Standard 1 Appendix

Royal Australasian College of Surgeons

Royal Australasian College of Surgeons

Position Paper

Indigenous Health Position Paper

The Royal Australasian College of Surgeons (RACS) recognises Aboriginal and Torres Strait Island people as the traditional landowners of Australia and Māori as the tangata whenua (people of the land) of New Zealand. RACS also recognises that the vast health and social inequities faced by these populations are wholly preventable and therefore sustained inequities are unjustifiable and unacceptable. Despite government initiatives these inequities persist between Indigenous and non-indigenous populations of Australia and New Zealand. RACS understands this situation and has made Indigenous health a priority by incorporating Indigenous health into strategic planning and creating a vision of 'building workforce and increasing services to better meet the health needs of Aboriginal, Torres Strait Island and Māori populations'.

This position statement outlines RACS' ongoing obligations under Te Tiriti o Waitangi[i], the United Nations Declaration on the Rights of Indigenous People (UNDRIP)[ii] and the Close the Gap Statement of Intent[iii]. It includes information that gives context to some of the issues faced by Indigenous people. It informs College Fellows, Trainees, International Medical Graduates (IMG) and external stakeholders of RACS' Indigenous health commitment, supports staff with understanding the importance of Indigenous health and how this relates to their work, and holds RACS accountable to achieving health equity.

RACS position on Indigenous health

In supporting this position statement and RACS obligations to improving surgical health outcomes for Aboriginal, Torres Strait Islanders and Māori, the College:

1. Acknowledges Aboriginal and Torres Strait Island peoples as the First Peoples and recognises Aboriginal and Torres Strait Islander rights as Indigenous people under the United Nations Declaration on the Rights of Indigenous Peoples as adopted by the Australian Government in 2009.
2. Acknowledges Māori as Tangata Whenua and their unique rights under Te Tiriti o Waitangi and rights as Indigenous people under the United Nations Declaration on the Rights of Indigenous Peoples as adopted by the New Zealand Government in 2009[iv].
3. Recognises the distinct differences between Aboriginal and Torres Strait Island peoples and Māori and the cultural diversity among and within Aboriginal and Torres Strait Island communities.
4. Understands that Indigenous people view health holistically and health encompasses wider aspects like family, community, kinship networks and the connection to land, culture, traditions, waterways and its resources. Further information on Indigenous health models is included in **Appendix 1**.
5. Understands that even though Indigenous people view health holistically, there are unique differences in the way health is regarded between Māori and Aboriginal and Torres Strait Island peoples.
6. Acknowledges, supports, and is guided by Aboriginal, Torres Strait Islanders and Māori leadership in health.
7. Understands the value of health knowledge of Aboriginal, Torres Strait Islanders and Māori.
8. Recognises the importance of Indigenous sovereignty in order to overcome the legacy of colonisation processes and dispossession.
9. Recognises that the effects of colonisation, dispossession, marginalisation and experiences of institutional racism has had a profound and lasting effect on Indigenous people and their health and wellbeing across generations.
10. Recognises the legacy of colonisation processes and the resultant racism and privilege at curricular and institutional levels.

11. Acknowledges that Indigenous people continue to experience poorer health outcomes compared to non-indigenous people in Australia and New Zealand.
12. Acknowledges that poorer health outcomes are a result of the ongoing history of discrimination, economic and educational disadvantage and accessing appropriate health care.
13. Understands that poor health is not a choice for Indigenous people.
14. Continues to advocate for Indigenous rights and Indigenous health advances.
15. Continues to develop strategies that address Indigenous health issues through the Reconciliation Action Plan (RAP) and Te Rautaki Māori (the Māori Health Strategy and Action Plan).
16. Allocates appropriate resources to achieve the activities set out in the RAP and Te Rautaki Māori.
17. Acknowledges the importance of strengths-based discourse about Aboriginal, Torres Strait Islander and Māori health, and about social determinants of health, including for policymaking and advocacy.
18. Emphasises the importance of genuine partnerships with Aboriginal, Torres Strait Islander, Māori and their representatives to improve health outcomes and develop appropriate, sustainable and effective health systems and services.
19. Understands and prioritises the importance of Indigenous research to inform Indigenous health.
20. Understands the importance of data sovereignty and that data be collected appropriately and is safeguarded and protected as per Indigenous people's standards.
21. Understands the Indigenous status of College staff.

Māori Māori make up 15 per cent of the New Zealand population and have occupied New Zealand for over 1000 years. Māori have the worst health statistics in New Zealand when compared to non-Māori, e.g. Māori mortality rates from all types of cancer was twice that of non-Māori. Cardiovascular disease mortality was two and a half times higher for Māori than non-Māori and Māori were twice as likely to be hospitalised than non-Māori. It is the same for stroke mortality and hospitalisation and other preventable diseases like diabetes and heart disease[v]. Māori as tangata whenua have unique rights under Te Tiriti o Waitangi (the Treaty of Waitangi) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). The Treaty of Waitangi formalises the relationship between Māori and the Crown and provides a foundation for policy development in New Zealand and means Māori values, traditions and practices are protected. It legitimises settler presence in New Zealand and governance by the British Crown. The UNDRIP	**Aboriginal and Torres Strait Island peoples** Aboriginal and Torres Strait Island peoples make up three per cent of the Australian population. Aboriginal and Torres Strait Island peoples had sophisticated social organisation, land tenure, governance and systems of law, underpinned by complex kinship systems. Traditional medicines, healing practice and plant knowledge were integral parts of Aboriginal and Torres Strait Islander society and were complimented with holistic community, family, environment and spiritual value systems. Prior to colonisation, between 250-300 Aboriginal and Torres Strait Islander language nations characterised the Australian continent. The decline in language and culture loss accelerated through the child removal programs during the assimilation policy periods of the 1900s. In 1990 it was estimated that 90 languages still survived of the approximately 250-300 once spoken. Of the 90, 70 per cent by 2001 were deemed as 'severely endangered' with only 17 spoken by all age groups.

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is an international human rights document outlining the rights of Indigenous people. It comprises a range of rights and freedoms, including the right to self-determination, culture and identity, and rights to education, economic development, religious customs, health and language. Pre-colonisation Māori were navigators, explorers, horticulturalists and traditional medicine practitioners with their own lore and systems. Acts of colonisation like the confiscation of communal lands resulted in the loss of resources that provided for quality life and wellbeing. The deliberate act of colonisers to strip Māori of their language and identity resulted in historical and generational trauma, still effecting Māori today. Te Reo Māori (the Māori language) is an official language of New Zealand under the Māori Language Act 1987. Before the 1800s Māori was the only language spoken in New Zealand. Due to colonisation processes and deliberate language domination, by 1960 only 25 per cent of Māori were speaking the language. Today there is a slight increase in te reo Māori speakers thanks to the efforts driven by community and the more recent initiatives implemented across the education sector by the New Zealand Government. The use of Te Reo Māori throughout RACS documents and communications enhances the integration of Māori knowledge, supports a te ao Māori (Māori world view) environment and creates a sense of belonging to which Māori can connect. Visit [insert weblink] for further information on Māori and Māori health.	For Aboriginal and Torres Strait Island peoples, life expectancy varies considerably by remoteness of residence. Comparatively, the life expectancy between remote and major city living of non-indigenous Australians is virtually the same. The unprecedented experience of colonisation, decimation of communities and the institutionalisation of the poverty cycle, life expectancy of Indigenous Australians does not mirror non-indigenous Australians. Since the late 1800s, numerous examples exist of Aboriginal and Torres Strait Islander peoples exercising and developing initiatives and strategies in response to colonisation and policies affecting Aboriginal and Torres Strait Islander society and community. Government responses to these initiatives was the development and implementation of consecutive policies and laws designed to remove Indigenous Australians from the decision making process. Since the introduction of the *Racial Discrimination Act 1975* and the adoption of policies in support of self-determination and self-management principles, the capacity for Indigenous Australians to have direct input into addressing the inequities now exists. Identifying and nurturing a strengths-based approach through collaboration and joint effort with Indigenous Australians will mean the complex set of circumstances and issues affecting the health and wellbeing of Indigenous Australians like institutionalisation of the poverty cycle, assimilation policies, a dispersed population over a large land mass, multiple languages, remote access issues, multigenerational trauma, combined with multiple layers of government will better assist RACS in contributing to eliminating health inequities afflicting Indigenous Australians. Visit [insert weblink] for further information about Aboriginal and Torres Strait Islander health.

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Health Equity

The World Health Organisation's (WHO) definition of equity[vi]:
"Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."

The UNDRIP also addresses health equity and the health rights of Indigenous people. Article 23 states that Indigenous peoples *"have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them…"* and Article 24 (2) states *"Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health."*

Colonisation

The impact colonisation has had on Indigenous people all over the world is devastating. Today's poorer health statistics for Aboriginal, Torres Strait Islander peoples and Māori is an outcome of colonisation, racism and a deliberate act of cultural suppression. Indigenous people have lived experiences of current and historical impacts of colonisation and resultant social, economic and health disparities.

RACS will make every effort to acknowledge and address the legacy of colonisation processes and the resultant racism and privilege at curricular and institutional levels. To support an understanding of how colonisation has contributed to such disparities, L Muller (2008)[vii] has adapted Professor Virgilio Enriques' five stages of colonisation:

1. *Denial and Withdrawal:* Colonisers deny Indigenous peoples' culture and moral values. In Australia's case, Indigenous peoples' very humanity was denied and withdrawn in the process of colonisation.
2. *Destruction/Eradication:* This includes destruction of culture, social systems and in Australia's case, Aboriginal and Torres Strait Islander peoples. Murder, massacres, eugenic breeding programs aimed at assimilation/absorption, forced removal and so forth have all been used in the colonisation of Australia.
3. *Denigration/Belittlement/Insult:* Indigenous culture, languages, practices, knowledge and beliefs are denigrated and, in some instances, outlawed. These are replaced by the coloniser's model.
4. *Surface Accommodation/Tokenism:* Remnants of the surviving culture are given token regard. This stage creates the 'noble savage' concept and other's definition of what constitutes a 'real' Indigenous person.
5. *Transformation/Exploitation:* Remnant culture is transformed and exploited by the dominating colonial society. Indigenous art is one example of this stage.

RACS makes every effort to understand the impacts of colonisation within the surgical environment and ensures surgical education incorporates avenues to gain further understandings on the impacts of colonisation and incorporate decolonisation processes into surgical education.

RACS Indigenous health initiatives

- Indigenous health is embedded across all sections of the RACS Strategic Plan.
- The Reconciliation Action Plan that addresses health inequities and the unique needs of Aboriginal and Torres Strait Island peoples.
- Te Rautaki Māori, Māori Health Strategy and Action Plan which addresses health inequities between Māori and non-Māori and progresses Māori health advancement.

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- Māori medals awarded to Fellows that contribute to the advancement of Māori health.
- Aboriginal and Torres Strait Islander medals awarded to Fellows that contribute to the advancement of Aboriginal and Torres Strait Islander health.
- Scholarships for Māori, Aboriginal or Torres Strait Islander Junior Doctors, Trainees and research.
- Introduction of the Aboriginal and Māori motifs.
- Introduction of the Māori name for RACS 'Te Whare Piki Ora o Māhutonga' used mostly in New Zealand.
- Aboriginal and Torres Strait Islander cultural safety and cultural competency eLearning courses that commenced in early 2020.
- Māori cultural safety and cultural competency eLearning developments currently underway with an expected start date of early 2021.
- Cultural safety incorporated as a fundamental surgical competency.

Despite these initiatives there is still a long way to go to achieve health equity within surgery, and ensuring a safe, acceptable and appropriate surgical environment for Indigenous people.

Partnerships and advocacy

It is important for RACS to develop partnerships with organisations that share a common vision of equitable health care and increasing the Indigenous health workforce. Such partnerships are pivotal for Indigenous health advancement, policy development and progressing strategic activities appropriately and according to Indigenous priorities (as identified by Indigenous people). RACS ensures existing partnerships e.g. Māori Medical Practitioners Association, Te Ohu Rata o Aotearoa (Te ORA) and Australian Indigenous Doctors' Association (AIDA) continue to strive for an aligned vision while continuing to identify a more cohesive way of working together that works for both organisations.

The surgical specialty societies are one of RACS biggest stakeholders. Indigenous health is relatively new for these societies. Therefore RACS aims to work collaboratively with the societies to ensure the best health outcomes for Aboriginal, Torres Strait Islanders and Māori. A focus for RACS Indigenous health is on co-designing curriculum and training initiatives and on developing a safe surgical environment with the specialty societies.

An extension to improved health outcomes for Indigenous people, is understanding the importance of ensuring Indigenous people are at levels of leadership, management and decision making levels. There is an increasing amount of evidence that indicates a strengths-based, human rights approach, focusing on resilience, Indigenous culture and positive identity, rather than deficits and problems, will lead to methods being more effective according to Indigenous priorities and definitions of health.

RACS is committed to developing Indigenous capabilities to support the progression of partnerships that advance Indigenous health outcomes and improve health equity.

Appendix 1: Indigenous models of health

Māori models of health

Māori health models allow health professionals to better understand Māori health. The most widely used today is Sir Mason Durie's Te Whare Tapa Wha[viii] (four sided house) developed in 1984. With its strong foundations and four equal sides, the symbol of the wharenui (Māori meeting house) illustrates the four dimensions of Māori well-being. Should one of the four dimensions be missing or in some way or damaged, a person, or a collective may become 'unbalanced' and subsequently unwell.

The four elements of Te Whare Tapa Wha are:

- *Taha tinana (physical health):* The most common identifier of health, physical health is required for optimal growth and development. For Māori this is just one aspect of health and wellbeing and cannot be separated from the other elements of health (mind, spirit and family).
- *Taha wairua (spiritual health):* For Māori the spiritual essence is known as mauri (life force). It is the life force that determines who and what you are, where you have come from and where you are going. Spiritual wellbeing can be expressed through beliefs, values, traditions and practices that support self-awareness and identity. *Taha wairua* provides a sense of meaning and purpose as well as experiencing a sense of connectedness to self, whānau, community, environment and the sacred.
- *Taha whānau (family health):* Whānau to Māori is more than the immediate family concept as widely recognised in westernised culture. It encompasses generational family members, friends and
- *Taha hinengaro (mental health):* Thoughts, feelings and emotions are vital factors of the body and soul. The capacity to think, communicate, and feel mind and body are inseparable. Taha hinengaro is about Māori having a connection and interaction which is uniquely Māori and the perception that others have of Māori.

Other Māori models of health

Te Wheke by Dr Rose Pere

Similar to Te Whare Tapa Wha, the concept of Te Wheke, the octopus, is to define family health. The head of the octopus represents the whānau, the eyes of the octopus as waiora (total wellbeing for the individual and family) and each of the eight tentacles representing a specific dimension of health. The dimensions are intertwined, and this represents the close relationship of the tentacles.
Te whānau - the family
Waiora - total wellbeing for the individual and family
Wairuatanga - spirituality
Hinengaro - the mind
Taha tinana - physical wellbeing
Whanaungatanga - extended family
Mauri - life force in people and objects
Mana ake - unique identity of individuals and family
Hā a koro ma, a kui ma - breath of life from forbearers
Whatumanawa - the open and healthy expression of emotion

Te Pae Mahutonga

Te Pae Mahutonga (Southern Cross Star Constellation) brings together elements of modern health promotion. The diagram shows that the four central stars of the Southern Cross represent four key tasks of health promotion:

Mauriora - cultural identity
Waiora - physical environment
Toiora - healthy lifestyles
Te Oranga - participation in society

The two pointers represent
Ngā Manukura - community leadership, and
Te Mana Whakahaere - autonomy.

Indigenous Australian models of health.

Defining and informing the understandings of Aboriginal and Torres Strait Islander models of health draws significantly on the research of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*[ix], where social and emotional wellbeing (SEWB) is identified as a signifier of Aboriginal and Torres Strait Islander peoples' concepts of health.

Discussion around the principles and practice relating to Indigenous Australians' SEWB are guided by the definition of Aboriginal health as adopted in 1979 by the National Aboriginal Community Controlled Health Organisation:

> *"Aboriginal health does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole-life-view. Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and must bring about the total wellbeing of their communities."*

Working Together defines Aboriginal and Torres Strait Islander SEWB as a multidimensional concept of health that includes mental health, but which also encompasses domains of health and wellbeing such as connection to land or 'country', culture, spirituality, ancestry, family, and community.

Nine guiding principles that underpin SEWB are identified in *Working Together*. These guiding principles shape the SEWB concept and describe several core Aboriginal and Torres Strait Islander peoples' cultural values. These are identified by:

1. Health as holistic
2. The right to self-determination
3. The need for cultural understanding
4. The impact of history in trauma and loss
5. Recognition of human rights
6. The impact of racism and stigma
7. Recognition of the centrality of kinship
8. Recognition of cultural diversity
9. Recognition of Aboriginal strengths

Cultural domains of social and emotional wellbeing

The following diagram in Figure 1 was developed by the Australian Indigenous Psychologists Association (AIPA) as part of AIPA cultural competence SEWB workshop module one. It shows some of the domains of wellbeing that typically characterise Aboriginal and Torres Strait Islander definitions of SEWB.

As *Working Together* explains: The SEWB of individuals, families and communities are shaped by connections to body, mind and emotions, family and kinship, community, culture, land and spirituality … The term 'connection' refers to the diverse ways in which people experience and express these various domains of SEWB throughout their lives. People may experience healthy connections and a sense of resilience in some domains, while experiencing difficulty and/or the need for healing in others. In addition, the nature of these connections will vary across the lifespan according to the different needs of childhood, youth, adulthood and old age.

Figure 1. Social and Emotional Wellbeing from an Aboriginal and Torres Strait Islanders' Perspective (from Chapter 4 Aboriginal and Torres Strait Islander social and emotional wellbeing, Working Together 3rd edition)

ASSOCIATED DOCUMENTS

Te Rautaki Māori. RACS Māori Health Strategy and Action Plan

RACS Reconciliation Action Plan (RAP)

Indigenous Health Committee Terms of Reference

REFERENCES

[i] Hayward, J. Principles of the Treaty of Waitangi – ngā mātāpono o te tiriti, Te Ara - the Encyclopedia of New Zealand. 2012. Accessed from: http://www.TeAra.govt.nz/en/principles-of-the-treaty-of-waitangi-nga-matapono-o-te-tiriti.

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https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

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[v] Ministry of Health. Tatau Kahukura: Māori Health Chart Book 2015 (3rd edition). Wellington, 2015. Accessed 3 March 2020.

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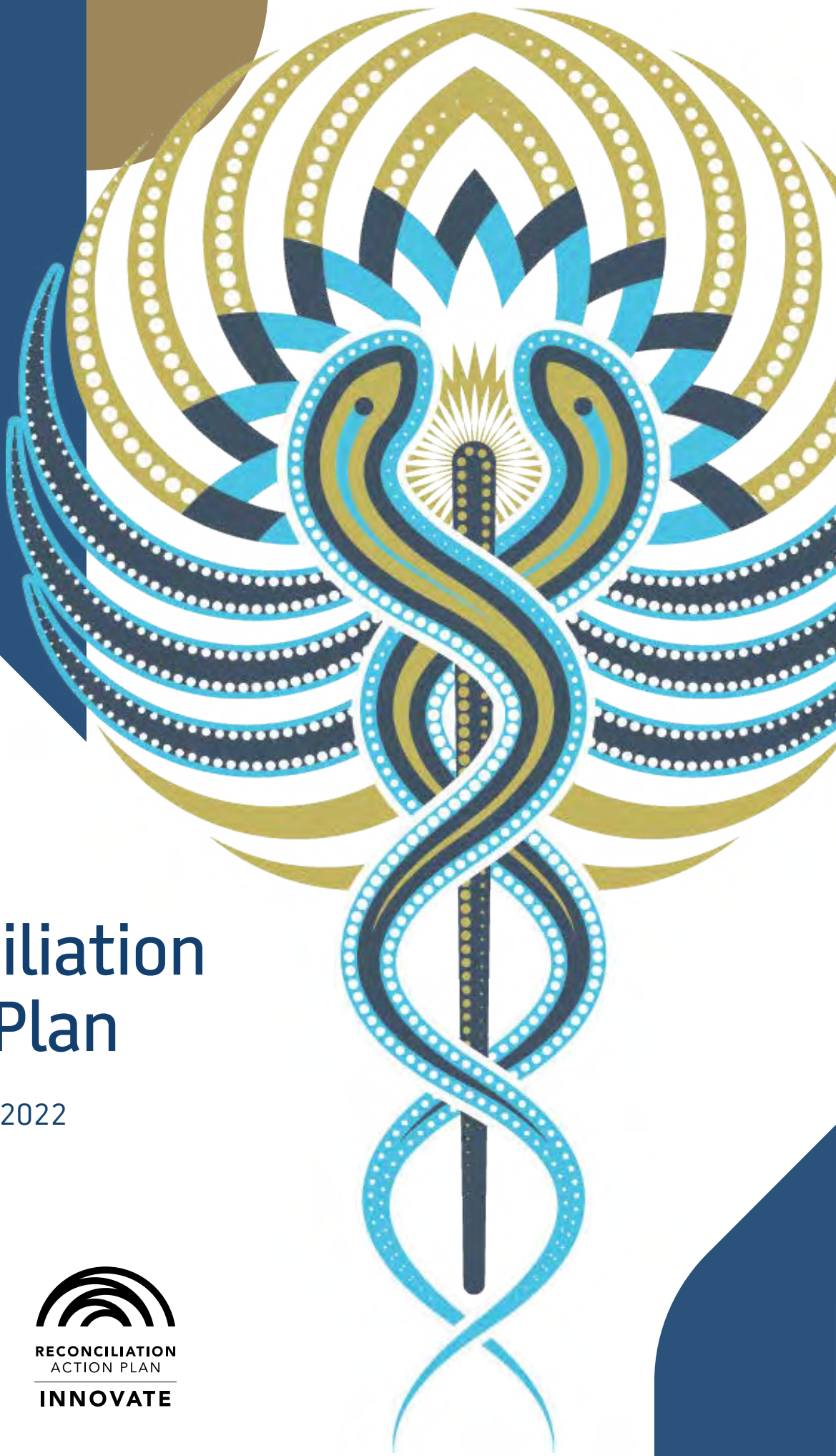

Reconciliation Action Plan

May 2020 - May 2022

Royal Australasian College of Surgeons

RECONCILIATION ACTION PLAN
INNOVATE

RECONCILIATION ACTION PLAN
INNOVATE

Message from Reconciliation Australia

On behalf of Reconciliation Australia, I am delighted to see the Royal Australasian College of Surgeons continue its reconciliation journey and to formally endorse its first Innovate RAP.

Through the development of an Innovate RAP the Royal Australasian College of Surgeons continues to play an important part in a community of over 1,000 dedicated corporate, government, and not-for-profit organisations that have formally committed to reconciliation through the RAP program since its inception in 2006. RAP organisations across Australia are turning good intentions into positive actions, helping to build higher trust, lower prejudice, and pride in Aboriginal and Torres Strait Islander cultures.

Reconciliation is no one single issue or agenda. Based on international research and benchmarking, Reconciliation Australia, defines and measures reconciliation through five critical dimensions: race relations; equality and equity; institutional integrity; unity; and historical acceptance. All sections of the community—governments, civil society, the private sector, and Aboriginal and Torres Strait Islander communities—have a role to play to progress these dimensions.

The RAP program provides a framework for organisations to advance reconciliation within their spheres of influence. This Innovate RAP provides the Royal Australasian College of Surgeons with the key steps to establish its own unique approach to reconciliation. Through implementing an Innovate RAP, the Royal Australasian College of Surgeons will strengthen its approach to driving reconciliation through its business activities, services and programs, and develop mutually beneficial relationships with Aboriginal and Torres Strait Islander stakeholders.

We wish the Royal Australasian College of Surgeons well as it embeds and expands its own unique approach to reconciliation. We encourage the Royal Australasian College of Surgeons to embrace this journey with open hearts and minds, to grow from the challenges, and to build on its successes. As the Council for Aboriginal Reconciliation reminded the nation in its final report:

> "Reconciliation is hard work—it's a long, winding and corrugated road, not a broad, paved highway. Determination and effort at all levels of government and in all sections of the community will be essential to make reconciliation a reality."

On behalf of Reconciliation Australia, I commend the Royal Australasian College of Surgeons on its second RAP, and look forward to following its ongoing reconciliation journey.

Karen Mundine
Chief Executive Officer
Reconciliation Australia

President's Message

The Royal Australasian College of Surgeons (RACS) recognises and acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of Australia and pays respect to their continuing connection to culture, land, sea, community and family.

RACS is proud to be part of the reconciliation journey and embraces our obligation as a peak national health organisation to make meaningful ongoing commitments to the principles of Reconciliation.

RACS' core mission is to lead and advocate for surgical standards, performance, education and professionalism to improve patient care in Australia and New Zealand. RACS is serious about addressing the disparities and inequities faced by Aboriginal and Torres Strait Islander peoples.

Therefore, its Strategic Plan 2019 – 2021 states:

"The College recognises the importance of relationships and collaboration. It is through collaboration and relationships that joint strategies and partnerships can be formed to achieve significant outcomes in Aboriginal and Torres Strait Islander health."

Our College recognises to achieve effective relationships and collaboration it is necessary to support initiatives and to raise awareness and understanding of issues and circumstances affecting Aboriginal and Torres Strait Islander people located in remote, urban and regional centres.

Significant gains toward addressing Indigenous health have been: the decision for the Indigenous Health Committee to report directly to RACS Council; and therefore Indigenous Health is now a standing item on Council agenda; Indigenous Health Committee to be chaired by a Councillor; and the addition of 'Cultural Competence and Cultural Safety Competency' as part of RACS' Surgical Competence and Performance standards.

We are a long way from achieving health equity and understand that, in order to make significant change, RACS will need to acknowledge and address the legacy of colonisation processes and the resultant racism and privilege at curricular and institutional levels.

Our Innovate RAP provides the mechanism in which to do so. Building upon our experience when implementing our Reflect RAP, we have gained exposure and knowledge to better guide and organise ourselves to continue this very important journey.

As with our overall approach to Indigenous health, we have come too far not to go further, and we have done too much not to do more.

Dr Anthony Sparnon
President

Message from the Chair, Indigenous Health Committee

The RACS Indigenous Health Committee (IHC) extends a warm acknowledgment to the Traditional Custodians of the lands in which we reside and pays respect to Elders past, present and emerging.

Aboriginal, Torres Strait Islander and Māori Fellows and Trainees comprise the executive membership of the RACS IHC. It is through our collective and shared experiences as Indigenous people that we understand the complexity of issues and circumstances afflicting Aboriginal and Torres Strait Islander people.

Combining our expert community and, medical specialty knowledge and experiences, the IHC is uniquely positioned to provide RACS with the necessary support, guidance and advice on how the surgical community can best serve Aboriginal and Torres Strait Islander people.

Acknowledging the intergenerational harm and damage caused by colonisation and institutionalisation of racism and poverty in Aboriginal and Torres Strait Islander communities and families is well overdue.

The IHC applauds RACS Council for committing to continuing the journey of Reconciliation with the RACS Innovate RAP. The good will and intent demonstrated with significant gains in critical strategic operational areas of the organisation is highly commendable. The IHC wishes to encourage and support RACS as it continues along a path of transformational change focused on reconciliation and health equity for Aboriginal and Torres Strait Islander people.

Consistent with RACS' commitment to addressing Indigenous health inequities, RACS Innovate RAP is a document designed to align with Reconciliation Australia's aims and objectives as well as outlining our commitment to improving the health inequities of Aboriginal and Torres Strait Islander people.

The Indigenous health Committee proudly supports RACS embracing its obligation to support and be part of Reconciliation Australia's initiatives.

Dr Maxine Ronald
Chairperson
RACS Indigenous Health Committee

RACS and reconciliation

Our vision for reconciliation

RACS is committed to contributing to improving the health inequities of Aboriginal and Torres Strait Islander peoples. Our vision for reconciliation is for no health discrepancies to exist between the Aboriginal and Torres Strait Islander and non-Indigenous populations of Australia.

As Australasia's surgical college RACS is uniquely placed to champion the rights of Aboriginal and Torres Strait Islander peoples.

Our aims are:

- The rate of infant mortality should not differ,
- There should be no significant discrepancy in life expectancy,
- The overall rates of disease and sickness should not differ significantly,
- The rates of injury should not differ significantly,
- There should be equity of access to medical and allied health services, including primary care, surgical and other hospital care, as well as after hospital care,
- There should be improvements in the social determinants of health to enable equity in health outcomes.

Embedding RACS commitment to improving the health outcomes of Aboriginal and Torres Strait Islander peoples in core business; RACS has introduced a 10th competency, 'Cultural Competence and Cultural Safety Competency', to the Surgical Competence and Performance Guide, developing and implementing an Aboriginal and Torres Strait Islander Surgical Pathway program, and making Aboriginal and Torres Strait Islander peoples health a standing item at Council meetings.

Our business

Professional skills and training

RACS was formed in 1927, and is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. RACS has nine offices in Australia and New Zealand. RACS is a not-for-profit organisation that represents more than 7,000 surgeons and 1,300 surgical trainees and International Medical Graduates and has over 231 administrative and support staff across Australia and New Zealand.

We currently have three surgeons, five trainees and two staff members who identify as Aboriginal or Torres Strait islander.

RACS supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. RACS trains nine surgical specialties: Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head-and-Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery.

RACS is committed to ensuring the highest standard of safe and comprehensive surgical care for the community by achieving excellence in surgical education, training, professional development and support.

Image: AIDA Conference 2019, Brad Newton Photography

The Aboriginal and Torres Strait Islander motif

The motif design was created to symbolise RACS' commitment to help Close the Gap in Aboriginal and Torres Strait Islander health across Australia. With dual concepts in mind, it features two snakes winding around the winged staff symbolising medicine and can also be seen as Rainbow Serpents entwined together carving out the land, creating our rivers and mountains. The white dotted pathways descend from the mountains, flow through the rivers and ascend back to the skies reforming as rainbows, the spirit of the Serpent. Symbolic of medicine, the two snakes winding around the winged staff also symbolise Aboriginal and Torres Strait Islander and non-Indigenous people coming together. The heights of the rainbow also symbolise greater professional equity as well as improved health, social and economic wellbeing for all Aboriginal and Torres Strait Islander people and communities across Australia. The motif was developed by Marcus Lee. Born and raised in Darwin, he is a descendant of the Karajarri people and is proud of his Aboriginal heritage.

Our Reconciliation Action Plan

History of community advocacy

The Royal Australasian College of Surgeons (RACS) has a proud history of community advocacy. The College has been influential with policy makers and legislators and was a major contributor in the 1960s and 70s towards mandatory seatbelt wearing, drink driving countermeasures and the compulsory wearing of helmets by pedal cyclists.

Embracing diversity and inclusion through reconciliation

The RACS Reconciliation Action Plan (RAP) reflects RACS values of respecting diversity and being an all-inclusive service provider and workforce. The College recognises that the health of Aboriginal and Torres Strait Islander people in Australia is a public health problem of serious proportions.

Furthermore, the College acknowledges that historical inequalities in social and economic status currently experienced by Aboriginal and Torres Strait Islander people caused through the colonisation process contribute significantly to poorer health outcomes, particularly to decreased life expectancy resulting from colonisation. The College recognises that Aboriginal and Torres Strait Islander people are over-represented in every way in the determinants of poor health.

For these reasons advocating and supporting the improvement in health inequities of Aboriginal and Torres Strait Islander people is why RACS Innovate RAP has been developed.

Aboriginal and Torres Strait Islander health a RACS Council standing item

Part of the process of prioritising Aboriginal and Torres Strait Islander peoples health has included the decision for the Indigenous Health Committee to report directly to RACS Council. RACS Council oversees all areas of RACS policy, programs and initiatives. Making Aboriginal and Torres Strait Islander peoples health a standing item is a significant milestone in the history of the College.

Cultural competency

A requirement to be a practicing surgeon is the ability to demonstrate competence and performance in several areas. RACS Council has now approved the introduction of a 10th competency: 'Cultural Competence and Cultural Safety Competency'. This represents a watershed milestone in RACS' commitment to Aboriginal and Torres Strait Islander peoples health.

Our Reconciliation Action Plan (cont)

Reconciliation Action Plan development

The RACS Reconciliation Action Plan (RAP) was developed through consultations with RACS Indigenous Health Committee, RACS Reconciliation Working Group (RWG) and with reference to the RACS position paper on Aboriginal and Torres Strait Islander peoples health. The RAP development process involved a series of consultation with the two groups between June – October 2019. Implementation of this RAP will involve engagement with our Fellows, Trainees, International Medical Graduates and all staff across RACS including Aboriginal and Torres Strait Islander stakeholders, to achieve the vision for equity in health outcomes and reconciliation.

RACS position paper on Aboriginal and Torres Strait Islander health

This position paper explains the framework in which RACS proposes development of productive and culturally appropriate approaches to improve Aboriginal and Torres Strait Islander peoples health. As a professional medical college, RACS is uniquely placed to champion health equity for Aboriginal and Torres Strait Islander people. RACS focuses on both prevention and treatment of surgical conditions and recognises that improvement of Aboriginal and Torres Strait Islander peoples health will require collaborative, cross-disciplinary efforts.

RACS Indigenous Health Committee

RACS Indigenous Health Committee (IHC) was formed in 2008 and was established to oversee the implementation of the RACS Position Statement and strategic commitments in Aboriginal and Torres Strait Islander and Māori health. The IHC drives the implementation and review of the RACS Indigenous health portfolio, programs and initiatives, to ensure that RACS continues to meet its aim to improve the health of Aboriginal and Torres Strait Islander people and Māori in partnership with those communities.

RACS Reconciliation Working Group

A Reconciliation Working Group (RWG) was formed in early 2015 with broad representation from RACS departments to develop ideas and engage with staff across our organisation. The RWG meets quarterly to focus on building relationships, having input into activities and raising awareness with staff to ensure there is a shared understanding and ownership of reconciliation, and to track the progress of initiatives and projects designated to the RWG for implementation.

How RACS ensures it incorporates Aboriginal and Torres Strait Islander community representation and perspectives

RACS is dedicated to engaging respectfully and constructively with the Aboriginal and Torres Strait Islander community. It supports equal engagement with the community and understands it is achieved through representation and perspective from the Aboriginal and Torres Strait Islander people. RACS has incorporated Aboriginal and Torres Strait Islander community representation and perspectives through the following methods:

1. The RACS RWG is chaired by RACS Indigenous Health Committee Senior Project Officer, an Aboriginal and Torres Strait Islander identified position. In the capacity of IHC Senior Project Officer (IHCSPO) and Chair of the RACS RWG, the position of IHCSPO ensures the RWG receives input, guidance and advice by both an Aboriginal employee within the organisation and RACS IHC.
2. RACS Cultural Awareness and Safety eLearning course was designed and developed by an Aboriginal and Torres Strait Islander consultant specialising in cultural safety. The knowledge and insight provided by the consultant contributes to incorporating Aboriginal and Torres Strait Islander peoples perspectives.
3. Aboriginal and Torres Strait Islander surgeons contribute directly to providing feedback and perspective to initiatives and programs.
4. RACS partners with the Australian Indigenous Doctors Association (AIDA) as part of its commitment to improving Aboriginal and Torres Strait Islander peoples health outcomes. Through AIDA RACS is provided perspectives from Aboriginal and Torres Strait Islander doctors and medical students.
5. RACS provides secretariat support to the Ear Health for Life Consortium of which a number of Aboriginal and Torres Strait Islander professionals and organisations are members. Being a research body, research methods and ethics are strictly adhered to when working in Aboriginal and Torres Strait Islander communities. This process ensures representation and perspectives is a number one priority.

RAP Working Group members

Paul Cargill
Fellowship Services Manager

Jessica Redwood
Foundation for Surgery Manager

Bronwyn Emerson
Human Resources Business Partner

Damien Loizou
IHC Senior Project Officer

Jessele Vinluan
Senior Project Officer, Victorian Audit of Surgical Mortality (VASM)

Katherine Walsh
Victoria State Office Manager

Caroline Muliaga
Program Administrator, Australian and New Zealand Surgical Skills Education and Training (ASSET)

Therese Rey-Conde
Senior Research Officer

Sue Pleass
ANZ Scholarship and Grant Coordinator

Adam Shepard
Finance Manager

Agron Dauti
Digital Media & Internal Communications Coordinator

RAP Champions

The RACS RAP Champions are from our Indigenous Health Committee, RACS Indigenous Health team and RACS Reconciliation Working Group:

Dr Maxine Ronald FRACS
Chairperson, RACS IHC

Dr David Murray
Deputy Chairperson, RACS IHC

Dr Kelvin Kong
Founder, RACS IHC

Paul Cargill
Manager, Fellowship Services

Damien Loizou
IHC Senior Project Officer (Aboriginal and Torres Strait Islander Indigenous Health Committee Administrative Team)

RACS reconciliation journey

RACS' reconciliation journey is reflective in our commitment to contributing substantively to addressing the health inequities experienced by Aboriginal and Torres Strait Islander people. Since the 2009 RACS position paper, the RACS Indigenous Health Committee (IHC)and RACS Reconciliation Working Group were formed, a senior project officer position for Aboriginal and Torres Strait Islander people was created and filled, Aboriginal and Torres Strait Islander peoples health is a permanent RACS Council Agenda item, the RACS Strategic Plan 2019 -2021 identifies Australia's First Nations peoples health as RACS priority issue.

Other initiatives and contribution to Aboriginal and Torres Strait Islander peoples health are described below.

Ear Health for Life Consortium

The Ear Health for Life Consortium is comprised of Australia's leading experts in ear health and was formed to address the unacceptable situation of ear health in Aboriginal and Torres Strait Islander communities, which places Australia on the list as the world's worse country for ear health status.

Australian Indigenous Doctors' Association

For several years RACS has been a major sponsor and has run workshops at the Australian Indigenous Doctors' Association (AIDA) conferences. In addition, RACS has a permanent seat on RACS IHC for an AIDA representative. RACS recognises the importance of our relationship with AIDA and fosters a working relationship as part of our commitment to increase the number of Aboriginal and Torres Strait Islander surgeons.

Scholarships

Since 2016 RACS has offered annual scholarships to Aboriginal and Torres Strait Islander people, medical students and young doctors as part of RACS strategy to increase the number of Aboriginal and Torres Strait Islander surgeons.

RACS Reflect RAP

RACS inaugural Reflect Reconciliation Action Plan was launched during National Reconciliation Week in June 2016, with actions across four priority areas: relationships, respect, opportunities and tracking progress, and reporting. The plan outlines 59 deliverables with 54 completed and five in progress. There has been a great deal of support from Fellows, Trainees, International Medical Graduates and staff in working towards reconciliation. Supporting training, our trainers and including reconciliation as part of all College business is ongoing.

