcare administrators and consumer and community representatives. (Standard 6.2.3)

Provider response

Significant progress has been made by RACS against this condition. Regularly collected feedback from non-surgical health professionals, healthcare administrators and consumer and community representatives is central to understanding the quality of the training programs.

Monitoring and Evaluation Framework

A Stakeholder Engagement Matrix is being developed as part of the Monitoring and Evaluation (M&E) Framework. The matrix will identify the key stakeholders in Australia and New Zealand and their respective roles in the evaluation component of the M&E Framework. To facilitate stakeholder engagement in each evaluation, a Stakeholder Engagement and Communication Template is also being developed. The Stakeholder Engagement and Communication Template will require the Evaluation team to identify 1) the stakeholders to be included in the evaluation, 2) the role of each stakeholder in the evaluation and 3) appropriate communication tools for communicating with stakeholders. This approach seeks to ensure that evaluations actively engage with stakeholders and seek their feedback on the surgical training program in meaningful ways.

STB feedback collection

RACS is also developing formal consultation methods at the specialty level. The STB in general surgery Au seeks input from external stakeholders through its community representative on the Board and the RACS IHC. The STB in P&RS Au continues to seek input from its External Member who is an academic with an education interest and holds a government role in medical workforce matters. The STB in OHNS's Community Representative has equal voting rights and their opinion and feedback is highly valued. A senior healthcare administrator has agreed to provide comment and guidance to the STB in urology regarding educational processes and policies, and interactions with healthcare jurisdictions. The AOA FTC continues to include external and non-surgical representatives within its governance structures and to engage non-orthopaedic surgeons in numerous core training processes including selection and accreditation

of training sites. The AOA FTC is working towards establishing a formal consultation process to regularly collect feedback, with a list of stakeholder groups having been agreed and a question set in development.

Provider documentation attached:

Condition 22	To be met by: 2019	2019 Finding: Progressing

Report the results of monitoring and evaluation through governance and administrative structures, and to external stakeholders. It will be important to ensure that results are made available to all those who provided feedback. (Standard 6.3)

Provider response

Progress is being made against this condition as RACS recognises the value in reporting results from M&E activities through internal channels and to external stakeholders.

Reporting from the M&E Framework

The M&E Framework Monitoring Plan will outline the system for reporting monitoring data through RACS governance and administrative structures and to STBs and Trainees. The Stakeholder Engagement and Communication Template will require the Evaluation team to identify external stakeholders and outline the communication/tools to be used to disseminate findings to these stakeholders based on their roles in the evaluation.

Reporting through RACS governance structures

Formalised reporting processes have been introduced within the RACS governance structure. The STBs conduct a range of monitoring and evaluation activities. The outcomes of these STB evaluation activities are reported through to BSET, which allows for consultation across specialties. The data from these activities will feed into the overarching M&E Framework that then provides an in-depth understanding of the impact of the training programs.

Technology to drive reporting

The One College Transformation Project will underpin reporting on the results of the M&E Framework. As described in Condition 17, data will be integrated allowing for increased automation of data evaluation and will facilitate controlled data dissemination to key stakeholders.

RACS will continue to work on its two-pronged approach to reporting: first to define and formalise processes and identify all relevant stakeholders, and second to implement technological solutions to deliver streamlined and collegiate data dissemination.

Provider documentation attached:

6.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 6. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs are continuing to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 6? *If yes, please describe below.*	☒ Yes	☐ No change

Significant developments have been made against Standard 6.

Surgical specialties are strengthening their internal monitoring and evaluation, which will drive quality assurance and improvement at the specialty level and contribute to the successful implementation of the overarching M&E framework.

The STB in P&RS Au has developed an all-of-program evaluation tool for use at the end of 2020. The respondents will be supervisors of training and the results will be compared to six-monthly Trainee evaluations (aggregated and de-identified).

The STB in general surgery Au's training program was evaluated in 2015, and the new program is being introduced based on findings from that evaluation. An evaluation strategy for the GSET program is currently being developed. This evaluation will include input from Trainees and supervisors as well as external stakeholders to ensure the graduate outcomes are being met and to assess the individual components of the GSET program.

The STB in OHNS has recently launched an LMS to assist with timely submission, feedback, tracking and notification of assessments.

The STB in general surgery NZ, in conjunction with the STB in general surgery Au where relevant, evaluates the following data with a view to improving performance or changing process accordingly in an evidence-based manner:

1) selection (tool performance in terms of scoring discrimination, process, outcomes in terms of diversity of candidates including gender/rural/metropolitan)

2) training events using participant surveys

3) curriculum review

4) SEAM review (eLearning modules with summative assessment)

5) logbook statistics (review looking at procedure numbers provided to all supervisors annually) 6) longitudinal study of Trainee outcomes, including analyses of the Trainee outcomes for those leaving the program since 2010 and use of this to analyse the predicted outcomes for Trainees.		
Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

6.3 Documentation requested

Nil

6.4 Statistics and annual updates

Please provide data for the following tables. If required, please adjust the table to suit the College's training and education program(s).

A. Summary of evaluations undertaken (Standard 6.2 and 6.3)

Provide data in the table below showing evaluations undertaken *since the last progress report* and including main issues arising from evaluations, the College's response and reporting to stakeholders.

Evaluation activity	Issues arising	College response to issues
AOA Trainee Surveys (T1 & T2)	Any number of training issues including supervision, caseload, access to structured teaching, inappropriate behaviour, difficulties with assessment	Reporting through education and training governance structure: action through staff, training committees and accreditation
AOA Supervisor Survey (circulated in May 2020)	Analyses pending	Not required
Trainee Hospital Evaluation Form		Board of vascular surgery already interrogating issue arising through hospital accreditation Standard 1
ASPS Training post evaluations	Accreditation conditions for review	Not required
GSA SEAM: An evaluation of SEAM was undertaken in relation to number of attempts and where Trainee scored on selection quartile. No issues were found except that those who scored in a higher quartile had more failures in the SEAM modules as opposed to those who scored in a lower percentile.	N/A	Not required
GSA SEAM: educational evaluation	A comprehensive review of the SEAM modules was independently undertaken by an educationalist. Several issues were raised in terms of ensuring consistent objectives, including formative assessments, activities, matching assessment questions with content, and aligning reading recommendations with objectives. These issues have now been rectified.	Not required
GSA selection (refer to presentations in documents)	Additional evaluations of selection from 2016–2019 were undertaken to review areas such as regional bias, gender and inclusion of rural points.	Not required
P&RS NZ SET selection	No issues	Not required

Standard 7 Trainees

The AMC accreditation standards are as follows:

7.1 Admission policy and selection

7.1.1 The education provider has clear, documented selection policies and principles that can be implemented and sustained in practice.

The policies and principles support merit-based selection, can be consistently applied and prevent discrimination and bias.

7.1.2 The processes for selection into the specialist medical program:

- use the published criteria and weightings (if relevant) based on the education provider's selection principles
- are evaluated with respect to validity, reliability and feasibility
- are transparent, rigorous and fair
- are capable of standing up to external scrutiny
- include a process for formal review of decisions in relation to selection which is outlined to candidates prior to the selection process.

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

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

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

7.2 Trainee participation in education provider governance

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

7.3 Communication with trainees

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

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

7.3.3 The education provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

7.4 Trainee wellbeing

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

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

7.5 Resolution of training problems and disputes

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

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

Status and submission request

Status: **Substantially met**	Number of remaining conditions = **3**
	Number of remaining recommendations = **2**
Significant developments requested	**Yes**
Documents requested	**Yes**
Statistics and annual updates requested	**Yes**

7.1 Remaining conditions

Condition 24	To be met by: 2020	2019 Finding: Progressing
Further develop the selection policies for each surgical training program, particularly with regard to the provision of transparent scoring of each element in the curriculum vitae and the standardisation in the structure of referee reports. (Standard 7.1)		

Provider response

RACS has addressed this condition of further developing the selection policies to provide transparent scoring of each element in the curriculum vitae (CV) and the standardisation of the referee reports.

Anyone who wishes to apply to the SET program must register with RACS and meet all generic eligibility requirements outlined in the RACS Registration for Selection into SET policy. The selection process for all specialties conforms to the RACS Selection to Surgical Education and Training policy agreed upon by BSET. The aim of each STB is to select candidates who possess attributes related to the RACS competencies. Applicants who satisfy the eligibility and application requirements are assessed by structured CV scoring, referee reports and interviews. Neurosurgery also includes an examination as part of its selection process. The selection regulations for each STB outline the detail of the selection tools. These regulations are reviewed for consistency with the overarching RACS policies by EB.

CV components for scoring

The structured CV is scored using multiple components. The core components that specialties implement are surgical and medical experience, skills courses and attendance of conferences, qualifications, research publications and presentations. Many specialties also award points for leadership, teaching experience, community involvement, recognition of prizes, awards and achievements.

Additionally, the STBs in general surgery Au and NZ award points for rural experience/exposure, and the STB in OHNS considers rural origin. The STBs in orthopaedic surgery NZ, P&RS NZ and general surgery NZ award points for cultural and language fluency in Te Reo Māori and Te Ao Māori. AOA FTC now uses the CV only as a minimum threshold; applicants need to demonstrate a score of six in order to be eligible to progress to an interview.