Highlights within the priority areas include:

Relationships

- RACS relationship with AIDA has continued to grow. AIDA is formally represented on the Indigenous Health Committee. RACS has been a gold sponsor and RACS President has attended AIDA's annual scientific meeting for the last four out of five years. The organisations collaborate leading initiatives in support of Aboriginal and Torres Strait Islander pathways into specialty medicine and in advocacy for key health issues.
- RACS has strengthened ties with the National Aboriginal Community Controlled Health Organisation (NACCHO).

Presenting at their annual meeting in 2017/18 and incorporating them as a partner in RACS ear health for life advocacy.

- Professor Martin Nakata was appointed as an Education Advisor to provide strategic advice relevant to RACS Indigenous health programs. Professor Nakata has addressed Council and the Board for Surgical Education and Training, presented as part of the 2018 Annual Scientific Congress program and is an active contributor through RACS Indigenous Health Committee.

Respect

- The College has formally introduced 'Cultural Competence and Cultural Safety Competency' as part of our Surgical Competence and Performance standards which will guide surgical training and ongoing professional development for surgeons.
- Acknowledgement and Welcome to Country protocols have been established.
- Commissioning of the Aboriginal and Torres Strait Islander motif has increased the visibility of Aboriginal and Torres Strait Islander health in the College and is prominently displayed during RACS Indigenous health activities.
- In 2018 RACS partnered with the Koorie Heritage Trust in Melbourne to deliver cultural competency training for staff. Training has been offered to all Melbourne based staff with programs investigated in the Australian states.
- Aboriginal and Torres Strait Islander health and cultural competence eLearning courses have been promoted to Fellows through the CPD program.
- In partnership with Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), the College has led a three year Ear Health for Life campaign in support of reducing the burden of ear disease in Aboriginal and Torres Strait Islander communities. A coalition of supporters has been developed including ear health researchers, allied health providers and peak bodies including the National Aboriginal Community Controlled Health Association and Australian Medical Association. A research road map was presented to the Australian Medical Research Advisory Board which guides investment in the Medical Research Future Fund at a Roundtable which aimed to set research priorities to improve Indigenous health. Wins to date have included a new $30 million investment in hearing assessments over four years, Federal Government support for the $7.9 million program addressing otitis media in the Northern Territory, the establishment of a Hearing Health Sector Committee led by Minister Wyatt and development of national KPIs as part of the Council of Australian Governments (COAG) process and the announcement of $160 million in funding for Aboriginal and Torres Strait Islander health research.
- In September 2018, RACS secured a two and a half year, $460,000 grant from the Australian Department of Health to support a review of needs across nine surgical specialties in terms of Aboriginal and Torres Strait Islander health and cultural safety.

Opportunities

- The Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative has been implemented by eight of nine training boards. The first trainee selected as part of the initiative started training in 2019.
- Aboriginal and Torres Strait Islander Health Network launched to connect Fellows interested in supporting Indigenous health initiatives.
- Formalised a list of Aboriginal and Torres Strait Islander suppliers and encouraged the use of Indigenous suppliers.
- RACS scholarships in support of Aboriginal and Torres Strait Islander medical students and doctors have increased from $15,000 in 2016 to $77,500 in 2020 funded by RACS, the Foundation for Surgery and with support from industry.

Tracking progress and reporting

- RACS reports annually to Reconciliation Australia.
- In addition, RACS has presented public updates on RAP progress at the Australian Indigenous Doctors' Association Conference in 2016 and 2018. In 2017, we presented at the Leaders in Indigenous Medical Education Conference.

RACS' first RAP reflected the overall commitment to contributing substantively to addressing Aboriginal and Torres Strait Islander health inequities and coordinating RACS response. This period also saw RACS commitment in funding an ongoing identified Senior Project Officer's role specifically attached to RACS Indigenous health portfolio and the Aboriginal and Torres Strait Islander Surgical Trainee Selection initiative.

Image: Photograph of Indigenous Scholarship

RACS Strategic Plan 2019 - 2021

RACS will prioritise Indigenous health, building the workforce and increasing services to better meet the health needs of Aboriginal and Torres Strait Islander and Māori people.

The focus is also on collaborating effectively with our partners and supporting the communities we serve.

The RACS Strategic Plan 2019-2021 presents an opportunity to build on the past while preparing the profession of surgery for a dynamic future. It reinforces our focus on core education, training and advocacy programs, better supporting surgeons to deliver excellence in contemporary patient care. The strategy is underpinned by the established RACS Mission, Vision and Values.

MISSION

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

VISION

Leading surgical performance, professionalism and improving patient care.

VALUES

Service, respect, integrity, compassion and collaboration.

THE FOUNDATIONS OF THE RACS STRATEGY

Mission and Vision

MISSION	VISION
The leading advocate for surgical standards, education and professionalism in Australia and New Zealand	Leading surgical performance, professionalism and improving patient care

Our three pillars

STANDARDS AND PROFESSIONALISM	ENDURING VALUE	MEMBERSHIP
Leading surgical practice through training, education and research	Creating opportunity for the surgical profession	Sustaining and supporting Fellows, Trainees and International Medical Graduates throughout their careers

Indigenous health
Aboriginal, Torres Strait Islander and Māori

Collaboration
Specialty societies

Community
Improving health outcomes

Values

SERVICE	RESPECT	INTEGRITY	COMPASSION	COLLABORATION

Governance

CONSTITUTION	CHARTER	CODE OF CONDUCT	POLICIES

Principles

Treat others as its Members would wish to be treated	Be open to, and informed by, the views of others	Develop expertise to act in areas of importance	Do no harm and act for the common good	Be transparent, fair and responsive	Preserve and enhance the sustainability of the College and its Members

Building relationships

RACS recognises the importance of relationships and collaboration. It is through collaboration and relationships that joint strategies and partnerships can be formed to achieve significant outcomes in Australia's First Nations peoples health. Furthermore, RACS appreciates the diversity in Aboriginal and Torres Strait Islander cultures, languages and spiritual beliefs. It recommends that Indigenous healthcare policies, projects and research from all institutions, specialty societies and organisations are developed in collaboration with Australia's First Nations Peoples to ensure they are culturally relevant and delivered in an understandable and useful way.

Action	Measurable target	Timeline and completion dates	Responsibility
Promote reconciliation through our sphere of influence.	- Implement strategies to engage our staff in reconciliation.	29 April 2021 and 2022	Reconciliation Working Group (RWG) Chairperson
	- Communicate our commitment to reconciliation publicly.	27 May 2020 and 2021	RWG Chairperson
	- Explore opportunities to positively influence our external stakeholders to drive reconciliation outcomes.	15 September 2021	Fellowship Services Manager
	- Collaborate with RAP and other like-minded organisations to develop ways to advance reconciliation.	22 April 2021 and 2022	RWG Chairperson
Promote positive race relations through anti-discrimination strategies.	- Engage with Aboriginal and Torres Strait Islander staff and/or Aboriginal and Torres Strait Islander advisors to consult on our anti-discrimination policy.	30 June 2020	Human Resources Business Partner
	- Conduct a review of HR policies and procedures to identify existing anti-discrimination provisions, and future needs.	31 July 2020	RWG Chairperson
	- Educate senior leaders on the effects of racism.	30 September 2020	RWG Chairperson
	- Develop, implement and communicate an anti-discrimination policy for our organisation.	30 November 2020	

Action	Measurable target	Timeline and completion dates	Responsibility
Celebrate and participate in National Reconciliation Week (NRW).	- Organise internal event each year at all College Offices to acknowledge and celebrate NRW.	May 2021 and 2022	RWG Chairperson
	- Circulate Reconciliation Australia's NRW resources and reconciliation materials to our staff.	May 2021 and 2022	Communications Coordinator
	- RAP Working Group members to participate in an external NRW event.	May 2021 and 2022	RWG Chairerson
	- Register all NRW events via Reconciliation Australia's NRW website.	21 May 2021 and 2022	RWG Chairperson
	- Encourage Fellows, Trainees, International Medical Graduates (IMG) and staff to participate in an external event to recognise and celebrate NRW.	May 2021 and 2022	Communications Coordinator
Develop and maintain mutually beneficial relationships with key local Aboriginal and Torres Strait Islander people, communities and organisations which align with our business.	- Identify opportunities to support initiatives and activities led by Aboriginal and Torres Strait Islander organisations that are relevant to the College's purpose.	31 July 2021	Indigenous Health Committee (IHC) Senior Project Officer
	- Meet with Aboriginal and Torres Strait Islander stakeholders to develop guiding principles for future engagement.	22 April 2021	RWG Chairperson
	- Engage regularly with Aboriginal and Torres Strait Islander stakeholders and organisations.	12 August 2020 – ongoing	Fellowship Services Manager
	- The College will continue to develop and foster relationships with stakeholders by attending conferences, sharing initiatives, collaborating when possible and seek advice from: • Leaders in Indigenous Medical Education (LIME) • Australian Indigenous Doctors Association (AIDA) • Medical schools with Indigenous medical programs	4 November 2020 - ongoing	Fellowship Services Manager
	- Develop and implement an engagement plan to work with Aboriginal and Torres Strait Islander stakeholders and organisations	- 9 April 2021 - ongoing	Indigenous Health Committee Senior Project Officer
Optimisation of pathways: Develop collaborative relationships with stakeholders and identify ways to optimise health outcomes and treatment of Aboriginal and Torres Strait Islander people.	- At conferences, stakeholder meetings, Ear Health for Life Consortium participate in meetings which identify opportunities to advocate and support the development and implementation for the optimisation of medical treatment with emphasis on servicing of community needs in collaboration with those communities.	7 May 2021 - ongoing	Fellowship Services Manager
	- Foster and development relationships for the purpose of identifying opportunities to contribute to RACS' reconciliation vision with: • Cancer Council of Australia • Ear Health for Life Consortium members • Medical schools	9 October 2021 and 9 October 2022	IHC Senior Project Officer

Building respect

The College is committed to making a contribution to improving the health inequities that exist between Australia's First Nations people and non-Indigenous Australians. To achieve this outcome, it is necessary to acknowledge and respect Aboriginal and Torres Strait Islander cultures, communities and histories. Respect through consultation, recognition and celebration contributes to developing respectful, supportive relationships and reflects cultural and community values.

Action	Measurable target	Timeline and completion dates	Responsibility
Demonstrate respect to Australia's First Nations People by observing cultural protocols.	- Develop, implement and communicate a cultural protocol document, including protocols for Welcome to Country and Acknowledgement of Country.	31 July 2020 - ongoing	IHC Senior Project Officer
	- Increase staff's understanding of the purpose and significance behind cultural protocols, including Acknowledgement of Country and Welcome to Country protocols.	31 July 2020 - ongoing	Fellowship Services Manager
	- Include an Acknowledgement of Country or other appropriate protocols at the commencement of important meetings.	31 July 2020 – ongoing	Fellowship Services Manager
	- Invite a Traditional Owner to provide Welcome to Country at significant College events, including RACS Annual Scientific Meeting and Regional Scientific Meetings.	20 May 2021 and 2022	RWG Chairperson
Promote Aboriginal and Torres Strait Islander presence and profile of people and cultures within college.	- Fly Aboriginal and Torres Strait Islander flags at College offices during NRW and NAIDOC Week.	May and July 2021 and 2022	RWG Chairperson
	- Display Aboriginal and Torres Strait Islander artwork and posters in RACS buildings and offices.	NAIDOC week July 2020 – ongoing	Communications Coordinator
	- Promote awareness of Indigenous health at the RACS Annual Scientific Congress.	20 May 2021 and 2022	Communications Coordinator
	- Encourage participation and engagement with RACS Indigenous health objectives by awarding IHC Medals.	20 May 2021 and 2022	Communications Coordinator
	- Develop RACS Indigenous health communication plan.	30 June 2021	Communications Coordinator
Build respect for Aboriginal and Torres Strait Islander cultures and histories by celebrating NAIDOC Week.	- RAP Working Group to participate in an external NAIDOC Week event.	NAIDOC week June 2021 and 2022	RWG Chairperson
	- Review policies and procedures to remove barriers to staff participating in NAIDOC Week.	NAIDOC week June 2021 and 2022	Human Resources Business Partner
	- Promote and encourage participation in external NAIDOC events to all staff.	NAIDOC week June 2021 and 2022	Fellowship Services Manager
	- Organise internal event each year at all College offices to acknowledge and celebrate NAIDOC Week.	NAIDOC week June 2021 and 2022	RWG Chairperson
	- Circulate NAIDOC resources and materials to our staff.	NAIDOC week June 2020, 2021, 2022	Communications Coordinator
	- Encourage Fellows, Trainees, IMGs and staff to participate in an external event to recognise and celebrate NAIDOC week.	NAIDOC week June 2021 and 2022	RWG Chairperson

Action	Measurable target	Time line Completion dates	Responsibility
Raise organisation understanding of Aboriginal and Torres Strait Islander peoples cultures and cultural protocols amongst staff.	- Develop and implement an Aboriginal and Torres Strait Islander cultural awareness training program for RACS administrative staff.	NAIDOC week 2020 – ongoing	Human Resources Business Partner
	- Promote Reconciliation Australia's 'Share Our Pride' online tool and resources to all staff (www. shareourpride. org.au).	NRW 2020 and 2021	Communications Coordinator
	- Recognise and communicate to staff Aboriginal and Torres Strait Islander dates of significance. List in College calendar.	19 March 2020 – ongoing	Fellowship Services Manager
	- Conduct a review of cultural learning needs within our organisation.	November 2020	IHC Senior Project Officer
	- Consult local Traditional Owners and/or Aboriginal and Torres Strait Islander advisors on the development and implementation of a cultural learning strategy for our staff.	23 June 2020 – ongoing	IHC Senior Project Officer
	- Provide opportunities for RAP Working Group members, HR managers and other key leadership staff to participate in formal and structured cultural learning.	5 February 2021 – ongoing	Fellowship Services Manager
Develop educational programs and materials and support for surgeons that focus on Aboriginal and Torres Strait Islander people health issues and cultural awareness.	- Develop and implement Cultural Competency Curriculum for all specialties in Surgical Education and Training, under the competencies of: • Professionalism • Communication • Health advocacy • Management and leadership • Collaboration and teamwork	10 February 2021 - ongoing	RWG Chairperson
	- Raise awareness and information amongst RACS Governing bodies to support their understanding of initiatives and strategies developed by IHC to assist them with their ability to address issues relating to Aboriginal and Torres Strait Islander peoples health.	10 February 2021 - ongoing	Fellowship Services Manager

Building opportunities

Social and economic factors are strong determinants of the wellness or otherwise of the individual and his\her community. These factors are compounded in Australia's First Nations populations by the multigenerational grief, loss and trauma associated with colonisation, the Stolen Generations, many layers of racism, discrimination, cultural dislocation. The College recognises that Closing the Gap is imperative if disparities in life expectancy are to be addressed.

Action	Measurable target	Time line Completion dates	Responsibility
Investigate and develop opportunities to improve and increase the number of Aboriginal and Torres Strait Islander employees within RACS.	- Support the onboarding of RACS RAP objectives and aims with new employees with information session about RACS RAP.	31 July 2020 ongoing	Human Resources Business Partner
	- Develop and implement an Aboriginal and Torres Strait Islander recruitment, retention and professional development.	31 July 2021	Human Resources Business Partner
	- Engage with existing Aboriginal and Torres Strait Islander staff to consult on employment strategies, including professional development.	30 June 2021	Human Resources Business Partner
	- Build understanding of current Aboriginal and Torres Strait Islander staffing to inform future employment and professional development opportunities.	31 July 2021	Human Resources Business Partner
	- Advertise job vacancies to effectively reach Aboriginal and Torres Strait Islander stakeholders.	September 30 2021 – ongoing	Human Resources Business Partner
	- Review HR and recruitment procedures and policies to remove barriers to Aboriginal and Torres Strait Islander participation in our workplace.	31 August 2021	Human Resources Business Partner
	- Increase the percentage of Aboriginal and Torres Strait Islander staff employed in our workforce.	31 October 2021 and 31 October 2022	Human Resources Business Partner
Increase Aboriginal and Torres Strait Islander people supplier diversity within RACS business operations.	- Develop and implement an Aboriginal and Torres Strait Islander procurement strategy.	31 August 2020	Finance Manager
	- Investigate Supply Nation membership.	30 September 2020	Finance Manager
	- Develop commercial relationships with Aboriginal and/or Torres Strait Islander businesses.	31 November 2021 - ongoing	Finance Manager
	- Review and update procurement practices to remove barriers to procuring goods and services from Aboriginal and Torres Strait Islander businesses.	7 May 2021	Finance Manager
	- Develop and communicate opportunities for procurement of goods and services from Aboriginal and Torres Strait Islander businesses to staff	9 July 2021	Finance Manager
Raise awareness and promote inclusive discourse about supporting Close the Gap in Aboriginal and Torres Strait Islander peoples health amongst RACS Fellows and administrative staff.	- Host internal staff information sessions to raise awareness and promote inclusive discourse about supporting Close the Gap by informing staff about Aboriginal and Torres Strait Islander histories, cultures and rights.	NAIDOC week June 2021 and 2020	IHC Senior Project Officer
	- Assist the *Surgical News* team to identify suitable stories and updates to be included in *Surgical News.*	31 July 2020 - ongoing	Communications Coordinator
	- Explore opportunities to raise awareness of IHC and Aboriginal and Torres Strait Islander peoples health initiatives and news using the various RACS publications.	31 July 2020 - ongoing	Communications Coordinator
Research collaboration: Understand holistic health issues affecting Aboriginal and Torres Strait Islander health and wellbeing and develop appropriate information, policy and research which reflects this understanding.	- Identify and facilitate collaborative partnerships on Aboriginal and Torres Strait Islander health projects with Aboriginal and Torres Strait Islander health organisations, primary healthcare workers, governments and other medical colleges.	25 August 2020	IHC Senior Project Officer
	• Provide ongoing support to the Ear Health for Life Consortium.	19 November 2021	Indigenous Health Committee Senior Project Officer

Action	Measurable target	Time line Completion dates	Responsibility
Inform Government and NGOs of issues concerning Aboriginal and Torres Strait Islander peoples health inequalities and advocate for change.	- Identify and support like-minded bodies in their efforts to advocate for improved health for the communities we serve, including improved Indigenous health. RACS will advocate for improvements in Aboriginal and Torres Strait Islander peoples health with a particular focus on surgery. The College will advocate for: • Improved health services • Disease and injury prevention • Improved availability of services • Improved access to services	16 September 2020 and 2021	Policy and Advocacy Manager
Healthy community: Continue to foster and nurture existing relationships to support progression of coordinated approach to improving Aboriginal and Torres Strait Islander health.	Support and nurture 'Ear health for life' consortium and investigate opportunities and ways to support research and opportunities for collaboration on research projects either through support in kind, advocacy or fund raising.	31 October 2020	IHC Senior Project Officer
Develop strategies to increase Aboriginal and Torres Strait Islander surgical workforce.	In consultation with Australian Indigenous Doctors' Association, the RACS IHC will develop strategies to increase the number of successful Aboriginal and Torres Strait Islander surgical training applicants, so that the proportion reflects the communities served. - Consult, develop and implement Indigenous surgeon recruitment pathway project. - Ensure all scholarships are awarded annually to support pathways towards a surgical career.	4 November 2020 November 2022 December 2021 and 2022	IHC Senior Project Officer
Capacity building: Develop and strengthen the knowledge of historical issues and policies and how they have impacted and contributed to the health inequities experienced by Aboriginal and Torres Strait Islander people.	- Develop and implement an information session around the operation of the poverty cycle in an Aboriginal and Torres Strait Islander community context and the other compounding issues and factors affecting Indigenous health. - Facilitate within the College through inductions, staff workshops and surgical training; understanding of the meaning of cultural safety, the impact of racism and unconscious biases on Aboriginal and Torres Strait Islander people. - Review information, policy and research used to inform ongoing surgical workforce and organisational workforce development - Develop surgical workforce which is culturally safe and competent to service rural and remote communities, and increase the capacity of the surgical workforce in rural and remote communities. - Develop information concerning the variation of issues and circumstances affecting urban and regional areas. - Raise awareness and understanding regional issues and circumstances impacting First Nation People. - Investigate opportunities to support initiatives which take into account remote and regional issues and circumstances.	31 July 2021 31 July 2021 31 July 2021 31 July 2021 17 November 2020 – ongoing 17 November 2020 – ongoing	IHC Chairperson Human Resources Business Partner IHC Senior Project Officer

Governance

Action	Measurable target	Time line Completion dates	Responsibility
Provide appropriate support for effective implementation of RAP commitments.	- Define resource needs for RAP implementation.	6 May 2020, 2021 and 2022	RWG Chairperson
	- Engage our senior leaders and other staff in the delivery of RAP commitments.	19 May 2020, 2021 and 2022	RWG Chairperson
	- Define and maintain appropriate systems to track, measure and report on RAP commitments.	21 April 2021	RWG Chairperson
	- Appoint and maintain an internal RAP Champion from senior management.	5 May 2020, 2021 and 2022	RWG Chairperson
Establish and maintain an effective RAP Working group (RWG) to drive governance of the RAP.	- Develop, have endorsed and launch of RACS Innovate RAP.	31 May 2020	RWG Chairperson
	- Meet at least four times a year to monitor RAP implementation.	8 March 17 June 9 September 8 December 2020, 2021 and 2022	RWG Chairperson
	- Ensure appropriate representation from RACS business units sitting on RACS RWG.	29 October 2020	RWG Chairperson
	- To ensure Aboriginal and Torres Strait Islander people are represented on the RWG throughout the duration of the RAP.	8 December 2020, 2021 and 2022	RWG Chairperson
	- Terms of Reference for the RWG updated.	10 November 2020	RWG Chairperson
Submit draft RAP to Reconciliation Australia for review, feedback and formal endorsement.	- In partnership with Reconciliation Australia, develop a new RAP based on learnings, challenges and achievements.	December 2021	IHC Senior Project Officer
Report RAP achievements, challenges and learnings internally and externally.	- Ensure RACS RAP achievements, challenges and learnings are made publicly available on the RACS website webpage.	30 November 2020	IHC Senior Project Officer
	- Complete and submit the annual RAP Impact Measurement Questionnaire to Reconciliation Australia.	30 September 2020, 2021 and 2022	Communications Coordinator
	- Report RAP progress to all staff and senior leaders quarterly.	7 December 2020, 2021 and 2022	Communications Coordinator
	- Publicly report our RAP achievements, challenges and learnings, annually.	15 December 2020, 2021 and 2022	Communications Coordinator
	- Include RAP Progress and implementation as standing agenda item at RACS Council.	31 July 2020, 2021 and 2022	IHC Senior Project Officer
	- Report RAP progress in the RACS Annual Report.	31 July 2020, 2021 and 2022	IHC Senior Project Officer

Acknowledgements

Indigenous Health Committee members

Mr Benjamin Cribb
FRACS

Dr Andrew Martin

Dr Stephanie Weidlich
FRACS

Dr David Murray
FRACS Deputy Chair

Dr John Mutu-Grigg
FRACS

Professor Stephen O'Leary
FRACS

Dr Maxine Ronald
FRACS Chairperson

Dr Benjamin Wheeler
FRACS

Mr Michael Wilson
FRACS

Reconciliation Working Group members

Paul Cargill
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Foundation for Surgery Manager

Bronwyn Emerson
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Program Administrator, Australian and New Zealand Surgical Skills Education and Training (ASSET)

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Agron Dauti
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RAP Champions

Dr Maxine Ronald FRACS
Chairperson, RACS IHC

Dr David Murray
Deputy Chairperson, RACS IHC

Dr Kelvin Kong
Founder, RACS IHC

Paul Cargill
Manager, Fellowship Services

Damien Loizou
IHC Senior Project Officer (Aboriginal and Torres Strait Islander Indigenous Health Committee Administrative Team)

Royal Australasian
College of Surgeons

RACS Indigenous Health Committee and Indigenous health administrative team contact details

RACS Indigenous Health Committee
Royal Australasian College of Surgeons
250-290 Spring Street,
East Melbourne VIC 3002,
Australia

Telephone: (03) 9249 1200

Email: indigenoushealth@surgeons.org
Webpage: www.surgeons.org

Royal Australasian College of Surgeons Reconciliation Action Plan 2020-2022.
Royal Australasian College of Surgeons. Melbourne, 2020.

RACS recognises and acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of Australia and pays respect to their continuing connection to culture, land, sea, community and family.

Committed to Indigenous health

Service | Integrity | Respect | Compassion | Collaboration

Royal Australasian
College of Surgeons

Royal Australasian College Of Surgeons
Māori Health Strategy and Action Plan

Te Rautaki Māori 2020 – 2023

Royal Australasian
College of Surgeons
Te Whare Piki Ora o Māhutonga

Committed to Indigenous health

He Whakamihi
Acknowledgement

It was important that Te Rautaki Māori be informed by the Māori community, therefore RACS would like to acknowledge the contribution of the individuals that attended Hui Akoako in November 2019, on behalf of the following organisations:

Cancer Society New Zealand
Health Quality & Safety Commission
Ministry of Health
Regional Public Health
Royal Australasian College of Anaesthetists
Royal Australian and New Zealand College of Psychiatrists
Royal New Zealand College of General Practitioners
RACS New Zealand National Board members
RACS Staff
Te Ohu Rata o Aotearoa (Te ORA)
Te Rūnanga o Raukawa
Tū Ora Compass Health

RACS would also like to thank all the members who dedicated their time and expertise to developing Te Rautaki Māori, in particular the knowledge, leadership and guidance of the Māori Health Advisory Group. Their dedication, hard work and enthusiasm is pivotal to RACS working toward equitable health outcomes and growing the Māori surgical workforce.

Indigenous Health Committee

Dr Maxine Ronald (Chair)
Dr David Murray
Dr Michael Wilson
Dr John Mutu-Grigg
Dr Benjamin Wheeler
Dr Benjamin Cribb
Dr Andrew Martin
Dr Ruth Mitchell
Dr Stephen O'Leary
AIDA representative
Te ORA representative

About the Indigenous Health Committee and Māori Health Advisory Group

The Indigenous Health Committee guides the ongoing review and development of RACS Indigenous health portfolio, to ensure that it continues to meet RACS' aim to improve the health of Indigenous people. The Indigenous Health Committee comprises Māori and Aboriginal Fellows and trainees and may include non-Indigenous Fellows and trainees.

The Māori Health Advisory Group is responsible for the implementation of Māori Health strategies, action planning and providing advice on Māori health initiatives, projects and content in RACS' position statements and policies. The Māori Health Advisory Group functions under the oversight of the Indigenous Health Committee and meets regularly to discuss Māori health advances and progressions.

For more information on the Indigenous Health Committee and Māori Health Advisory Group visit Indigenous Health on the RACS website

Māori Health Advisory Group

Dr Patrick Alley (Chair)
Prof. Jonathan Koea
Dr Maxine Ronald
Dr John Mutu-Grigg
Dr Benjamin Wheeler
Dr Benjamin Cribb
Dr Rachelle Love
Dr Jaclyn Aramoana-Alridge,
Trainee representative

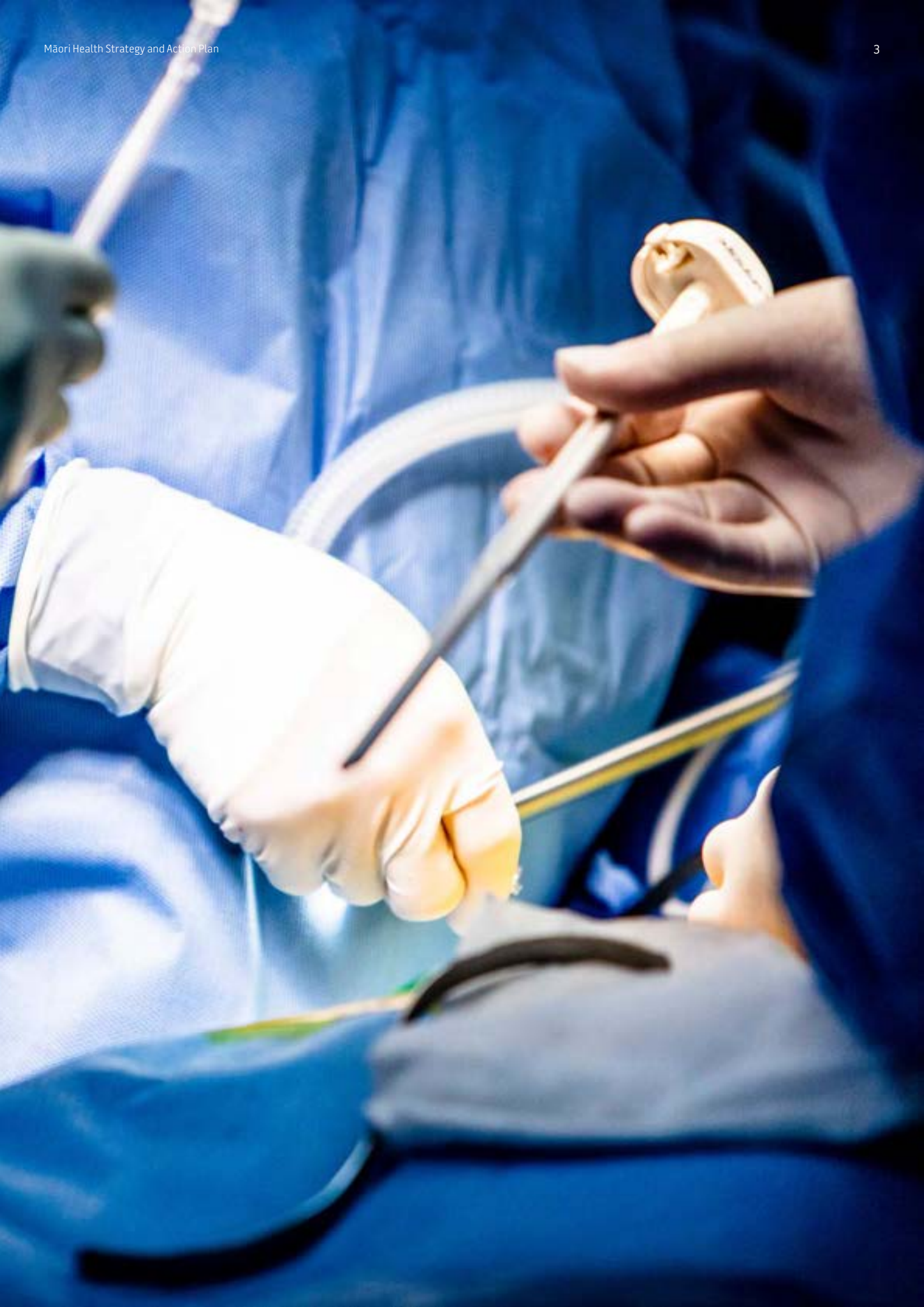

Table of contents

Important note: Some of the Māori words used throughout this document are not direct translations of the corresponding English word, rather it is the word that most describes the meaning of what the word is, from a Māori perspective.

Service | Integrity | Respect | Compassion | Collaboration

Wāhinga Kōrero
Foreword

The Royal Australasian College of Surgeons' (RACS) mission is to lead and advocate for surgical standards, performance, education and professionalism to improve patient care in Aotearoa[1] and Australia. RACS is serious about addressing the disparities and inequities faced by Indigenous populations, as stated in our Strategic Plan 2019 – 2021:

"RACS will prioritise Indigenous Health, building workforce and increasing services to better meet the health needs of Māori, Aboriginal and Torres Strait Island people. Focus is also on collaborating effectively with our partners and supporting the communities we serve."

We have achieved significant gains toward addressing Indigenous health. First, the Indigenous Health Committee will report directly to RACS Council[2], making Indigenous health a standing item on Council agenda. Second, the Indigenous Health Committee is to be chaired by a Councillor. Third, a 10th competency (Cultural Competency), has been added to the nine surgical competencies.

The Māori Health Advisory Group has been instrumental in advancing Māori Health issues, facilitating the development of Te Rautaki Māori and ensuring Māori views and aspirations are reflected throughout the College.

Te Tiriti o Waitangi is articulated in Te Rautaki Māori with the adoption of the principles, tino rangatiratanga (Māori sovereignty), partnership, active protection, options and equity, as recommended by the WAI 2575 Hauora Report[3]. RACS understands the importance of Te Tiriti o Waitangi being the foundation of policy review and development, planning, and building partnerships.

We are a long way from achieving health equity and understand that, in order to make significant change RACS will need to acknowledge and address the legacy of colonisation processes and the resultant racism and privilege at curricular and institutional levels. Te Rautaki Māori provides the mechanism to implement this.

"Tawhiti rawa tou haerenga ake te kore haere tonu.
Nui rawa ou mahi te kore mahi nui tonu"

We have come too far not to go further
and we have done too much not to do more

- Ta Hemi Henare No Ngā Puhi, Te Taitokerau.

Dr Anthony Sparnon
President

Dr Maxine Ronald
Chair,
Indigenous Health
Committee

Dr Patrick Alley
Chair,
Māori Health Advisory
Group

1 The Māori word for New Zealand.
2 Council oversee and make decisions on all RACS policies and sets RACS strategic direction.
3 Waitangi Tribunal. 2019. HAUORA: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Wellington. Waitangi Tribunal

Ka tangi te titi ka tangi te kaka ka tangi hoki ahau, tihei mauri ora!
Kia tau mai te aroha ngā manaakitanga o ngā Atua.
Ka mihi ka tangi hoki ki te hunga mate nō reira haere haere haere.
Tātau te hunga ora tēnā tātau katoa.
Tēnā anō tātau I runga I ngā tīni aronga o te wā.
Nau mai piki mai kake mai!

This *mihimihi* is a Māori introduction to this document that provides a sense of connection for Māori. It acknowledges the gift of life and pays homage to those that have gone before us. It then gives strength to the present day and the challenges we face ahead.

Tirohanga Whānui

Vision

"Te Whare Piki Ora o Māhutonga[4] aims to achieve a culturally safe and competent surgical workforce and advocate for Māori health equity"

Te Rautaki Māori 2020 – 2023 presents an opportunity to build upon some of the work implemented through the previous Action Plan. It sets the future direction toward achieving the vision of Māori health equity and a culturally safe and competent surgical workforce. RACS understands this journey will be a long one and is committed to supporting the elimination of Māori health inequity.

RACS is well positioned within the health sector to advocate for Māori health issues. Being one of the largest postgraduate medical training institutes in Aotearoa and Australia, RACS can use its position to influence medical education and the health sector.

It is not acceptable that Māori suffer far worse health outcomes than non-Māori. There are many factors that have led to the current state of Māori health. In *Educating for Indigenous Health Equity: An International Consensus Statement* (2019) the authors state:

"Colonization, racism and privilege are fundamental determinants of Indigenous health that are also deeply embedded in Western medical education. To contribute effectively to Indigenous health development, medical education institutions must engage in decolonisation processes and address racism and privilege at curricular and institutional levels. Indigenous health curricula must be formalised and comprehensive and must be consistently reinforced in all educational environments."[5]

This statement provides a description of the issues to be addressed within medical education in order to contribute to Māori health development. In supporting this statement, RACS seeks to understand the rights, interests and perspectives of Māori by engaging with Māori communities, building partnerships with Māori organisations and embedding Te Tiriti o Waitangi perspectives into policy and education. RACS also understands that achieving health equity is everyone's responsibility, therefore building capabilities of Fellows, trainees and staff as well as building partnerships are key components of Te Rautaki Māori. RACS will also seek and utilise existing Māori resources that support progression of Te Rautaki Māori, e.g. Te Arawhiti's Engagement Guidelines .[6]

4 Te Whare Piki Ora o Māhutonga is the Māori name for RACS used in New Zealand. This is further explained on page 8.

5 Jones R, Crowshoe L, Reid P, Calam C, Curtis E, Green M, Huria T, Jacklin K, Kamaka M, Lacey C, Milroy J, Paul D, Pitama S, Walker L, Webb G, Ewen S. Educating for Indigenous Health Equity: An International Consensus Statement. Acad Med. 2019 Apr; 94(04): 512-519. doi: 10.1097/ACM.0000000000002476. Accessed 18 October 2019

6 https://tearawhiti.govt.nz/te-kahui-hikina-maori-crown-relations/engagement/

These kaupapa (priority areas) inform our objectives and activities. It is intended that these kaupapa and Te Tiriti o Waitangi remain the foundation of Te Rautaki Māori beyond 2023 and further action plans be developed.

Te Rautaki Māori includes six kaupapa (priority areas):

1. *Pae Ora* (Healthy futures), the New Zealand Government's vision for Māori health which provides a platform for Māori to live well and healthy in an environment that supports a good quality of life;
2. *Mātauranga Māori* (Māori knowledge and capability) provides the foundation for building a capable surgical workforce and increasing the Māori knowledge of RACS governance groups and staff to make informed decisions on issues relating to Māori;
3. *Whakatipu* (Workforce development) focuses on increasing and maintaining the Māori surgical workforce and creating an environment that is safe for Māori;
4. *Rangahau Māori* (Research and development) is using kaupapa Māori methodology to undertake research that is beneficial for Māori and increases understanding of te ao Māori and mātauranga Māori;
5. *Kaupapa Here* (Stronger policy and development). Policies that are reviewed and/or developed will produce better results for Māori and better reflect the needs and aspirations of Māori;
6. *Ngā Hononga* (Partnerships) will be developed and maintained to support the progression of Te Rautaki Māori.

These kaupapa (priority areas) inform our objectives and activities. It is intended that these kaupapa and Te Tiriti o Waitangi remain the foundation of Te Rautaki Māori beyond 2023 and further action plans be developed.

RACS values (Service, Integrity, Respect, Compassion and Collaboration) are also incorporated in the strategy as they align with Māori ideology, especially respect, compassion and collaboration.

The Treaty of Waitangi

Te Tiriti o Waitangi

Te Tiriti o Waitangi (Te Tiriti) formalises the relationship between Māori and the Crown and provides a foundation for policy development in Aotearoa and means Māori values, traditions and practices are protected. It legitimises settler presence in Aotearoa and governance by the British Crown.

The Waitangi Tribunal is a standing commission of inquiry. It makes recommendations on claims brought by Māori relating to legislation, policies, actions or omissions of the Crown that are alleged to breach the promises made in Te Tiriti.

The Waitangi Tribunals WAI 2575 Health Services and Outcomes Kaupapa Inquiry claims that the three Ps, namely participation, protection and partnership, are a reductionist view of Te Tiriti and that contemporary thinking has moved on significantly. Therefore, it recommends the following obligations be reflected in Māori Health Action Plans, policies and relevant documentation:

- **Tino rangatiratanga** – *The guarantee of self-determination.*
- **Partnership** – *Good faith, mutual respect, be able to express tino rangatiratanga.*
- **Active protection** – *Mana motuhake, manage affairs according to own tikanga, also tikanga present in mainstream health services.*
- **Options** – *Right to choose social and cultural path and exercise authority.*
- **Equity** – *Specifically target disparities, expected benefits of citizenship.*

RACS agrees with the recommended obligations and has adopted these as the foundation for Te Rautaki Māori.

RACS Māori name

Te Whare Piki Ora o Māhutonga

The Māori name is metaphorical rather than a literal English translation and this broadly equates to The School (or House) of Ascension to Health Under the Southern Cross. This encapsulates RACS' commitments to continued excellence in learning, its dedication to the attainment of good health, and the College's bi-national history.

Māori motif

The development of the Māori motif, designed by Mr Mark Kopua (Te Aitanga a Hauiti, Ngāti Ira, Ngāti Porou), brings together several key elements to represent RACS' Māori health initiatives. The representation is explained by:

- the taniwha (serpent) through the centre, being symbolic in Māoridom for guardianship or protector. It closely resembles the serpent of the Rod of Asclepius (the Greek god of healing)
- the head of the taniwha is representative of Rongomatane, the Māori god of good health, wellbeing, medicine and peace
- the three parallelograms in the motif represent the three kete (baskets) of knowledge in Māori tradition – kete o te wānanga. Each symbolises a different area of knowledge – Kete Tuauri (natural world), Kete Tuatea (agriculture) and Kete Aronui (literature, arts and philosophy)
- the two scalpels represent Te Āwhiorangi (top right) and Te Whironui (bottom left), the principal blades used to sever Papatūānuku (earth mother) from Ranginui (sky father) in Māori legend, thus letting light into the world. While surgery is much more than procedures, scalpels are obvious and immediate imagery for surgery
- other design elements include the repeated image of the koru (furled fern frond) which represents new beginnings, growth and regeneration. It is a symbol that has become synonymous with Aotearoa/New Zealand. The triangular designs throughout are often represented in Māori art, and feature in the tukutuku panels that decorate the walls of the wharenui (meeting house) on marae.

Aronga Rautaki
Strategic Framework and Action Plan

Te Tiriti o Waitangi *Treaty of Waitangi Principles*

The Te Tiriti Principles are the foundation
for policy review and development, planning and building partnerships.

Tino Rangatiratanga Partnership Active Protection Options Equity

Tirohanga Whānui *Vision*

Te Whare Piki Ora o Māhutonga aims to achieve a culturally safe
and competent surgical workforce and advocate for Māori health equity.

Whakataukī

Whakataukī are metaphors that support critical thinking by allowing the receiver of the whakataukī
to consider another way of thinking from a worldview other than their own. Whakataukī are an important part of the Māori world view.

Ko te pae tawhiti whāia kia tata, ko te pae tata whakamaua kia tina.
Seek distant horizons in pursuit of excellence.
- Mete Kingi Te Rangi Paetahi

Service Integrity Respect Compassion Collaboration

Pae Ora *Healthy Futures*

Ngā Whāinga *Objectives*	**Ngā Tukanga** *Key Actions*	**Tātaihia Ngā Piki** *Measuring success*
RACS Governance structure is reflective of supporting te ao Māori and Māori health.	Actively support Boards and Committees to effectively report on Indigenous matters (Aboriginal Torres Strait Island health and Māori health). Propose an increase of the number of New Zealand and New Zealand Māori Fellows on Council and reflect this in the Council Terms of Reference.	Council meeting minutes reflect reporting on Indigenous matters. Committees and Boards are reporting to Council on Indigenous health advances and issues within their area of operation. Council's Terms of Reference are reviewed and updated to reflect the objective/s.
RACS office bearers understand the socio-political context within which RACS operates in Aotearoa.	Te Tiriti o Waitangi education sessions are planned and implemented. Include information on the socio-political context of Aotearoa and Te Tiriti in the Governance manual and include in governance training. Conferences etc. (includes societies and specialty associations conferences) include Māori Health content. RACS promotion also includes this information.	Council's Terms of Reference are updated to reflect the Actions, i.e. Te Tiriti and information of the socio-political context is included as governance training. This governance training is mandatory for all incoming Councillors / office holders. RACS are supporting specialty societies to include Māori health at events, conferences etc.
RACS supports legislation, statements, proposals etc. that addresses positive health outcomes for Māori.	Regular external environmental scanning to ensure awareness of issues relating to Māori health. Oral and written advocacy to support this objective.	Information is recorded and reported on.
RACS are leaders in addressing racism and unconscious biases.	Based on the research findings (from the Rangahau Māori objective), develop a project plan that addresses the issues e.g. similar to the Building Respect project and campaign that began in 2015[7]. Implement this plan with the understanding that this project could exceed beyond 2023.	Adequate resources, i.e. funding, are sourced for the implementation of this project. A time limited (18 – 24 months) working group is formed to undergo this project and includes RACS staff and Indigenous Fellows. The plan is developed and implemented by the working group.
Success is celebrated!	Share successes on all RACS media platforms (Blog, Fax mentis, Pulse, twitter etc.) Provide opportunities for celebrating success.	Te Rautaki Māori is achieving its goals and news of this has increased on media platforms.

Kaupapa Here *Stronger Policy and Development*

Ngā Whāinga *Objectives*	**Ngā Tukanga** *Key Actions*	**Tātaihia Ngā Piki** *Measuring success*
Policies that are reviewed and/or developed benefit the progression of Te Rautaki Māori and work toward improving health equity (where applicable).	Develop a policy process/system to guide policy makers and reviewers on potential risks and consequences to Māori health when developing/reviewing policies. Where necessary (according to the process/system developed in the previous action point), Māori are informed of and included in the policy review. Keep up to date with internal work on policies.	Policies (reviewed/new) have considered Indigenous issues and perspectives. Relevant policies deliberately address health inequities.

7 https://umbraco.surgeons.org/media/3642/building-respect-phase-1-evaluation-report-2019-10-21.pdf

Mātauranga Māori *Māori Knowledge and Capability*

Ngā Whāinga *Objectives*	**Ngā Tukanga** *Key Actions*	**Tātaihia Ngā Piki** *Measuring success*
Strengthen the cultural knowledge and capability of non-Māori to improve Māori health.	Te Tiriti o Waitangi information and training resources are sourced/developed and are available online. Cultural training opportunities are resourced adequately and are reflected across RACS activities. Fellows, trainees and staff are encouraged to access training opportunities.	Training opportunities are introduced and promoted across RACS. Track the number of times the online training resources are accessed. Record the number of Fellows, staff and trainees attending cultural training. Report on numbers annually (e.g. June Council meeting).
Māori knowledge is embedded into RACS activities to ensure culturally capable staff, Fellows and trainees.	A proposal for a Tikanga Māori Policy is submitted to RACS Council and/or relevant Boards. Tikanga Māori resources are sourced and/or developed to support the policy. RACS ASC has imbedded Indigenous ways and perspectives (tikanga) into processes	The Tikanga Māori Policy and resources is launched and implemented across RACS activities. Track (by recording and reporting at Māori Health Advisory Group meetings) how this is being used and how effective it is. RACS ASC is effectively implementing Indigenous perspectives and tikanga across the whole conference.
RACS curriculum and training includes Māori health and Māori cultural competence and safety training opportunities.	An overarching surgical curriculum is developed that specialty societies can use and build upon for their specialty. Training modules are developed and introduced. Confirm a cultural safety and competency accreditation process that supports surgical training boards.	RACS curriculum includes Māori health. Cultural Safety training modules are developed (for New Zealand). An accreditation process is confirmed. Indigenous health / Māori health training is compulsory for all training supervisors, Fellows and trainees.

Whakatipu *Workforce Development*

Ngā Whāinga *Objectives*	**Ngā Tukanga** *Key Actions*	**Tātaihia Ngā Piki** *Measuring success*
The surgical workforce is proportionately reflective of the communities it serves, e.g. Māori make up 15% of New Zealand's population, therefore the goal is 15% of surgeons in New Zealand are Māori.	Develop and implement a Māori surgical trainees recruitment strategy. Develop strategies that support, increase and retain the current Māori surgical workforce. Obtain accurate data on current Māori surgical workforce that allows us to track numbers over time.	RACS can accurately measure an increase in Māori trainees over time. RACS can accurately measure an increase in Māori Fellows over time. RACS employs a Cultural Navigator / Kaiawhina to support Māori Trainees progression. Regular gatherings are confirmed with trainees to foster whanaungatanga.
RACS has the resources and capability to complete and maintain the actions of Te Rautaki Māori.	The Māori Health Project Officer develops internal relationships that progress Te Rautaki Māori, e.g. the Education team to progress with cultural training opportunities. Continue to employ Māori staff for the implementation and delivery of Te Rautaki Māori.	FTE confirmed for the implementation of Te Rautaki Māori. Identify and track current Māori staff numbers. Evidence is reported annually.


RACS Maori ASC Award
RACS Maori ASC Award

Rangahau Māori *Research Development*

Ngā Whāinga *Objectives*	**Ngā Tukanga** *Key Actions*	**Tātaihia Ngā Piki** *Measuring success*
Understand cultural safety, racism and unconscious biases within RACS (staff, Fellows, IMGs and trainees) to inform strategies that address these issues. *Note: This objective is the research component to inform the Pae Ora objective.*	Seek external funding options to fund this research project, e.g. Ngā Pae o te Maramatanga, Health Research Council of NZ etc. Form a working group (Fellows and staff) to coordinate the research project. Undergo research that identifies the levels of racism and unconscious biases. This research will inform the racism project in Pae Ora.	Funding is sourced for this research project. The working group is established, and progress is reported on biennially to the Māori Health Advisory Group and Indigenous Health Committee.
Ethnicity data is a requirement and easily tracked.	Ensure research is conducted using Kaupapa Māori methodology. Work with RACS data analysts to analyse the current ancestry data and recording methods and develop strategies on obtaining future data to better inform Māori numbers. Promote the importance of ethnicity data and what this informs.	RACS can identify the number of Māori surgeons and trainees and track this over time. Recording ethnicity data is compulsory.

Ngā Hononga *Partnerships*

Ngā Whāinga *Objectives*	**Ngā Tukanga** *Key Actions*	**Tātaihia Ngā Piki** *Measuring success*
Partnerships with Māori (Iwi, Hapū, Organisations, Community) is established to support Te Rautaki Māori progression.	A Māori engagement strategy based on Te Arawhiti's guidelines is developed and implemented. Existing relationships are identified, and their significance determined. Develop an evaluation plan to determine the ongoing success of partnerships.	Success is determined by the evaluation plan.
Partnerships with the Ministry of Health (MoH) and District Health Boards (DHBs) are established to support Te Rautaki Māori progression.	Determine the purpose of a relationship with DHBs. Develop partnerships with MoH and DHBs, particularly those with high proportion of Māori	Progress toward this goal is reported annually.
Cross-organisational communication is prioritised.	Communication with relevant RACS training boards/ committees is strong and prioritised in a way that progresses Te Rautaki Māori and surgical outcomes for Māori. Support relevant RACS training boards/ committees to implement Te Rautaki Māori 2020 – 2023	Progress toward this goal is reported annually.
Relationships with Specialty Societies are strengthened.	Determine the purpose of this relationship and determine a common goal. Relationships with Specialty Societies are built and maintained in a way that progresses Te Rautaki Māori and surgical outcomes for Māori.	An aligned partnership is established and a common goal is confirmed. Progress toward this goal is reported annually.

Royal Australasian
College of Surgeons
Te Whare Piki Ora o Māhutonga

Further information

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Service | Integrity | Respect | Compassion | Collaboration

The Indigenous Health Committee Governance Structure

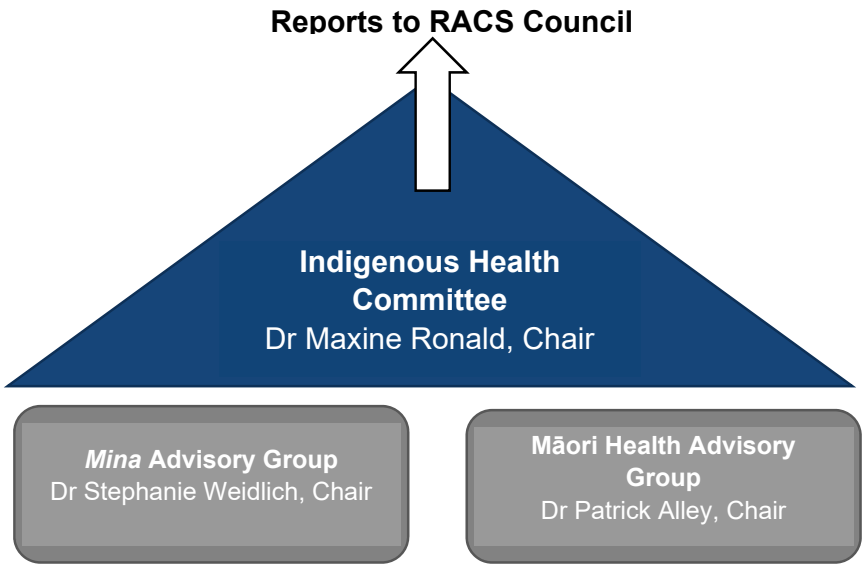
The Indigenous Health Committee guides the ongoing review and development of RACS Indigenous health portfolio, to ensure that it continues to meet RACS aim to improve the health of Indigenous people. Indigenous Health Committee is made up Māori and Aboriginal Fellows and trainees and may include non-Indigenous Fellows and trainees.

The **Māori Health Advisory Group** is responsible for the implementation of Māori Health strategies, action planning and providing advice on Māori health initiatives, projects and content in RACS position statements and policies. Māori Health Advisory Group functions under the oversight of the Indigenous Health Committee and meets regularly to discuss Māori health advances and progress.

The very recently formed ***Mina* Advisory Group** is responsible for advice, guidance and feedback on the development and implementation of key Aboriginal & Torres Strait Islander health initiatives, projects and policies.

The word *'Mina'* translates to knowledge in the *Gathang* Nation people's language. It is also the language nation of Australia's first Aboriginal surgeon Dr Kelvin Kong, a founding member of the IHC and a RACS Indigenous health advocate and champion.

The 'Mina Advisory Group', is a term to denote the English translation Aboriginal & Torres Strait Islander knowledge Advisory Group.



Aboriginal and Torres Strait Islander Curriculum Project

The Department of Health funded Aboriginal and Torres Strait Islander STP curriculum project was commenced in early 2019. The project objectives included implementing curriculum across face to face courses, developing new eLearning resources and accompanying policy and accreditation documents. Since the project commenced significant progress has been made towards developing and implementing a range of RACS wide changes to support the inclusion of Indigenous Health and Cultural Safety curriculum.

The project work has been underpinned by different RACS wide changes including the inclusion of a dedicated 10th competency and the development of the supporting Professional Standards Framework along with the newly drafted hospital accreditation. The project has collaborated closely with other areas of RACS to ensure that any options for collaboration are identified.

A major part of the project focus has been the design and development of a suite of new eLearning courses. This four course, Aboriginal and Torres Strait Islander Health and Cultural Safety platform, was planned to ensure learners are provided with all the necessary resources. The full set of courses is planned to be fully available by mid 2021. Currently Course 1 is available via the RACS website with plans to have Course 2 live in the next 2 months. Courses 3 and 4, which focus more on self-reflection and analysis, will be available towards the end of 2020 and mid-2021, respectively. It is planned that Fellows and Trainees will do one course per year, as they require a significant time commitment and will also provide their annual Category 4 – CPD of Reflective Practice.

The project has also worked closely with the RACS Education Department to develop content for inclusion in various RACS face to face courses and training sessions. This has included the 2019 and 2020 Academy webinars and the 2019 RACSTA meeting. However, due to the changes that have occurred due to coronavirus, some face to face activities and the ASM and its associated meetings, have been delayed and will be reassessed for delivery in late 2020 or early 2021.

For the remaining time in 2020 the project plans to focus on inclusion of content for the 10th competency across a range of face to face courses in the Skills and PD.

It is proposed that as part of the new 2021 STP application the focus will be shifted to the specialty areas with development of support resources and content for SET entry, throughout training curriculum and the Fellowship exam questions. This was originally included as a focus area for the first project plan but has been on hold while the 10th competency and Professional Standards curriculum along with the supporting eLearning course resources were developed. In order to ensure it is done appropriately the project team will be contacting the Specialty Societies to discuss options for the new proposal and approval through BSET in October before commencing.

Māori Cultural Competency and Cultural Safety training – New Zealand

In addition to the curriculum progress mentioned above and the development of the 10th Competency, RACS Māori Health Advisory Group has collaborated with MIHI (Māori Indigenous Health Institute) Otago University to develop a series of eLearning modules and a face to face course. The course is expected to start at the beginning of 2021.

Aboriginal and Torres Strait Islander Surgical Pathway Project

RACS is committed to improving surgical health outcomes for Aboriginal and Torres Strait Island Peoples and in doing so is committed to increasing the Indigenous surgical workforce. Indigenous people are more likely to present for medical treatment and comply with treatment guidelines if the workforce reflects Indigenous people. The Aboriginal and Torres Strait Islander Surgical Pathway Project (ISPP) is aimed at increasing the Aboriginal and Torres Strait Islander surgical workforce.

The ISPP working group was established and convened for the first time on 5 May 2020. The group comprises of two Fellows and the Indigenous Health Senior Project Officer. The purpose of this group is to provide strategic advice toward the implementation of the project.

One of the activities of the project is the collaboration between RACS and the Royal Darwin Hospital to develop an engagement model that engages, fosters and coordinates medical administration, subspecialties, departments, emergency department, Top End Health Service (TEHS) and Aboriginal health support in an effort to provide the best quality care to Indigenous patients.

RACS has also began a relationship with Flinders Medical School beginning with a presentation to the medical students to promote the aspirations of the ISPP.

ITEM: SET.25 – Active SET Indigenous Trainees by Specialty

		CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL 2019
Aboriginal and Torres Strait Islander	Male	1	1	0	3	1	0	0	0	0	6
	Female	0	0	0	1	0	0	0	0	0	1
	Total	1	1	0	4	1	0	0	0	0	7
Māori	Male	0	0	1	7	3	0	0	1	0	12
	Female	0	4	0	1	0	0	0	0	0	5
	Total	0	4	1	8	3	0	0	1	0	17
Total	Male	1	1	1	10	4	0	0	1	0	18
	Female	0	4	0	2	0	0	0	0	0	6
	Total	1	5	1	12	4	0	0	1	0	24

Note: Includes Trainees who have identified their ethnicity/ancestory.
Identifying as Aboriginal and Torres Strait Islander or Māori is optional.

Royal Australasian
College of Surgeons

Building Respect, Improving Patient Safety Action Plan

Phase 1 Evaluation
Final Report

June 2019

www.thethreadconsulting.com.au

Table of Contents

Executive Summary

Background

Action Plan history

In 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG) to investigate the extent of discrimination, bullying and sexual harassment within the surgical profession. EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. This raised serious concerns for the wellbeing of individual surgeons and surgical trainees, of surgical teams and especially for the quality of care and safety of patients.

RACS responded to these issues by developing an Action Plan, *Building Respect, Improving Patient Safety* (Action Plan) (Attachment 1), which outlines how RACS intends to counter and drive out unacceptable behaviours from surgical practice and surgical training.

Goals

The Action Plan describes the actions needed to address each of the EAG recommendations. It contains eight goals, arranged under the three key action areas identified by the EAG. These goals are supported by a comprehensive workplan, which has been prioritised and gradually implemented.

Context

Implementation of the Building Respect Action Plan is a highly complex challenge, involving negotiation of multiple partnerships and priorities across health jurisdictions in two countries. It has been accomplished in an environment with many contextual influences, including rapidly changing community attitudes and expectations regarding respectful behaviours, as exemplified in the #Metoo movement. Achieving the goals of the Action Plan will require significant cultural change, and some resistance is to be expected, with some groups taking longer to change their attitudes and behaviours than others.

The Phase 1 evaluation

This was the first evaluation of the Building Respect Action Plan. As such, it was primarily focussed on further development and implementation of the program, whilst also looking for very early indicators of progress towards outcomes. The scope for this evaluation covered:

- Measure whether program implementation, governance and oversight are proceeding as intended.
- Measure whether early outcomes (delivery of pathways for identifying and addressing concerns about behaviour; program reach; target audience perceptions of the Action Plan) are being achieved as intended.
- Identify program strengths, what is working well, barriers to progress.

- Make recommendations on areas for program adjustment or improvement, based on findings.

The evaluation was conducted by collecting evidence against two Key Evaluation Questions (KEQ) focussed on Action Plan implementation and governance. A number of evidence sources were used, including documents, reports, presentations, a survey of College members, and in-depth interviews with selected Fellows, Trainees and International Medical Graduates (IMGs) to explore emerging issues. The findings and draft recommendations were validated with the Project Reference Group (PRG) before being finalised in this report.

Findings

The Key Evaluation Questions (KEQ) are shown below, together with their related findings.

KEQ 1: Has the Action Plan been implemented as intended to date?

Key points

- A significant amount of work has been delivered.
- Almost all of the program elements have been delivered according to plan.
- Visible commitment by College and Council is a strength.
- Building Respect elements are reaching target audiences.
- Deep permeation of the key messages.
- Some pockets of resistance to cultural change remain.
- RACS' complaints process, like other complaints processes, is not perceived as safe.
- Trainees do not appear to be very engaged with the College.
- Very strong support for the Action Plan amongst RACS membership.
- Challenge for RACS is that respectful behaviour is a whole of healthcare issue.
- Implementation of the Action Plan is in line with societal change.

Summary

The College's swift action in response to the recommendations of the EAG, its allocation of significant resources to the Building Respect Action Plan, and its appointment of a senior position to lead the implementation have been seen by the majority of interviewees and survey respondents as a strong commitment to the Action Plan. Almost all of the Action Plan has been delivered as planned, a significant achievement, given the size of the task. Overall the Action Plan has been positively received and is very strongly supported by Fellows, Trainees and IMGs.

The College is now seen to be in step with public opinion and broader societal shifts. More than this, the College is now seen as leading the way as an institution that has acknowledged these problems and made a serious commitment to addressing them.

The right audiences are receiving Action Plan communications via multiple sources, contributing to the high level of awareness of the key messages and the majority of actions that the College has taken. Survey respondents declared that they had a strong understanding of the issue around respectful behaviours and the need to take action. The visibility of the issue has brought it out in the open, with many people describing a new and growing dialogue within the workplace, with the reach of awareness extending beyond surgery to encompass other medical disciplines.

The survey highlighted a remarkably high level of support for the College's commitment to addressing discrimination, bullying and sexual harassment in surgery, with 95% of 1346 Fellows, 96% of 244 Trainees and 93% of 62 IMGs supporting the College's commitment. Early outcomes such as perceived cultural change in the workplace and representation of women in surgical training, are making good progress. RACS is leading the way in developing a model for introduction of respectful behaviours, with other Colleges and organisations turning to the College for policy advice and education programs.

A significant and visible element of the Action Plan was the education program, including the mandatory online e-module, which has now been completed by over 98% of Fellows, Trainees and IMGs; the face to face Operating With Respect course (OWR) mandated for surgical supervisors and RACS major Committee Members; and the Foundation Skills for Surgical Educators course (FSSE), with only 3% of the mandated cohort being followed up as this report was being prepared.

Despite this success, there remains a significant cohort of members that are resistant to change and unable to adjust their communication style. Interviewees reported scepticism amongst some of their colleagues regarding the Action Plan and pockets of resistance from others who describe the Action Plan as "*political correctness gone mad*." An incidental finding was that Trainees do not seem to be well engaged with the College, possibly through time limitations or fear of negative consequences for those highlighting unacceptable behaviours.

The major area for improvement is the College's complaints process, which, despite an increase in the number of complaints relating to respectful behaviours, is, like other complaints processes, not perceived as safe by more than half of Trainees.

Strengths

Implementation of the Action Plan has been successful and well delivered. One of the key strengths of the Action Plan has been highlighting the evidence linking behaviour to patient safety in its messaging and call to action. This is evidenced by the strong awareness of this message, shown in the survey responses. Another strength of the Action Plan has been the communications function. There has been strong

branding, development of a professional logo and strapline and very effective messaging targeted at the key audiences.

The huge and visible level of commitment and enthusiasm from College and Council have been observed by interviewees and survey respondents alike. This commitment has also been displayed in the prioritisation of resources to the Action Plan implementation, another strength of the College's approach to addressing this issue.

Opportunities for improvement

The RACS complaints process, like other complaints processes, is not perceived as safe by more than half of Trainees, and a substantial proportion of IMGs and females. The major reason for this is a lack of confidence that it will lead to positive outcomes, and fear that it could result in severe negative career consequences. The College has already recognised that the complaints system needs improvement, and it is currently being revised.

Despite the strong awareness of the key Action Plan messages, there is still a range of attitudes and entrenched beliefs about what is acceptable behaviour in the surgical workplace. Although it is expected that change will happen at a different pace for different cohorts, and there are likely to be people for whom the changes will take longer, there is an opportunity to consider ways to influence these "pockets of resistance" or whether the cultural change should be allowed to more gradually permeate.

Trainees are not as engaged with the College as other groups. Trainees and IMGs are not as aware of the key messages as Fellows. This could become an issue for future Fellows who may not have absorbed the messages early in their careers. Therefore, there is an opportunity to target messages specifically to these cohorts.

KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?

Key points

- The Action Plan has been resource-intensive.
- Action Plan outputs and activities are being closely monitored.
- Program outcomes are being evaluated as they develop.
- Emerging evidence and lessons learned inform practice.
- RACS is addressing identified strategic challenges for further implementation.
- RACS reports transparently to stakeholders about progress towards building a culture of respect.

Summary

The Building Respect Action Plan is extensively and effectively monitored. At this early stage of program implementation, the focus is on Action Plan outputs and activities,

with regular reporting through senior management and the CEO, to Council, Board of Council and the Building Respect Implementation Group. External evaluation and review have been built in to provide outcomes reporting at the appropriate stage of program development and to inform the continuous improvement approach. There is evidence to indicate that adjustments are being made to the Action Plan as new evidence or practical barriers emerge. Importantly, RACS management and Council have identified the key strategic challenges for further implementation and already have plans to address them.

Strengths

Dedicated senior position

One of the major strengths of the Action Plan has been the establishment of a dedicated senior position to drive program implementation. This has achieved a focal point for advocacy, coordination and progress monitoring, which has contributed to the strong achievements to date.

Culture of continuous improvement

Another strength is the culture of continuous improvement, evident through the close monitoring of actions and outputs against plans, and the openness to receive recommendations from external reviewers and examine the evidence for emerging trends and ideas. This underpins the Action Plan's adaptability, agility and responsiveness.

Transparent reporting

Transparency is also a key strength of the Action Plan. There has been extensive reporting both within and externally to the College about progress towards a culture of respect and this has strengthened the College's position as a leader in this significant undertaking, and validated the importance of this work to its members.

Opportunities for improvement

Addressing the cost of the Action Plan

Action Plan implementation has been resource-intensive, particularly the mandatory education, which has been funded by diverting resources from other priorities. There is no comprehensive cost recovery plan which could support sustainability of the Action Plan in the longer term.

Incorporating Building Respect principles into Business as Usual

Although the Action Plan is nominally mentioned in the current RACS Strategic Plan, the Building Respect principles are not incorporated into the all the elements of the Plan.

Inform Council about the introduction of outcome reporting

Councillors spoke of their need to see outcomes reporting against the Action Plan, however, it is very early in the program implementation to be able to measure many of the outcomes with any certainty. It is important to inform the Council about the planned schedule for outcome reporting over the remaining two phases of the evaluation.

Recommendations

1. Maintain momentum through visible high-level support for the Action Plan.

1.1 Maintain focus and drive through the Executive Leadership Team.
Maintain the momentum for implementation by continuing to focus on Action Plan outcomes at senior level.

1.2 Maintain the high visibility of Council support through external reporting and presentations.
Continue with the President's presentations, other presentations at conferences and both internal and external annual reporting to demonstrate the commitment of the Council and other office bearers, including at the STANZ level, to building a culture of respect.

1.3 Maintain high visibility of the Action Plan through a strong communications function.
Continue to fund and support the communications function, to review and update the messages and to refocus the communications on changing priority areas as the Action Plan is implemented.

1.4 Ensure Business as Usual integration by incorporating the Action Plan principles throughout the RACS Strategic Plan and annual workplans.
Demonstrate Council's commitment to the Action Plan goals by visibly integrating the principles into Business as Usual and make it central to how all College activities are delivered. Strengthen its place in the Strategic Plan and annual workplans to underpin all activities and values.

2. Review the complaints process to increase confidence that problems will be dealt with proportionately

2.1 Clarify and articulate RACS's role in the complaints process
Establish and agree the appropriate role for the College in the overall complaints system, including its legal and moral obligations to ensure a safe training environment, and to support cultural change in the practice of surgery. Once agreed, this should be clearly communicated to members.

2.2 Review the complaints process to ensure alignment with best practice
Ensure incorporation of best practice complaints handling, as outlined in the EAG recommendations, with the current review of the RACS complaints system. This includes a system which is clearly communicated to members, is transparent, timely and procedurally fair. As far as practical, align the RACS complaints process with hospital and regulatory systems.

2.3 Continue with regular external reviews of the complaints process
Maintain the practice of regular review and revision of the complaints process to ensure alignment with best practice principles and maintain a continuous improvement approach.

2.4 Increase the capacity of the mediation and advice/support process
Create positions within the College or in workplaces, to act as a source of informal advice and support as an alternative to making a formal complaint. Ensure these positions cover a diverse range of age, gender and geographical distribution.

2.5 Build expectations and rebuild confidence
Manage expectations around the potential outcomes of complaints and the proportionate responses for each level of inappropriate behaviour. Continue to publish the statistics from the complaints process, to highlight actions taken in response to complaints.

2.6 Monitor data, analyse trends and act to prevent further issues
Gather and regularly analyse complaints and other related data so that repeat offenders or hotspots can be identified. Continue to monitor workplaces where complaints have been unsubstantiated. Build a stronger partnership with RACSTA to facilitate Trainee engagement. Take action through training post accreditation.

3. Leverage the strengths of the existing Building Respect communications approach.

3.1 Maintain high visibility of the Action Plan through a strong communications function.
Continue to fund and support the communications function. Continue to build understanding of issues underlying discrimination, bullying and sexual harassment, to inform review and update of the messages. Refocus the communications on emerging priority areas as the Action Plan is implemented, to keep these issues at top of mind across the profession.

3.2 Use local champions to amplify the message
Establish a diverse group of local champions, for peer to peer communication and amplification of the key messages. Continue with work on development of the Surgical Directors groups and development of Key Opinion Leaders in each craft group.

3.3 Target communications to Trainees and IMGs
Develop specific messages and communication mechanisms for Trainees and IMGs to improve their awareness of key messages, the complaint system and the available support services.

4. Embed Action Plan into College planning and governance.

4.1 Align Action Plan reviews with RACS strategic planning
Align periodic reviews of the Action Plan with the Action Plan evaluation schedule and RACS strategic and annual planning to ensure consistency and embed building respect principles into the College's planning process. Align contextual reviews so that emerging priority action areas such as safe working hours, rotation of training impact on leave or the status of unaccredited trainees can be incorporated into Action Plan

activities, where relevant. Reviews should consider updating of measurable targets and timelines for the implementation so progress can be readily measured.

5. Investigate cost recovery options for Building Respect courses.

5.1 Integrate the Building Respect principles into RACS core curriculum.
Identification of opportunities to incorporate the Building Respect principles into the core RACS curriculum is in progress. This will avoid the need for separate and expensive courses.

5.2 Investigate other cost recovery models for delivering professional skills training.
Consider other options for delivery of the Building Respect messages, including through partnerships with hospitals and other colleges.

6. Improve understanding of the issues faced by Trainees.

6.1 Conduct an extensive consultation with Trainees.
Develop and deliver a comprehensive, staged and targeted consultation process to engage with surgical Trainees and gain understanding and insights into their issues, views and challenges in relation to the culture of surgical education and other related matters. This could be achieved through a combination of existing mechanisms such as the RACSTA survey and through internally or externally facilitated surveys, interviews and focus groups. Use findings to incorporate into the review of the Action Plan and adapt the Action Plan accordingly.

Structure of this report

This report documents the Phase 1 evaluation of the Building Respect, Improving Patient Safety Action Plan, covering the period 2015-2018.

Section 1, the *Introduction,* provides the background and context to the Action Plan and the scope and purpose of this evaluation.

Section 2 presents the detailed *Methodology* for the conduct of the evaluation.

Section 3 presents the *Findings* from all data sources, presented under each of the two KEQs. The KEQs were the research questions for this evaluation, forming the backbone of the evaluation. The KEQs are supported by sub-questions. The purpose of the sub-questions was to structure data gathering, to ensure collection of appropriate information to answer each KEQ in detail.

Section 4 presents the overall *Conclusions* followed by the *Recommendations.*

Section 5 presents the *Attachments* to this report:

Attachment 1: Building Respect, Improving Patient Safety Action Plan

Attachment 2: Building Respect Program Evaluation Framework

Attachment 3: Building Respect Program Logic Model

Attachment 4: Stakeholder Engagement Plan

Attachment 5: Survey Questions

Attachment 6: Semi-structured Interview Questions

Attachment 7: Definitions and common terminology

1. Introduction

1.1 Background

Action Plan history

In 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG) to investigate the extent of discrimination, bullying and sexual harassment within the surgical profession. EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. This raised serious concerns for the wellbeing of individual surgeons and surgical trainees, of surgical teams and especially for the quality of care and safety of patients. The EAG report was unequivocal in emphasising the need for cultural change:

> *"…there must be a profound shift in the culture of surgery and an unwavering commitment to achieving this… Discrimination, bullying and sexual harassment must become problems of the past…"* (EAG report 2015)

RACS responded to these issues by apologising to all people affected by unacceptable behaviours, accepting all of the EAG's recommendations and developing an Action Plan, *Building Respect, Improving Patient Safety* (Action Plan) (Attachment 1), which outlines how RACS intends to counter and drive out unacceptable behaviours from surgical practice and surgical training.

Vision

The Action Plan's vision is to *build a culture of respect in surgical practice and education*, which will contribute towards:

- Improved patient safety.
- Surgical workplaces that are safe and free from unacceptable behaviours.
- A surgical profession that is more representative of the cultural and gender diversity across the community.

Goals

The Action Plan aims to bring significant, but necessary changes to the culture of health workplaces and surgical training. It has been developed to reflect the principles of the Vanderbilt Model1.

The Action Plan outlines how RACS Council intends to achieve the vision and demonstrate the values. It provides details on the actions needed to address each of the EAG recommendations. The Action Plan addresses eight goals, arranged under the three key action areas identified by the EAG. These goals are supported by a comprehensive workplan, which has been prioritised and gradually implemented.

[1] Hickson GB, Pichert J, WEBB LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. Acad. Med. 2007 Nov;82(11):1040-8

Action area 1: Cultural Change and Leadership

Goal 1: Build a culture of respect and collaboration in surgical practice and education.

Goal 2: Respecting the rich history of the surgical profession, advance the culture of surgical practice so there is no place for discrimination, bullying and sexual harassment (DBSH).

Goal 3: Build and foster relationships of trust, confidence and cooperation on DBSH issues with employers, governments and their agencies in all jurisdictions.

Goal 4: Embrace diversity and foster gender equity.

Goal 5: Increase transparency, independent scrutiny and external accountability in College activities.

Action area 2: Surgical Education

Goal 6: Improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency and professionalism.

Goal 7: Train all Fellows, Trainees and International Medical Graduates (IMGs) to build and consolidate professionalism including:

- Fostering respect and good behaviour;
- Understanding DBSH: legal obligations and liabilities;
- 'Calling it out'/not walking past bad behaviour;
- Resilience in maintaining professional behaviour.

Action area 3: Complaints Management

Goal 8: Revise and strengthen RACS complaints management process, increasing external scrutiny and demonstrating best practice complaints management that is transparent, robust and fair.

1.2 Context

Implementation of the Building Respect Action Plan has taken place in an environment with many contextual influences, some of which are described below.

Community attitudes have changed

One significant enabling contextual change over the last three years has been the change in community attitudes and expectations around respectful behaviours. Campaigns such as #Metoo and public shaming of celebrity offenders have brought these issues to the forefront and have helped to amplify, normalise and reinforce the Action Plan messages.

Implementation is complex

Implementation of the Action Plan has taken place over a relatively short time (3 years to date), working through partners such as hospitals and across different health jurisdictions in two countries. The Action Plan elements have been delivered via different areas of the College, with central coordination. This has required negotiation

of partnerships, coordination of priorities and building of relationships across a broad range of organisations with conflicting priorities.

Achieving the goals requires significant cultural change

A major cultural change program such as the Building Respect Action Plan brings issues around change management and bedding down of processes and systems across a bi-national program. Uncertainty caused by change can manifest in negative or unproductive attitudes and behaviours, for example through resistance to change by not following standards, procedures or policies. These are common reactions to change and it can be anticipated that some groups will take longer to change their attitudes and behaviours than others.

1.3 Phase 1 Evaluation

Focus

The purpose of this first evaluation of the Building Respect Action Plan was to evaluate the Action Plan implementation and very early outcomes.

The focus was to:

- Measure whether program implementation, governance and oversight are proceeding as intended.
- Measure whether early outcomes (delivery of pathways for identifying and addressing concerns about behaviour; program reach; target audience perceptions of the Action Plan) are being achieved as intended.
- Identify program strengths, what is working well, barriers to progress.
- Make recommendations on areas for program adjustment or improvement, based on findings.

Evaluation audience

The findings of this evaluation will be reported to the following:

- RACS Council and major committees;
- Building Respect Implementation Group;
- Building Respect Expert Advisory Group; and
- RACS Fellowship/ Trainees/(IMGs).

Scope

This evaluation is a process evaluation, covering the Action Plan implementation and governance. One sub-question has been included for an indication of very early progress towards the short-term outcomes.

The Key Evaluation Questions (KEQ) and sub-questions are shown below.

KEQ 1: Has the Action Plan been implemented as intended to date?

1.1 Have the program elements been delivered according to the plan to date?

1.2 Are the program elements reaching the intended audiences?

1.3 What are the reactions of the program's target audiences to the program activities?

1.4 What are the barriers/enablers for program implementation?

1.5 Have there been any unintended consequences, positive or negative, of program activity?

1.6 To what extent is data showing early progress towards short term outcomes?

KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?