Referee reports

Referee reports for all STBs include questions that map to the RACS competencies, and applicants are required to identify relevant consultants who may then be selected to act as a referee. Information will be obtained, in confidence, about the applicant's skills and attributes. Some specialties have introduced telephone interviews; for example, the STB in neurosurgery collects references using confidential telephone interviews. The overall score in the referee report stage will contribute to whether the applicant is successful in securing an invitation to interview. A structured interview proforma is used, and a single moderator participates in every interview conducted to ensure scoring is applied consistently across the interview panels.

Details of each selection tool are clearly and transparently provided in the publicly available selection regulations.

Provider documentation attached:

RACS Registration for Selection into SET policy

RACS Selection to Surgical Education and Training policy

Condition 27	To be met by: 2019	2019 Finding: Progressing

Promote and monitor the Diversity and Inclusion Plan through the College and specialty training boards to ensure there are no structural impediments to a diversity of applicants applying for and selected into all specialty training programs. (Standard 7.1)

Provider response

RACS has promoted and monitored the implementation of a number of initiatives under the D&I Plan to ensure there are no structural impediments to a diversity of applicants.

Cultural diversity

RACS recognises the importance of cultural diversity and is pleased to report a continued increase in the numbers of Trainees identifying as Māori, Aboriginal and Torres Strait Islander. In 2019, 17 Trainees identified as Māori and 7 Trainees as Aboriginal and Torres Strait Islander. This is continued success from the initiatives RACS has implemented as described in Condition 4.

Gender proportions for selection

As part of the D&I Plan actions, RACS is committed to understanding and addressing the circumstances that women face when considering a career in surgery. An analysis of selection data for 2018, 2019 and 2020 demonstrates that there was a higher proportion of male applicants for the SET program, with the proportion of female applicants averaging 30.5 per cent across all specialties in the two-year period. Within that same time period, the likelihood of a female applicant being accepted onto the SET program was 32.0 per cent, compared to 30.5 per cent for male applicants across all specialties, confirming that there is no bias in the selection tools. These results demonstrate that women are proportionally less likely to want to pursue a surgical career in the medical school and prevocational stages of their career.

A recent survey report*, Breaking barriers; developing drivers for female surgeons*, targeted female medical students and prevocational junior doctors about perceived barriers and drivers in various medical specialties. In comparison to other medical specialties, surgery was perceived as having the highest barriers for women. Some common barriers included lack of flexibility, and a perception of poor culture. RACS is aware that diversifying the surgical workforce is extremely important, and more work around improving culture and the perception of the surgical profession is needed.

Female leaders in surgery

To increase gender diversity, it is vital that there is an environment that is conducive to and encouraging of female surgical leaders. This then also provides female leaders as role models for the next intake of surgical aspirants. RACS is contributing to a research collaboration with Victoria University to 'drive a systems approach to increase the number of women in male-dominated leadership positions'. The aim is to bring cross-sector organisations together to decode the complexity of encouraging women as leaders in the workforce and to apply this understanding to design and evaluate an intervention to change practices in the workplace to encourage more women in male-dominated leadership positions. The progress to date has included identifying a cross-sector advisory group, conducting a desktop review to identify global industry system approaches that have shown evidence of good practice and success to increase women as leaders. Participants are currently being recruited to take part in a pilot within a chosen setting. This project will provide insights into supporting women to gain leadership positions.

Selection processes to support diversity

Several specialties have already implemented, or are planning to implement, selection initiatives in an attempt to diversify the surgical Trainee cohort. For the 2021 intake, the STB in OHNS has introduced an additional point for applicants who are of rural origin, and by 2025 the PhD score will be decreased to avoid inadvertent bias toward applicants based in rural areas. The STB in OHNS NZ made changes to the SET selection criteria to promote diversity. Those changes included adding cultural competence interview questions, updating CV scoring to favour research with Indigenous populations and allowing for diversity selection where candidates meet minimum criteria and have closely banded scores. The STB in urology is likely to award points for rural or regional rotations and points for attending a rural medical school in the future. The STB in orthopaedic surgery NZ accepts applications in Te Reo Māori and includes a specific station on cultural competence in its interview process. It is also possible for interviewers to select candidates based on diversity from those who are statistically similar. The STB in general surgery Au has included both the Aboriginal and Torres Strait Islander initiative and awards points for rural experience. Furthermore, it conducted an analysis of selection data from 2016 to 2019 and this demonstrated there was no gender bias in selection and no significant differences between men and women in terms of their selection outcomes (outcomes were proportionate to gender sample size). The data also indicates that the number of offers being made to women has been increasing steadily from 2016, and from 2016 to 2019 within their gender cohort the probability of being made an offer if female has also increased. The AOA FTC has reported on their range of initiatives on selection and diversity previously, including the requirement for inclusion of one woman and one non-surgeon on every interview panel and preference given to female and/or Indigenous applicants with scores around the cut-off band. The STB in P&RS Au has shown improvements in the proportion of women successfully attempting selection onto the training program, and in 2019 the successful selection applicants comprised 50 per cent female and 50 per cent male. The STB in vascular surgery considers gender parity in the selection process with an equal representation of men and women on the panel.

Given the importance of a diverse surgical workforce, RACS will continue to progress the D&I Plan actions to deliver the intended outcomes.

Provider documentation attached:

Breaking barriers; developing drivers for female surgeons

Condition 28	To be met by: 2019	2019 Finding: Progressing
Increase transparency in setting and reviewing fees for training, assessments and training courses, while also seeking to contain the costs of training for trainees and Specialist International Medical Graduates. (Standard 7.3.2 and 10.4.1)		

Provider response

In response to interrogating the fees set for Trainees, SIMGs, assessments and training courses, RACS has commissioned KPMG to review the Trainee fees and has introduced the new role of Project Accountant to conduct activity-based costing across the board.

KPMG audit of Trainee fees

KPMG has prepared some initial findings regarding Trainee fees. These findings have been reported to the Risk Management and Audit Committee. Recommendations on how to improve the processes for setting and collecting Trainee fees are summarised below:

- Verify the key components that comprise the RACS portion and the specialty society portion of the training fees to gain greater clarity over the appropriateness of fee setting.
- Review and revise the historical determination of fee setting.
- Tighten the control environment within the current process.

Activity-based costing

With the appointment of the Project Accountant, we are now able to conduct a review of the costs and fees of our courses, examinations, SIMG and training programs. RACS acknowledges it is timely for such a review to occur. This review will commence with activity-based costing of all these activities to understand the current associated expenditure. RACS decisions are not driven by finances and will therefore establish a fair and transparent pricing model.

The service agreements between RACS and the specialty societies formalise the expectation that all fees associated with running the training programs will be charged at the cost of delivering the activity. The associated costs will be shared between the two parties and with Trainees in a transparent manner.

The Clinical Examination

RACS also recognises its responsibility to ensure that those interested in pursuing a career in surgery are prevented where possible from paying excessive fees. The position of RACS is that it is much more responsible to implement a rigorous selection process to identify those surgical aspirants who are likely to complete surgical training and become a Fellow, with the aim of reducing the overall attrition rate. This will prevent payments on a training program that may not be suitable for that individual. We believe that transitioning the Clinical Examination to contribute to the selection process will increase this rigour and, despite increasing costs at this stage, will prevent inappropriate candidates progressing further than they should and expending unnecessary costs. The Clinical Examination has not been held since February 2020 and its format is under review given the restrictions imposed by COVID-19. Therefore, there has been a delay in transitioning the Clinical Examination into the selection space and as such we are yet to collect data on this move to analyse the pass rate or determine whether the level of resourcing is sufficient.

RACS believes that conducting activity-based costing for all educational activities will allow the charge to closer reflect the current realities of delivering the training programs and improve transparency.

Provider documentation attached:

7.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 7. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs are continuing to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 7? *If yes, please describe below.*	☒ Yes	☐ No change

There have been significant developments made by RACS against Standard 7.

Improving diversity

RACS continues to have strong relationships with the Australian Indigenous Doctors' Association (AIDA) and the Leaders in Indigenous Medical Education. In 2020, the College launched a pilot Indigenous Surgical Specialist Pathways program through the Department of Health funded Specialist Training Program. Working with surgeons in Darwin and Flinders University, the program provides surgical pre-SET training and mentorship opportunities for Aboriginal and Torres Strait Islander doctors interested in pursuing careers in surgery.

The AOA FTC has continued its progress with delivery of its Diversity Strategy. A recent review of the elapsed 23 months of the 3-year strategy demonstrates considerable progress with action/progress against 15 deliverables, with the remaining 13 complete and ongoing. A Cultural Inclusion Working Group has also been established with a number of key objectives in mind. The objectives include developing a cultural inclusion strategy with corresponding implementation plan and providing advice to the AOA FTC on cultural inclusion matters pertinent to orthopaedic surgery.

Creating supportive learning environments for Trainees

RACS is contributing to a collaboration with Deakin University and the CICM centred on feedback culture. These specialist medical training programs can be taught through several mechanisms, primarily through feedback using both formal platforms and as part of on-the-job training. Feedback, done well, is a proven driver of behaviour change in clinical environments, indicating the strength of its effect; however, studies suggest that feedback processes, that are

fundamental to training surgeons, can be deficient. Despite evidence providing a number of options on how to improve feedback processes, there is a dearth of knowledge on how culture influences feedback. The aim of this project is to identify features that promote learning-focused cultures of feedback, in multidisciplinary teams, through observation and interview. This project is at the participant recruitment phase.

Trainee wellbeing

RACS recognises the importance of Trainee wellbeing, and work is being conducted at the specialty level; for example, the AOA FTC developed a Trainee support program in consultation with Australian Orthopaedic Registrars Association (AORA) to address Trainee wellbeing, particularly for those Trainees requiring additional support. Significant progress has been made in this area with provision of support to Trainees and through awareness-raising, including via Fairy Floss Friday, which sheds light on mental illness within the healthcare community, supported by the AOA FTC. Carrie Kollias, a Victorian orthopaedic surgeon, is in the process of attaining ethics approval for a research project on Trainee wellbeing, which will hopefully be advantageous for Trainees and further assist in developing support mechanisms and awareness-raising. Topics around wellbeing have purposefully been incorporated into Bone Camp with Trainees encouraged to establish a mentor relationship. Furthermore, the STB in general surgery Au ran a wellness seminar in 2019 for Trainees and SIMG. The seminar was very well received and will be repeated when the ability to run face-to-face events resumes. In particular, during the COVID-19 pandemic, fortnightly communication was sent to Trainees to keep them informed on the issues the Australian Board in general surgery was considering and the decisions made. A communication process was established whereby Trainees could submit a question which would then be answered in the next scheduled communique.

Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

7.3 Documentation requested (not related to responses to conditions/recommendations)

Please provide the **latest version** of the following documents either as an attachment or as a link to the College website as appropriate. If the College has made changes to the following document(s) since the last accreditation/progress report, please include a description of the change under significant developments.

Document	Attached	Link to document (if available)
Policy on selection into training	☒ Yes	Selection to Surgical Education and Training Policy (Standard 7 Appendix)

7.4 Statistics and annual updates

A. Trainee and selection data (Standard 7.1.1 and 7.13)

Provide data on the number of Trainees, including Aboriginal and Torres Strait Islander and Māori Trainees who entered and completed the training program since the last accreditation assessment in **2017, 2018, 2019 and 2020** to date.

Table 23. Number of Trainees entering training program, 2018–2020 to date

Training program	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
2017	1	32	69	0	25	0	40	19	47	233
2018	0	33	83	0	19	0	53	19	33	240
2019	0	38	72	0	15	0	62	22	38	247
2020 (May 31)	0	35	89	0	13	0	67	18	49	271
Aboriginal and Torres Strait Islander and Māori Trainees	**ACT**	**QLD**	**NSW**	**NT**	**SA**	**TAS**	**VIC**	**WA**	**NZ**	**Total**
2017	0	0	1	0	0	0	0	0	2	3
2018	0	1	1	0	0	0	0	0	1	3
2019	0	0	2	0	0	0	0	0	7	9
2020 (May 31)	0	0	1	0	0	0	1	0	4	6

Table 24. Number of Trainees completing training program, 2017–2020 to date

Training program	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
2017	2	29	55	0	15	0	49	12	26	188
2018	4	26	73	0	12	0	45	10	29	199
2019	1	40	67	0	12	0	79	24	26	249
2020 (May 31)	1	14	26	0	3	1	13	4	4	66
Aboriginal and Torres Strait Islander and Māori Trainees	**ACT**	**QLD**	**NSW**	**NT**	**SA**	**TAS**	**VIC**	**WA**	**NZ**	**Total**
2017	0	0	0	0	0	0	0	0	0	0
2018	0	0	0	0	0	0	0	0	1	1
2019	0	0	0	0	0	0	0	0	1	1
2020 (May 31)	0	0	0	0	0	0	0	0	0	0

Table 25. Number of Aboriginal and Torres Strait Islander and Māori applicants, 2017–2020 to date

Training program	Applied		Interviewed		Entered	
	Au	NZ	Au	NZ	Au	NZ
2017	3	11	3	9	2	1
2018	2	13	2	12	2	7
2019	3	7	2	6	2	4
2020 (May 31)	1	2	0	0	0	0

Table 26. Gender of Trainees undertaking each training program, 2017–2020 to date

Training program	Male	Female	Unspecified	Total
2017	877	372	0	1249
2018	897	393	0	1290
2019	908	432	0	1340
2020 (May 31)	968	448	0	1416

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

The AMC accreditation standards are as follows:

8.1 Supervisory and educational roles

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

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

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

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

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

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

8.2 Training sites and posts

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

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

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

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

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

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

Status and submission request

Status: **Substantially met**	Number of remaining conditions = **3**
	Number of remaining recommendations = **4**
Significant developments requested	**Yes**
Documents requested	No
Statistics and annual updates requested	**Yes**

8.1 Remaining conditions

Please provide a summary update of the College's responses to the remaining conditions (listed below) from the last AMC Accreditation Report. Please detail progress made, plans for further work, and the evidence to support progress.

Condition 30	To be met by: 2020	2019 Finding: Progressing
Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standard 8.1)		
Provider response RACS has made significant progress in developing and implementing cultural safety training. RACS is currently working on developing the professional skills curriculum to support the implementation of the 10th competency across all surgical specialties. The 10th competency specifies that a surgeon must behave in a culturally safe way, along with having an Indigenous health focus. As part of the overall implementation of this new curriculum, RACS is cognisant of the fundamental importance of all supervisors, clinical trainers and assessors being trained in this competency prior to supervising and assessing Trainees. To achieve this, in 2020 RACS launched courses 1 and 2 of the Aboriginal and Torres Strait Islander Health and Cultural Safety eLearning program. The program is envisioned to include progressive learning across four stages each with approximately ten hours of content to engage surgeons, Trainees and SIMGs. In New Zealand, the College has partnered with the Māori/Indigenous Health Institute (MIHI) at the University of Otago, Christchurch, to develop a hybrid online learning and practical workshop for surgeons to learn and apply Hauora Mori competencies with a focus on the Hui Process and Meihana Model. These new eLearning courses are currently promoted as part of the RACS Continuing Professional Development (CPD) program. Courses relating to cultural competence continue to be developed. Once courses are completed, RACS will work on a strategy to ensure that all supervisors, trainers and assessors are trained appropriately to allow them to fulfil the requirements of their positions.		
Provider documentation attached:		

Condition 31	To be met by: 2021	2019 Finding: Progressing
In conjunction with the specialty training boards, finalise the supervision standards and the process for reviewing supervisor performance and implement across all specialty training programs. (Standard 8.1)		

Provider response

RACS has made substantial progress against this condition and is expecting to have finalised the supervision standards by the deadline of 2021.

The Supervisor Framework has been drafted and is currently undergoing a period of consultation with supervisors and STBs. RACS has held focus groups with supervisors from Australia and New Zealand and sought feedback from STBs and a project group internal to RACS. The feedback received was reviewed and actioned, and a final draft presented at the October BSET meeting for endorsement. Feedback was taken on board, the framework was finalised, and was published on the website in early 2021. Work will now commence to work with the STBs to implement the Framework.

Work is also progressing at the specialty level; for example, new accreditation standards for the AOA FTC are interlinked with both the Director of Training (DoT) and the Trainee Supervisor position descriptions. Feedback on DoT and Trainee Supervisor performance is sought and received from Trainees via the Trainee Survey, and key performance indicators are also monitored via training data on TIMS. The FTC has also adopted a DoT and Trainee Supervisor Recognition Program where the profile of these important roles can be raised.

Provider documentation attached:

Condition 33	To be met by: 2019	2019 Finding: Progressing

In the hospital and training post accreditation standards for all surgical training programs, include a requirement that sites demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence. (Standard 8.2.2)

Provider response

This condition is being addressed as part of the review into the RACS hospital accreditation criteria, which will be delivered as part of the hospital training post accreditation project. The activities within this project are to review RACS' current accreditation standards and the accreditation process, and to ensure the standards adhere to the AMC's Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs 2015, as well as the MCNZ's Accreditation Standards for New Zealand Training Providers of Vocational Medical Training and Recertification Programmes 2019.

A working party has been formed with representation from all surgical specialties and across both Australia and New Zealand to encourage the adoption of a consistent approach.

The main changes to the accreditation process will be:

- structured accreditation outcomes
- sharing information across specialties
- sharing information with hospitals regarding complaints.

Accreditation will be shared between RACS and the STBs. RACS will be responsible for generic shared accreditation standards, and the STBs will accredit posts based on specialty-specific information. RACS intends to pilot the revised accreditation standards and processes in 2021 with select hospitals.

The importance of hospital sites demonstrating a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence is evidenced by the dedicated cultural competency accreditation standard. The first draft of this cultural competency accreditation standard was developed with RACS staff involved in Indigenous health projects learning and development. The development of this accreditation standard was guided by questions about what commitment might look like in a hospital setting, how it could be evidenced, who the standard should apply to, and what hospitals currently offer as a 'commitment to cultural competency and safety'. The accreditation standard was presented to RACS IHC (responsible for developing RACS policies and position papers on Indigenous health) for review and feedback. Feedback received was incorporated into the second draft of the accreditation standards.