2.1 Is the program sufficiently resourced?

2.2 Is program progress being monitored?

2.3 Are program outcomes being monitored/evaluated?

2.4 Are adjustments being made to the program in light of emerging data trends and/or practical barriers?

2.5 Is there adequate oversight of and accountability for program delivery?

2.6 Is RACS reporting transparently about progress towards building a culture of respect?

Structure of this report

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Section 4 presents the overall *Conclusions* followed by the *Recommendations.* The high-level themes were developed after analysis, validation and integration of the findings. The relationship of each theme to the relevant KEQs is indicated.

Section 5 presents the *Attachments* to this report:

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Attachment 4: Stakeholder Engagement Plan

Attachment 5: Survey Questions

Attachment 6: Semi-structured Interview Questions

Attachment 7: Definitions and common terminology

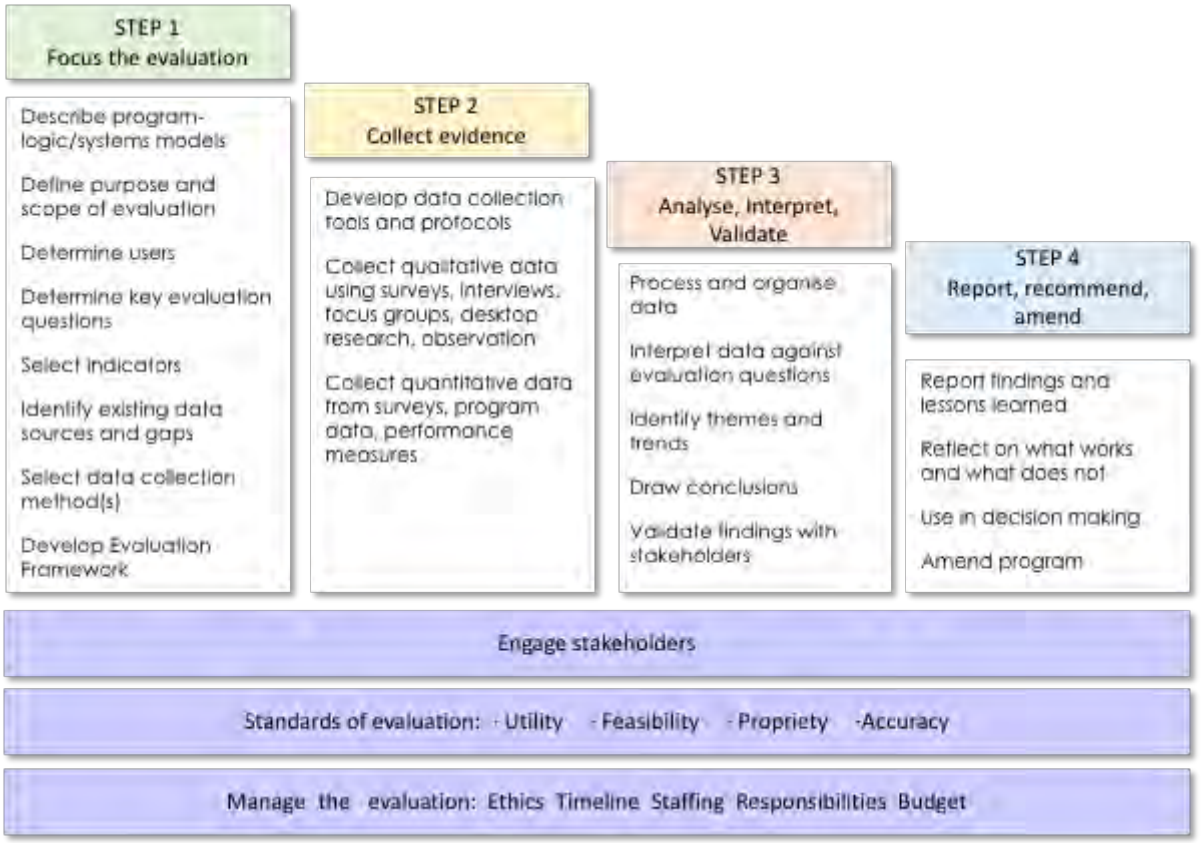
2. Methodology

2.1 Overall evaluation approach

Evidence based model for Program evaluation

The evaluation model used for this evaluation was a four-step, evidence-based modification of the University of Wisconsin evaluation model as shown in the figure below. This approach also complies with the NSW Government Program Evaluation Guidelines (2016), widely used for evaluations of government agencies across Australia. The evaluation was structured around the Building Respect Program Evaluation Framework (developed in 2018 and following the elements of Step 1 below) (Attachment 2) and conducted in an iterative way, with each step building upon the outputs of the previous step and consultation throughout the process.

Figure 2.1 Evidence-Based Evaluation Model



Adapted from Taylor-Powell and Henert, University of Wisconsin, 2008

Use of best practice principles

The evaluation approach was guided by the following, evidence-based principles, sourced from the model above and from government program evaluation guidelines widely used in Australia.2.

Principle	How it was expressed
1. Build evaluation into Program design	A detailed program logic model was developed during the evaluation design stage (Attachment 3). This logic model informed the development of the key evaluation questions. The resulting Evaluation Framework (Attachment 2) guides this and future evaluations.
2. Base evaluation on sound methodology	The Evaluation Framework was developed using methodology adapted from the recognised University of Wisconsin model (Step 1 in Figure 2.1 above). The design of this evaluation follows the Evaluation Framework, the NSW Government Program Evaluation Guidelines (2016) and the evidence-based principles of utilization focussed evaluation[3].
3. Include resources and time to evaluate	The Building Respect Action Plan includes resources and timing for evaluations. The Evaluation Framework includes a schedule of evaluations. This evaluation was conducted with an approved work plan, timeline and budget which allocated appropriate resources to conduct the evaluation to the required standard.
4. Use the right mix of expertise and independence	The evaluation was conducted by Ruth Friedman from The Thread Consulting (TTC), a professional independent evaluator. She employed a methodology based on significant stakeholder engagement to ensure the findings represent a range of viewpoints and experiences and to ensure contextual understanding in interpretation of findings and development of recommendations.
5. Ensure proper governance and oversight	The project governance framework for this evaluation included a work plan agreed at the beginning of the evaluation, regular written progress reports and regular progress meetings with the Building Respect Executive Lead. Development of the Evaluation Framework was guided by a Project Reference Group including Deputy CEO (later CEO) John Biviano; Executive Project Lead, Building Respect Improving Patient Safety, Judy Finn; Dean of Education, Associate Professor Stephen Tobin; Communications Consultant, Nicole Newton. The Phase 1 evaluation was guided by a Project Reference Group comprised of the Deputy CEO (later CEO) John Biviano; Executive Project Lead, Building Respect Improving Patient Safety, Judy Finn; Acting EGM Education, Rob di Leva; Communications Consultant, Nicole Newton; Academy of Surgical Educators Program Coordinator, Grace Chan. This group reviewed and approved each deliverable during the evaluation.
6. Be ethical in design and conduct	Ethical considerations were incorporated into the evaluation design to ensure access for stakeholders and confidentiality of interview and survey information. All evidence and findings have been presented in de-identified form. TTC consultants are members of the Australasian Evaluation Society and abide by its *Code of Conduct for Ethical Evaluations*.
7. Be informed and guided by relevant stakeholders	Data collection was conducted via individual interviews, a survey and examination of documents, to ensure a broad range of input to the findings. In addition, PRG workshops, circulation of drafts, and extensive consultation with the PRG and the Executive Project Lead was conducted to provide oversight and input into each deliverable, to ensure the validity of interpretations and to incorporate contextual factors into the analysis and recommendations.
8. Consider and use evaluation data meaningfully	Evaluation data were organised against the KEQs and analysed for emerging themes, trends and meaning, within the context of the practical realities of the program. Findings and interpretations were validated by the PRG, after which recommendations for improvement were developed.
9. Be transparent and open to scrutiny	An agreed work plan with timelines, responsibilities and deliverables was used to ensure transparency and support good project management throughout the evaluation.

[2] NSW Government Program Evaluation Guidelines. Department of Premier and Cabinet [Internet]. 2016 [cited 2017 Aug 17]. Available from: https://arp.nsw.gov.au/sites/default/files/NSW%20Government%20Program%20Evaluation%20Guideline%20January%202016_1.pdf
Government Program Evaluation Guidelines (2016)

[3] Patton MQ. Essentials of utilization-focused evaluation. Thousand Oaks, California: Sage; 2012

Stakeholder consultation

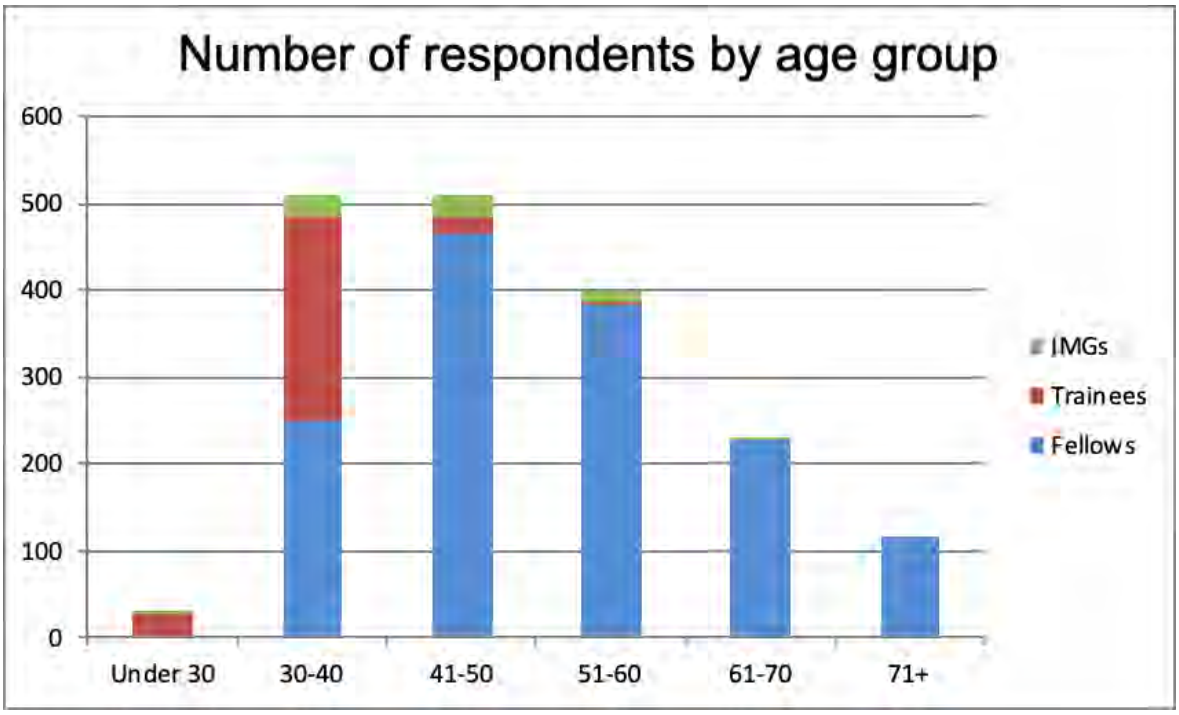
Internal stakeholder consultation was built into every step of the evaluation, to ensure broad input into the evidence, validation of the findings and interpretations, and support for the evaluation approach from the people who have the most detailed knowledge of the Action Plan. The consultation methods included a variety of access points to ensure stakeholders had an opportunity to provide input to the evaluation:

- Three interactive workshops with the PRG to confirm the evaluation methodology, validate findings and discuss the practical application of draft recommendations.
- Circulation of draft surveys and interview guides to the PRG for comment and input.
- Semi-structured and open-ended Interviews (in-depth telephone interviews) with 10 Fellows, 6 Trainees, 5 IMGs and 3 Councillors.
- A survey sent to 7,765 Fellows, Trainees and IMGs with a 23% response rate.
- Meetings with the Executive Project Lead to confirm the approach, validate findings and ensure input of contextual information.
- Presentations to the RACS Board and the Building Respect Implementation Working Group to report on progress.
- Circulation of the draft report to the PRG for comment.

Some interviewees (Fellows) were selected by random, stratified sampling to provide representation across geographic regions, specialties and gender. The intention had been to select Trainees and IMGs in the same way, however, this proved difficult as these two cohorts were not as willing to participate in interview. Therefore, snowball sampling was implemented, using the contacts of known people to gain as random and broad a sample of willing participants as possible, whilst ensuring geographical and gender diversity.

Analysis of survey respondents indicated there were 1446 Fellows (1158 males: 80%; 283 females: 19.6% and 5 intersex/indeterminate: 0.34%). There were 280 Trainees (158 males: 56%; and 122 females: 44%) and 72 IMGs (57 males: 79%; and 15 females: 21%). (Figure 2.2).

Figure 2.2: Analysis of survey respondents



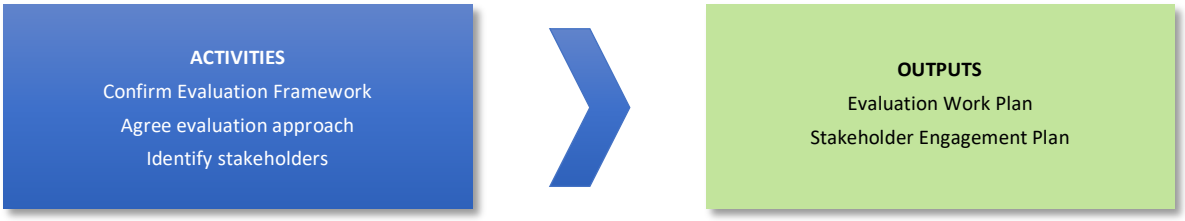
58% of Fellows responding to the survey were mainly employed in the Public sector, with 42% mainly in the Private sector. Almost all Trainees were employed in the public sector. IMGs were split with 85% in the Public sector and 15% in the Private sector. There were no significant differences in responses to the survey questions between people mainly employed in the private sector and those in the public sector. There was no significant difference in the responses of people working mainly in rural locations compared with those in metropolitan locations.

Differences in response between Fellows, IMGs, Trainees, males and females have been noted where they occurred.

Project governance

The project was delivered according to an agreed work plan with timelines, budgets and an approved stakeholder list. Regular progress reports were provided to the Executive Project Lead against the agreed work plan. All project deliverables were approved by the PRG before being finalised.

2.2 Focussing the evaluation



Confirmation of the Evaluation Framework and evaluation approach

The Building Respect Evaluation Framework was developed in 2018 to guide each of the three phases of the evaluation of the Building Respect Action Plan, scheduled for 2019, 2020-2021 and 2026. The Evaluation Framework is a comprehensive document which contains a listing of each KEQ and sub-question, how it will be answered (indicators) and the data source for each question. It provides the 'road map' for each evaluation.

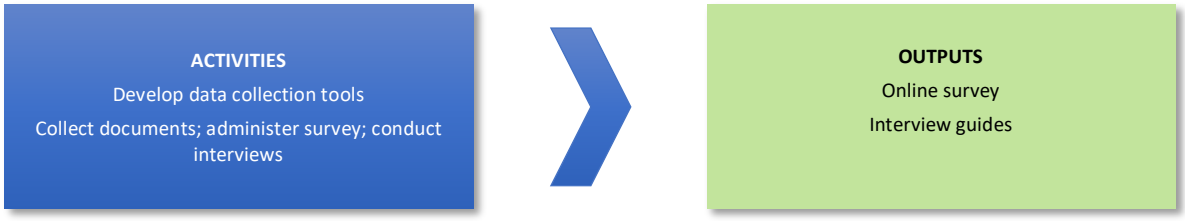
However, the Building Respect Action Plan is complex, delivered through multiple streams of activity across Australia and New Zealand. Implementation of the Action Plan is occurring in a dynamic and complex environment, meaning that the Evaluation Framework, developed in 2018, may need some updating and adjustment before commencement of each scheduled evaluation.

Therefore, this evaluation began with an in-depth discussion with the PRG about the current context, the planned evaluation approach and stakeholders to be consulted. The purpose of this discussion was to identify the potential challenges, risks and practical issues that could arise during the evaluation, in particular during the data collection phase. The relevance of the Evaluation Framework and the KEQs were confirmed with minor changes, and an evaluation approach taking into consideration the current context was agreed.

The following deliverables were produced:

- Evaluation Work Plan.
- Stakeholder Engagement Plan (Attachment 4).

2.3 Collection of evidence



Ensuring validity of data

One of the central issues in evaluation is ensuring that findings and recommendations are based on valid data. Quantitative data are quoted in numerical terms and tested for statistical significance. Qualitative data are tested for their substantive significance through presentation of findings, patterns and themes. In mixed methods evaluations, both types of data are used to establish and confirm the validity of the findings.

The validity of findings can be demonstrated by ensuring:

- Confidence that data highlight what is really happening in the program.
- An agreed approach for dealing with outliers.
- Minimisation of bias.
- Confidence in the inferences drawn from the data.

A number of data collection and analysis strategies were used to address these issues:

- Multiple data sources were used, from a range of geographical and demographic perspectives, to ensure a range of views from which to draw conclusions. Gathering information from a range of sources serves to triangulate the findings, with each source confirming and extending understanding of the findings from the other sources, to increase confidence in the validity of the findings and reduce the impacts of bias. This evaluation included examination of a range of data sources (policy documents, progress reports, external reviews, statistics and business plans); 24 interviews (via telephone) with Fellows, Trainees, IMGs and Councillors; and an online survey sent to all Fellows, Trainees and IMGs.
- Quantitative data were collected, via the online survey. These data provided an answer to the question: What is happening? in relation to the KEQ.
- Quantitative information was supplemented with deep contextual information from qualitative data sources such as in-depth interviews. Additional qualitative data was included from the comments and major themes taken from the open-ended response section of the survey. The qualitative data was

not intended to provide statistical information, and is therefore not presented in a quantifiable manner. It was collected to explore issues "in-depth" and provide an increased understanding of Action Plan successes, strengths and weaknesses at a deeper level and within the realities of program delivery. The data enabled identification of the contextual situation which provided some explanation of the question: *Why is this happening?*

- Data were analysed and cross referenced to support triangulation of the data i.e. ensure a number of data sources as well as a number of data collection methods to support and corroborate each finding and to identify outliers, views or inputs that significantly differ from the main findings. In this report, each finding has been reported from multiple data sources and methods, where available, to demonstrate validity and corroboration and increase confidence in the finding.

- Findings were further validated, whilst maintaining the independence of the external evaluator, firstly by discussion with the Executive Program Lead, and secondly by presenting them to the PRG (knowledgeable stakeholders) who provided practical knowledge to discuss, challenge or confirm the plausibility, relevance and utility of the findings, interpretations and proposed recommendations. This consensual validation of the findings, by three sources (consultant, Action Plan experts, and the Program Managers) is the standard for validating and reporting of qualitative data.

Data collection included quantitative and qualitative methods

A survey was used as the major data collection instrument and distributed to all RACS members (7765 people received the survey, 1798 (23%) responded). The survey distribution ensured access for all RACS members to express their views and to provide input to the evaluation. The survey was developed using a mixed methods approach to ensure it addressed issues and used language relevant to the target audiences. This was achieved by conducting eight exploratory open-ended interviews with purposively selected stakeholders representing a range of Fellows, Trainees and IMGs from different geographical locations and of different gender. Whilst the KEQs formed the basis for the survey, the themes and issues identified in the exploratory interviews provided the detail within each question (Attachment 5: Survey questions).

Semi-structured in-depth telephone interviews were conducted with 17 people. Consistency between interviews was supported by the use of an interview guide, developed from the KEQs, the initial, exploratory interviews and in consultation with the Executive Project Lead and PRG. Different aspects of the interview guides were used, depending on the interviewees, for example, the governance questions were not asked of people who did not have a role in the Action Plan governance. (Attachment 6: Semi structured interview questions).

Interviews provided important contextual information on unintended consequences, very early outcomes and the lived experience of Fellows, Trainees and IMGs. This

information supplemented the more quantitative data from the survey and provided stories and examples from which meaning and context could be better extracted.

Documents and reports included policy documents, progress reports, external reviews, statistics and business plans. Information from these documents was extracted and organised against the KEQs, to support other findings and provide more detailed understanding.

2.4 Analysing, interpreting and validating findings

Structured data analysis and interpretation

The KEQs, as taken from the Evaluation Framework, were the research questions for this evaluation, forming the backbone of the evaluation. The sub questions provided detail to help more specifically answer the KEQs by breaking down the information required. Findings were arranged against the KEQs to collect the evidence which formed the answer to each research question.

Raw quantitative and qualitative data were organised against the KEQs to reveal patterns and trends. Numerical responses and ratings from survey data were presented as graphs. Interviews, comments and open-ended questions from the survey were analysed to identify emerging issues, perceptions and strengths. Action Plan data was analysed for trends and evidence of effective implementation.

The relationships between the data were tested, and examined for corroboration of findings between data sources, until the most important findings emerged for each KEQ.

Quotes from respondents were identified to represent the emerging findings, with some quotes included to identify conflicting views, where present, to ensure a balanced reporting of those views against the rest of the findings. Where available the position of the respondent has been included.

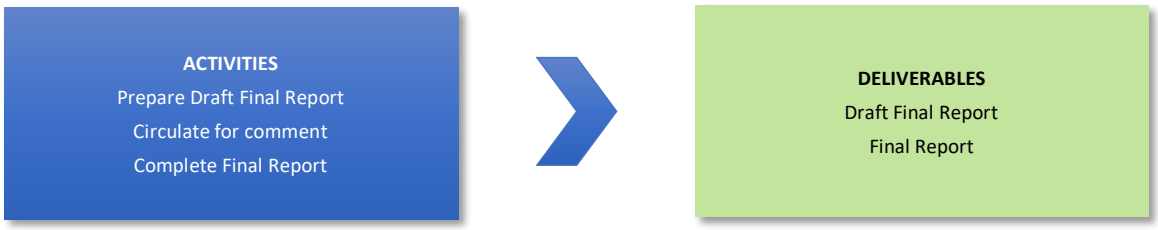
Themes and data trends were considered within the consultant's understanding of cultural and contextual factors, developed through the interviews and discussions with the Executive Project Lead and the PRG. This supported interpretation of the meaning and significance of the findings, highlighting strengths and opportunities for improvement.

Recommendations have been developed to leverage the Action Plan strengths and address areas identified for improvement. Recommendations have been kept to those priority recommendations which can most practically be implemented by the College.

Validation of findings

Findings and interpretations were presented firstly to the PRG and then to the Building Respect Implementation Group and RACS Board for discussion, contextual input and analysis, including testing of assumptions, conclusions and draft recommendations for practicality and feasibility.

2.5 Final Report



Preparation of Report

Feedback from the validation workshop was incorporated into a Draft Report and circulated for comment before completion.

3. Evaluation Findings

This section presents the evaluation findings organised under the two KEQs relevant to the scope of this evaluation, extracted from the Evaluation Framework. (Attachment 2). The KEQs form the backbone of the evaluation and provide a structure against which the findings are reported. The sub-questions that appear in the evaluation framework under each KEQ were used to structure data gathering to ensure appropriate information was collected to answer each KEQ in detail.

KEQ 1: Has the Action Plan been implemented as intended to date?

Overall assessment of findings for this KEQ

Almost all of the Action Plan has been delivered as planned, a significant achievement, given the size of the task. Overall the Action Plan has been positively received and is very strongly supported by Fellows, Trainees and IMGs but there are small pockets of resistance to the key messages.

The right audiences are receiving Action Plan communications via multiple sources, contributing to the high level of awareness of the key messages and the majority of actions that the College has taken. Early outcomes such as perceived cultural change in the workplace and representation of women in surgical training, are making good progress. RACS is leading the way in developing a model for introduction of respectful behaviours, with other Colleges and organisations turning to the College for policy advice and education programs.

The major area for improvement is the College's complaints process, which, despite an increase in the number of complaints relating to respectful behaviours, is, like other complaints processes, not perceived as safe by more than half of Trainees.

Strengths

Implementation of the Action Plan has been successful and well delivered. One of the key strengths of the Action Plan has been highlighting the evidence linking behaviour to patient safety in its messaging and call to action. This is evidenced by the strong awareness of this message, shown in the survey responses. Another strength of the Action Plan has been the communications function. There has been strong branding, development of a professional logo and strapline and very effective messaging targeted at the key audiences.

The huge and visible level of commitment and enthusiasm from College and Council have been observed by interviewees and survey respondents alike. This commitment has also been displayed in the prioritisation of resources to the Action Plan implementation, another strength of the College's approach to addressing this issue.

Opportunities for improvement

The RACS complaints process, like other complaints processes, is not perceived as safe by more than half of Trainees, and a substantial proportion of IMGs and females. The major reason for this is a lack of confidence that it will lead to positive outcomes, and

fear that it could result in severe negative career consequences. The College has already recognised that the complaints system needs improvement, and it is currently being revised.

Despite the strong awareness of the key Action Plan messages, there is still a range of attitudes and entrenched beliefs about what is acceptable behaviour in the surgical workplace. Although it is expected that change will happen at a different pace for different cohorts, and there are likely to be people for whom the changes will take longer, there is an opportunity to determine whether communication should be targeted towards these "pockets of resistance" or whether the cultural change should be allowed to more gradually permeate.

Trainees are not as engaged with the College as other groups. Trainees and IMGs are not as aware of the key messages as Fellows. This could become an issue for future Fellows who may not have absorbed the messages early in their careers. Therefore, there is an opportunity to target messages specifically to these cohorts.

Detailed findings

A significant amount of work has been delivered.

A significant amount of work, covering a broad range of activities under the banner of the Building Respect Action Plan, has been completed and delivered. The Progress Update reports (2016, 2017, 2018) show that almost all actions have been delivered as planned, which is a major achievement.

The most visible area of activity has been the Let's Operate With Respect campaign, which includes videos, social media, posters and merchandise such as branded surgical caps. This was the first digital campaign for the College, and it has been widely shared across social media, with extensive use of the hashtag #operatewithrespect.

The other significant and visible element of the Action Plan was the education program, including the mandatory online e-module, which has now been completed by over 98% of Fellows, Trainees and IMGs; the face to face Operating With Respect course (OWR) mandated for surgical supervisors and RACS major Committee Members; and the Foundation Skills for Surgical Educators course (FSSE), with only 3% of the mandated cohort being followed up as this report was being prepared. Although there was some resistance to completing the training, especially due to time constraints, interviewees reported examples of people experiencing change during the face to face courses, others reported learning more about themselves and several acknowledged the excellent access to courses, with multiple courses delivered at numerous locations.

Important work has been completed to underpin cultural change, including development of the Diversity and Inclusion Plan, with targets for gender diversity in surgical training and on RACS committees; development or updating of policies, standards, procedures, fact sheets and guides. Thirty-five partnership agreements have been established with hospitals or health networks across Australia and New

Zealand, health jurisdictions, medical colleges and universities. These have evolved into collaborations on communication of campaign messages, education and training programs, consideration of models to facilitate flexible training and establishment of pilots for innovative programs being tested before upscaling. A complaints process has been established, with a policy, user guide, manual and other information available on the RACS website.

Almost all of the program elements have been delivered according to plan.

Although there have been delays to some areas of the Action Plan, such as Multi Source Feedback, discussions with the Executive Project Lead and the Building Respect Implementation Group revealed that a significant amount of work has actually been done on MSF, including establishment of a model for IMGs, however work continues, to overcome issues associated with the sustainability of the model being trialled. Similarly, work is progressing regarding establishment of protocols for sharing of hospital complaints information with the College, with St Vincent's Health Australia.

Visible commitment by College and Council.

The College's swift action in response to the recommendations of the EAG, its allocation of significant resources to the Building Respect Action Plan, and its appointment of a senior position to lead the implementation have been seen by the majority of interviewees and survey respondents as a strong commitment to the Action Plan. This has been complemented by a range of highly visible activities such as the presentations to surgeons and to external groups, by College Presidents and Office bearers, development of partnerships across Australia and New Zealand and a significant level of external reporting on progress and goals.

> "*Willingness to do what it takes*." (Councillor)
>
> "*Impressed more and more with how things are being rolled out.*" (Fellow)
>
> "*Patchy*." (Fellow, referring to the implementation of the Action Plan)
>
> "*Tsunami-like change*." (Fellow referring to implementation of the Vanderbilt model nationally, including the private sector, in such a short time frame)

Barriers for implementation.

Some pockets of resistance to cultural change

The program logic model for the Building Respect Action Plan acknowledges that cultural change takes time, often taking many years before behaviour change can be seen. This presents a major, but expected, challenge for Action Plan implementation. Interviewees reported some degree of scepticism amongst some of their colleagues regarding the Action Plan and pockets of resistance from others who describe the Action Plan as "*political correctness gone mad*." Others described surgeons in their workplace who do not seem to be able to adjust their communication style to be more respectful. They feel entitled to speak harshly in theatre because of a situation which they see as relating to patient safety. These people represent the group most resistant to change that will require particular communication and may take the longest to impact.

Respectful behaviour is a whole of healthcare issue

As a leader in making cultural change, the College faces a number of challenges. The College faces the challenge of working with multiple partners, across many jurisdictions, in two countries, in order to achieve its goals for cultural change. There are the challenges of following up on the multiple partnership agreements and in working closely with other medical disciplines where training on respectful behaviours has not taken place. These challenges have been anticipated and planned for, however, they do impact on the speed at which change can be achieved.

Implementation of the Action Plan is in line with societal change.

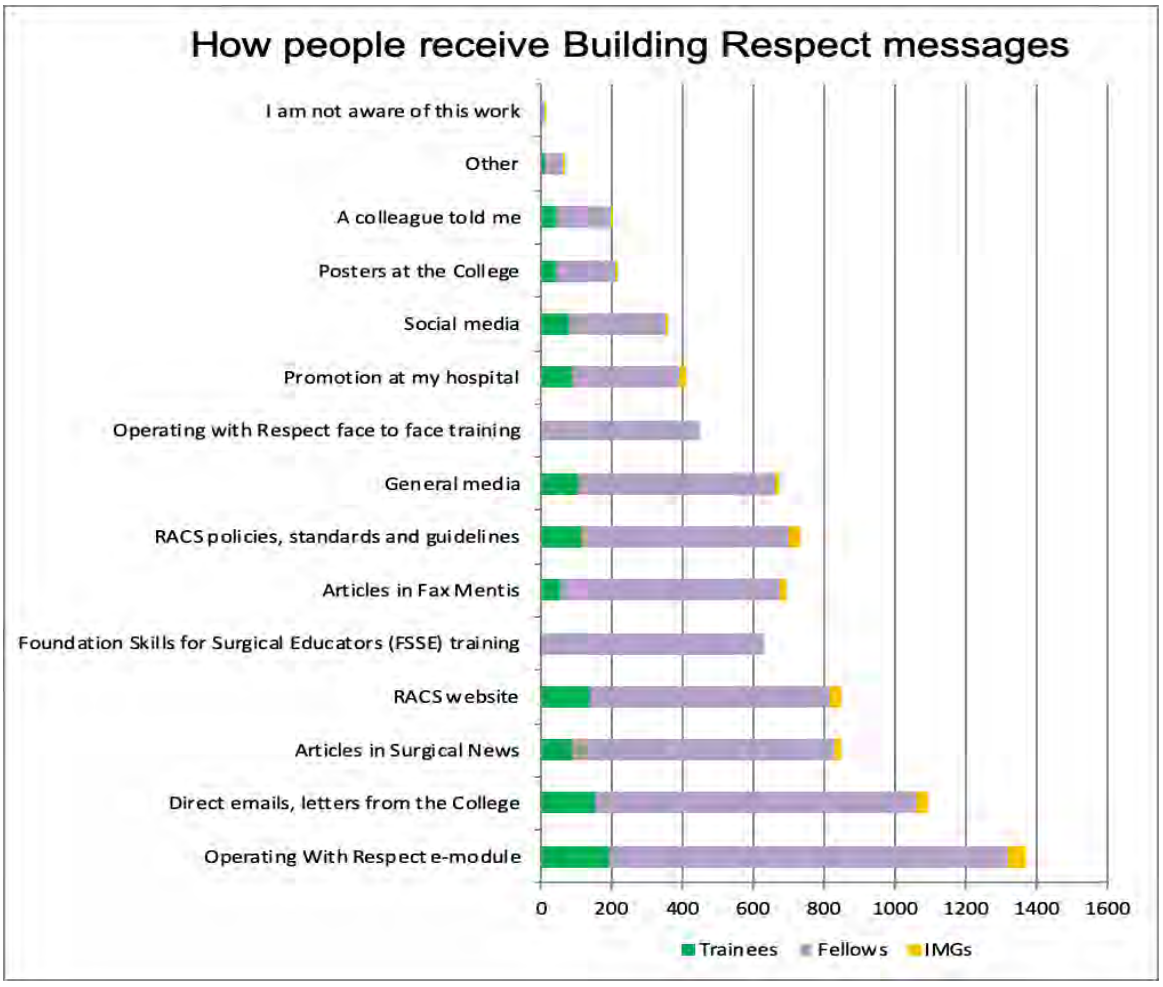
Community views on bullying, discrimination and sexual harassment have moved a long way since the early days of development of the Action Plan. The College is now seen to be in step with public opinion and broader societal shifts. More than this, the College is now seen as leading the way as an institution that has acknowledged these problems and made a serious commitment to addressing them. Evidence of the links between behaviour and patient safety continues to grow, providing further support for the Action Plan and providing a strong base for communication with members.

Building Respect elements are reaching target audiences.

People are receiving communications from multiple sources

The Action Plan, its messages, activities and achievements have been extensively communicated to the target audiences of Fellows, Trainees and IMGs via multiple streams. Figure 3.1 below shows that almost every survey respondent was aware of the Action Plan through one or more of twelve different types of communication. The most successful communication mechanisms in terms of reach, were through completion of the e-module, direct emails from the College, articles in the Surgical News and the RACS website. This finding was confirmed by the majority of interviewees, who had all completed the e-module and stated that this was the main way they had become aware of the Action Plan.

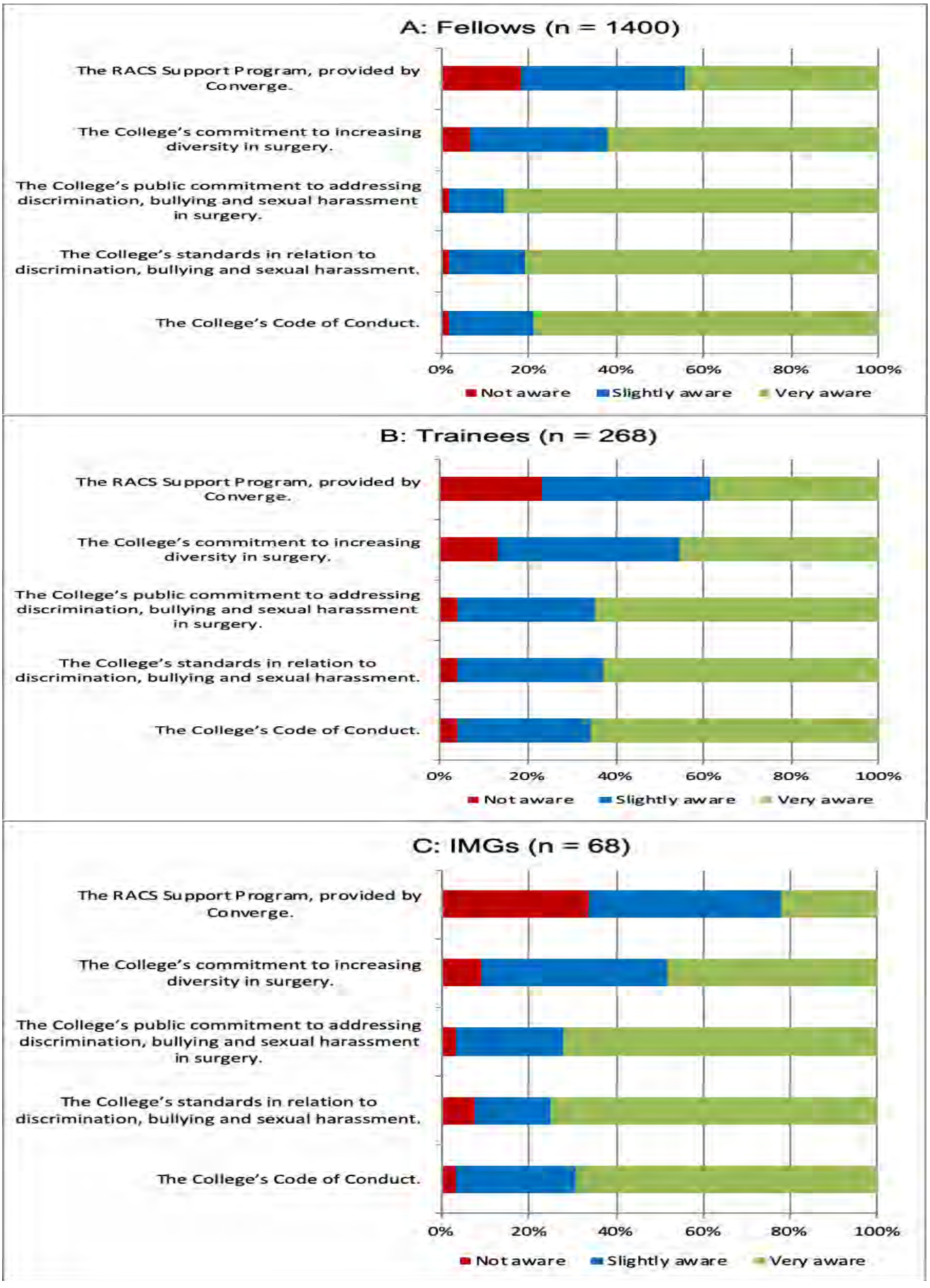
Figure 3.1 Mechanisms of communication for the Building Respect messages



Less awareness of RACS Support Program (Converge) and the commitment to diversity

Moving beyond audience reach to the actual penetration of messages, there has been significant success in raising awareness of the College's key activities to build a culture of respect. Figure 3.2 shows that there is strong awareness of the College's Code of conduct, standards and public commitment to addressing discrimination, bullying and sexual harassment. The survey showed that over 80% of Fellows (Panel A, n = 1400), over 60% of Trainees (Panel B, n = 268) and more than 70% of IMGs (Panel C, n = 68) indicated they are aware of these College activities. However, awareness of the RACS Support Program (Converge) program is relatively lower, with 43% of Fellows, 38% of Trainees and only 22% of IMGs indicating awareness of these items. Trainees and IMGs generally have a lower awareness of all of the Action Plan elements.