The STBs are cognisant of the importance of embedding this commitment to cultural competence at every level of hospital post accreditation; for example, the AOA FTC includes cultural competence in its Hospital Accreditation Standards. Hospitals must demonstrate a commitment to cultural competence, including Aboriginal and Torres Strait Islander, Māori and all other cultures.

RACS expects to have this piece of work finalised in 2021.

Provider documentation attached:

8.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 8. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs are continuing to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 8? *If yes, please describe below.*	☒ Yes	☐ No change

Significant developments have been made against Standard 8.

Supervisor training

RACS has developed two new courses, entitled Difficult Conversations with Underperforming Trainees and Promoting Advanced Surgical Education (PrASE), as a result of feedback from supervisors and trainers. The Difficult Conversations with Underperforming Trainees course provides supervisors with a comprehensive framework to follow when preparing for and conducting a difficult conversation and the steps to take following the conversation. This course gives supervisors the opportunity to practise using the framework through a roleplay activity and receive feedback from experienced faculty and other participants on their performance. The PrASE course builds on the basic standard of surgical education covered in the Foundation Skills for Surgical Educators (FSSE) course. It further explores the areas of learner-centred surgical education, trust and feedback, and assessment and supervision. The course also discusses Trainees at risk and leadership in surgical education. The aim is to further develop each supervisor's knowledge and skills in surgical education through a variety of interactive activities including group discussions and microteaching practice. The Supervisors and Trainers for SET (SATSET) course was reviewed and a new course developed Induction for Surgical Supervisors and Trainers (ISST). This course was piloted successfully in November 2020 with a second pilot to be undertaken in March 2021. Following the second pilot the combined evaluations will be used to make necessary changes before rolling the course out more widely. Keeping Trainees on Track (KTOT) is also under review with online delivery planned for 2021.

The uptake of the FSSE course has been significant; 98 per cent of the mandatory group in Australia and New Zealand, which includes SET supervisors, SIMG supervisors and trainers, have completed the course. Data from the AOA FTC demonstrates that 98 per cent (increased from 92 per cent at last report) of surgical supervisors have completed the FSSE/AOA 21 workshops or are exempt. The remaining 2 per cent are in the process of meeting this requirement. This means that 100 per cent of AOA surgical supervisors have either met or are currently working towards meeting the FSSE requirement. In total, 88 per cent (increased from 72 per cent at last report) of trainers have completed the FSSE/AOA 21 workshops or are exempt, with 7 per cent in in the process of achieving this. This means that 95 per cent of AOA trainers have either met or are working towards meeting the FSSE requirement. Lack of compliance is being actively followed up through the accreditation of Hospitals and Training Posts for Surgical Education and Training.

Hospital post accreditation

General progress is being made at the specialty level on the hospital post accreditation processes; for example, the new AOA 21 Accreditation Standards were successfully rolled out in 2019 with 40 accreditation reviews conducted against the new standards. Feedback suggested that the new format is easy to follow, and expectations are mostly clear. Minor changes were made in response to feedback to provide further clarification. In addition, an expression of interest step has been incorporated into the process for sites wishing to apply for new or additional posts. This step allows for preliminary feedback and guidance to be provided prior to a full application being completed. Furthermore, the STB in general surgery Au's selection of supervisors is undertaken at the hospital level. At the inspections, a standard that is examined is whether all trainers, including the supervisors, have undertaken the mandatory courses.

In 2019, members of the STB of vascular surgery visited each state and territory where there are accredited training posts in vascular surgery. The purpose of these visits is to focus on supporting supervisors and trainers and make sure they are aware of the recently published RACS Supervisor Standards.

Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

8.3 Documentation requested

Nil

8.4 Statistics and annual updates

A. Supervisor data (Standard 8.1.1)

Provide data on supervisor numbers by state/country since the last accreditation assessment for 2017, 2018, 2019 and 2020.

Table 27: Supervisor numbers 2017–2020

Training program	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	USA	Total
2017	10	181	5	88	35	12	134	46	89	1	601
2018	9	182	7	92	37	14	135	42	90	1	609
2019	8	176	5	95	40	13	129	43	92	1	602
2020	8	164	4	83	36	11	119	41	79	1	546

B. Accreditation of training sites (Standard 8.2)

Provide a summary of site accreditation activities since the last accreditation assessment for 2017, 2018, 2019 and 2020. Data tables for the number of sites/posts should be for the current year only.

Table 28. Site accreditation activities since accreditation review, 2017

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	US	Total
Number of sites (posts)	9 (32)	45 (218)	110 (455)	3 (15)	22 (100)	5 (24)	69 (351)	21 (105)	29 (263)	1 (2)	314 (1565)
Number of sites (posts) visited	1 (1)	21 (41)	26 (33)	3 (8)	18 (38)	7 (13)	53 (90)	10 (21)	44 (131)	1 (2)	184 (378
New training sites											
Number accredited	0	0	1	0	0	0	0	0	0	0	1
Number not accredited	0	1	0	0	0	0	0	0	0	0	1
Reaccredited training sites											
Number accredited	1	2	25	2	16	1	54	12	46	0	159
Number not accredited	2	1	1	0	2	0	0	0	0	0	6
Number at risk of losing accreditation	1	0	0	0	0	0	2	1	1	0	5

Table 29. Site accreditation activities since accreditation review, 2018

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	US	Total
Number of sites (posts)	9 (34)	43 (198)	115 (434)	3 (13)	20 (72)	5 (23)	66 (288)	21 (97)	27 (245)	1 (2)	310 (1406)
Number of sites (posts) visited	3 (8)	20 (39)	78 (208)	2 (2)	15 (31)	1 (4)	22 (40)	7 (10)	10 (17)	1 (2)	159 (361)
New training sites											
Number accredited	2	3	43	0	5	1	6	0	0	0	60
Number not accredited	0	0	1	0	0	0	0	0	0	0	1
Reaccredited training sites											
Number accredited	2	22	44	2	9	0	21	7	12	1	120
Number not accredited	0	0	2	1	0	0	0	0	0	0	3
Number at risk of losing accreditation	0	1	2	0	2	0	0	0	0	0	5

Table 30. Site accreditation activities since accreditation review, 2019

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	US	Total
Number of sites/posts	4 (33)	38 (212)	104 (375)	3 (10)	16 (76)	5 (20)	61 (280)	19 (102)	24 (186)	1 (2)	275 (1296)
Number of sites/posts visited	0	43 (112)	71 (136)	1 (1)	3 (11)	1 (1)	24 (36)	5 (14)	16 (42)	1 (2)	165 (355)
New training sites											
Number accredited	0	3	0	0	0	1	0	0	5	0	9
Number not accredited	0	0	0	0	0	0	0	0	0	0	0
Reaccredited training sites											
Number accredited	1	43	85	1	9	1	28	6	18	1	193
Number not accredited	0	1	1	0	0	0	0	0	0	0	2
Number at risk of losing accreditation	0	4	1	0	1	0	2	1	0	1	10

Table 31. Site accreditation activities since accreditation review, 2020 (May 31)

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	US	Total
Number of sites/posts	8 (34)	76 (285)	158 (475)	5 (10)	33 (83)	10 (20)	114 (309)	40 (104)	77 (255)	1 (2)	522 (1577)
Number of sites/posts visited	0	3 (10)	1 (3)	0	1 (5)	2 (4)	0	0	0	1 (2)	8 (24)
New training sites											
Number accredited	0	0	0	0	0	0	0	0	0	0	0
Number not accredited	0	0	0	0	0	0	0	0	0	0	0
Reaccredited training sites											
Number accredited	0	3	2	0	4	2	18	1	0	1	31
Number not accredited	0	0	0	0	0	0	0	0	0	0	0
Number at risk of losing accreditation	0	1	0	0	1	0	1	0	0	0	3

Standard 9 Continuing professional development, further training and remediation

The AMC accreditation standards are as follows:

9.1 Continuing professional development

9.1.1 The education provider publishes its requirements for the continuing professional development (CPD) of specialists practising in its specialty(s).

9.1.2 The education provider determines its requirements in consultation with stakeholders and designs its requirements to meet Medical Board of Australia and Medical Council of New Zealand requirements.

9.1.3 The education provider's CPD requirements define the required participation in activities that maintain, develop, update and enhance the knowledge, skills and performance required for safe and appropriate contemporary practice in the relevant specialty(s), including for cultural competence, professionalism and ethics.

9.1.4 The education provider requires participants to select CPD activities relevant to their learning needs, based on their current and intended scope of practice within the specialty(s). The education provider requires specialists to complete a cycle of planning and self-evaluation of learning goals and achievements.

9.1.5 The education provider provides a CPD program(s) and a range of educational activities that are available to all specialists in the specialty(s).

9.1.6 The education provider's criteria for assessing and crediting educational and scholarly activities for the purposes of its CPD program(s) are based on educational quality. The criteria for assessing and crediting practice-reflective elements are based on the governance, implementation and evaluation of these activities.

9.1.7 The education provider provides a system for participants to document their CPD activity. It gives guidance to participants on the records to be retained and the retention period.