Figure 3.2 Awareness of RACS' actions to build respect and improve patient safety



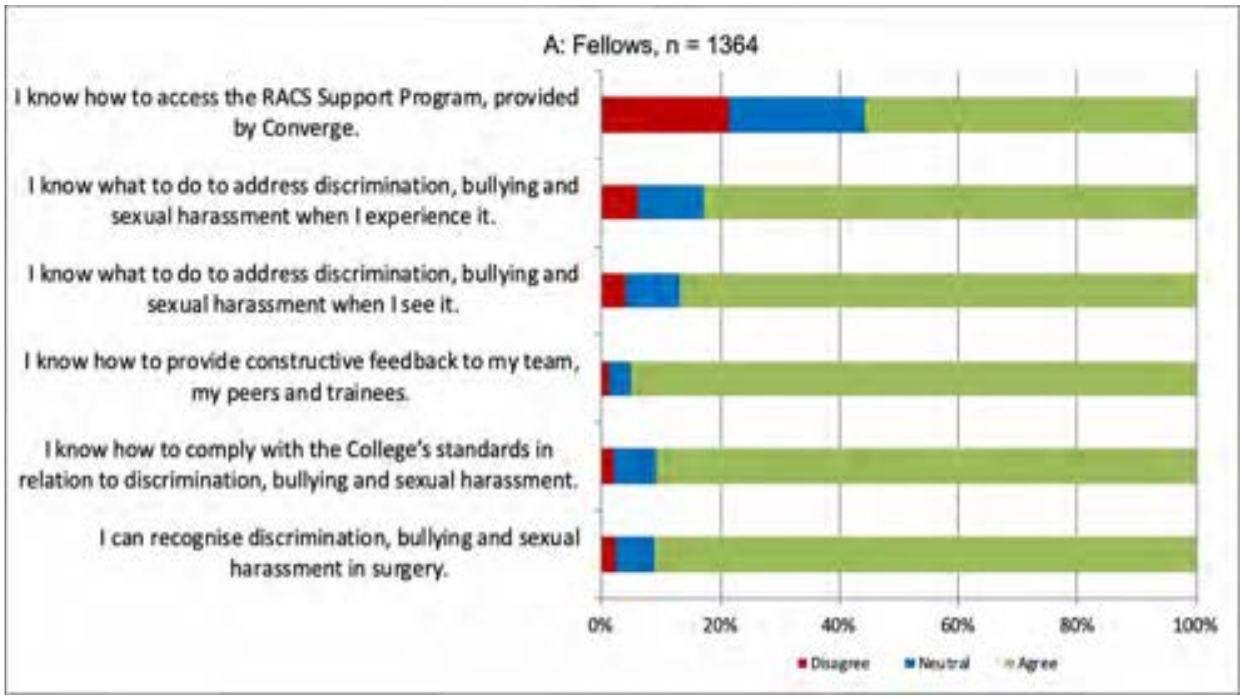
There is very strong permeation of the key messages

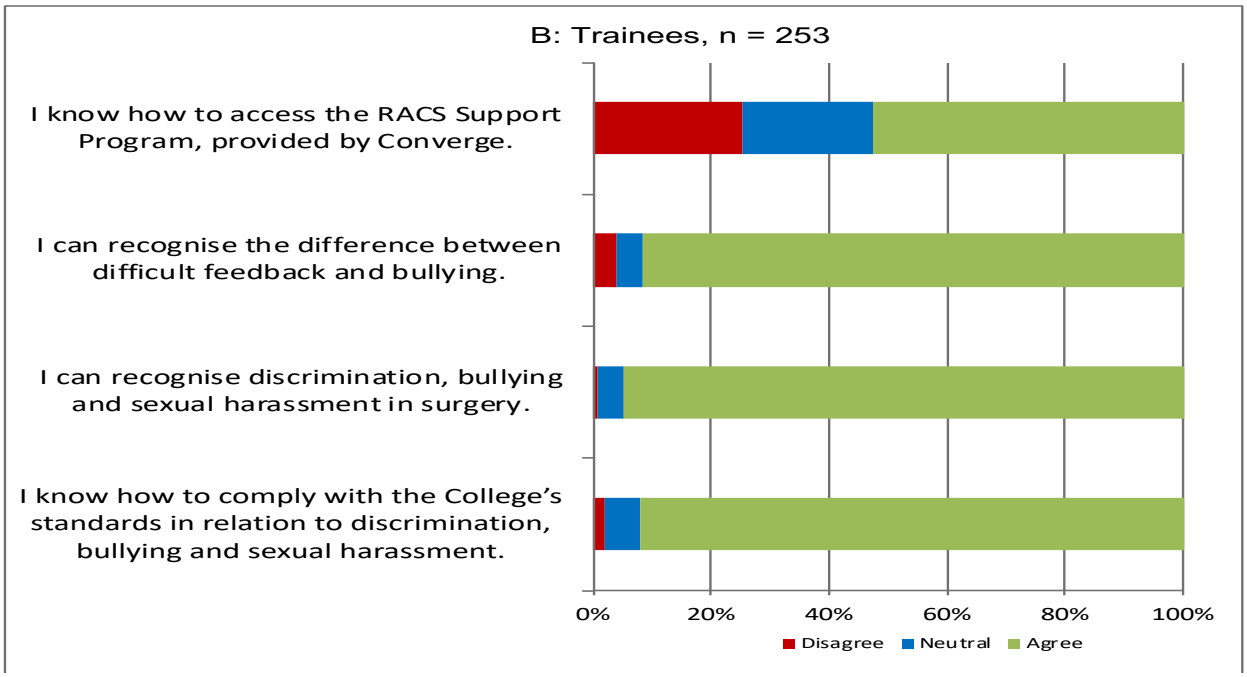
Interviewees reported that, since the beginning of the Action Plan, the issues of discrimination, bullying and sexual harassment have become very high profile in hospitals.

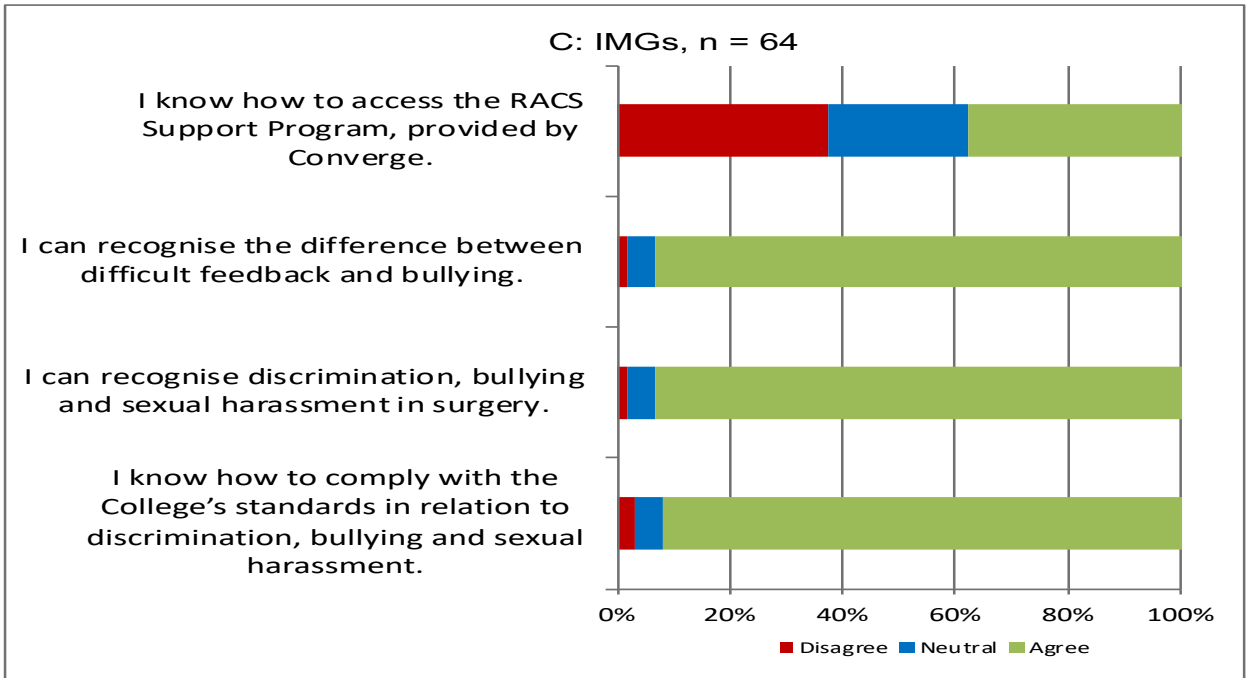
> *"Hospitals have posters everywhere"* (Fellow)
>
> "*Call to arms is being heeded*" (Councillor)
>
> "*The more it's in your face, on the College website and other places, the more its normalised*." (Trainee)
>
> *"It's 2019, are we allowed to say that anymore? We're supposed to Operate with Respect."* (Trainee referring to new forms of language in the workplace)

Both Trainees and Fellows declared that they had a strong understanding of the issues and the need to take action. The visibility of the issue has brought it out in the open, with many people describing a new and growing dialogue within the workplace around the issue of respectful behaviours, with the reach of awareness extending beyond surgery to encompass other medical disciplines. The survey confirmed that more than 90% of Fellows (Panel A, n = 1364), Trainees (Panel B, n = 253) and IMGs Panel C, n = 64) (Figure 3.3) perceive that they can recognise discrimination, bullying and sexual harassment, identify the difference between bullying and difficult feedback (Trainees and IMGs), know how to provide constructive feedback to their teams (Fellows) and know how to comply with the College's standards. Once again, the RACS Support Program (Converge) program was not as well understood as other aspects of the Action Plan, with nearly 50% of Fellows and Trainees and over 60% of IMGs not knowing how to access the program.

Figure 3.3 Knowledge about discrimination, bullying and sexual harassment







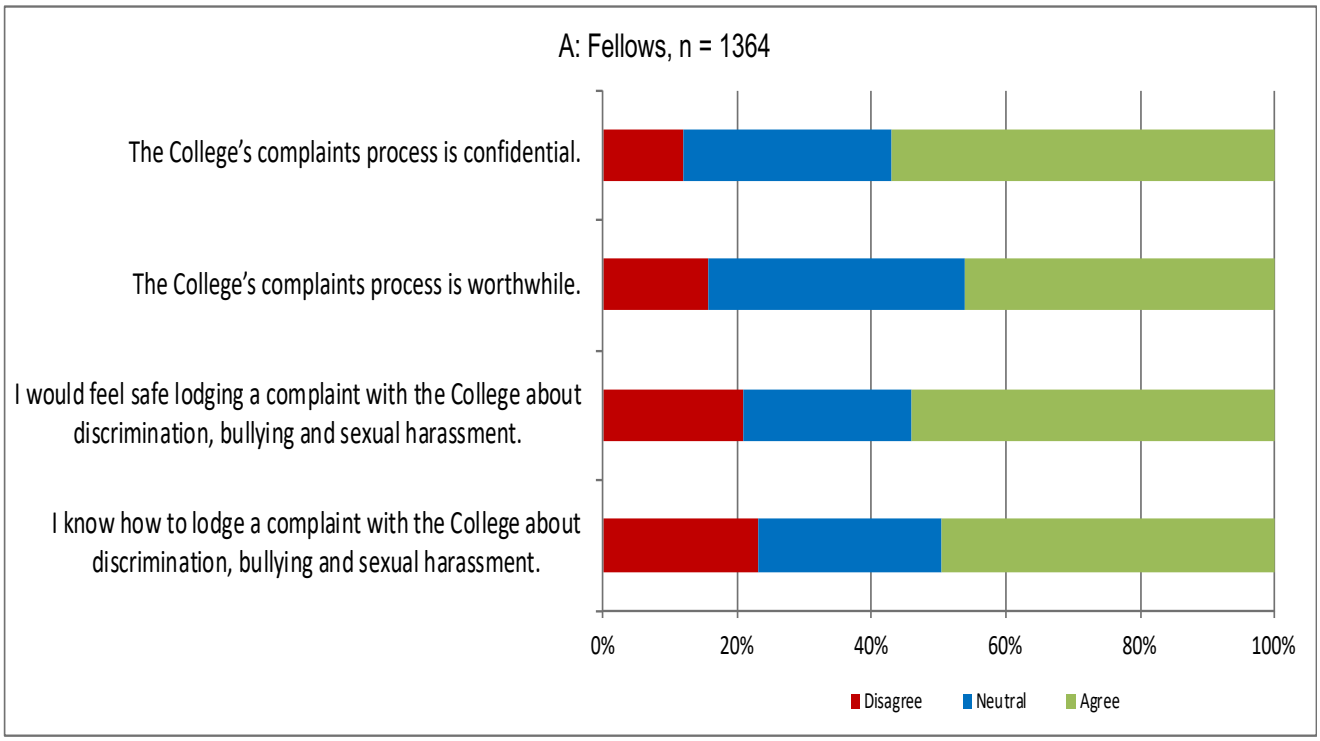
RACS' complaints process, like other complaints processes, is not perceived as safe.

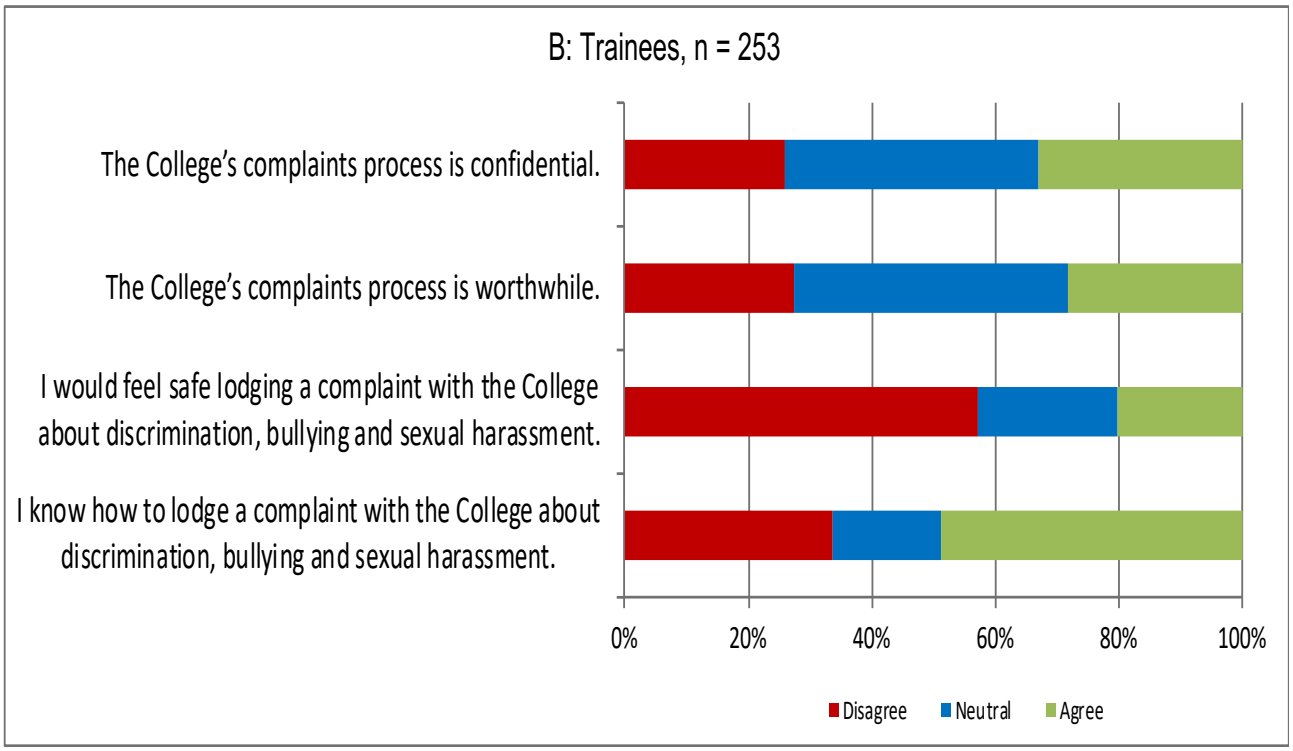
Figure 3.4 (Panels A-E) below highlights the differences in perception of the RACS complaint system. A significantly higher proportion of Trainees (55% of 253), IMGs (41% of 64) and females (37% of 265) do not feel safe to use the complaints system compared with males (17% of 1094) and Fellows (21% of 1364). These figures are comparable to the feelings of safety when making a complaint in the workplace (Figure 3.5, Panels A-C), where a greater proportion of Trainees (57% of 237) and IMGs (34% of 59) would not feel safe to lodge a complaint, compared to 22% of 1317 Fellows.

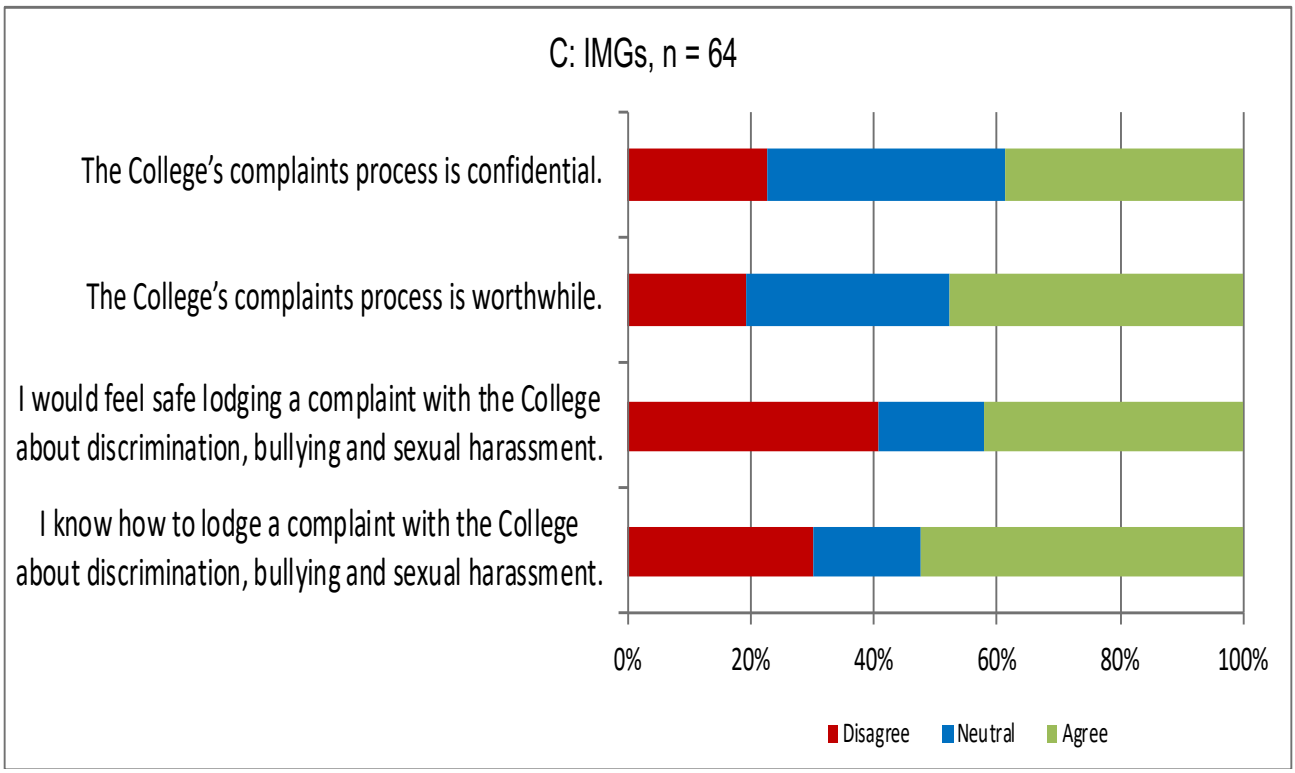
Overwhelmingly, the reason given for this perception was fear of being identified as the complainant and the potentially severe and negative career consequences, especially for those in small sub specialties. Other reasons given by Trainees included lack of time whilst completing studies; not knowing the detail of the process and a feeling that no action would be taken in response to their complaint. At least part of the perception about lack of action regarding complaints may be from historical experiences before implementation of the Action Plan.

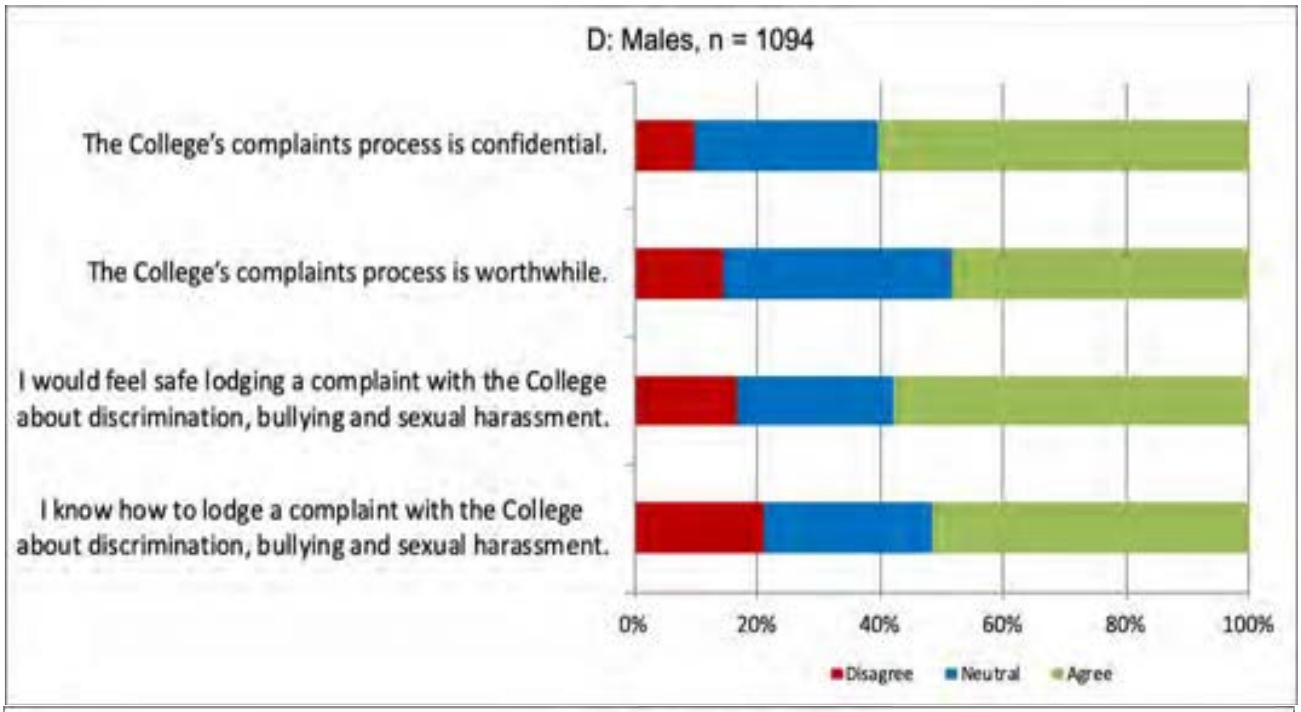
> *"My previous experience (of bullying) made me feel like I'm the bad one and nothing has been done about it."* (Trainee talking about a bullying complaint from 2014)
>
> *"… in 2019, I got swift action. There has been a culture change in that time…. This is no longer tolerated."* (same Trainee as above, about a complaint lodged in 2019)
>
> *"Every Trainee knows if you lodge a complaint you've shot yourself in the foot."* (Trainee)
>
> *"Complaints is the major thing holding back the Action Plan." (*Fellow)
>
> *"People need to be convinced that something will change before they will complain."* (Fellow)

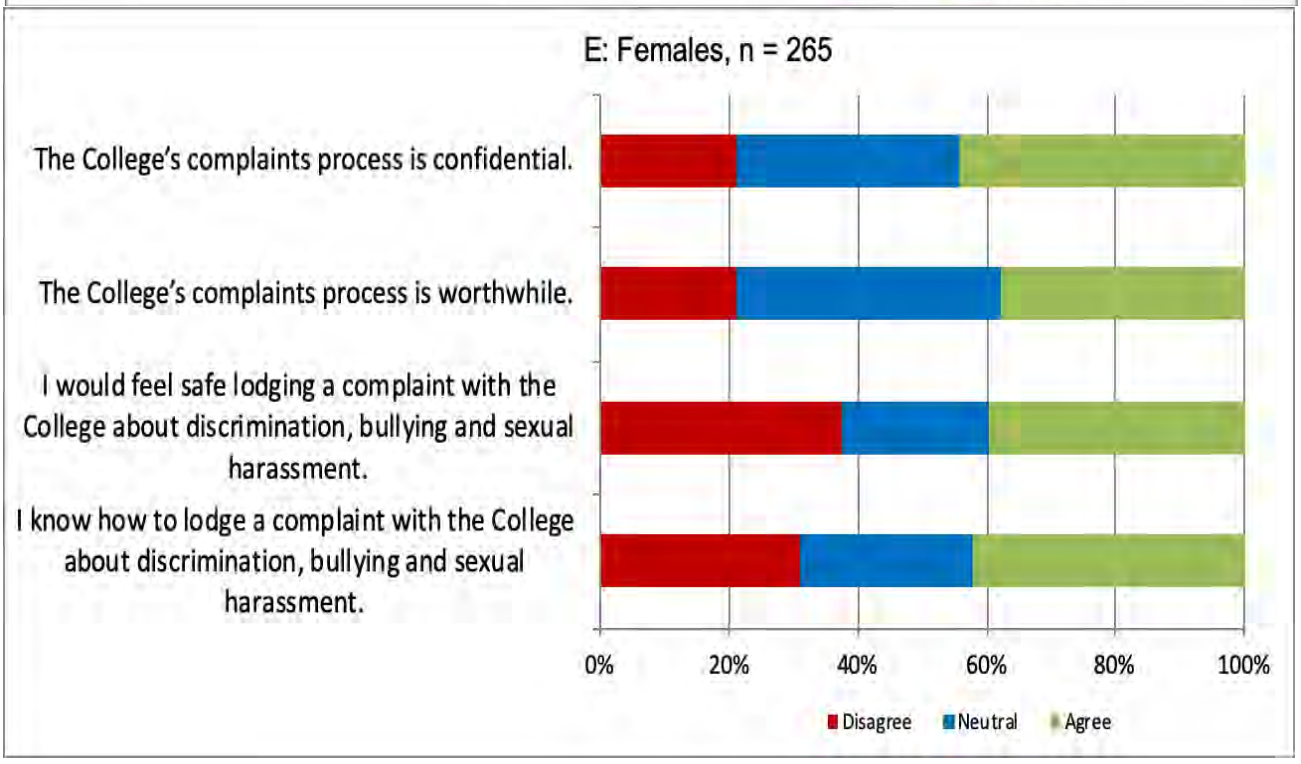
Figure 3.4 Perception of RACS complaints process




B: Trainees, n = 253
The College's complaints process is confidential.
The College's complaints process is worthwhile.
I would feel safe lodging a complaint with the College about discrimination, bullying and sexual harassment.
I know how to lodge a complaint with the College about discrimination, bullying and sexual harassment.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree


C: IMGs, n = 64
The College's complaints process is confidential.
The College's complaints process is worthwhile.
I would feel safe lodging a complaint with the College about discrimination, bullying and sexual harassment.
I know how to lodge a complaint with the College about discrimination, bullying and sexual harassment.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree

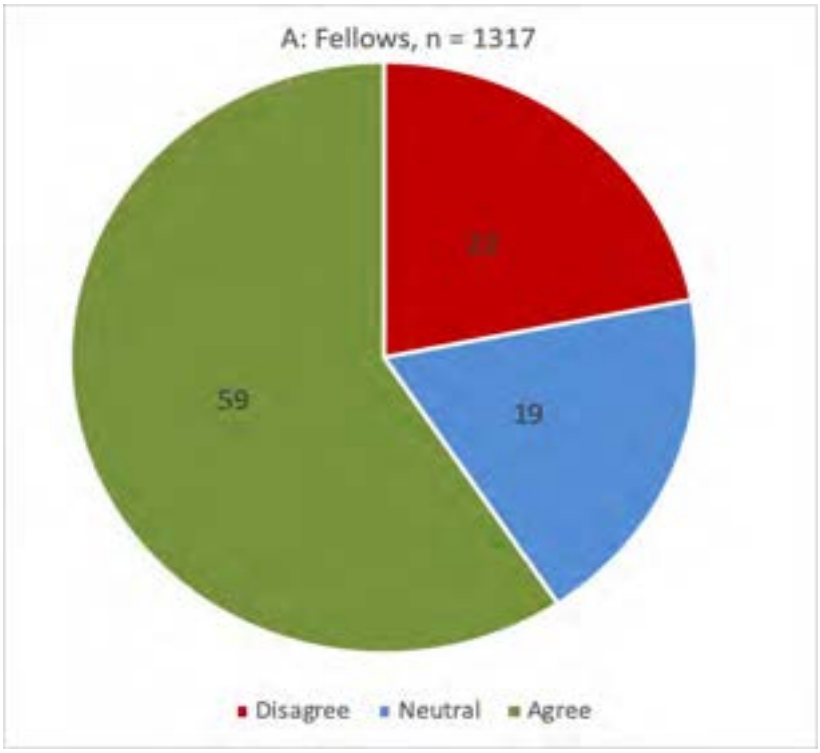


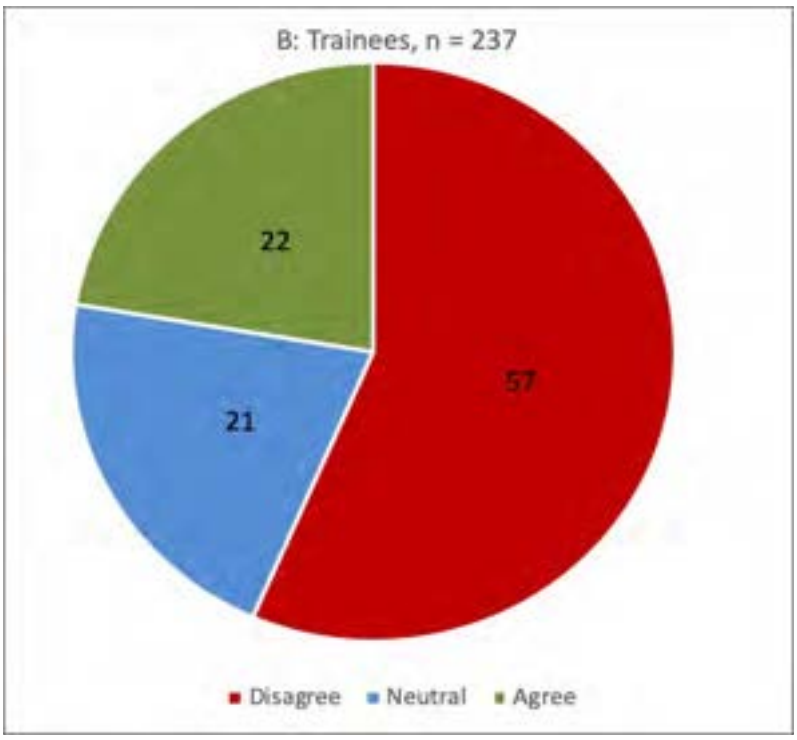


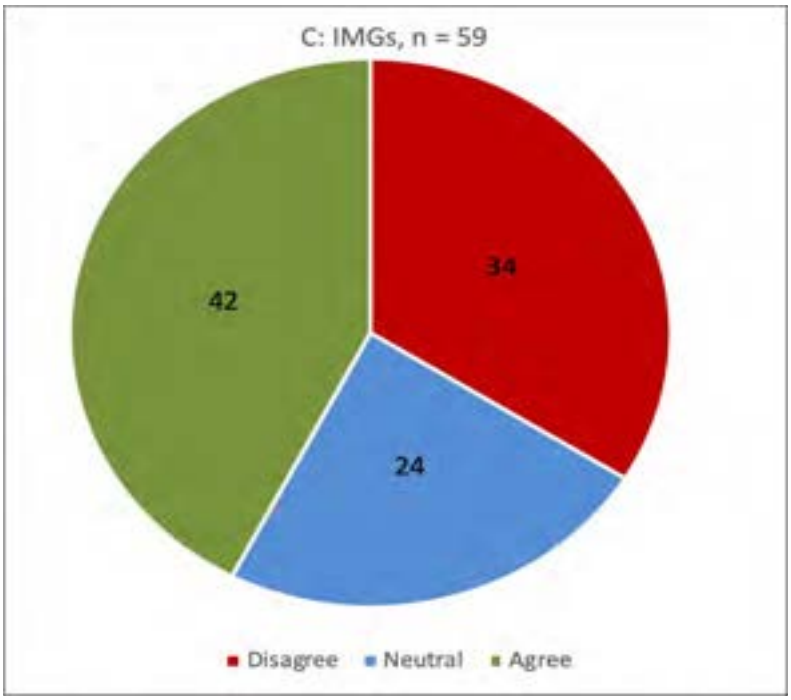
Whilst nearly 50% of Fellows and IMGs consider the College's complaints system to be worthwhile, slightly less than 30% of Trainees agree (Figure 3.4). A range of views were expressed about appropriate sanctions for offenders, ranging from removal from jobs to feelings of concern about harming another surgeon's career. However, there were many comments about known offenders staying in their jobs or being appointed to positions of power within the College. Interviewees and survey respondents expressed anger and frustration over times when the College has said it cannot take action as it is not the employer. This has been viewed amongst some as the College shirking its responsibility.

Trainees and IMGs also stand out as having far less confidence in the confidentiality of the complaints process, with only 33% of Trainees and 39% of IMGs feeling it is confidential, compared to 58% of Fellows. Other findings in relation to the RACS complaints process were that 50% of Fellows, Trainees and IMGs did not know how to lodge a complaint. Interviewees reported a lack of understanding of the processes, which is complicated by duplication with hospital process.

Figure 3.5 Feelings of safety regarding lodgement of a complaint about discrimination, bullying or sexual harassment at work







There is very strong support for the Action Plan.

The survey highlighted a remarkably high level of support for the College's commitment to addressing discrimination, bullying and sexual harassment in surgery, with 95% of 1346 Fellows, 96% of 244 Trainees and 93% of 62 IMGs supporting the College's commitment (Figure 3.6 Panels A, B and C respectively). When analysed by gender, the results show 92% of 1080 males and 96% of 261 females supporting the Action Plan (Panels D and E). These findings were confirmed at interview, with both Trainees and Fellows very supportive and impressed with how the College has approached the issue.

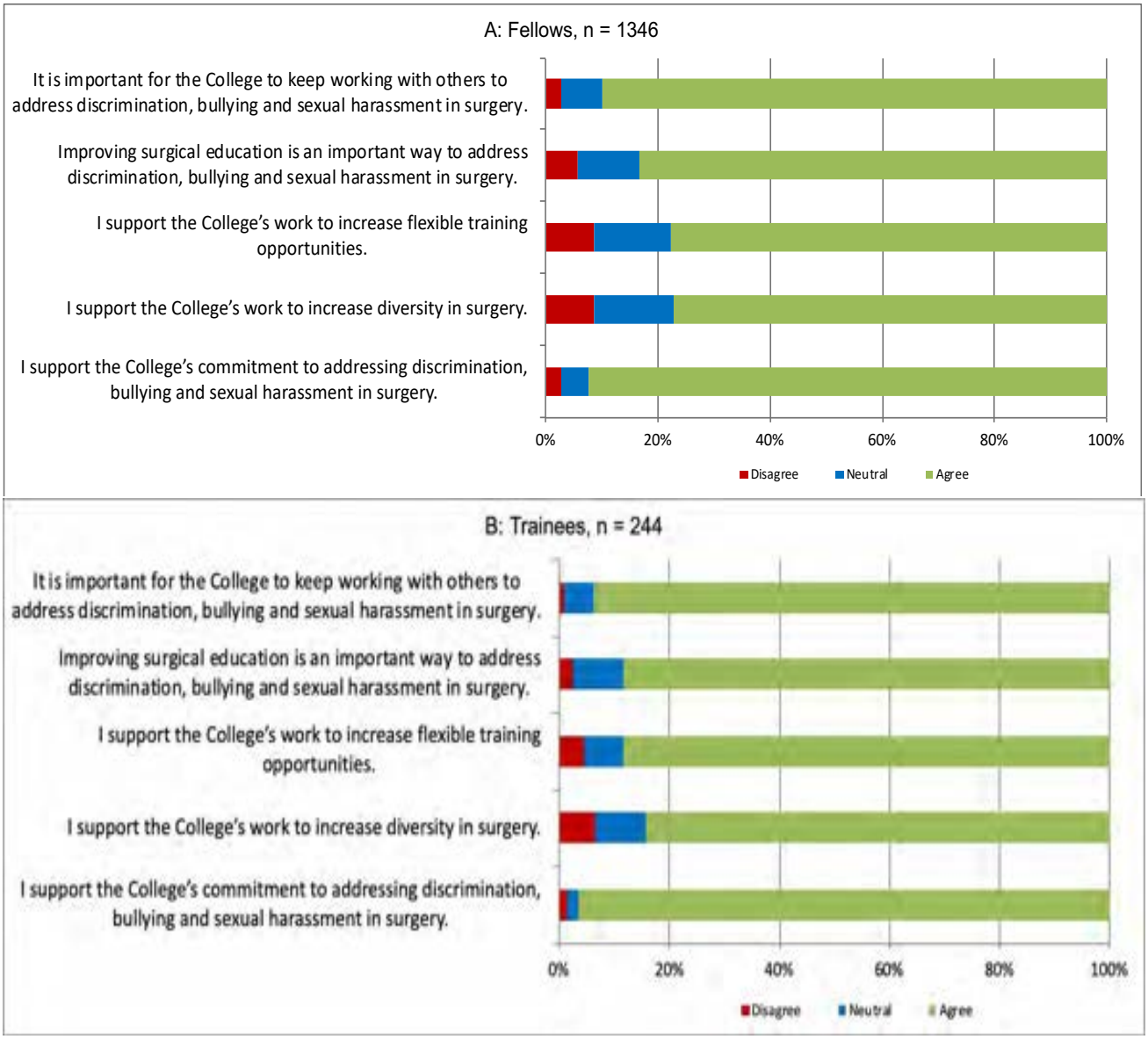
> "*The College is persistent. Hasn't let go of this." (Fellow)*

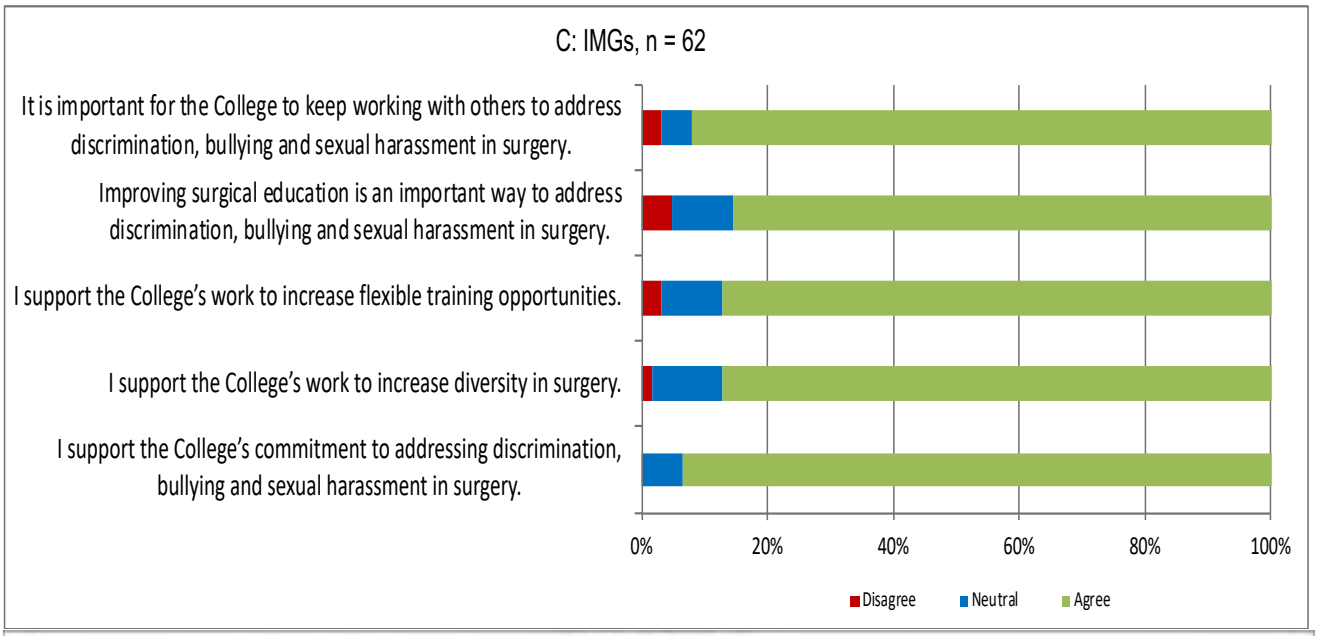
Survey respondents also indicated a high degree of support for the College to keep working with partners to achieve its goals, with 90% of 1346 Fellows, 94% of 244 Trainees and 92% of 62 IMGs expressing support (Figure 3.6 Panels A, B and C respectively).