9.1.8 The education provider monitors participation in its CPD program(s) and regularly audits CPD program participant records. It counsels participants who fail to meet CPD cycle requirements and takes appropriate action.

9.2 Further training of individual specialists

9.2.1 The education provider has processes to respond to requests for further training of individual specialists in its specialty(s).

9.3 Remediation

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

Medical Council of New Zealand Requirements

In the *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs 2015*, please refer to the notes that accompany Standard 9 for further information on the requirements in Australia for CPD programs and in New Zealand for recertification.

Status and submission request

Status: **met**	Number of remaining conditions = **nil**
	Number of remaining recommendations = **2**
Significant developments requested	**Yes**
Documents requested	No
Statistics and annual updates requested	**Yes**

9.1 Remaining conditions

Nil remain.

9.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 9. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs are continuing to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 9? *If yes, please describe below.*	☒ Yes	☐ No change

RACS has made significant progress against Standard 9.

The revised RACS CPD program will be launched in July 2021 with a number of key changes. These changes are:

- The Surgical Competence and Performance Framework has been revised and includes the addition of a 10th competency: Cultural Competence and Cultural Safety. Changes to this framework will filter through to the CPD program during the development of scope-of-practice requirements.
- The compliance period will change from January–December to July–June to provide greater alignment with Australian registration requirements (where CPD compliance is required).
- Verification of submitted CPD has been increased to 10 per cent of participants, and the selection process is being adjusted to ensure more participants who have never previously been verified are selected.
- Revisions to categories and minimum standards have been approved (see table below).

Summary of other significant developments

Category	Standard	Requirement
Learning Plan		One (1) per annum
Audit	Audit of self/own practice	One (1) per annum
Performance Review	Performance related to self Performance related to others	At least one (1) per annum At least one (1) per annum
Education activities	A minimum of 40 hours over two of more activities per annum	40 hours per annum Fellows will be strongly encouraged to undertake 'highly recommended' activities based on Area of Practice

- Updates to scope of practice, recommended activities, verification requirements and exemptions are under discussion and should be finalised by the end of 2020.

The revised CPD program will also require participants to complete a learning plan, which will be tailored to their scope of practice. The verification process has been strengthened to ensure participants are undertaking relevant clinical and non-clinical CPD.

The AOA has made changes to the CPD program requirements for 2020 in response to the changed conditions resulting from COVID-19. A move to financial year reporting is currently being investigated to align with the RACS program.

Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

9.3 Documentation requested

Nil

9.4 Statistics and annual updates

A. Participation in CPD program (Standard 9.1)

Provide data on the number and proportion of Fellows/non-Fellows participating in, and meeting the requirements of, the College's CPD programs for each year since the last accreditation assessment, showing Australian and New Zealand information separately.

Table 32. Fellows participating in and meeting the requirements of the College's CPD programs, 2017

Number of Fellows			Fellows participating in CPD					
			Australia		New Zealand		Other	
Australia	New Zealand	Other	Total	%	Total	%	Total	%
4222	563	315	4216	99	563	100	163	52

Table 33. Non-Fellows participating in CPD, 2017

Australia		New Zealand		Other	
Total	%	Total	%	Total	%
18	15	97	83	2	2

Note: These figures reflect participation by surgeons who do not hold FRACS and are not on a pathway to Fellowship. In 2017 there were 117 surgeons enrolled into the Maintenance of Professional Standards (MOPS) program.

Table 34. Fellows participating in and meeting the requirements of the College's CPD programs, 2018

Number of Fellows			Fellows participating in CPD					
			Australia		New Zealand		Other	
Australia	New Zealand	Other	Total	%	Total	%	Total	%
4278	559	315	4278	100	559	100	302	100

Note: All active Fellows have a requirement to participate in either the College CPD program or an alternative approved CPD program. In 2018 there were 6440 Fellows participating in the College CPD or other CPD approved program. Approved alternative programs in 2018 were: Australian Orthopaedic Association (AOA); New Zealand Orthopaedic Association (NZOA); Royal Australian and New Zealand College of Ophthalmologists.

Table 35. Surgeons (Non-FRACS) participating in CPD, 2018

Australia		New Zealand		Other	
Total	%	Total	%	Total	%
29	23	94	80	3	2

Note: These figures reflect participation by surgeons who do not hold FRACS and are not on a pathway to Fellowship. In 2018 there were 126 surgeons enrolled into the Maintenance of Professional Standards (MOPS) program.

Table 36. Fellows participating in and meeting the requirements of the College's CPD programs, 2019

Number of Fellows			Fellows participating in CPD					
			Australia		New Zealand		Other	
Australia	New Zealand	Other	Total	%	Total	%	Total	%
4451	573	322	4353	98	567	99	134	42

Note: All active Fellows have a requirement to participate in either the College CPD program or an alternative approved CPD program. In 2019 there were 6686 Fellows participating in the College CPD or other CPD approved program. Approved alternative programs in 2019 were: Australian Orthopaedic Association (AOA); New Zealand Orthopaedic Association (NZOA); Royal Australian and New Zealand College of Ophthalmologists.
Due to the impact of the COVID-19 pandemic, the finalisation of CPD activities has been extended and is ongoing.

Table 37. Surgeons (Non-FRACS) participating in CPD, 2019.

Australia		New Zealand		Other	
Total	%	Total	%	Total	%
6	5	112	94	1	1

Note: These figures reflect participation by surgeons who do not hold FRACS and are not on a pathway to Fellowship. In 2019 there were 119 surgeons enrolled into the Maintenance of Professional Standards (MOPS) program.

Standard 10 Assessment of Specialist International Medical Graduates

The AMC accreditation standards are as follows:

10.1 Assessment framework

10.1.1 The education provider's process for assessment of Specialist International Medical Graduates is designed to satisfy the guidelines of the Medical Board of Australia and the Medical Council of New Zealand.

10.1.2 The education provider bases its assessment of the comparability of Specialist International Medical Graduates to an Australian- or New Zealand- trained specialist in the same field of practice on the specialist medical program outcomes.

10.1.3 The education provider documents and publishes the requirements and procedures for all phases of the assessment process, such as paper-based assessment, interview, supervision, examination and appeals.

10.2 Assessment methods

10.2.1 The methods of assessment of Specialist International Medical Graduates are fit for purpose.

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

10.3 Assessment decision

10.3.1 The education provider makes an assessment decision in line with the requirements of the assessment pathway.

10.3.2 The education provider grants exemption or credit to Specialist International Medical Graduates towards completion of requirements based on the specialist medical program outcomes.

10.3.3 The education provider clearly documents any additional requirements such as peer review, supervised practice, assessment or formal examination and timelines for completing them.

10.3.4 The education provider communicates the assessment outcomes to the applicant and the registration authority in a timely manner.

10.4 Communication with Specialist International Medical Graduate applicants

10.4.1 The education provider provides clear and easily accessible information about the assessment requirements and fees, and any proposed changes to them.

10.4.2 The education provider provides timely and correct information to Specialist International Medical Graduates about their progress through the assessment process.

Information on New Zealand specific requirements can be found here:
http://www.mcnz.org.nz/news-and-publications/guides-and-booklets

Information on Medical Board of Australia, *Good practice guidelines for the Specialist International Medical Graduate assessment process,* November 2015, can be found here:

http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Specialist-Pathway.aspx

Status and submission request

Status: **Substantially met**	Number of remaining conditions = **1**
	Number of remaining recommendations = **nil**
Significant developments requested	**Yes**
Documents requested	No
Statistics and annual updates requested	**Yes**

10.1 Remaining conditions

Condition 35	To be met by: 2020	2019 Finding: Progressing
Develop and adopt alternative external assessment processes such as workplace-based assessments to replace the Fellowship Examination for selected Specialist International Medical Graduates. (Standard 10.2.1)		

Provider response

Further development of the SIMG WBA pilot has been made by the RACS SIMG Committee in 2019 and 2020 to meet this condition. Recommendation for external validation of professional performance (EVOPP) is to be included as a requirement for all newly assessed SIMGs with a partially comparable assessment outcome, as approved by the SIMG Committee and endorsed by BSET in October 2019. This will be used as a valuable feedback tool during the WBA piloting process. There have been four pilots undertaken to date: two in 2018, one in 2019 and one in 2020. This is lower than what was scheduled due to the COVID-19 related restrictions preventing visits to hospitals at which the pilots were to be conducted. These pilots will be re-commenced once restrictions are lifted to the required level.

Overall, the process has been successful with assessors feeling confident in rating SIMGs against the RACS competencies. Recommendations were made to 1) revise some questions included in the assessor training program, 2) include de-identified assessor and observer reports from the four pilots as examples for the future and 3) ensure the timetable is finalised a minimum of two weeks prior to a visit to allow for adequate preparation time.

The Education portfolio has added a new 1.0 FTE team member on an ongoing basis with the primary responsibility of developing and coordinating the EVOPP WBA process.

Provider documentation attached:

10.2 Summary of other significant developments

Please indicate whether the College has made, or is planning to make, any other changes relevant to Standard 10. This information will provide the AMC with information on the continuing evolution of the College's programs and assists the AMC in determining if these programs are continuing to meet the approved accreditation standards.

There is no need to outline changes that have been reported in the College's progress reports since the last accreditation assessment, as the team will have access to these.