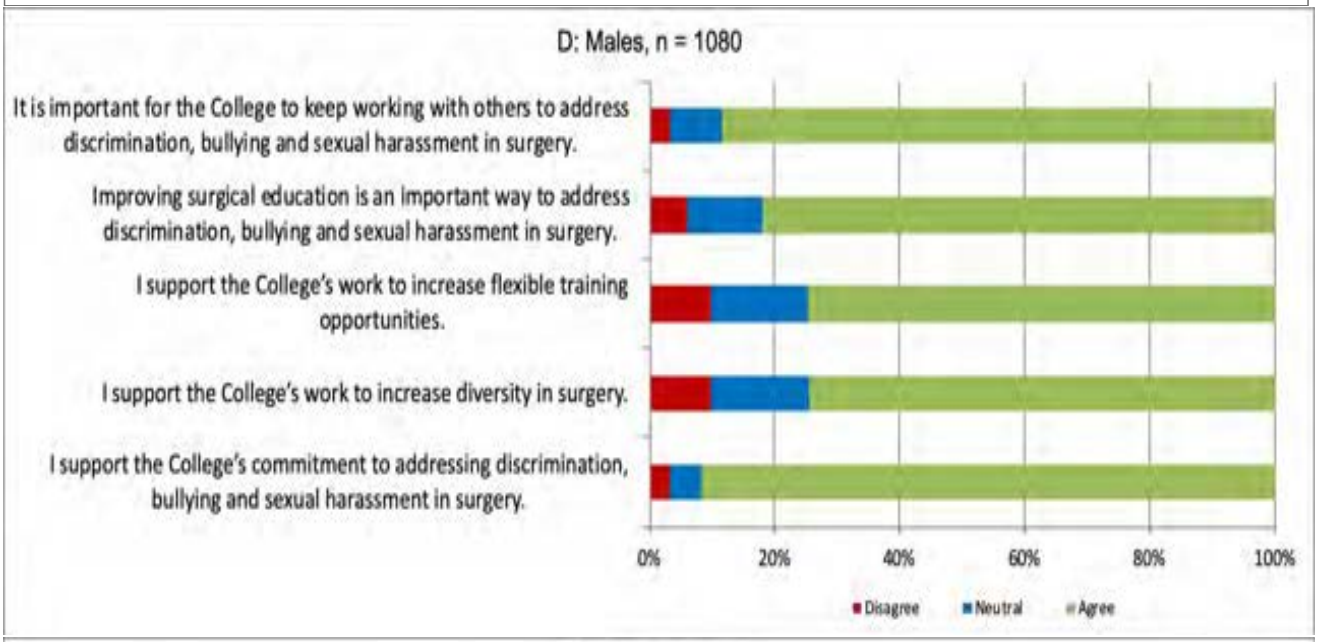
However, both at interview and through the survey, small but significant pockets of resistance to change were identified. Several interviewees (Fellows) expressed concerns regarding the availability of flexible training options, believing that this would dilute the experience of Trainees or significantly extend their training period to an unmanageable length. Concerns were expressed about the quality of surgical training in future if such measures were available. This finding was confirmed in the survey where 22% of 1346 Fellows either disagreed or were neutral about the availability of flexible training, and 18% were not convinced that education was the way to address discrimination, bullying and sexual harassment in surgery (Figure 3.6 Panel A). Work to increase diversity in surgery had similar levels of disagreement, with 22% of Fellows disagreeing or feeling neutral about this initiative. All of the more

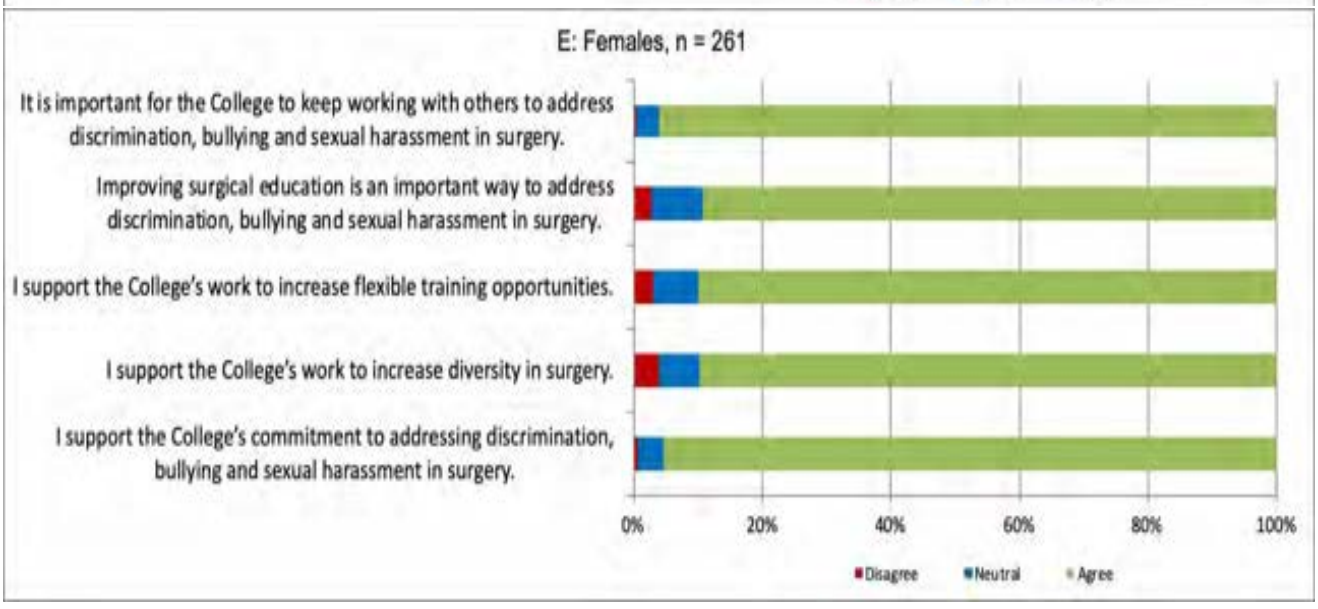
underrepresented groups, such as Trainees, IMGs and females, were more supportive of these changes (89% of 244 Trainees supporting flexible training and use of education to address the issues, 84% supporting work to increase diversity (Panel B) and similar figures for IMGs and females (Panels C and E). Overall, males were the least supportive of changes, with male Fellows the least supportive group of all. However, although this issue needs to be addressed, it is important to note that this represents only approximately 20% of Fellows, showing a high degree of support from the vast majority.

Figure 3.6 Level of support for key elements of the Action Plan




C: IMGs, n = 62
It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.
Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery.
I support the College's work to increase flexible training opportunities.
I support the College's work to increase diversity in surgery.
I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree


D: Males, n = 1080
It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.
Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery.
I support the College's work to increase flexible training opportunities.
I support the College's work to increase diversity in surgery.
I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree


E: Females, n = 261
It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.
Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery.
I support the College's work to increase flexible training opportunities.
I support the College's work to increase diversity in surgery.
I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree

There is a strong understanding of the relationship between behaviour and patient safety.

The power of the message that an individual surgeon's behaviour or that of the team can impact on patient safety was demonstrated by the responses to the survey question shown in Figure 3.7 below, Panels A, B and C respectively. 95% of 1346 Fellows, 98% of 244 Trainees and 97% of 62 IMGs agreed. This message has been reported by interviewees as a strength of the Building Respect Action Plan and could be described as a critical success factor for the excellent outcomes achieved so far.

The FSSE course is seen as a strength.

Although only 65% of Fellows agreed that the FSSE course was relevant to their daily lives as surgeons, this course was also identified by interviewees as a key strength of the Action Plan. People delivering the courses were described as credible, enthusiastic and engaged, and the committee which runs the course is seen to be continually improving it and responsive to feedback. Interviewees reported observing people changing during the course, with some reluctant attendees saying, after the course, that they learned something.

> *"People who initially didn't want to be there come out and thank you at the end*." (FSSE trainer)
>
> "*FSSE course was brilliant on how to deal with pushback*." (Fellow)
>
> "*Big tick for convenors*." (Fellow)
>
> "*Engagement and enthusiasm of course presenters is infectious"*. (Fellow)

Two thirds of respondents found the Action Plan elements to be relevant.

63% of Fellows and 62% of Trainees felt that the e-module was relevant to their daily lives as surgeons, compared with 84% of IMGs. The interviews did not clarify the reasons for this difference.

Several interviewees (Fellows) reported that they did not believe they need to learn how to behave more respectfully, whilst others had heard their colleagues say the e-module was a waste of their time.

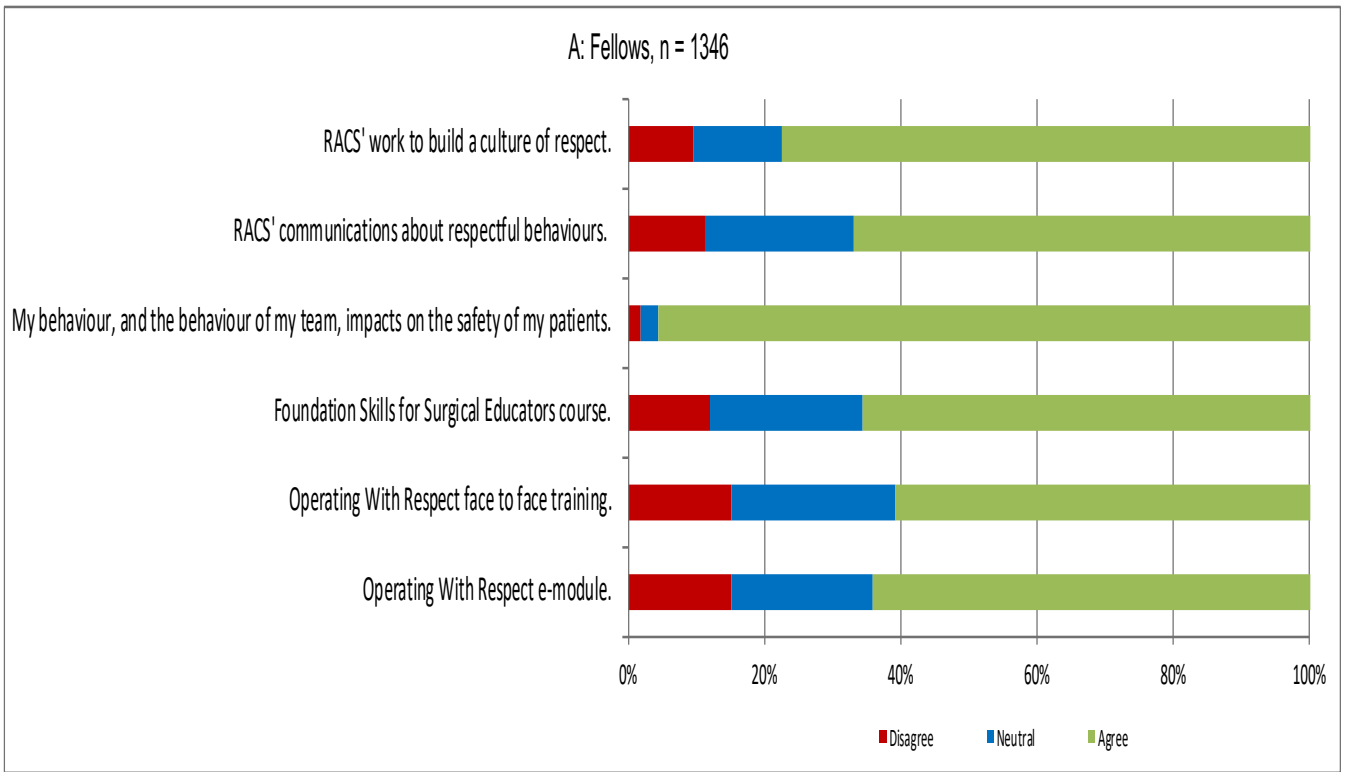
Interviewees who had completed the OWR face to face course spoke very positively about their experience. They believed that it is addressing a very relevant need and that it was well presented. They especially valued learning the practical use of the Vanderbilt approach. 61% of 1346 Fellows regarded the FSSE course as relevant (Figure 3.7 below, Panel A).

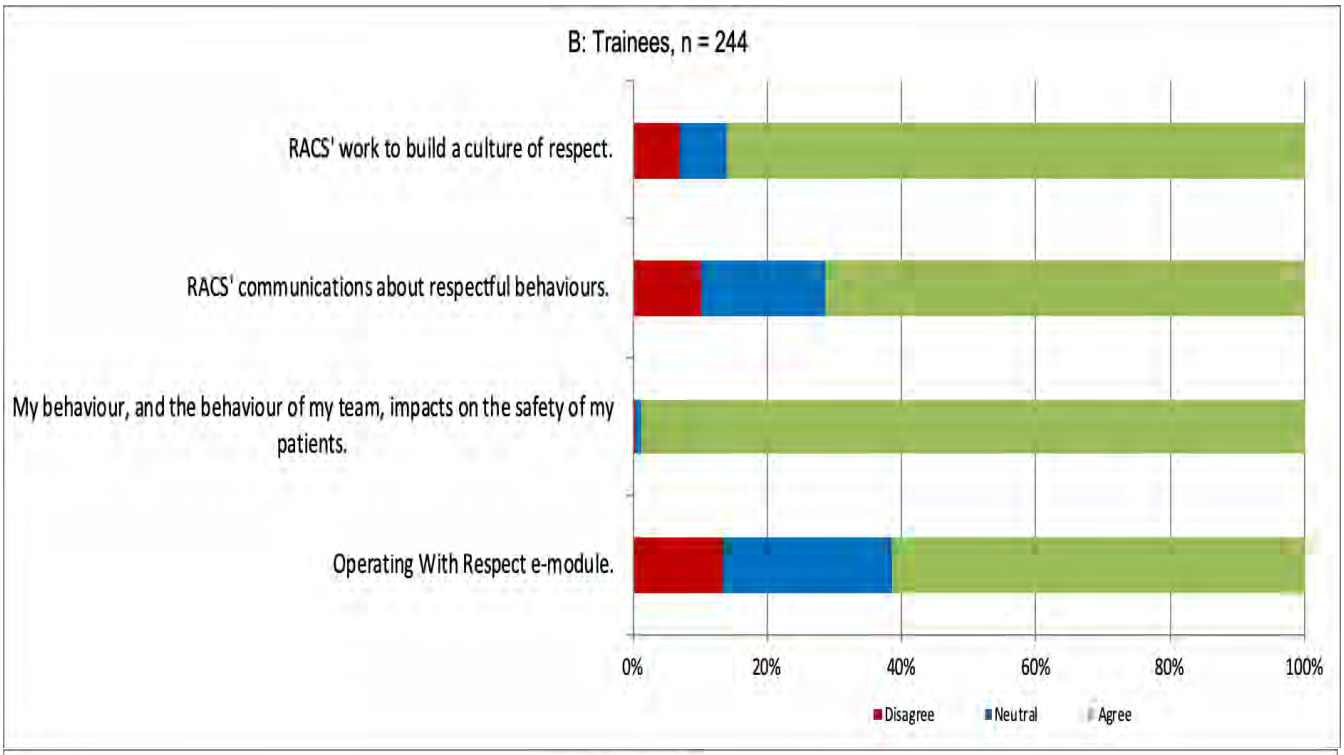
> The OWR e-module video was … "*exactly the same bullying I was receiving….it was subtle… glad it was displayed on the video.*" (Trainee)

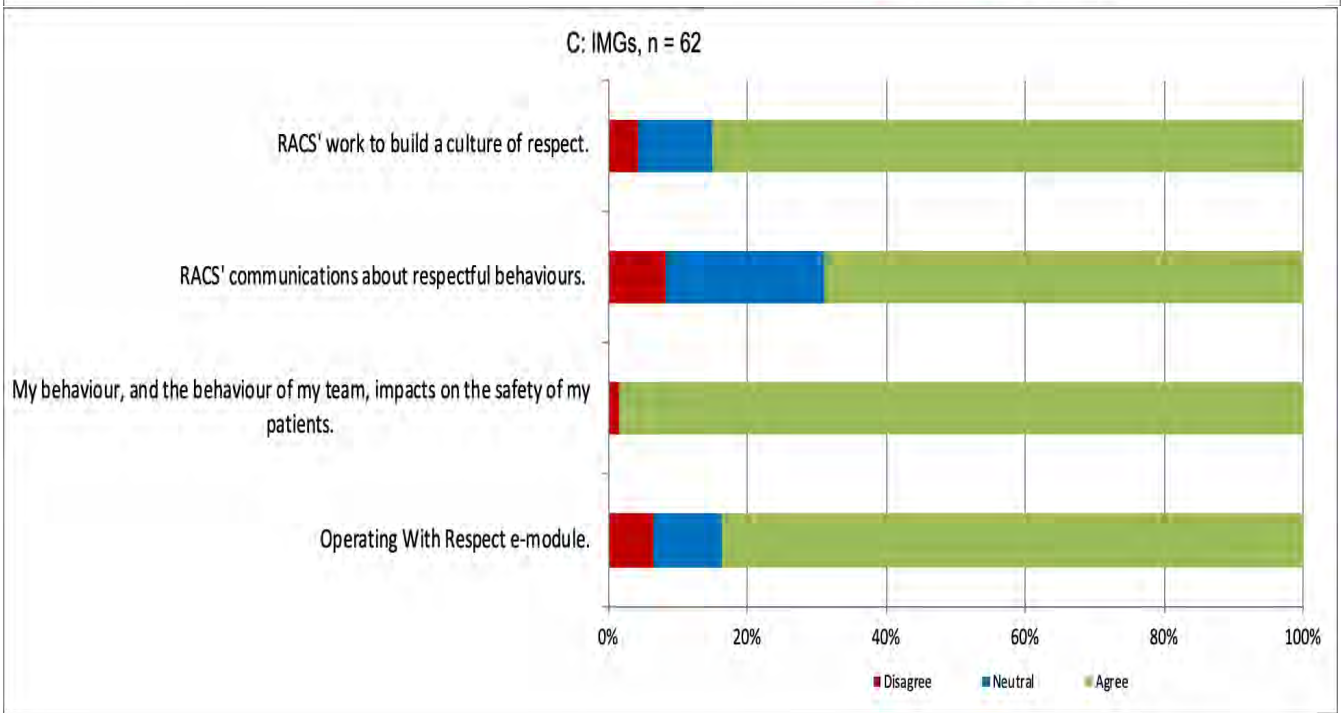
Around 70% of respondents found the communications to be relevant (68% of Fellows, 72% of Trainees and 68% of IMGs). More Trainees and IMGs felt that the College's work to build a culture of respect was relevant (87% of Trainees and 85% of IMGs compared with 78% of Fellows).

However, whilst all groups reported their support for the Action Plan and perceived it to be relevant to their surgical experiences, an incidental finding during this evaluation, was that Trainees do not seem to be as well engaged with the College as the other groups. This was evidenced by the extreme difficulty experienced in accessing Trainees for interviews, together with some reluctance of Trainees to discuss issues regarding unacceptable behaviours. The limited scope of this evaluation did not allow for this issue to be more fully explored, however it is possible that time limitations or fear of negative consequences for those highlighting unacceptable behaviours may be the underlying factors.

Figure 3.7 Perceived relevance of key elements of the Action Plan







Early outcomes are exceeding expectations.

Although this first phase evaluation was focussed on the implementation and governance of the Action Plan, one set of questions was included in the survey and interviews to obtain a baseline for comparison of future measurements of some of the important anticipated outcomes. The findings indicate some early changes are well progressed.

Increased awareness of the issues

Over 80% of survey respondents reported increased awareness of the issues of discrimination, bullying and sexual harassment in the workplace, including in other medical disciplines (81% of 1317 Fellows, 86% of 237 Trainees and 84% of 59 IMGs (Figure 3.8, Panels A, B and C respectively). 45-60% of respondents said that people are more likely to raise the issue (59% of 1317 Fellows, 45% of 237 Trainees and 58% of 59 IMGs (Figure 3.8, Panels A, B and C respectively). Although Trainees were the least likely to raise the issues, at interview they generally reported a change in workplace behaviour and feelings of increased confidence to call out unacceptable behaviour.

> *"Now I can speak for myself better than before. I can say this behaviour is not acceptable anymore."* (Trainee with previous experience of bullying)

> *"Increased awareness of the problem in other disciplines."* (Fellow)

Positive change in workplace culture

40 to 45% of respondents reported a positive change in workplace culture (41% of 1317 Fellows, 42% of 237 Trainees and 45% of 59 IMGs (Figure 3.8, Panels A, B and C respectively) whilst 38% of Trainees and 43% of IMGs felt that senior surgeons are more respectful when giving feedback. Some interviewees gave details of consultants now being much more aware of the need for care when providing negative feedback, and sometimes having a second person attend the meeting. Some Fellows said they are now less confident of providing negative feedback to their teams, because of a fear of being reported for bullying, however, 66% of Fellows in the survey, reported increased confidence.

Interviewees (Fellows and Trainees) stated that consultants are starting to understand what behaviours could be perceived as bullying, whilst others described the increased skills at addressing unacceptable behaviours as being really helpful. Although some interviewees felt that the pace of change was slow, others recognised that cultural change is gradual and the pace will increase over time.

> *"Floodgates are open now."* (Fellow, about the likelihood of positive changes)

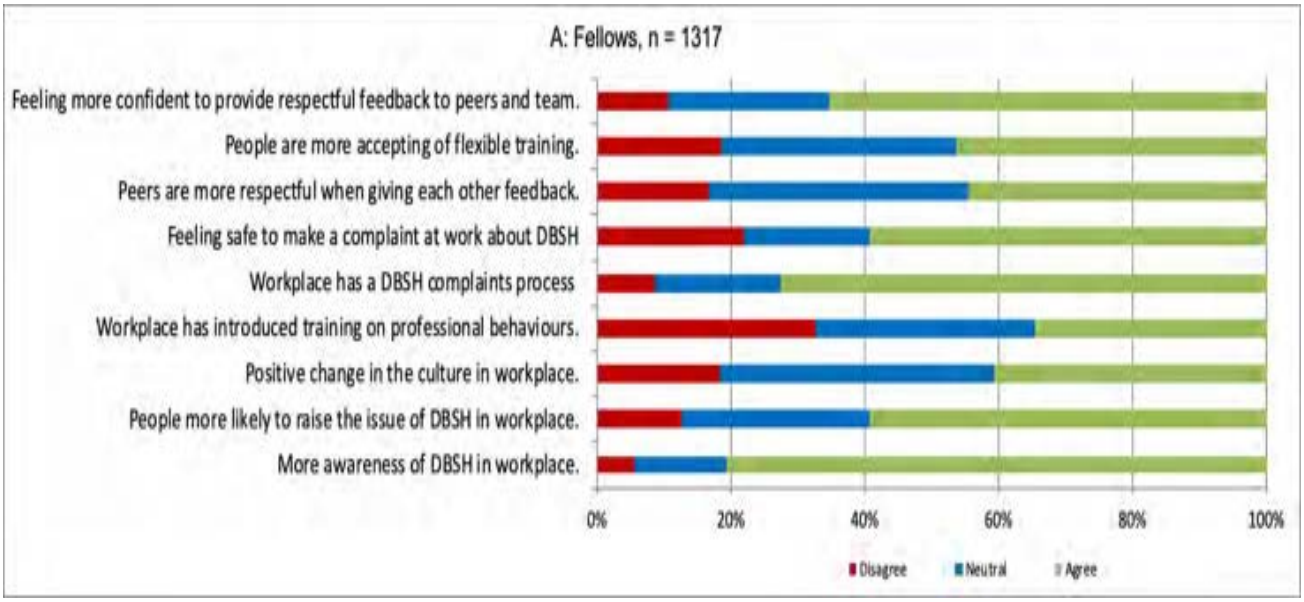
> "Slow pace of change is frustrating." (Fellow)

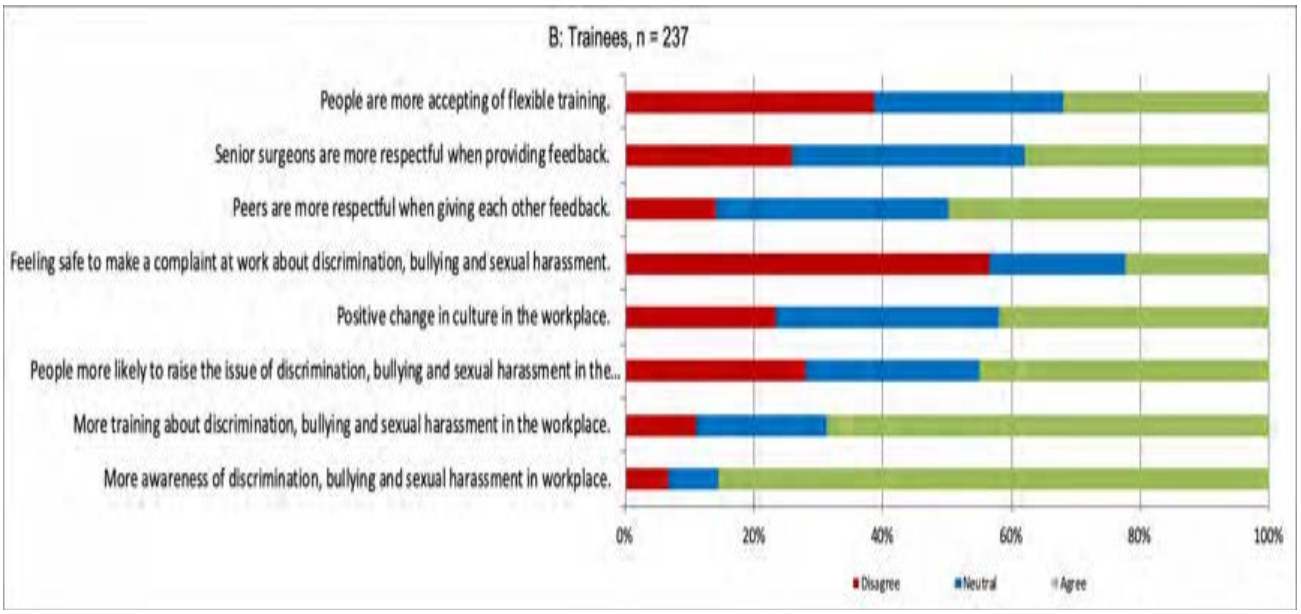
> "*Surgeons look after junior staff wellbeing*." (Trainee observing culture change)

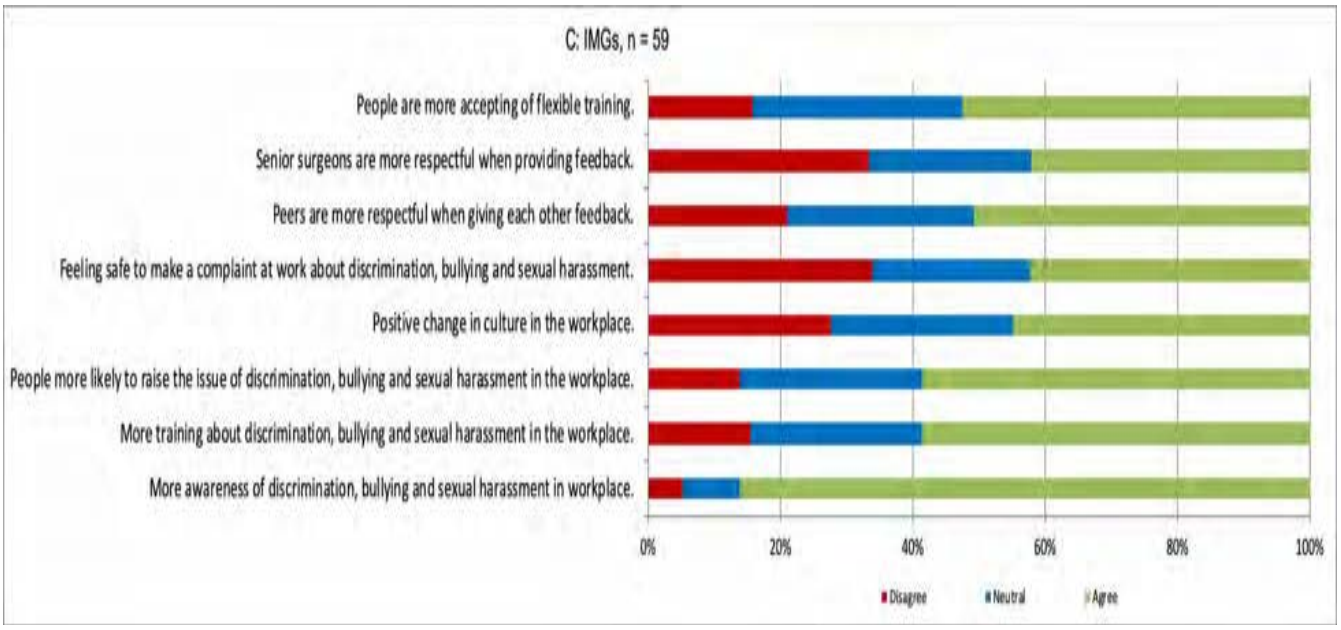
RACS is leading the way

The College is being quoted by other medical disciplines as a source of policy on acceptable behaviours. Although less than 40% of survey respondents reported that their workplace has introduced training in professional behaviours, many hospitals are now in the process of introducing the Vanderbilt principles, following the RACS example. The work of the College has also influenced other medical Colleges, including ANZCA, RANZCOG, RANZCO, ACEM and some international colleges, which are introducing the RACS model.

Figure 3.8 Perception of very early changes in the workplace







Representation of women is increasing towards gender equity targets.

Recent figures (Table 3.1) show that the representation of women is growing and progressing well towards gender equity targets. In 2018, 33% of applications for surgical training were from women, and 35% of those accepted into training were women, with the target for 2021 set at 40%. Representation of women on RACS Boards and Committees is ahead of target, at 27% in 2018, against a target of 20% by 2018 and 40% by 2020. Although this represents significant progress, there have been reports, by interviewees, of mixed reactions from a small number of female surgeons who do not want to be held up for special recognition because of their gender.

Table 3.1

	Applications to Surgical Training	Accepted into Surgical Training	New Fellows	Total Active Fellows	Women on Council and Main RACS Committees
2016	30%	25%	22%	12%	21%
2017	29%	31%	24%	14%	23%
2018	33%	35%	24%	13%	27%

KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?

Overall assessment of findings for this KEQ

The Building Respect Action Plan is extensively and effectively monitored. At this early stage of program implementation, the focus is on Action Plan outputs and activities, with regular reporting through senior management and the CEO, to Council, Board of Council and the Building Respect Implementation Group. External evaluation and review have been built in to provide outcomes reporting at the appropriate stage of program development and to inform the continuous improvement approach. There is evidence to indicate that adjustments are being made to the Action Plan as new evidence or practical barriers emerge. Importantly, RACS management and Council have identified the key strategic challenges for further implementation and already have plans to address them.

Strengths

Dedicated senior position

One of the major strengths of the Action Plan has been the establishment of a dedicated senior position to drive program implementation. This has achieved a focal point for advocacy, coordination and progress monitoring, which has contributed to the strong achievements to date.

Culture of continuous improvement

Another strength is the culture of continuous improvement, evident through the close monitoring of actions and outputs against plans, and the openness to receive recommendations from external reviewers and examine the evidence for emerging trends and ideas. This underpins the Action Plan's adaptability, agility and responsiveness.

Transparent reporting

Transparency is also a key strength of the Action Plan. There has been extensive reporting both within and externally to the College about progress towards a culture of respect and this has strengthened the College's position as a leader in this significant undertaking, and validated the importance of this work to its members.

Opportunities for improvement

Addressing the cost of the Action Plan

Action Plan implementation has been resource-intensive, particularly the mandatory education, which has been funded by diverting resources from other priorities. There is no comprehensive cost recovery plan which could support sustainability of the Action Plan in the longer term.

Incorporating Building Respect principles into Business as Usual

Although the Action Plan is nominally mentioned in the current RACS Strategic Plan, the Building Respect principles are not incorporated into the all the elements of the Plan.

Inform Council about the introduction of outcome reporting

Councillors spoke of their need to see outcomes reporting against the Action Plan, however, it is very early in the program implementation to be able to measure many of the outcomes with any certainty. It is important to inform the Council about the planned schedule for outcome reporting over the remaining two phases of the evaluation.

Detailed findings

The Action Plan has been resource-intensive.

Councillors reported that the College has committed significant funds, and has diverted resources from other priorities, in order to implement the Action Plan. At this stage, the education program, which has been the major area of activity in the Action Plan, has no cost recovery plan. Although Councillors are committed to the Action Plan, some concern was raised by interviewees about the need to develop a cost recovery plan so that activities can be sustained over the longer term.

Action Plan outputs and activities are being closely monitored.

Documentary evidence and discussions with the Executive Project Lead indicate that the Action Plan implementation is being closely monitored. The Executive Project Lead monitors all activities under the Action Plan and produces a detailed monthly Progress Update for the Building Respect Implementation Group, against each proposed action, highlighting achievements against targets, status and next steps. Monthly Building Respect progress reports are also submitted to Council and Board of Council as part of the CEO Report. The Expert Advisory Group meet biennially to review progress against the Action Plan.

Annual Progress Reports highlighting progress against the major action areas of Culture Change and Leadership, Diversity and Inclusion, Strengthening Surgical Education and Complaints Management, and including proposed next steps, are published and widely distributed both within the College and to external stakeholders.

Interviews with Council members confirmed that they feel well-informed and that the Action Plan is discussed at every meeting, with a focus on education, which has so far been the major thrust of the Action Plan. Councillors reported some concern that the information they received on complaints may not have reflected the most accurate status of complaints, however this is currently being reviewed.

One area for improvement raised by Councillors was that this reporting is focussed on activities, and outputs, such as attendance figures for education courses, compliance and numbers of complaints, and they have not received any information on outcomes. At this stage of implementation, it is appropriate to focus on outputs, as the Action Plan is still in the early phase of implementation and it is too early to formally measure any significant outcomes. This evaluation will provide the first evidence of the very early outcomes being achieved. It will be followed by a second phase evaluation, with a greater emphasis on outcomes, due to report in mid 2021.

Program outcomes are being evaluated as they develop.

Behaviour change programs are based on changes firstly to awareness or knowledge, then to attitude, followed by behaviour change, noting that this process is not actually linear in practice and often many of these outcomes can be observed happening at once. The outcomes for a cultural change program such as the Building Respect Action Plan, take considerable time, often years, to develop to the extent that they can be measured. Therefore, it is important to measure the outcomes after an appropriate implementation period has been in place, and it is not practical to measure or report on progress in time periods of less than 12-24 months.

An Evaluation Framework for the Building Respect Action Plan was developed in 2018. This was specifically designed to build on data already being collected to evaluate the outcomes of the Building Respect Action Plan over the short, medium and long term (at 3-, 5- and 10-years after implementation). The three planned evaluations will provide a measure of the extent to which the program outcomes have been achieved, and will inform program improvement.

In addition to the formal evaluations of the overall Action Plan, RACS has engaged an independent external reviewer for the complaints process, to provide continuous improvement opportunity in this critical area. The first review took place in late 2017 and reported in January 2018, however, due to delays in completing the response to the recommendations, the second review has not yet taken place i.e. it is six months behind schedule.

The Diversity and Inclusion plan has not been subject to evaluation in its entirety however, progress against all actions in the plan are reported on a twice-yearly basis. A gender diversity dashboard is also updated twice yearly and includes figures showing female participation in a range of activities including selection to surgical training. Evaluation of this plan is to be included as part of Phase 2 evaluation of the program as a whole.

Emerging evidence and lessons learned inform practice.

Evidence continues to inform practice in adapting the Action Plan to new developments. Gerald Hickson, a leading researcher, was invited by the College to Australia to present his insights and the latest research findings, in October 2018 at select meetings and May 2019 at the Annual Scientific Conference and to RACS staff and partners. This evidence-based information continuously informs the complaints handling and education programs of the Action Plan.

RACS has responded to the external review of its Discrimination, Bullying and Sexual Harassment complaints process by completing implementation of the majority of the recommendations within less than six months. The remaining actions are either in progress or under review due to subsequent changes to the complaints process.