Summary of other significant developments		
Has there been any significant development made against Standard 10? *If yes, please describe below.*	☒ Yes	☐ No change
At the end of July 2020, the term International Medical Graduate (IMG) was changed to Specialist International Medical Graduate (SIMG) to align with terminology used by the AMC. Furthermore, RACS has proposed that the assessment processes for the Vocational Registration and the Fellowship of RACS for SIMGs in New Zealand become once again harmonised by holding them concurrently. This will be advantageous for SIMGs in New Zealand when making a decision on whether to also pursue a RACS Fellowship and gain the associated benefits in doing so. In response to the COVID-19 outbreak, the AOA rapidly escalated development of their LMS to facilitate storage of recordings of digitally delivered bone school sessions and other leading resources for easy access by Trainees. Work is underway to make this resource available to SIMGs via a non-member access system.		
Have there been significant changes affecting the delivery of the program? *If yes, please describe the changes below and any potential impact to meeting the standards.*	☐ Yes	☒ No change

10.3 Documentation requested

Nil

10.4 Statistics and annual updates

A. Assessment of Specialist International Medical Graduates (Standard 10.1 and 10.3)

Provide data on the number of applications considered from Specialist International Medical Graduates and the outcomes of their applications since the last accreditation assessment showing Australia and New Zealand separately.

Table 38. Assessment of Specialist International Medical Graduates, 2016–2019

	2016		2017		2018		2019	
	Au	**NZ**	**Au**	**NZ**	**Au**	**NZ**	**Au**	**NZ**
Total applicants	**66**	**33**	**65**	**46**	**77**	**36**	**78**	**33**
Specialist/vocational registration	63	33	56	46	70	36	70	33
Area of need	3	0	9	0	7	0	8	0
Initial assessment/ Preliminary assessment NZ	66	14	63	28	77	20	35 (28 in progress)	13
Second stage assessment/ Interview assessment NZ	52	16	49	23	58	35	28 (28 in progress)	24
Assessment outcome:								
Not comparable/neither comparable nor as satisfactory to NZ	32	1	30	6	30	7	14	5
Partially comparable/ as satisfactory to NZ	22	3	24	5	32	17	18	12
Substantially comparable/ equivalent to NZ	13	12	11	12	15	11	3	7
In progress	0	7	0	11	0	3	43	5
Completed requirements and admitted to Fellowship	53	0	26	2	31	2	23	1

Section B: Report on remaining quality improvement recommendations

The College's accreditation report contains quality improvement recommendations for the education provider to consider. These are not conditions on accreditation.

Please provide a brief summary update of the College's response to these recommendations remaining since the last accreditation assessment and/or progress report. The AMC is interested in how the College has considered these recommendations and any action that has occurred as a result.

If the College will not be considering the recommendation, please also briefly comment on the reasons for this.

Quality improvement recommendation	**Has the College undertaken any activities against this recommendation?** *If yes, please describe activities in the box below*	**If no activities have occurred, will the College consider this recommendation in future?** *If yes, please indicate below when the College is likely to consider the recommendation* *If no, please comment below on why the College has decided not to adopt the recommendation*
Standard 1: The context of training and education		
AA Broaden the definition of conflict of interest to include reflection on an individual's demography, committee roles, public positions or research interests that may bias decision-making in areas such as selection or Specialist International Medical Graduate assessment. (Standard 1.1.6)	☒ Yes ☐ No RACS is currently in the process of addressing this recommendation. The definition of conflict of interest is defined in the RACS Conflict of Interest Policy. RACS established a working group in 2020 to undertake a review of the current policy and to ensure that the breadth of potential conflicts is captured in the revised policy. STBs fulfil this recommendation at the board level, as it is required that any conflict of interest be declared formally at each board meeting. Members who declare a conflict of interest leave the meeting during that part of the discussion, and this is formally recorded in the minutes. This requirement also extends to selection interviews for panel members.	☐ Yes ☐ No

Standard 2: The outcomes of specialist training and education			
BB	Benchmark the graduate outcomes of each of the surgical training programs internationally. (Standard 2.2 and 2.3)	☒ Yes ☐ No This recommendation is currently being addressed through the review and revision of curricula. RACS recognises that an important phase of a curriculum review is to benchmark against relevant training programs to leverage those components that are performing highly and to identify areas requiring revision. A number of STBs have already incorporated international benchmarking of training programs in their curriculum review to produce contemporary, community-focused graduate outcomes. Other STBs are currently undergoing a curriculum review that will address this recommendation by the end of 2021.	☐ Yes ☐ No
CC	Improve the uniformity of presentation of training program requirements and graduate outcomes for each of the surgical specialties (particularly on the website), taking into account feedback from Trainees, supervisors and key stakeholder groups. (Standard 2.2 and 2.3)	☒ Yes ☐ No RACS is addressing this recommendation in a number of ways. The RACS competencies have been revised and are on the RACS website and referred to on specialty websites. Work is being undertaken by each of the STBs to align all specialty curricula with these updated 10 competencies through the staggered curricula reviews. In addition, alignment is being identified across the curricula through a mapping exercise which is part of the professional skills curriculum development, to gain uniformity where applicable. Once all curricula have been finalised, a formalised approach to presentation will be undertaken to ensure transparency of graduate outcomes. Service agreement negotiations are ongoing between RACS and the specialty societies. To date, one agreement has been	☐ Yes ☐ No

		executed, with a further six expected to be finalised in 2020. The agreements clearly outline the roles and responsibilities of both parties and refer to providing transparency of documentation and information on the training programs where applicable, therefore facilitating uniformity of presentation.	
Standard 3: The specialist medical training and education framework			
EE	Develop explicit criteria to consider whether training periods of less than the standard six months can be approved, and ensure that prior learning, time and competencies acquired in non-accredited training are fairly evaluated as to whether they may count towards training. (Standard 3.1)	☒ Yes ☐ No RACS has undertaken work to ensure that flexible training is accessible for Trainees. The RACS policy on flexible training endorses training rotations with a minimum of 50 per cent full-time training as suitable for assessment of competence. Several STBs, including general surgery Au and NZ, neurosurgery, P&RS Au and OHNS will allow flexible training in increments of less than six months; for example, the STB in P&RS Au will allow a Trainee to complete a six-month training period either full-time over three months, or 0.5 FTE over six months. The STB in general surgery Au allows split rotations so Trainees are able to combine time spent over two rotations to enable this to be accredited towards their time in training. The AOA FTC recognises training in blocks of three months. STBs include information regarding flexible training in their training regulations, which set out a list of criteria a Trainee must comply with; for example, most STBs require applicants to have a satisfactory professional performance assessment immediately prior to application for flexible training, and Trainees cannot be on probation during the term. Clearly, there are challenges with creating part-time posts as permanent solutions due to the variability in experience and location of Trainees who may request a part-time allocation. There are also reservations in defining what constitutes as	☐ Yes ☐ No

		particular circumstances too narrowly or rigidly, as this may reduce eligibility and therefore access to flexible training. RACS provides details on what qualifies for RPL. RACS publishes on its website a list of skills courses that are equivalent to the ASSET, CCrISP®, EMST and CLEAR courses for which RPL will be automatically granted when supported by a certificate of completion. The STBs publish regulations governing RPL for clinical experience, research and any other training skills courses and examinations that it administers and that form part of the SET program; for example, the STB in urology has established provisions for RPL that determine the Trainees' level of training at entry.	
Standard 4: Teaching and learning approach and methods			
GG	Consider options to mitigate the lack of training in some parts of Australia and New Zealand, such as in outpatient settings, endoscopy and aesthetic surgery. (Standard 4.2.1)	☒ Yes ☐ No RACS continues to ensure Trainees are exposed to all relevant core skills and conditions of training, including outpatient settings, endoscopy and aesthetic surgery. Trainee progress and their exposure to a range of experiences in which to develop key skills is monitored, and some specialties, such as the STB in paediatric surgery, conduct yearly interviews to identify any areas of interest or training needs that require addressing. The STB in general surgery Au has introduced a new regulation for hospital inspections in that any new post must include an outpatient clinic. Any new post that does not have this established will not be accredited. The STB in general surgery NZ reports that there are no issues with access to outpatient settings within New Zealand hospitals for general surgery Trainees. There continues to be limited access to endoscopy in hospitals, especially where there is a resident gastroenterology consultant. The STB is working hard to build bridges with the gastroenterology community to leverage equitable access for	☐ Yes ☐ No

		Trainees to endoscopy training throughout New Zealand. Trainee access to this training is a matter of great importance, as the delivery of endoscopy and colonoscopy services in provincial and rural settings is nearly always general-surgeon led. The STB in urology has implemented processes to ensure core surgical procedures will be able to be delivered in all jurisdictions, and outpatient opportunities are available. In addition, RACS has undertaken work to ensure hospital posts include an outpatient clinic, with most STBs implementing this as part of the hospital accreditation process.	
Standard 5: Assessment of learning			
JJ	For all surgical specialties, adopt behaviour-related reporting (i.e. descriptive of the key features) rather than simple scoring for all work-based assessments. (Standard 5.2.3)	☒ Yes ☐ No The RACS Surgical Competence and Performance Guide provides a framework to aid the development and assessment of skills required to become a competent surgeon. It also provides the framework for the assessment of behavioural markers for professional skills performance both in and outside of the operating theatre. RACS continues to advance in this area as most surgical specialties have already adopted behaviour-related reporting, and others are progressing steadily; for example, the behavioural descriptors are linked to the relevant competencies in the AOA FTC curriculum so that each assessment provides direct feedback on whether the Trainee is behaving as expected. Behavioural descriptors are used for all competencies. Many STBs have developed WBAs to include descriptive wording and a competence scale to guide Trainees through	☐ Yes ☐ No