RACS is also supporting research to inform its gender diversity commitment. Research into the reasons why women leave surgical training at higher rates than men has been completed and published, with the findings progressively informing the Action Plan

activities. Separate research into the barriers for women selecting surgery as a specialty is underway, and the findings expected to inform future activity.

RACS has also made a commitment to evaluating its Action Plan at three time points (2019, 2020 and 2026) and to adapting the Action Plan in response to the recommendations.

RACS is addressing identified strategic challenges for further implementation.

A key strength of the Action Plan oversight is that RACS has identified the major challenges ahead and has begun to plan how they will be addressed. In a presentation made in November 2018, the Council President identified the following challenges and illustrated how Council intends to address them.

- Measuring progress: Already addressed through development of the Evaluation Framework.
- Overcoming communications fatigue: A refreshed communications campaign has already begun to be implemented, targeting new behaviours.
- Overcoming training fatigue: No new mandatory training is planned; however, all new Trainees must complete the online module as part of their application for a training place.
- Resonating with a diverse membership: Constant review and updating of communications.
- Cynicism (and fears) around complaints management and information sharing: The complaints process is currently under review.
- Fear of identification and reprisal in raising a complaint (trainees): As above, but also acknowledging the need to communicate positive stories.
- Stigma associated with flexible training: Plans to share experiences of good outcomes to show acceptability.
- How to maintain progress in achieving gender equity targets? Possible insights from the work of other colleges, plus other groups such as male Champions of Change.
- Maintaining momentum: Planning for integration of the Action Plan into Business as Usual.

However, despite a commitment to integrating the Building Respect principles into Business as Usual, it is not explicit in the 2019-2022 RACS Strategic Plan.

RACS reports transparently to stakeholders about progress towards building a culture of respect.

The commitment and achievements of the RACS Building Respect Action Plan have been widely reported, both internally and externally. This has been achieved through publication and external dissemination of the Annual Progress Updates, presentations by the Council President at the Annual Scientific Conference and by invitation to various audiences throughout the year, through updates provided by STANZ Chairs at State-level meetings and via MOU meetings with representatives from jurisdictional health departments and hospital or employer partner meetings.

In addition, the RACS website has a significant amount of up to date information and reports, there has been much information dissemination via social media and regular articles appear in the RACS member newsletters, *Surgical News and Fax Mentis.*

4. Conclusions and Recommendations

4.1 Conclusions

The Building Respect Action Plan is being implemented effectively and is achieving its intended goals so far. This is a significant achievement, given the size and complexity of the task, which involves coordination of a broad range of activities through partnerships with health jurisdiction and hospitals across two countries.

A strong and effective communications campaign, together with an extensive and targeted education program, conducted in the context of a society that no longer tolerates disrespectful behaviour, has resulted in strong permeation of the Building Respect messages throughout the membership. This is leading to very positive early changes in behaviour and attitudes in workplaces across Australia and New Zealand.

Visible support from the most senior levels of the College is a strength which underpins the success of the implementation, and it is essential that this level of support continues into the future, to maintain the momentum of early implementation success.

Opportunities for improvement centre on review and adjustment of the complaints process, to achieve best practice principles and improve trust and acceptance of the process. Related to this is the opportunity to improve the messaging to Trainees and IMGs and increasing understanding of their issues and experiences. Integrating Action Plan activities into Business as Usual, including incorporation of the education into the core curriculum, will ensure ongoing and cost-effective actions towards a building a culture of respect.

4.2 Recommendations

1. Maintain momentum through visible high-level support for the Action Plan

Why it is important

The strong and visible commitment of the RACS Council to deliver the Action Plan goals has been a critical success factor for the successful implementation of the Building Respect Action Plan. This is evidenced by the level of resourcing for Action Plan implementation and the focus that Council has maintained at every meeting. It is important not to lose sight of the contribution of this commitment to keeping the College in the lead on this issue. Maintaining this level of focus on the Action Plan goals will keep the momentum as the Action Plan enters the next phase of delivery.

How it would look in practice

1.1 Maintain focus and drive through the Executive Leadership Team.

Maintain the momentum for implementation by continuing to focus on Action Plan outcomes at senior level.

1.2 Maintain the high visibility of Council support through external reporting and presentations.
Continue with the President's presentations, other presentations at conferences and both internal and external annual reporting to demonstrate the commitment of the Council and other office bearers, including at the STANZ level, to building a culture of respect.

1.3 Maintain high visibility of the Action Plan through a strong communications function.
Continue to fund and support the communications function, to review and update the messages and to refocus the communications on changing priority areas as the Action Plan is implemented.

1.4 Ensure Business as Usual integration by incorporating the Action Plan principles throughout the RACS Strategic Plan and annual workplans.
Demonstrate Council's commitment to the Action Plan goals by visibly integrating the principles into Business as Usual and make it central to how all College activities are delivered. Strengthen its place in the Strategic Plan and annual workplans to underpin all activities and values.

2. Review the complaints process to increase confidence that problems will be dealt with proportionately

Why it is important
Establishment of a trustworthy, effective and reliable complaints process is a critical success factor for achievement of the Action Plan goals. Cultural change towards a more respectful workplace depends substantially on the ability to call out offenders, which, in turn, relies on having an effective complaints system in place.

How it would look in practice
2.1 Clarify and articulate RACS's role in the complaints process
Establish and agree the appropriate role for the College in the overall complaints system, including its legal and moral obligations to ensure a safe training environment, and to support cultural change in the practice of surgery. Once agreed, this should be clearly communicated to members.

2.2 Review the complaints process to ensure alignment with best practice
Ensure incorporation of best practice complaints handling, as outlined in the EAG recommendations, with the current review of the RACS complaints system. This includes a system which is clearly communicated to members, is transparent, timely and procedurally fair. As far as practical, align the RACS complaints process with hospital and regulatory systems.

2.3 Continue with regular external reviews of the complaints process
Maintain the practice of regular review and revision of the complaints process to ensure alignment with best practice principles and maintain a continuous improvement approach.

2.4 Increase the capacity of the mediation and advice/support process
Create positions within the College or in workplaces, to act as a source of informal advice and support as an alternative to making a formal complaint. Ensure these positions cover a diverse range of age, gender and geographical distribution.

2.5 Build expectations and rebuild confidence
Manage expectations around the potential outcomes of complaints and the proportionate responses for each level of inappropriate behaviour. Continue to publish the statistics from the complaints process, to highlight actions taken in response to complaints.

2.6 Monitor data, analyse trends and act to prevent further issues
Gather and regularly analyse complaints and other related data so that repeat offenders or hotspots can be identified. Continue to monitor workplaces where complaints have been unsubstantiated. Build a stronger partnership with RACSTA to facilitate Trainee engagement. Take action through training post accreditation.

3. Leverage the strengths of the existing Building Respect communications approach.

Why it is important
The communications function has been a critical success factor for the Building Respect Action Plan. The strong messages have permeated through the membership and support and underpin the cultural change activities by keeping the call to action at the front of mind. Messages have been updated for year three of the Action Plan. Maintaining the focus on strong and effective messaging, whilst adapting the messages for each new phase of implementation will be critical to support the Action Plan goals.

How it would look in practice
3.1 Maintain high visibility of the Action Plan through a strong communications function.
Continue to fund and support the communications function. Continue to build understanding of issues underlying discrimination, bullying and sexual harassment, to inform review and update of the messages. Refocus the communications on emerging priority areas as the Action Plan is implemented, to keep these issues at top of mind across the profession.

3.2 Use local champions to amplify the message
Establish a diverse group of local champions, for peer to peer communication and amplification of the key messages. Continue with work on development of the Surgical Directors groups and development of Key Opinion Leaders in each craft group.

3.3 Target communications to Trainees and IMGs
Develop specific messages and communication mechanisms for Trainees and IMGs to improve their awareness of key messages, the complaint system and the available support services.

4. Embed Action Plan into College planning and governance.

Why it is important

A major goal of the Action Plan implementation is to embed it into Business as Usual for the College. Incorporating Building Respect principles into College planning, including strategic planning, will ensure that all activities will include Building Respect performance indicators and help to maintain a focus on the Action Plan goals in everything the College does.

How it would look in practice

4.1 Align Action Plan reviews with RACS strategic planning

Align periodic reviews of the Action Plan with the Action Plan evaluation schedule and RACS strategic and annual planning to ensure consistency and embed building respect principles into the College's planning process. Align contextual reviews so that emerging priority action areas such as safe working hours, rotation of training impact on leave or the status of unaccredited trainees can be incorporated into Action Plan activities, where relevant. Reviews should consider updating of measurable targets and timelines for the implementation so progress can be readily measured.

5. Investigate cost recovery options for Building Respect courses.

Why it is important

The Action Plan has been an expensive initiative for the College, with education as the centrepiece of the first two years of activity. It would not be sustainable for the College to maintain this level of financial commitment to the education component into the future. Now that over 98% of members have completed the mandatory training, it is timely for the College to examine a cost-effective way to integrate the Building Respect principles into future education and training.

How it would look in practice

5.1 Integrate the Building Respect principles into RACS core curriculum.

Identification of opportunities to incorporate the Building Respect principles into the core RACS curriculum is in progress. This will avoid the need for separate and expensive courses.

5.2 Investigate other cost recovery models for delivering professional skills training.

Consider other options for delivery of the Building Respect messages, including through partnerships with hospitals and other colleges.

6. Improve understanding of the issues faced by Trainees.

Why it is important

One of the main drivers for the establishment of the Action Plan was the wish to improve the experience for surgical Trainees. Understanding their daily experiences, their issues and their viewpoints in relation to the culture of surgical education is therefore a crucial part of ensuring that the Action Plan continues to adapt to address issues relevant to this important cohort.

How it would look in practice

6.1 Conduct an extensive consultation with Trainees.

Develop and deliver a comprehensive, staged and targeted consultation process to engage with surgical Trainees and gain understanding and insights into their issues, views and challenges in relation to the culture of surgical education and other related matters. This could be achieved through a combination of existing mechanisms such as the RACSTA survey and through internally or externally facilitated surveys, interviews and focus groups. Incorporate findings into the review of the Action Plan and adapt the Action Plan accordingly.

5. Attachments

Attachment 1: Building Respect, Improving Patient Safety Action Plan

Attachment 2: Building Respect Program Evaluation Framework

Attachment 3: Building Respect Program Logic Model

Attachment 4: Stakeholder Engagement Plan

Attachment 5: Survey Questions

Attachment 6: Semi-structured Interview Questions

Attachment 7: Definitions and common terminology

AN EVALUATION FRAMEWORK FOR THE ROYAL AUSTRALASIAN COLLEGE OF SURGERY BUILDING RESPECT, IMPROVING PATIENT SAFETY ACTION PLAN

July 2018

Table of Contents

1. Building Respect, Improving Patient Safety Action Plan

1.1 Background

Action Plan history

In 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG) to investigate the extent of discrimination, bullying and sexual harassment within the surgical profession. EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. This raised serious concerns for the wellbeing of individual surgeons and surgical trainees, of surgical teams and especially for the quality of care and safety of patients.

RACS responded to these issues by apologising to all people affected by unacceptable behaviours, accepting all of the EAG's recommendations and developing an Action Plan, *Building Respect, Improving Patient Safety* (Action Plan), which outlines how RACS intends to counter and drive out unacceptable behaviours from surgical practice and surgical training.

Action Plan vision

The Action Plan's vision is to *build a culture of respect in surgical practice and education*, which will contribute towards:

- Improved patient safety.
- Surgical workplaces that are safe and free from unacceptable behaviours.
- A surgical profession that is more representative of the cultural and gender diversity across the community.

1.2 Action Plan values and goals

The Action Plan aims to bring significant, but necessary changes to the culture of health workplaces and surgical training. It has been developed to reflect the principles of the Vanderbilt Model[1].

Values underpinning the Action Plan

- Every healthcare worker has the right to a workplace free of unacceptable behaviours and every student/Trainee has the right to an education free of unacceptable behaviours.
- Patient safety should be the absolute and common priority in the workplace and every patient has the right to expect that their healthcare will not be compromised by unacceptable behaviours.
- Every applicant, trainee and surgeon has the right to be treated equally and with respect, regardless of their gender or cultural background.
- Teams work most effectively when there is respect for the skills, experience and contribution of each member.
- The success of work-based teams is measured by the safety of the workplace and the educational environment and by the extent to which all team members recognise

[1] Hickson GB, Pichert J, WEBB LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. Acad. Med. 2007 Nov;82(11):1040-8

that what they achieve together is more valuable than anything they can achieve on their own.

Action Plan goals

The Action Plan outlines how RACS Council intends to achieve the vision and demonstrate the values. It provides details on the actions needed to address each of the EAG recommendations. The Action Plan addresses eight goals, arranged under the three key action areas identified by the EAG. These goals are supported by a comprehensive workplan, which has been prioritised and gradually implemented. Progress reports on implementation and Action Plan achievements are regularly released and widely distributed.

***Building Respect, Improving Patient Safety* Action Plan Goals**

Cultural Change and Leadership

Goal 1: Build a culture of respect and collaboration in surgical practice and education.

Goal 2: Respecting the rich history of the surgical profession, advance the culture of surgical practice so there is no place for discrimination, bullying and sexual harassment (DBSH).

Goal 3: Build and foster relationships of trust, confidence and cooperation on DBSH issues with employers, governments and their agencies in all jurisdictions.

Goal 4: Embrace diversity and foster gender equity.

Goal 5: Increase transparency, independent scrutiny and external accountability in College activities.

Surgical Education

Goal 6: Improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency and professionalism.

Goal 7: Train all Fellows, Trainees and International Medical Graduates to build and consolidate professionalism including:

- Fostering respect and good behaviour;
- Understanding DBSH: legal obligations and liabilities;
- 'Calling it out'/not walking past bad behaviour;
- Resilience in maintaining professional behaviour.

Complaints Management

Goal 8: Revise and strengthen RACS complaints management process, increasing external scrutiny and demonstrating best practice complaints management that is transparent, robust and fair.

2. The Evaluation Framework

2.1 Objectives, scope and audience of the Evaluation Framework

Objectives

The *Building Respect, Improving Patient Safety* Action Plan Evaluation Framework (Evaluation Framework) has been developed in response to the requirement for clear, transparent and rigorous evaluation of the commitment by RACS to driving out unacceptable behaviours from surgical practice and training.

The first step towards evaluation is development of a comprehensive Evaluation Framework. The Evaluation Framework provides a guide to objectively analyse how effectively the Action Plan has been implemented, whether its intended outcomes have been achieved and what benefits have been delivered. It provides a structure for gathering the information required to gain an understanding of the Action Plan's performance, build capacity, support improvement and contribute to long-term planning.

The Evaluation Framework applies to three evaluations of different aspects of the Action Plan, to be conducted over a period of eight years. It provides key evaluation questions (KEQ), indicators and data sources designed to assess the evaluation criteria of effectiveness, efficiency, appropriateness, equity, impact and sustainability across the three major Action Plan areas.

Scope

This Evaluation Framework covers the breadth of work outlined in the *Building Respect, Improving Patient Safety* Action Plan.

Audience

Evaluation of this Action Plan is intended to be transparent and widely reported. The audience for each evaluation report will include:

- Fellows, Trainees and International Medical Graduates (IMGs);
- RACS Council and major committees;
- Building Respect Implementation Working Group;
- Building Respect Expert Advisory Group; and
- External stakeholders/public.

2.2 Structure of the *Building Respect, Improving Patient Safety* Action Plan Evaluation Framework

Purpose of the Evaluation Framework

The Evaluation Framework is intended to give the evaluation team a 'roadmap' from which to conduct each of the three planned evaluations. It consists of a series of structured questions, indicators and data sources, which are intended to support learning and continuous improvement. The Evaluation Framework is a guide and emerges from the context in which the Action Plan is operating. It should therefore be reviewed for its applicability at the commencement of each evaluation, and adjusted, if necessary, to ensure

each evaluation provides the most practical and useful information for reporting and improvement.

Features of the Framework

The major features of the Evaluation Framework are summarised below:

- It forms the roadmap for three evaluations;
- The Key Evaluation Questions cover all eight Action Plan Goals;
- Each evaluation is linked in time to the outcomes from the Program Logic;
- Repetition of questions, where possible, allows for comparability;
- Data collection is built on what is already in place;
- Prevalence survey will be a key data source;
- The evaluation survey/interviews will supplement existing data sources;
- Multiple data sources will allow for triangulation of findings to increase validity; and
- Fellows, Trainees and IMGs will be consulted via survey, interview and focus group.

How the Evaluation Framework will be used

The working sections of this document are the Program Logic Model (Attachment 3.4), the Program Evaluation Summary and Schedule (Attachment 3.5) and the Evaluation Framework (Attachment 3.6).

The Program Logic Model describes the changes that the Action Plan aims to achieve, and the major steps towards achieving them. It provides a common understanding of the Action Plan and forms the basis from which all of the evaluation questions have been developed. It will remain relevant for each evaluation because it identifies how the Action Plan was intended to be delivered and provides a basis from which to assess whether the planned actions and outcomes were delivered as intended. It will be reviewed and updated after each evaluation to ensure it is current and describes the next phase of the Action Plan.

The Program Evaluation Summary and Schedule identifies when each evaluation is due to take place and which areas of the program are within scope for each evaluation.

The Evaluation Framework includes the Key Evaluation Questions and sub-questions for each evaluation, including how they will be answered (indicators) and where the information will come from (data sources). It provides the roadmap for the evaluation team and will be used to develop the detailed Evaluation Plan.

At the beginning of each evaluation, a detailed Evaluation Plan and methodology will be developed, based on these source documents. The Evaluation Plan will include a timeline, data collection instruments such as surveys, interview guides and data collection spreadsheets and a stakeholder communication strategy.

2.3 The Key Evaluation Questions

The three evaluation Phases and the Key Evaluation Questions are shown in the table below. The full set of evaluation questions, including the more detailed sub-questions, indicators and data sources can be found in the Evaluation Framework Final Report (available on request).

Key Evaluation Questions for each Evaluation Phase

PHASE 1: 2018/19 • Measure whether program implementation, governance and oversight are proceeding as intended. • Measure whether early outcomes (delivery of pathways for identifying and addressing concerns about behaviour; program reach; target audience perceptions of the Action Plan) are being achieved as intended. • Identify program strengths, what is working well, barriers to progress. • Make recommendations on areas for program adjustment or improvement, based on findings.
KEQ 1: Has the Action Plan been implemented as intended to date?
KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?
PHASE 2: 2020 • Measure whether program implementation, governance and oversight are proceeding as intended. • Measure whether short-term outcomes (awareness of standards of respectful behaviour and approaches to address unacceptable behaviours; delivery of policy framework to underpin respectful behaviours; key partnerships formed; better educator skills; focus of surgical education on principles of respect, transparency and professionalism, complaints management process) are being achieved as intended. • Identify program strengths, what is working well, barriers to progress. • Make recommendations on areas for program adjustment or improvement, based on findings.
KEQ 1: Has the Action Plan been implemented as intended to date?
KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?
KEQ 3: To what extent has awareness of the standards of respectful behaviour increased across the surgical profession?
KEQ 4: To what extent has awareness of approaches to address unacceptable behaviours increased across the surgical profession?
KEQ 5: Has RACS put in place structures and a policy framework to support respectful behaviours?
KEQ 6: To what extent have relationships of trust, confidence and cooperation on Discrimination, Bullying, Sexual Harassment issues supported progress towards RACS Action Plan goals?
KEQ 7: To what extent has surgical education improved and focussed on the principles of respect, transparency and professionalism?
KEQ 8: To what extent is the RACS complaints management process transparent, robust and fair?

PHASE 3: 2026

The 2026 evaluation has been planned to provide a guide for future thinking. However, because it is eight years away, the questions provided should be considered indicative at this stage. We have also made the assumptions that the Action Plan will be revised after the 2020 evaluation and a new program of work will be developed going forward.

- Measure whether program implementation, governance and oversight are proceeding as intended.
- Measure whether intermediate/long-term outcomes (normalisation of respectful behaviours, key partnerships, focus of surgical education on principles of respect, transparency and professionalism, complaints management process, incorporation of respectful behaviours into RACS strategic plan, policies and activities, reduction of cultural and gender barriers) are being achieved as intended.
- Identify program strengths, what is working well, barriers to progress.
- Make recommendations on areas for program adjustment or improvement, based on findings.

KEQ 1: Has ongoing program activity been implemented as intended to date?

KEQ 2: Is program governance and oversight effectively supporting delivery of the program of work?

KEQ 3: To what extent are respectful behaviours normalised across the surgical profession and within surgical education?

KEQ 4: To what extent have relationships of trust, confidence and cooperation on Discrimination, Bullying, Sexual Harassment issues supported progress towards RACS Action Plan goals?

KEQ 5: To what extent has surgical education improved and focussed on the principles of respect, transparency and professionalism?

KEQ 6: To what extent is the RACS complaints management process transparent, robust and fair?

KEQ 7: To what extent has the Building Respect Action Plan achieved its intended outcomes?

Attachment 3: Building Respect Program Logic Model

The issue

In 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG) to investigate the extent of discrimination, bullying and sexual harassment within the surgical profession. EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. This is of concern for the wellbeing of individual surgeons and surgical trainees, of surgical teams and especially for the quality of care and safety of patients.

The response

RACS responded by apologising to all people affected by these unacceptable behaviours, accepting all of the EAG's recommendations and developing an Action Plan, *Building Respect, Improving Patient Safety,* which outlines how RACS intends to counter and drive out these unacceptable behaviours from surgical practice and surgical training.

Values underpinning the Action Plan

- Every healthcare worker has the right to a workplace free of unacceptable behaviours and every student/Trainee has the right to an education free of unacceptable behaviours.
- Patient safety should be the absolute and common priority in the workplace and every patient has the right to expect that their healthcare will not be compromised by unacceptable behaviours.
- Every applicant, trainee and surgeon has the right to be treated equally and with respect, regardless of their gender or cultural background.
- Teams work most effectively when there is respect for the skills, experience and contribution of each member.
- The success of work-based teams is measured by the safety of the workplace and the educational environment and by the extent to which all team members recognise that what they achieve together is more valuable than anything they can achieve on their own.

The vision of RACS' Action Plan

The Action Plan's vision is *to build a culture of respect in surgical practice and education*, which will contribute towards:

1. Improved patient safety.
2. Surgical workplaces that are safe and free from unacceptable behaviours.
3. A surgical profession that is more representative of the cultural and gender diversity across the community.

Cultural Change and Leadership					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Revise and introduce new policies and procedures which incorporate standards of respectful behaviour and value diversity and collaborative practice Lead the surgical profession (Surgical Training Boards, RACS Committees and Specialty Societies) on introduction of policies and practices that promote respectful behaviours	Principles, policies, procedures, codes of conduct, terms of reference, RACS Code of Conduct, Standards of behaviour Terms of reference for Training Boards revised to include external representatives, access to medical education experts, female surgeons and Trainees	Implementation of a structure and policy framework to underpin desired behaviours Fellows, trainees and IMGs are aware of the expected standard of conduct	Specialty Societies, Specialty Society Training Boards and RACS collaborate on incorporation of respectful behaviours into policy and practice More diverse membership of Specialty Societies, Specialty Society Training Boards and RACS committees including external, non-surgical representatives	Fellows, trainees and IMGs feel safer and less at risk of unacceptable behaviours and more confident to speak up about unacceptable behaviours The membership of RACS reflects the diversity of the general community	
RACS Diversity Plan published and communicated Conduct cultural competency training promoting awareness of Aboriginal and Torres Strait Islander, and Maori culture	Targets established for the involvement of female surgeons in leadership positions, such as on Training Boards and as examiners System of monitoring, reporting and acting on the rates of application, selection and attrition Cultural competence training programs conducted	RACS Diversity and Inclusion Plan developed and disseminated Diversity principles are communicated to RACS employees, partners, selection and training bodies and the whole surgical profession Barriers to provision and uptake of flexible training options are identified Diversity opportunities are communicated to Trainees Regular review of monitoring data on the rates of application, selection and attrition to identify barriers for women, Aboriginal and Torres Strait Islanders, Maori, and people from other diverse cultural backgrounds in surgical training and RACS committees	Trainees are aware of opportunities for flexible training and more confident to seek these out Increase in flexible options for surgical training (eg part time placements) Review of training program and selection process to address identified barriers The applicant field for surgical training is increasingly diverse	More women and culturally diverse surgeons, trainees, IMGs and Fellows remain in surgical training Reduced barriers based on gender or culture for entry to or progression within the surgical profession RACS becomes the industry leader in facilitation and promotion of flexible training opportunities	

Cultural Change and Leadership					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Conduct communication, awareness raising and capacity building activities to increase recognition of and skills in managing unacceptable behaviours	*Let's operate with respect* campaign, posters, blogs, newsletter articles, promoting training courses, events, presentations, speakers, commentators, research	Fellows, Trainees and IMGs can recognise unacceptable and reportable behaviours in themselves and others Fellows, Trainees and IMGs understand the need to address unacceptable behaviours in themselves and others Fellows, Trainees and IMGs understand the need to demonstrate professional behaviours Open discussion of what constitutes 'respectful' and 'unacceptable' behaviour	Fellows, Trainees and IMGs have the confidence to address unacceptable behaviours Fellows Trainees and IMGs have the required skills to speak up about unacceptable behaviours Fellows, Trainees and IMGs observed engaging in unacceptable behaviours receive constructive feedback	Fellows, Trainees and IMGs take appropriate action to address unacceptable behaviours in themselves and others Fellows, Trainees, IMGs and patients perceive a fair and safe surgical workplace People who work with surgeons perceive improvement in teamwork, collaboration and communication	
Develop and progress implementation of models for collaboration with hospitals, governments and universities in Australia and New Zealand on programs to incorporate respectful behaviours Lead and create partnerships within the health sector in Australia and New Zealand to improve management of unacceptable behaviours	Recognition of common goals, roles and responsibilities with partner organisations MOUs with collaborating orgs Established partnerships	Increased cooperation / collaboration with hospitals, governments and employers about prevention and management of unacceptable behaviours Increased communication and sharing of knowledge on respectful behaviours across organisations and within the profession Active engagement of the RACS Surgical Directors Section and STANZCommittees and Boards Established agreements, MOUs and SOIs with partner organisations	Development of joint or aligned processes for cultural change programs Development of joint or aligned processes for complaints management and sanctions Organisations employing or training surgeons collaborate to improve standards of behaviour and training Government policies in Australia and New Zealand consistent with the goals of this Action Plan Alignment and information sharing with MOU partners (within the law) about complaints management	MOU partner organisations, where surgeons work, align policies, practices and management of unacceptable behaviours with the principles of the Vanderbilt model Hospitals and other employers of surgeons, who are MOU partner organisations, actively support RACS initiatives in building a respectful culture Successful pilot models and strategies are progressively shared with and promoted to other hospitals and employers Hospitals and other employers of surgeons, who are MOU partner organisations, effectively implement and actively monitor respectful behaviour policies and action plans	

Cultural Change and Leadership					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Advocate for integration of respectful behaviour training into medical training	Dialogue with universities about respectful behaviour training	Medical schools incorporate respectful behaviour training and its links to patient safety as part of the curriculum	SET-1 Trainees begin their surgical training with knowledge and skills about respectful behaviour	Acceptance across SET Trainees of the relationship between patient safety and respectful behaviour RACS is recognised as a leader in promoting respectful behaviour in surgical practice	
Monitor, evaluate and continuously improve the *About respect* program of work	Evaluation framework developed Planned evaluations conducted Repeat DBSH prevalence surveys every five years Publication of annual reports and activities reports	RACS systematically gathers data to measure the effectiveness and impact of the Action Plan Data analysis leads to understanding of program effectiveness and identifies areas for improvement / refinement Pilot programs are evaluated RACS' activities in building a culture of respect are transparently reported to members Data gathered to monitor FTI's understanding of the need for and importance of the Action Plan	The Action Plan is adapted and improved as part of continuous improvement activities and response to progress and the changing context Learning from Pilot programs is used to extend successful models to other locations Learning from pilot programs is used to inform FTIs of the need for and importance of the Action Plan	A culture of continuous improvement is reinforced within RACS Fellows, Trainees and IMGs are aware of the Action Plan and support its requirements and achievements	
Ensure appropriate governance and oversight of the Action Plan	Regular reports within RACS to Council, CEO and management	Transparent and accountable processes in place to oversight the implementation of the Action Plan	Action plan principles are embedded in the RACS strategic plan thus becoming normal business	All RACS activities incorporate respectful behaviours as a matter of course Respectful behaviours are normalised across the surgical profession	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Establish training in respectful behaviours as a mandatory component of continuing professional development and in Surgical Education and Training (SET) Provide face to face advanced training (OWR) in respectful behaviours to all members of Training Boards and other major committees of RACS, including surgical, IMG and research supervisors/assessors Conduct training on respectful behaviours and provision of constructive feedback for Fellows, trainees, IMGs, Training Boards and RACS Committees Develop advanced feedback module for surgical educators Develop Surgical Leadership Program for surgeons Improve FSSE course to include training in respectful behaviours and provision of constructive feedback for Fellows involved in surgical education	Mandated training via e-learning module (Operating with Respect) for all Fellows, IMGs and Trainees on identifying, preventing and taking action on unacceptable behaviours and on building a respectful culture Face to face OWR course is mandated for surgical supervisors and trainers, IMG assessors, Training Boards and RACS Committees. Advanced feedback module piloted Surgical Leadership course developed Train the trainer courses for OWR trainers Mandated FSSE course for all surgical supervisors and trainers and IMG assessors includes training in providing respectful and constructive feedback to trainees	Fellows, IMGs and Trainees recognise unacceptable behaviours in themselves and others and increase their understanding of respectful behaviours Fellows, IMGs and Trainees appreciate that professional behaviours are a determinant of patient safety Surgical educators and IMG assessors gain skills in identifying and addressing unacceptable behaviours Surgical educators and IMG assessors understand their professional obligations regarding respectful behaviours Surgical educators and IMG assessors increase their knowledge of how to provide respectful, constructive and effective feedback to trainees Surgeons have access to leadership training Increased capacity to deliver the OWR course to a broader audience Feedback from Trainees and IMGs indicates that surgeons are becoming better educators Continuous monitoring of FSSE, specifically on outcomes relating to provision of feedback	Fellows, IMGs and Trainees gain skills in identifying and addressing unacceptable behaviours More people feel confident in speaking up about unacceptable behaviours Surgical educators and IMG assessors provide respectful, constructive and effective educational feedback to trainees, in line with new policies Fellows in leadership positions accept that they have a responsibility for addressing unacceptable behaviours by regulating their own behaviours and modulating the behaviour of others Advanced feedback module is accessible to surgical educators Faculty members feel adequately prepared to teach the OWR and FSSE courses Course participants perceive the courses as credible and high quality	Integration of respectful behaviours within surgical education is normalised Training in respectful behaviours becomes normalised and embedded in all training curricula Trainees recognise the values underpinning RACS surgical education Increased retention of trainees Decreased attrition of trainees due to unacceptable behaviours Surgical leaders model respectful behaviours and advocate for these behaviours in the workplace Respectful and constructive feedback is normalised Trainees seek out and value feedback from their supervisors	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Revise accreditation standards for surgical education posts to include respectful behaviours	Agreed accreditation standards across all Training Boards Agreed safe and confidential pathways for communicating training concerns to Specialist Training Boards and RACS	New standard for respectful behaviour is included in the accreditation guidelines Accreditation of training posts in hospitals includes respectful behaviours Safe and confidential pathways for identifying and addressing concerns about behaviours in educational posts are developed, defined and communicated Model for conducting bi-annual reviews of training posts is developed	RACS, Training Boards and hospitals understand their roles and responsibilities in addressing behavioural issues Trainees are aware of processes for raising concerns about behaviours Bi annual review of training posts conducted and de-identified results published RACSTA survey shows improvement of educational experience against the accreditation standards	Responsibilities between hospitals and RACS are aligned and consistent All surgical education posts demonstrate respectful behaviour standards and agreed complaints resolution processes Trainees feel safe and confident to raise concerns RACS acts on the findings of surgical education surveys	
Establish a process for independent review of training rotations for SET	Agreed model for RACS-led independent reviews of training rotations	Development of criteria to trigger a review Specialist Training Boards support the training rotation review process Pilot methodology established	Process for independent review of training posts established Independent reviews of training rotations conducted Learnings from pilots inform model development and improvement Improved review model implemented	Agreed and sustainable model achieved Stakeholders are confident in the review methodology The training environment is optimised Trainee satisfaction with SET improves Trainee attrition reduces	
Establish a process for independent review of IMG training rotations	Agreed model for IMG reviews	Development of criteria to trigger a review Pilot methodology established Reassessment process is standardised and transparent	Process for independent review of IMG training posts established Independent reviews of IMG training rotations conducted Learnings from pilots inform model development and improvement Improved review model implemented	Agreed and sustainable model achieved Stakeholders are confident in the review methodology The training environment is optimised IMGs are confident in the system IMG attrition reduces	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Ensure independent review of SET selection processes to support diversity of surgical trainees	SET selection panels modified to include external, non-medical panel members	Selection weightings are revised Selection interviewers are trained Consistent selection principles are applied across selection panels	An industry approach to knowledge, skills and attributes is implemented SJTs are piloted Template referee reports are developed and introduced	Selection into SET is transparent and consistent Reduced SET attrition rates	
Ensure the surgical education training (SET) program includes a focus on building resilience and managing stress	Evidence-informed resources, self-assessment tools, are identified and made available Accreditation standards for evidence-informed external courses are agreed Courses, tools in building resilience and managing stress/ personal wellbeing developed and made compulsory within SET program. Resilience and managing wellbeing is integrated into the SET program	External courses and tools are identified and appropriately accredited Trainees have access to appropriate courses and tools to gain skills and awareness about building resilience	Trainees are aware of the importance of resilience to support their own wellness Trainees gain skills and awareness of methods to build resilience	Trainees consistently demonstrate more resilience in maintaining professional behaviour Resilience becomes part of surgical training and feedback Resilience and stress management are recognised as a necessary component of surgical skills	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Develop respectful behaviour standards for all surgeons involved in education and supervision of research Provide underperforming supervisors with a remedial education plan to improve skills	Explicit standards developed for all surgeons involved in education and supervision of research Standards promoted to Fellows Formal assessment process against standards is established Processes established for individual coaching to support behaviour change	Fellows are aware of and understand how to comply with the standards of professional behaviour Standards for surgical supervisors incorporate respectful behaviours	Fellows have the skills to remain professional and respectful when under stress Fellows access individual coaching Underperforming supervisors are identified in a formal assessment process Underperforming supervisors participate in educational programs and individual coaching for behavioural change	Fellows comply with identified standards of behaviour Individuals who do not meet the standards are managed appropriately, including through individual support for behavioural change as needed Underperforming supervisors show improvement after support and intervention from the Boards and RACS RACS recognises that some surgeons are not suited to supervision and leadership	
Review selection criteria for all supervisors to include training as educators including respectful behaviours Provide underperforming supervisors with a remedial education plan to improve skills	Defined standards for heads of departments, supervisors and other senior positions, include demonstration of leadership regarding respectful behaviours New selection criteria for all supervisors (including training as educators, understanding respectful behaviours and dealing with concerns of unprofessional behaviour) Within two years Training Boards review all supervisors to ensure that underperforming supervisors are being provided with remedial education plan to improve skills Educational, coaching and support programs established for underperforming supervisors	Leadership positions are increasingly filled by people who demonstrate respectful behaviours Supervisory positions increasingly filled by people who demonstrate respectful behaviours	Leaders comply with and are accountable to identified standards of behaviour Supervisors comply with and are accountable to identified standards of behaviour Underperforming supervisors are identified in a formal assessment process (through Trainee feedback/multi-source feedback (MSF)/complaints mechanisms) Underperforming supervisors participate in educational programs and individual coaching for behavioural change	Appointments to hospital leadership positions have regard to the RACS standards Underperforming supervisors show improvement after support and intervention from the Boards and RACS	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Advocate for integration of respectful behaviour training into pre-vocational training	Dialogue about respectful behaviour training with pre-vocational medical councils, hospitals and networks	J-Docs program administrators recognise the importance of respectful behaviours as part of surgical practice	Pre-vocational training incorporates respectful behaviours and its links to patient safety as part of the curriculum SET-1 Trainees begin their surgical training with knowledge and skills about respectful behaviour	Acceptance across SET Trainees of the relationship between patient safety and respectful behaviour RACS is recognised as a leader in promoting respectful behaviour in surgical practice	
Develop policies, procedures and systems for introduction of Multi source feedback (MSF)	Clear criteria developed and in place for the successful introduction of MSF inclusive of respectful behaviours MSF introduced in reviews of all Trainees, supervisors, surgical department heads Systems established to ensure feedback is recorded, acknowledged and used to improve quality A program for Trainees to engage constructively with feedback is developed	Pilot activities are conducted to define the most appropriate model of MSF for surgical education and training Post-Pilot review by Training Boards of all pilot supervisors to ensure they are using MSF	Learnings from pilot inform development of MSF model for upscaling across the profession Adequate resources provided to support implementation of MSF Supervisors across the surgical profession begin to participate in training about MSF Supervisors understand how to provide constructive feedback using MSF	MSF is implemented across the profession Supervisors provide constructive feedback to trainees through MSF Trainees engage constructively with MSF feedback MSF is evaluated and adapted for continuous improvement of the program MSF is the standard approach for reviews of all trainees, supervisors, surgical department heads	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Review IMG assessment process Ensure cultural awareness is incorporated into assessment and management of IMGs Review composition of IMG committee	Composition of IMG assessment panels reviewed Training on unconscious bias provided to IMG supervisors An independent review process is established for all Trainees and IMGs placed on probation to ensure all cultural issues are being addressed IMG Committee membership is diverse and includes representatives external to RACS Dedicated ongoing support for IMGs provided	Increased independent oversight of IMG assessment Position established for a Clinical Director IMG Assessment and Support IMG assessment panels are composed of more diverse people, including people external to RACS Clear, culturally sensitive criteria are developed for assessment of IMGs IMGs on probation are provided with constructive and culturally effective feedback for improvement	Cultural issues are addressed when reviewing trainees and IMGs Process for mitigating unconscious bias established in IMG assessment Implementation of the 2 Day Work-based Assessment approach	IMG assessment meets AMC accreditation standards for cultural competence	
Explore and understand the percentage of women choosing surgery as a career	Research methodology developed Research findings / insights available to inform future work	Research undertaken to explore and understand barriers for women in choosing surgery as a career Research undertaken into reasons for leaving surgical training	Key barriers to participation and completion of surgical training are understood and addressed	More women participate in and complete surgical training	
Advocate for and facilitate flexible training opportunities for surgical training	CBME principles support flexible training	RACS engages with jurisdictions to advocate for provision of flexible training Training regulations and accreditation standards appropriately reflect the provision of flexible training	Trainees access flexible training options	Flexible training for all surgical trainees is destigmatised and seen as acceptable	

Complaints Management					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Develop effective, fair and timely complaint mechanisms that are consistent with best practice Establish a framework of accountability for taking, and reporting on, the actions and outcomes arising from complaints to participants in the process Conduct communication and awareness raising activities about complaints procedures and available support Work in partnership with hospitals and other health sector organisations to develop a commonly understood approach to sanctions, including mechanisms for identifying, preventing and eliminating illegal and inappropriate behaviour and reporting surgeons as needed	Revised RACS Code of Conduct and sanctions policy Introduction of centralised lodgement, assessment, co-ordination and ongoing oversight of complaints across all specialities of the College, including complaints about surgical practice, education and behaviour. Clear and straightforward information about complaints management is accessible centrally Provide external expert mediation for complaints where required Provide support for investigations, when mediation fails Oversight by independent review including the appointment of an external reviewer Communication to all stakeholders about the changes to the policy and about the process	Fellows, trainees and IMGs are aware of avenues for making complaints about unacceptable behaviour Development and implementation of supports for people experiencing unacceptable behaviour Complaints confidentiality is strengthened Complaints management is centralised within RACS External reviewer appointed to review College processes and make recommendations where processes not followed or are inadequate	Fellows, trainees and IMGs are aware of supports for people experiencing unacceptable behaviour Fellows, trainees and IMGs experiencing unacceptable behaviour have improved access to support Fellows, trainees and IMGs are more confident to make complaints Recommendations from external review of complaints management are implemented for program improvement Improved feedback from surgeons and complainants about the RACS complaints process. Surgeons subject to a complaint learn from the process and change their behaviour External stakeholders are aware of the revised policy and process	Workplace culture supports the effective and timely reporting and management of unacceptable behaviour Calling out unacceptable behaviour is normalised in the surgical workplace Reduced recidivism regarding unacceptable behaviours	

Complaints Management					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Establish a Peer Support program for respondents and complainants	Promotion of Peer Support program to Fellows, Trainees and IMGs Supports for behavioural change provided	Complainants and respondents receive peer support throughout the process	Fellows, Trainees and IMGs who are the subject of a complaint are supported to change their behaviour Fellows, Trainees and IMGs who have received peer support perceive it as a useful intervention	Fellows, trainees and IMGs have increased confidence and trust that the complaints process has been fair	
Monitor complaint issues/trends, resolution rates and user satisfaction to inform continuous improvement and improve the quality and effectiveness of complaint mechanisms and make further interventions as needed.	All complaints received are effectively recorded and monitored Data about complaints is recorded centrally and reported regularly User satisfaction is regularly monitored and reviewed	Consistent with privacy and confidentiality principles, complaints and their outcomes are publicly reported including Activities reports, Annual report User satisfaction measures or indicators are introduced	User satisfaction data informs process improvements User satisfaction data is published	User satisfaction in the complaints process continues to increase Continuous improvement is incorporated into the complaints process	

Attachment 4: Stakeholder Engagement Plan

Objective
To hear and understand the breadth and depth of views of Fellows, Trainees and IMGs on issues relating to the scope of the evaluation.