		SET, and PBAs are set up in a rubric style with marking criteria and performance level; for example, under the new GSET program, the STBs in general surgery Au and NZ will have clear behavioural, attitude or skill-based milestones that will form the basis of the In Training Assessment. The EPAs and PBAs will provide descriptive behaviours that the Trainee is to be assessed against. Where the Trainee falls below the standard expected, the assessment will compel the assessor to provide information on how the Trainee can improve. This will be available to both Trainees and their supervisors to develop appropriate learning plans where required. The STBs in P&RS Au and urology planned to trial the new WBAs in the second half of 2020, with delays occurring due to COVID-19. The STB in urology expects to further refine and implement the WBA as a component of EPAs.	
KK	Explore the use of multi-source feedback for all surgical training programs at set points throughout training. (Standard 5.3.1)	☒ Yes ☐ No RACS has implemented the use of multi-source feedback (MSF) for some specialties, with plans to ensure progress in this area continues. Some STBs incorporate MSF into their suite of assessments. The STB in vascular surgery uses MSF through mini-CEX and DOPs. The STBs in urology and P&RS plan to incorporate routine use of MSF for EPAs, which will occur at different stages of the training programs. The STB in general surgery NZ's new suite of EPAs and PBAs will allow assessors other than the supervisor in each unit to provide snapshot feedback on Trainee performance. Other STBs only implement MSF for particular circumstances. The STB in paediatric surgery uses MSF for all early SET 1 Trainees and as required for all other SET levels. For the AOA	☐ Yes ☐ No

		FTC, MSF continues to be an optional assessment tool in the AOA 21 Training Program and may be mandated as part of a remedial program. The STB in OHNS does not currently use MSF unless required for Trainees on probation. The STB in general surgery Au currently uses MSF for underperforming Trainees. The new program will see the introduction of EPAs and clear milestones that will be able to assess the same areas as an MSF, particularly in terms of the EPA, where information and feedback from various contacts can be collected. RACS recognises the importance of collecting MSF on Trainees and supervisors to understand the performance of those at the centre of the training program and aims to introduce regular feedback from multiple key sources within the hospital setting.	
LL	Review whether the term ‘essay-type’ is appropriately used in all its current contexts. Where essay-type questions are used, consideration should be given as to whether they could be replaced with short-answer type questions. (Standard 5.4.1)	☒ Yes ☐ No This recommendation continues to progress with the ongoing review of the relevant examinations. It is timely for RACS to commence an overarching, comprehensive review of assessments and examinations that fall prior to and within the training programs. RACS has scheduled an assessment commission for 2021, which will incorporate examination design and question format. Progress being made at the specialty level includes the Specialty Court of Examiners in OHNS carefully reviewing the content and structure of the Fellowship Examination (FEX). Each exam paper includes four short-answer questions and essay-type questioning. These two styles of questioning are valuable for the specialty when used together, as the essay-type responses in particular can require higher-level thinking,	☐ Yes ☐ No

		and the professional skills competencies can be more easily assessed. A further example is the STB in paediatric surgery, which has introduced essay-type questions to the pathophysiology exam, which also supports Trainees in their preparation for the FEX where this style of questioning is implemented. As previously mentioned, these essay-type questions allow Trainees to demonstrate their higher-order understanding of the content in the exam. It is acknowledged that while this is possible in short-answer questions, longer formats are more effective in developing and validating an exam that covers the breadth of the curriculum in a format that is non-repetitive between years. The scope of the RACS assessment commission will be defined in early 2021 in consultation with key partners, for commencement in late 2021.	
Standard 6: Monitoring and evaluation			
MM	Explore with Trainees how response rates to surveys on training posts could be improved. (Standard 6.1.3)	☒ Yes ☐ No Progress continues to be made against this recommendation, with time required to understand the success of different strategies being introduced. RACS is currently undertaking work to improve the RACSTA survey. A survey review is currently being conducted, which includes comparisons between the Medical Training Survey, RACSTA survey and STB survey questions to identify areas of overlap. This is to streamline survey questions where appropriate to reduce survey fatigue of Trainees. Increased promotion of the results of the RACSTA survey and the resultant initiatives implemented is hoped to increase engagement from Trainees.	☐ Yes ☐ No

		STBs have also reviewed their strategies for their specialty-specific surveys; for example, the STB in OHNS has elected to incorporate their survey within their LMS. To ensure the survey is completed, Trainees must provide their feedback before they are able to submit assessments for their next rotation. The STBs in general surgery Au and neurosurgery have reported excellent response rates, and the STB in urology and the AOA FTC now achieves 99 per cent–100 per cent response rates for their respective trainee survey. For the smaller specialties, the STBs have been working hard to ensure confidentiality of responses and to reassure Trainees that they are not at risk of being identified should they participate in the surveys. This is hoped to increase response rates where required. The review of surveys and the associated response rates will continue as a core source of feedback on the programs. This will feed into the overarching M&E Framework that will allow deeper understanding of the performance of the training programs.	
Standard 7: Issues relating to Trainees			
OO	In relation to selection into the surgical training programs: i. Evaluate the objectives of the selection process to ensure they are both clear and consistent across all surgical training programs. ii. Develop a process to ensure that updates and changes to entry prerequisites undergo a consultation process and provide appropriate lead time for prospective applicants to meet them.	☒ Yes ☐ No The overall objective of the selection process is to select the highest-calibre Trainees for the SET program on the basis of merit through a fair and accountable process. RACS continually reviews the selection process to ensure its validity and objectiveness, with any changes to the selection regulations reviewed by the RACS EB. Potential applicants are advised of changes that are made to the selection process within an appropriate timeframe; for example, the STB in orthopaedic surgery NZ 2020 regulations advised of the introduction of the Clinical Exam as being a prerequisite two years in advance. The AOA FTC reviews the selection process annually and any significant changes to the process	

	iii. Explore the means by which prevocational work performance and technical ability may be more appropriately assessed as part of the selection process. iv. Examine the key discriminators (e.g. academic record, research, experience, interview performance) in the current selection process and whether these are the most relevant for predicting performance both as a Trainee and as specialist. (Standard 7.1.1)	are advertised in the standards published the year prior to their implementation. As part of the selection process review, some STBs will regularly assess the validity of the selection tools, and ensure they align with the RACS competencies. The STBs in general surgery, OHNS and orthopaedic surgery NZ, as previously mentioned in Condition 24, have adapted their CV scoring to include components such as rural origin, fewer points for PhD and Master's education and cultural knowledge. The RACS analytics department identified two areas of the selection process for the STB in OHNS that required attention. The CV was disproportionally influential on selection outcomes, and the referee reports did not have the intended influence on the overall selection of candidates. In 2019, for the 2020 intake, the STB in OHNS performed their referee reports telephonically. This provided a greater variance of scores, which more accurately reflected the skills and attributes of the candidate. Implementing the highest standards of selection criteria is vital to identifying those aspirants who are most likely to thrive in the training programs and develop into a competent surgeon. The process of reviewing the current selection tools and maintaining knowledge on the latest evidence on tool performance must be an ongoing activity.	
PP	Implement a program to increase awareness of the presence and role of the RACS Trainees' Association (RACSTA). Standard 7.2 and 7.3)	☒ Yes ☐ No In February 2020, RACSTA decided to develop a communication plan to Trainees and other stakeholders that describes the action taken on issues identified through the RACSTA survey. The Trainee Engagement Working Group has formulated a communications plan, with a number of associated actions to increase Trainee engagement. The prior 2018 communications plan remains relevant, and in 2020 the	☐ Yes ☐ No

		Committee met the key performance indicators (KPIs) of increased induction conference attendance (target: 100, actual: 118) and RACSTA Newsletter click rate (target: 38 per cent, actual: average open rate of 58 per cent across three newsletters). The RACSTA Survey response rate KPI (target: 50 per cent, actual: 28 per cent across two surveys) was not met. Strong messaging on the objectives of RACSTA will be embedded in all communication from RACS to surgical Trainees. Tri-annual RACSTA Newsletter communications to trainees have been produced, with an emphasis on highlighting RACSTA's role and advocacy activities, particularly the issues raised in the RACSTA Survey and the significant challenges posed by COVID-19 impacts on training. RACSTA marketing collateral was updated during 2020 and the materials received by attendees at the Induction Conference significantly expanded. The 2020 RACSTA strategic planning process was delayed due to deferral of in-person Committee meetings in 2020. The development of a RACSTA strategic plan will aim to consolidate all recent engagement, communications and marketing plans under a unified plan for 2021–2023, which will align with RACS strategic and operational plans. It is likely that this will commence in mid-2021, ideally face-to-face with RACS staff facilitation, pending relaxation of domestic travel restrictions.	
Standard 8: Implementing the program – delivery of education and accreditation of training sites			
QQ	Develop a policy that is adhered to by all specialty training boards, which stipulates the minimum advanced notice	☒ Yes ☐ No	☐ Yes ☒ No

	required prior to requiring commencement of new rotations and which also minimises the number of interstate/international rotations. Standard 8.2.2)	RACS commenced consultation with STBs regarding all SET regulations and policies in July 2020, and in November 2020 a workshop was held to discuss and agree on feedback and proposed changes. RACS circulated 17 SET regulations and policies for feedback and identified several documents as pending to allow outcomes from other RACS and STB strategic initiatives to support document review. RACS will work to embed policy recommendations in existing RACS SET regulations and policies. Advising hospital allocations more than 12 months in advance can be challenging due to changing circumstances of incumbent Trainees. The circumstances are often unknown or only known at a late stage during planning decisions; for example, the current advanced notice for the STB in general surgery and the AOA FTC is approximately three months for the first clinical rotation and nine months for the second rotation in each year. For the STB in general surgery Au, Trainees do not rotate interstate in Australia except for a small percentage that rotate through Tasmania, Northern Territory (NT) and Australian Capital Territory (ACT), with ACT Trainees usually requesting to be allocated to this network. With NT, Trainees usually request rotation to Darwin or Alice Springs in order to gain particular experience. In terms of advance notice, rotations are finalised by November of the previous year at the latest; this provides Trainees with anywhere from three (Term 1) and nine months' notice (Term 2). Neurosurgery ordinarily makes its allocations six months in advance.	
RR	Work with the jurisdictions to assist in preventing the loss of employment benefits when Trainees transfer between jurisdictions. (Standard 8.2.3)	☒ Yes ☐ No RACS has worked closely with the RACSTA Committee on portability of leave entitlements for Trainees with the aim to establish agreements from all Australian states, territories and	☐ Yes ☐ No

		New Zealand to support reciprocal leave entitlements consistent with the *Public Service Act*. The progress as of June 2020 is as follows: • ACT, SA, NSW and QLD provide for a gender-specific entitlement (maternity leave for the mother only) while NT, TAS, VIC and WA offer the entitlement to the 'primary care giver'. • Specific entitlement that ensures no parental leave disadvantage for a Trainee returning to their home jurisdiction having moved because of learned medical college requirements now exists in NSW, NT, QLD, SA, TAS, VIC and WA. • Specific entitlement to ensure no parental leave disadvantage for a Trainee arriving at one jurisdiction, for the first time, from another jurisdiction (for any reason) now exists in ACT, QLD, SA, VIC and WA.	
SS	Consider how to expand the surgical training programs in rural and regional locations. (Standard 8.2.2 and 8.2.3)	☒ Yes ☐ No RACS continues to make considerable progress expanding the surgical training program in rural and regional locations. As an overarching strategy, in June 2020, RACS Council commissioned a strategic paper – 'Equitable distribution of the surgical workforce' – as a RACS response to the National Medical Workforce Strategy. The strategic paper will receive contributions from all RACS portfolios and was submitted to Council in October 2020. Potential outcomes of this paper could include a taskforce to develop a RACS-wide approach. This will be a strategic priority for RACS in 2021. With a focus on selection, the RACS Rural Surgery Section (RSS) Committee presented a paper to BSET in June 2020 to consider reviewing selection into training to support establishing a sustainable rural surgical workforce. The paper	☐ Yes ☐ No

is part of a longer-term, staged strategy that the RSS has devised. Recognising the importance of this, each specialty has been asked to actively adopt as many elements of the suggested rural selection initiative as possible and find ways of offering training across specialties to enable a graduating rural surgeon to develop skills for an appropriate scope of practice.

Recommendations of the paper included:

- weighting for those with a rural background/rural experience at medical school or rural experience at prevocational level
- being alert to unintended consequences of selection criteria that require predominantly urban work experience and therefore disadvantage rural origin and rural work location applicants
- developing a Rural SET Selection initiative with quarantined positions.

STBs are making significant progress towards providing rural experience for Trainees. Many STBs have accredited rural training posts which are available for Trainees who wish to train in regional locations. It is common for general surgery Trainees based in Australia to spend the first one to two years in rural rotations due to the nature of general surgery training. In New Zealand, it is only some smaller rural hospitals with insufficient numbers of supervisors with a RACS Fellowship for the required 12-month period that are not accredited. There may be some opportunities where a Trainee is allocated to a smaller centre for six months and to a larger centre for another six months. The four New Zealand P&RS Training Units are all able to provide services to the smaller regional centre. Other STBs, such as vascular surgery and paediatric surgery, are currently planning opportunities to expand rural training. The STB in paediatric surgery is exploring ways to recognise rural and remote experience prior to SET and developing curriculum standards around

participation in ‘outreach’ services, which is the mechanism most centres utilise to develop appropriate care in rural and remote communities. The STB in vascular surgery voted to create a Rural Vascular Stream made up of existing accredited training posts. The Board will continue to progress this through training program regulations. For the AOA FTC, work continues on developing the potential rural Fellowship post for transition to practice and the possibility of a rural-based training pathway. The AOA FTC has participated in several workshops with the Australian Government Department of Health regarding rural training and workforce issues.

Strategies are also being implemented at the Fellow level. At the start of 2020, the Australian Government Department of Health approved co-funding for two New Fellow positions under the Specialist Training Program (STP), one at Cairns Hospital and one at Royal Darwin Hospital, as part of a New Fellow Rural Placement pilot program. The aim of the New Fellow Rural Placement is to provide a New Fellow with a comprehensive, high-quality experience in a rural location that will help them consolidate their skills and encourage them to consider working in a rural setting long-term.

Additionally, a number of projects aiming to help incentivise rural placements for Trainees are being undertaken by RACS and funded through STP. First, a gap analysis project on rural training positions was undertaken in March 2020 and completed at the end of 2020. The aim of the study was to make evidence-based recommendations to increase the number of Trainees and Fellows preferencing rural and remote surgical practice. The project identified barriers to Trainees preferencing rural allocation, as well as the barriers to Trainees and Fellows considering a rural career. Second, RACS is conducting a support for clinical studies project to encourage and empower rurally located Trainees to conduct clinical studies that are relevant to their patients, by identifying

		and addressing the unique, setting-specific challenges they face. It will create practical training tools for rural Trainees and equip them to lead clinical studies within their practice. The modules of the training syllabus will provide a practical guide on comparator studies. The training will be delivered via webinars and eLearning modules. Trainees will also be supported through a clinical study 'help desk' provided by RACS staff. Finally, a project to develop a rural-facing surgical curriculum has been endorsed by the RACS STP Governance Group; the project is expected to commence in 2021 pending funding. It aims to produce a rural-facing surgical curriculum that has core generic surgical elements and specialty-specific elements unique to each specialty relevant to working in rural, regional and remote settings. Implementation of a rural-facing surgical curriculum has the potential to maximise the experience gained from non-urban training positions, as well as positively impact rural surgeon recruitment and retention.	
TT	Support collaboration among the specialty training boards to develop common accreditation processes and share relevant information. (Standard 8.2.4)	☒ Yes ☐ No This recommendation is being addressed as part of the review into the RACS hospital accreditation criteria. A working party made up of representatives from across the STBs (Fellows and staff) has been established. This has been essential for specialist feedback on the standards and understanding how the accreditation process works in practice. A working party charter document has been created to clarify objectives. Two of the key objectives of the working party are to 1) collaborate on the review of the current RACS accreditation standards against which training posts are assessed and 2) collaborate on the review of the current RACS processes for accrediting or reaccrediting hospital posts against the standards. Feedback and collaboration from across the STBs are essential to create a process which is suitable for all specialties.	☐ Yes ☐ No
Standard 9: Continuing professional development, further training and remediation			

UU	Implement a mechanism for the newly established CPD Audit Working Group to provide more robust feedback to Fellows with a particular focus on the breadth of surgeon's individual practice. (Standard 9.1.3)	☒ Yes ☐ No There has been some progress made against this recommendation. The Surgical Audit Working Party held its first meeting in June 2020 and early feedback has been sought from specialty associations and societies. It is anticipated that the revised standard will be finalised in early 2021.	☐ Yes ☐ No
WW	Explore the College's role in identifying the poorly performing Fellow. (Standard 9.2.1)	☒ Yes ☐ No RACS has made progress in this area. The Surgical Audit Guide is under review and is anticipated to be completed by the end of 2020. Due to the unique circumstances of 2020, the Code of Conduct review has been re-scheduled to 2021. STBs have also made progress; for example, there was a Practice Visit Peer Review scheme piloted in 2020 by the STB in general surgery NZ. The peer review is intended to promote sharing of good practices and experiences, rather than specifically identifying poor performance. If adopted by the STB in general surgery NZ, it will be voluntary participation with CPD points for the reviewers and participants. Furthermore, the AOA FTC has now made participation in the audits of surgical mortality a compulsory component of the AOA CPD program.	☐ Yes ☐ No
Standard 10: Assessment of Specialist International Medical Graduates – Nil remain.			

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