Approach
A mixed methods approach is best practice. For this evaluation we have designed the following:

1. QUAL ⟶ 2. QUANT ⟶ 3. QUAL

1. The first step was to conduct eight open ended interviews with a range of representative stakeholders to identify the issues and experiences from their perspective. Representatives were purposively sampled from each stakeholder type: Fellows, Trainees and IMGs, for their ability to provide insights and stories of their experience. This allowed us to ensure all further data collection was based on issues grounded in the real experience of stakeholders and not from the assumptions of the evaluator. Data from this step of the process has been presented in qualitative form, as themes.

2. Analysis of the themes and issues supported development of an online survey which was sent out to all (7988) Fellows, Trainees and IMGs. This provided the breadth of information about the issues, ie it answers the question '*what is happening'*. This approach also ensures all Fellows, Trainees and IMGs have been given the opportunity to have a voice in the evaluation. Data from this step of the process has been presented in quantitative form, as graphs and tables.

3. Once the survey was analysed, we had a broad understanding of the views on particular issues. This provided an insight into areas where further exploration may be needed, to gain an answer to the question '*why is this happening?'* For this step of the process, 5 Fellows, 3 Councillors, 3 IMGs and 5 Trainees were randomly selected for a telephone interview. We used stratified random sampling, to ensure a representative mix of gender and location across all groups, and that selection was not biased. But it is important to note that this was a qualitative exercise, to gain deep dive insights into the issues highlighted by the survey. Data from this step of the process was presented in qualitative form, as themes.

Attachment 5: Survey Questions

RACS Action Plan: *Building Respect, Improving Patient Safety*
Phase 1 Evaluation Survey

Introduction
Thank you for agreeing to take part in this short survey.

In 2015, RACS committed to dealing with discrimination, bullying and sexual harassment in surgery, through the *Action Plan: Building Respect, Improving Patient Safety*. The plan sets out a multi-year program of work which requires a sustained commitment.

After three years, we want to track our progress. This survey checks whether we have done the work we said we would do. Future evaluations will check what difference it is making. This survey is one part of our evaluation methodology and gives everyone a chance to have their say.

Please note: This is not a prevalence survey. A second prevalence survey will be conducted in 2021.

Privacy and Confidentiality
Your answers will remain strictly confidential. The information gathered from this survey will not be identifiable. We will aggregate the results and use the information to improve our work.

Consent
This survey is voluntary, but we are very interested in your views and ask you to give us this important feedback.

Questions?
If you have any questions about this survey or any of the evaluation activities, please feel free to contact the evaluator, Ruth Friedman, from The Thread Consulting at ruth@thethreadconsulting.com.au

Support
A reminder: the RACS Support Program, provided by Converge, offers confidential support to RACS members and their families, at no cost.

This survey will close on Monday 4th March 2019.

Demographics

Please indicate your age:
Under 30
30-40
41-50
51-60
61-70
71+

Please indicate the sector where you do most of your work: (Please tick one)
Public sector
Private sector

Please indicate the location where you do most of your work: (Please tick one)
Metropolitan
Rural

What is your gender? (Please tick one)
Male
Female
Intersex/ Indeterminate

I am a: (Please tick one)
Fellow of the College
Surgical Trainee
International Medical Graduate

How are you involved with the College? (Please tick all that apply)
Not involved
Surgical supervisor
Surgical trainer
IMG supervisor
Member of a Specialty Training Board
Member of a College committee
RACS Councillor
Other

Awareness

Survey Q Fellows	Survey Q Trainees/IMGs
Q1: How did you become aware of RACS' work to address discrimination, bullying and sexual harassment in surgery? (Tick all that apply) I completed the *Operating With Respect* e-module I completed the *Operating with Respect* face to face training course I completed the Foundation Skills for Surgical Education (FSSE) training Promotion at my hospital Posters at the College Articles in Fax Mentis Articles in Surgical News RACS policies, standards and guidelines Direct emails, letters from the College RACS website Social media General media A colleague told me I am not aware of this work. Other	Q1: How did you become aware of RACS' work to address discrimination, bullying and sexual harassment in surgery? (Tick all that apply) I completed the *Operating With Respect* e-module Promotion at my hospital Posters at the College Articles in Fax Mentis Articles in Surgical News RACS policies, standards and guidelines Direct emails, letters from the College RACS website Social media General media A colleague told me I am not aware of this work. Other

Q 2: How aware are you of the following RACS actions to build respect and improve patient safety in surgery? (1 = Not at all aware; 2 = Slightly aware; 3 = Moderately aware; 4 = Very aware; 5 = Extremely aware; 6 = NA/Don't know) The College's Code of Conduct. The College's standards in relation to discrimination, bullying and sexual harassment. The College's public commitment to addressing discrimination, bullying and sexual harassment in surgery. The College's commitment to increasing diversity in surgery. The RACS support program, provided by Converge. Knowledge Q 3. Thinking about what you know about discrimination, bullying and sexual harassment, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I know how to comply with the College's standards in relation to discrimination, bullying and sexual harassment. I know how to provide constructive feedback to my team, my peers and trainees. I can recognise discrimination, bullying and sexual harassment in surgery. I know what to do to address discrimination, bullying and sexual harassment when I see it. I know what to do to address discrimination, bullying and sexual harassment when I experience it. I know how to access the RACS support program, provided by Converge.	Q 2: How aware are you of the following RACS actions to build respect and improve patient safety in surgery? (1 = Not at all aware; 2 = Slightly aware; 3 = Moderately aware; 4 = Very aware; 5 = Extremely aware; 6 = NA/Don't know) The College's Code of Conduct. The College's standards in relation to discrimination, bullying and sexual harassment. The College's public commitment to addressing discrimination, bullying and sexual harassment in surgery. The College's commitment to increasing diversity in surgery. The RACS support program, provided by Converge. Knowledge Q 3: Thinking about what you know about discrimination, bullying and sexual harassment, how strongly you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I know how to comply with the College's standards in relation to discrimination, bullying and sexual harassment. I can recognise discrimination, bullying and sexual harassment in surgery. I can recognise the difference between difficult feedback and bullying. I know how to access the RACS support program, provided by Converge.

Q 4: Thinking about RACS' complaints process, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I know how to lodge a complaint with the College about discrimination, bullying and sexual harassment. I would feel safe lodging a complaint with the College about discrimination, bullying and sexual harassment. The College's complaints process is worthwhile. The College's complaints process is confidential.	Q 4: Thinking about RACS' complaints process, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I know how to lodge a complaint with the College about discrimination, bullying and sexual harassment. I would feel safe lodging a complaint with the College about discrimination, bullying and sexual harassment. The College's complaints process is worthwhile. The College's complaints process is confidential.

Support and relevance

Q5: Thinking about your views on RACS' work to build a culture of respect in surgery, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery. I support the College's work to increase diversity in surgery. I support the College's work to increase flexible training opportunities. Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery. It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.	Q5: Thinking about your views on RACS' work to build a culture of respect in surgery, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery. I support the College's work to increase diversity in surgery. I support the College's work to increase flexible training opportunities. Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery. It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.

Q 6: Thinking about the relevance to you of RACS' work to build a culture of respect in surgery, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) The *Operating With Respect* e-module was relevant to me. The *Operating With Respect* face to face training was relevant to me. The FSSE course was relevant to me. My behaviour, and the behaviour of my team, impacts on the safety of my patients. The College's communications about respectful behaviours have been relevant to me. The College's work to build a culture of respect is relevant to my daily experience as a surgeon.	Q 6: Thinking about the relevance to you of RACS' work to build a culture of respect in surgery, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) The *Operating With Respect* e-module was relevant to me. My behaviour, and the behaviour of my team, impacts on the safety of my patients. The College's communications about respectful behaviours have been relevant to me. The college's work to build a culture of respect is relevant to my daily experience as a surgical trainee.

Changes in the workplace Q 7: Thinking about your workplace, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) There is more awareness of discrimination, bullying and sexual harassment in my workplace. People are more likely to raise the issue of discrimination, bullying and sexual harassment at my workplace. I can see a positive change in the culture in my workplace. My workplace has introduced training on professional behaviours. My workplace has a complaints process for raising concerns about discrimination, bullying and sexual harassment. I would feel safe to make a complaint <u>at work</u> about discrimination, bullying and sexual harassment. My peers are more respectful when giving each other feedback. People are more accepting of flexible training. I feel more confident about providing respectful feedback to my peers and my team.	Changes in the workplace Q 7: Thinking about the workplace, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) There is more awareness of discrimination, bullying and sexual harassment in the workplace. There is more training about discrimination, bullying and sexual harassment in the workplace. People are more likely to raise the issue of discrimination, bullying and sexual harassment in the workplace. I can see a positive change in the culture in the workplace. I would feel safe to make a complaint <u>at work</u> about discrimination, bullying and sexual harassment. My peers are more respectful when giving each other feedback. Senior surgeons are more respectful when providing feedback. People are more accepting of flexible training.
Q.8 Please provide any further feedback below: Thank you for your time.	Q.8 Please provide any further feedback below: Thank you for your time.

Attachment 6: Semi-structured Interview Questions

Thankyou for your time. This interview is part of the evaluation for the Building Respect Action Plan evaluation.
All your answers will be collated and presented in de-identified form.

Role
Please describe your role and interaction with the College.

Action Plan activities

Which of the Building Respect activities have you participated in?
E module
OWR F2F
FSSE
Advanced feedback
Surgeons as Leaders
Other?

What did you think of the way they have been presented and offered to Fellows? What could be improved?

Have you learned anything new from the Building Respect activities? What, if anything, do you do differently since you completed the activities?

Barriers/enablers
What do you see as the major successes of the action Plan?

What are the major challenges for implementing this change? How can they be addressed?

Have there been any unintended consequences from the program?

Complaints

Do you know how to lodge a complaint with the College about DBSH?

Do you think people feel safe to make a complaint through the RACS process?

What needs to be done to increase confidence in the complaints process?

Diversity

What do you see as the challenges to increasing diversity across the surgical profession?

What do you see as the challenges to increasing flexible training opportunities across the surgical profession?

Outcomes

Can you see any changes in your workplace/or the profession as a result of the action plan? Training, culture, awareness, feeling safe, likelihood of raising issues, calling it out

Governance (for Councillors)

How do you feel the program is tracking? How do you know that? Ie what reports are you getting?

Do you feel adequately informed about the progress of the Action Plan?

What decisions, if any, have been made about changes to the action plan ie in light of emerging information?

What could be improved about the way the action plan is monitored and governed?

Resourcing

Do you think the action plan is adequately resourced to do this work?

Attachment 7: Definitions and common terminology

Term	Definition
Action Plan	The RACS *Building Respect, Improving Patient Safety* Action Plan
AMC	Australian Medical Council
BRIPS	Building Respect, Improving Patient Safety
BSET	Board of Surgical Education and Training
Bullying	Unreasonable and inappropriate behaviour that is repeated over time, or forms a pattern of behaviour, that places physical or mental health at risk.
CBME	Competency Based Medical Education
DBSH	Discrimination, Bullying and Sexual Harassment
DBSH Prevalence Survey	A survey of Fellows, Trainees and IMGs which has been conducted once by RACS in 2015 and will be conducted again in 2020 and 2026
Discrimination	Treating a person less favourably on the basis of a legally protected attribute or personal characteristic
EAG	RACS Expert Advisory group
Evaluation Survey	An online survey containing any relevant questions that are not covered in the DBSH Prevalence Survey
FSSE	Foundation Skills for Surgical Educators
FTIs	Surgical Fellows, Trainees and International Medical Graduates
Harassment	Unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended based on a legally protected attribute or personal characteristic. Harassment is a form of discrimination.
IMGs	International Medical Graduates
IRR	Independent Rotation Review
JDocs	Surgical competency framework for junior doctors
Key Informant Interviews	Telephone or face to face interviews with representatives from a range of stakeholder groups

MOU	Memorandum of Understanding
MSF	Multi Source Feedback
OWR	Operating With Respect training course
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainees' Association
SET	Surgical Education and Training
Sexual harassment	Unwanted, unwelcome or uninvited behaviour of a sexual nature that makes a person feel humiliated, intimidated or offended.
SJT	Situational Judgement Test
SOI	Statement of Intent
STANZ	State and Territory Offices of Australia and New Zealand
TOR	Terms of Reference
Unacceptable behaviours	Bullying, discrimination or sexual harassment

Royal Australasian
College of Surgeons

2019 PROGRESS UPDATE

DIVERSITY AND INCLUSION PLAN

INTRODUCTION

Diversity, in all its dimensions, will strengthen the profession of surgery and the College.

Recognising this, in 2016 Royal Australasian College of Surgeons (RACS) created its first Diversity and Inclusion Plan. We made this specific commitment as part of our wider work to build a culture of respect in surgery.

The RACS Diversity and Inclusion Plan sets five objectives and our progress against these is detailed in this report. We are working towards:

- inclusive culture and leadership excellence
- gender equity
- inclusion of diversity groups
- diverse representation on Boards and in leadership roles, and
- benchmarking and reporting.

Responsibilities for implementing the plan are integrated across the College, to reflect our commitment to diversity and inclusion as a core part of our operation.

RACS is proud to be introducing cultural competency as the tenth core surgical competency. There is no more important way for us to state that cultural competence is as central to surgical excellence as the existing nine competencies of Collaboration and Teamwork, Communication, Health Advocacy, Judgement – clinical decision making, Management and Leadership, Medical Expertise, Professionalism and Ethics, Scholarship and Teaching and Technical Expertise. We will progressively update our education and policy framework to support this change.

This 2019 Progress Update presents the work we have done in recent years to increase diversity in our profession. Ensuring the surgical profession reflects the community we serve remains a priority for RACS. Work towards achievement of the goals and objectives in this plan will continue.

Mr Richard Perry
RACS Vice President

OBJECTIVE 1. INCLUSIVE CULTURE AND LEADERSHIP EXCELLENCE

Intentionally create a culture of inclusion amongst the surgical community through advocacy, championing and communicating diversity.

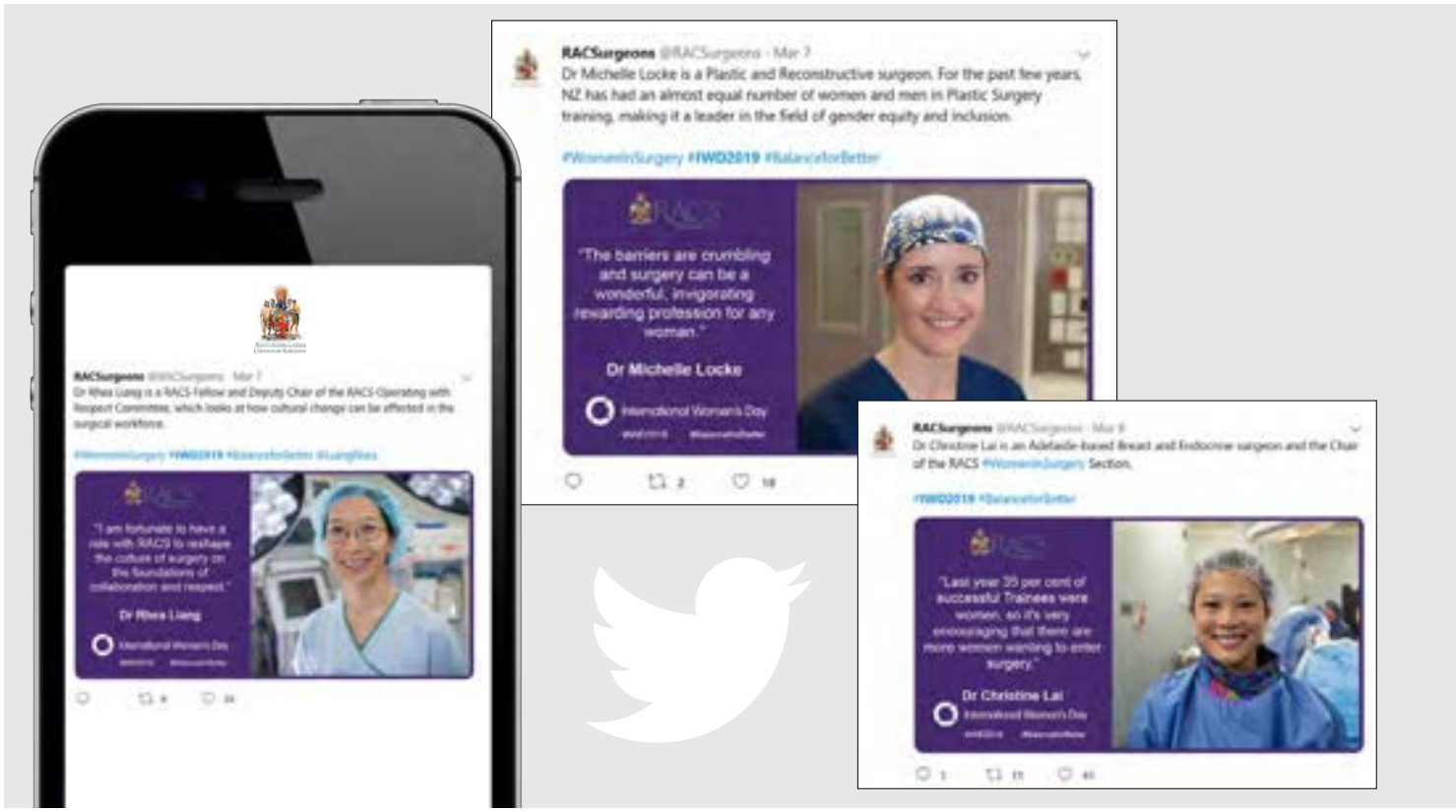
Action	Task	Administrative responsibility	Measurable target	Status
1.1 Implement a consistently inclusive communication strategy.	1.1 Implement a consistently inclusive communication strategy.	Communications Manager	Our publications, photos, social media and communication approach is inclusive of diversity	Ongoing
	1.1.2 Update RACS website with more representation of women surgeon leaders and other diverse groups	Communications Manager	Website reviewed and updated on a regular basis	Ongoing
1.2 Identify and utilise cultural symbols to promote diversity and inclusion	1.2.1 Review prominent displays of photos and other artefacts within RACS premises with a view to be more inclusive	COO via Curator, Archivist	Increased number of symbols used to promote diversity and inclusion	Ongoing
	1.2.2. Consider naming rooms or other structures after prominent women surgeons or other diversity champions	COO	Agenda, minutes	Complete
1.3 Promote cultural awareness	1.3.1 Publish articles promoting diversity with real life examples	Communications Manager	Four articles published	Ongoing
	1.3.2 Create opportunities for discussions and experiences of inclusion for all diversity groups e.g. UN days of celebration	Communications Manager	Three annual events e.g. ASC session, regional events	Ongoing
1.4 Educate in cultural safety and competence	1.4.1. Deliver education programs in cultural competence in line with AMC and MCNZ standards	EGM Fellowship Engagement, EGM Education	50% of Fellows, Trainees and IMGs report completion of Cultural Competence activity	Ongoing
	1.4.2 Include cultural competence and leading in diversity in the curriculum of relevant RACS courses	EGM Education	Curricula audited and opportunities identified; cultural competence and leading in diversity integrated across a range of curricula	In Progress
	1.4.3. Train surgical educators in identifying and rectifying patterns of unconscious bias.	EGM Education	Training not applicable	Ongoing
	1.4.4 Provide cultural competence training to RACS staff as per the RAP.	EGM People and Culture	75% of staff complete the nonmandatory Cultural Competence Program	-

	Progress commentary/metrics
	An audit of RACS communications demonstrated appropriate diversity mix in all publications and communications channels. RACS has an ongoing and explicit focus on this issue.
	Website review including consideration of diversity lens is now an ongoing process which is part of our publications planning process.
	Displays addressing this need have included women in surgery, women in the military. RACS first female President is sited prominently. Rotating e-display (reception) area reflects diversity in profession and amongst office bearers, as is consistent with our communications policy.
	Considered and noted for future naming decisions
	This is ongoing and addressed via our publications planning process which includes both print and social media. For example, the May issue, 2018 of *Surgical News* supported the *Building Respect, Improving Patient Safety* strategy to profile diversity and women in surgery achieved the following: • Cover - surgeon Dr Pecky De Silva • Pg 10: Story interviewing female rural surgeon Dr Christina Steffen. *Building Respect, Improving Patient Safety* discussed in story • Pg 24: Research featured by WA Plastics Trainee by Dr Emily Ryan • Pg 28: Susan Halliday piece on conscious and unconscious bias. Social media posts promoting women in surgery continuously achieve strong engagement. An example are posts in May 2019 featuring Dr Ruth Mitchell, a neurosurgery Trainee and founding member of the International Campaign to Abolish Nuclear Weapons (ICAN), and Victorian Orthopaedic Surgeon and Clinical Director for Surgery and Perioperative Services for RAAF, Dr Annette Holian, FRACS giving the Dawn Service address at Melbourne's Shrine of Remembrance.
	RACS celebrates days of national and international focus such as International Women's Day, NAIDOC week, National Reconciliation Week, Close the GAP day.
	The College provides opportunities for Fellows, Trainees and IMGs to complete Intercultural competency e-learning. Fellows are encouraged to undertake intercultural competency training as part of their Annual CPD program. In 2018, 17% (887 RACS Fellows) reported completing an activity for cultural competence in their CPD record.
	• Identification of curriculum inclusion in Academy Studio Session, Australia and New Zealand Surgical Skills Education and Training (ASSET), Critical Literature Evaluation and Research (CLEAR) and Difficult Conversations with Underperforming Trainees courses - complete • Developing the first full draft of the eLearning storyboards for courses 1 and 2 Health and Cultural Safety • Applying for additional funding to prepare the eLearning course levels 3 and 4 (planned for commencement in early 2020) • Identifying curriculum for the Bioethics forum, Foundation Skills for Surgical Educators (FSSE), Promoting Advancement in Surgical Education (PrASE) and Younger Fellows Forum (YFF) • Mapping content of IMG, Skills and Professional Development courses to identify location of appropriate Cultural Safety and Indigenous Health content • Discussing with external education providers options for including customised content in their courses, including Process Communication Model (PCM) • Consideration of options for preparing online faculty training from an Indigenous Health and Cultural Safety expert or member of Indigenous Health committee
	A review of evidence suggests that training is not an effective mechanism to address unconscious bias. Unconscious bias is being addressed as part of the review of selection processes. A key focus is on ensuring that selection processes are designed that mitigate against unconscious bias.
	54.8% of RACS staff completed non-mandatory cultural competence training at 31 December 2018. In 2020, this will be included as part of RACS staff induction.

OBJECTIVE 1. INCLUSIVE CULTURE AND LEADERSHIP EXCELLENCE

Intentionally create a culture of inclusion amongst the surgical community through advocacy, championing and communicating diversity.

Action	Task	Administrative responsibility	Measurable target	Status
1.5. Identify and promote diversity champions	1.5.1 Allocate the roles of diversity champions in various groups (e.g. RACSTA, Rural SS, IHC, Senior Surgeons, Military)	Communications Manager	12 diversity champions named and their messages communicated	Ongoing
	1.5.2 Provide communication mechanisms for the messages by diversity champions to reach as wide an audience as possible	Communications Manager	All RACS media channels utilised	Ongoing
1.6 Support research into aspects of diversity and inclusion in surgery and disseminate findings	1.6.1 – 1.6.4: Identify research partners, develop proposal, collaborate to complete planned research, publish and communicate findings	EGM Education	Two research studies completed.	Complete
1.7 Collaborate with other health care system stakeholders to lead in diversity and inclusion to enhance surgical profession	1.7.1 Identify stakeholders for collaboration and influence	ELT, STANZ	Evidence of discussions with stakeholders.	Ongoing
	1.7.2 Engage in discussions and diversity projects	ELT, STANZ	Evidence of participation in D and I initiatives	Ongoing



Progress commentary/metrics

A range of diversity champions have been identified informally and these people are featured in various RACS communications and events.

This is now an ongoing process which is part of our publications planning process.

Two research projects have been auspiced by RACS in this reporting period:

A study exploring the reasons for and experience of leaving surgical training. Ardnell Group 2016, dissemination as reported under 2.8. Barriers to women choosing surgery as a medical specialty - final report January 2020. Dissemination plan developed.

Key issue for collaboration has been removal of barriers and promotion of takeup of flexible training, with hospitals accredited to host surgical Trainees, and MOU partners

RACS participation in Male Champions of Change initiatives (various); advocacy to promote transferability of leave entitlements and discussions with MOU partners

TOWARDS GENDER EQUITY

RACS' Women in Surgery section continues to strongly support our work to foster increased gender equity in the surgical profession. Specific highlights of their work includes a program of visits to medical schools across Australia, to encourage female medical students to consider surgery as a career. A national essay competition for female medical students clearly resonated with medical students, with 70 high quality essays submitted on the topic of surgery and social media.

Increasing access to flexible training has been a critically important focus of our work to remove barriers to the participation of people with carers' responsibilities in surgery. It is an important issue for both women and men who want to or who are starting or raising families while they undertake surgical training.

Since 2016 we have witnessed a range of different models of flexible training that have been effectively introduced at different sites in Australia and New Zealand. In all cases, strong grassroots support and effective collaboration and goodwill between supervisors, Trainees and employers has provided the energy and impetus to make flexible training a reality.

While we have learned that local solutions are the most effective, RACS has been explicit about its support for flexible training in its policy and programs, and transparent in monitoring and publishing take-up rates. RACS Specialty Training Boards report on a regular basis to the Board of Surgical Education and Training (BSET) about their progress with increasing opportunities to pursue flexible training. Sharing what we have learned about different models of flexible training currently in use is one of our priorities in 2020.

Take up of flexible training:

	2016	2017	2018	2019
Female	5	6	10	10
Male	1	1		9
Total	**6**	**7**	**10**	**19**

OBJECTIVE 2. GENDER EQUITY:

Increase the representation of women in the practice of surgery by removing barriers to participation and introducing flexible training models for any Trainee or surgeon, irrespective of gender

Action	Task	Administrative responsibility	Measurable target	Status
2.1 Set targets and guidelines for increased representation of women in SET across all specialties	2.1.1. Review each specialty's participation rates in surgery for the purpose of monitoring and reporting on the number of women	EGM Education	As women already represent 29% of Trainees RACS target is to reach 40% across all specialties by 2021	Complete
	2.1.2 Set aspirational and achievable targets for an increased representation of women in SET across all specialties	EGM Education	As above	Complete
	2.1.3 Issue guidelines and directions to achieve and report on the progress	All EGMs	Directions minuted, via Advocacy Board	Complete
2.2 Re-design training models and liaise with hospitals to ensure greater flexibility and family friendly protocols for all with respect to: • opportunities for less than full-time and flexible models • enable easier access to interrupted training e.g. parental and adoption leave • less frequent geographic change of rotation arrangements	2.2.1 BSET and RACS STBs to review/ investigate/create models for flexible training	EGM Education	Reduction in number of Trainees reporting inability to obtain a flexible training position (through RACSTA end of term survey) Reporting through BSET shows progress by each STB in implementing flexible training	Complete
	2.2.2 Review and redevelop if necessary the procedures for Trainees' applications for interrupted training and flexibility, ensuring their availability irrespective of gender	As above	As per completion of the action described	Complete
	2.2.3 Review educational basis for frequent change of training location.	As above	As per completion of the action described	Ongoing
2.3 Actively promote the availability of flexible training	2.3.1 Develop communication materials promoting availability of flexible training	Communications manager	*Surgical News* articles. RACSTA Newsletter, Communication to Specialty Societies	In progress
	2.3.2 Communicate new flexible training models available and procedures to access them	As above	Increased number of trainees applying and utilising flexible training options	In progress
2.4 Identify the appropriate resources (Fellows, staff) that will support liaison and collaboration between the training boards, hospitals, government and industrial organisations to implement less than full-time training, identify flexible posts and support Trainees	2.4.1 Liaise with Training Boards to identify resources required	EGM Education	Increased number of flexible posts available and taken up by Trainees	Ongoing
	2.4.2 Develop protocols for collaborative use and management of the shared resource	As above	Resources developed	In progress
	2.4.3 Work with employers, government, and industrial organisations to create part-time posts	As above	Improved takeup of flexible training	Complete
	2.4.4 Actively offer support to Trainees seeking flexible options	As above	Trainees report feeling supported	In progress

Progress commentary/metrics
Each specialty now provides data on numbers of women applying to SET training and the numbers of women who are successful in their application
Target is agreed: to increase representation of women in SET from 29% in 2016 to 40% by 2021
Biannual reporting schedule and reporting framework established and implemented.
All RACS Specialty Training Boards include flexible training as an option for male and female Trainees. Details vary across specialty as determined by the requirement of the different training program, but details about flexible training are included in all training regulations and reports are provided to BSET RACSTA survey results show that at the end of rotation 1, 2019 only one Trainee was unable to secure flexible training position and three were awaiting a response.
Flexible training is available to male and female applicants. Each RACS Specialty Board oversees its application process. RACS is actively working to reduce barriers to takeup of flexible training.
RACS has researched the implications of frequent change of training location and identified this as one of the contributing factors as to why people either do not select surgery or leave surgical training prematurely. This has been noted by the Boards of Surgical Education and Training. Removing the need to travel poses difficulties for smaller specialties; where the requirement to travel does not apply, specialty training boards are encouraged to keep a Trainee in a single state.
Flexible training is profiled in each RACS' communications channels and via regional scientific meetings on a regular basis. The RACSTA Induction conference 2019 for new SET Trainees featured a session in flexible training. A current urology Trainee shared her experience of applying for and securing a flexible training position after a period of interruption.
The requirement to offer training on a flexible/ less than full time basis is now reflected in RACS Training Policy and in the training regulations of each Specialty training Board. RACS has communicated this in writing to all hospitals accredited to host Trainees. Flexible training is organised for Trainees upon request, on a case by case basis and is largely dependent on the unique circumstances of each post at a particular time. The number of Trainees in flexible training positions in rotation 2, 2019 is 20 across 10 hospitals. This is a considerable increase from recent years (2015 = 4, 2016 = 7 and 2017 = 7, 2018 = 10). So far 14 have been approved for rotation 1, 2020 and data is still being collected fom a number of specialties.
Hospitals provide information as to whether flexible training posts can be accommodated. This information is collected as part of the accreditation reports when posts are inspected (standard 5) and the provision of flexible employment options are a minimum requirement for hospitals.
The SET team has been identified as the first point of contact for Trainees seeking assistance in obtaining flexible training positions. Current and past Trainees in flexible training will be contacted to ascertain their willingness to act as informal "information sources" for future Trainees seeking flexible training positions
Refer commentary supporting objective 1 in this report
As for 2.4.2

OBJECTIVE 2. GENDER EQUITY

Increase the representation of women in the practice of surgery by removing barriers to participation and introducing flexible training models for any Trainee or surgeon, irrespective of gender

Action	Task	Administrative responsibility	Measurable target	Status
2.7 Investigate reasons why women are not applying to RACS surgical training programs in proportions representative of graduation from medical schools	2.7.1 Undertake survey of women in the medical workforce and final year medical students to identify real and perceived barriers to applying to surgical training programs	EGM Education	Survey results to inform a recruitment and promotion strategy.	In progress
2.8 Investigate barriers to women's successful participation in and completion of surgical training following selection	2.8.1 Implement responses to findings in Leaving Training Report and SET evaluation	EGM Education	Known improvements to experience of training compared to 2016 benchmark	In progress
	2.8.2 Plan a follow up study of experiences of training	As above	Study conducted	New
	2.8.3 Explore feasibility with government and other entities to enable parental leave to work across state boundaries	CEO	Harmonisation of legislation/regulation across states and territories	In progress

SURGERY AS A CAREER FOR WOMEN

Highlighted are events that promoted surgery as a profession, including a focus on women in surgery

ACT

ACT Health Intern Orientation program mini expo; Jan 2019

International Women's Day; 2019

Women in Surgery career evening; 2019

ASM presentation on women in surgery; 2019

NSW

Women in Medicine; 2016, 2017, 2018

NSW Prevocational meeting; 2017, 2018

JDoc Forum organised by NSW Health President attended; 2017

Equality in Medicine; 2019

NT

Flinders University Careers Expo; 2019

AIDA Conference; 2019

QLD

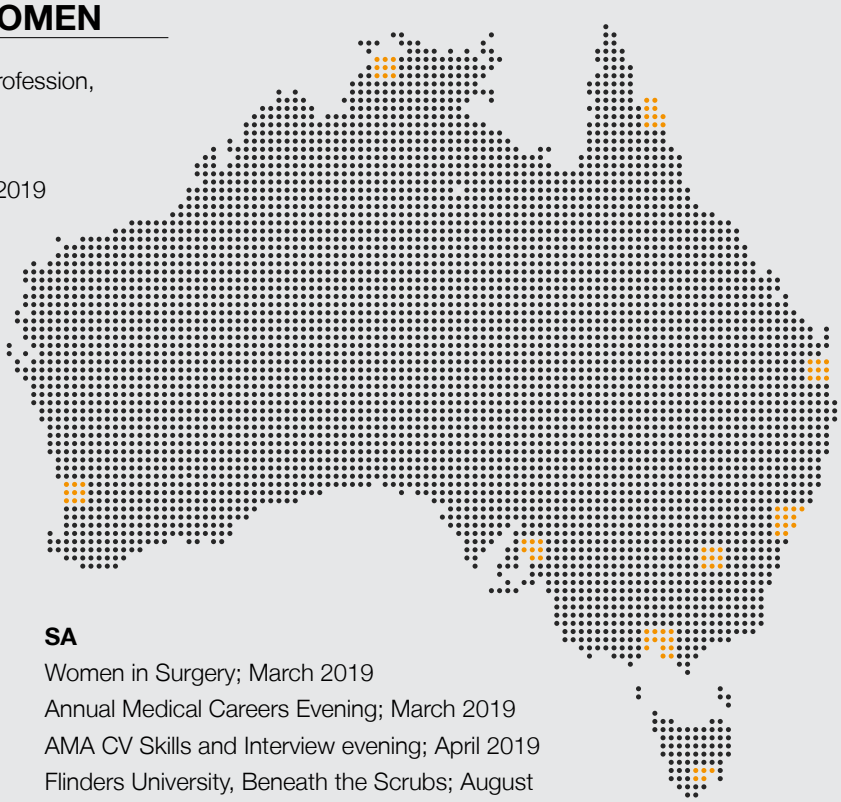
Medical student surgical skills competition; 2016, 2017, 2018, 2019

Medical careers expos; 2016, 2017, 2018, 2019

QLD State Conference; 2019

Women in Surgery events; August 2019

- Cairns
- Gold Coast
- Sunshine Coast
- Brisbane



SA

Women in Surgery; March 2019

Annual Medical Careers Evening; March 2019

AMA CV Skills and Interview evening; April 2019

Flinders University, Beneath the Scrubs; August 2019

SA, NT and WA ASM; September 2019

Port Lincoln High School Even, September 2019

Adelaide University, Women in Surgery; September 2019

SET for SET; September 2019

Progress commentary/metrics

"Barriers to women selecting surgery as a medical specialty" research phase complete; analysis of findings in progress. Final report to be delivered in January 2020.

Research report was delivered in June 2017. Findings presented to BSET, RACS Council and widely disseminated via print media. Report has been submitted for publication in the peer reviewed literature.

Report findings in relation to the culture in surgical training are consistent with the findings of the EAG, DBSH. These findings inform the Building Repsect Action Plan and activities implemented in response.

Report findings in relation to conditions of training inform the agenda of BSET and require an ongoing focus.

This will be considered following the phase 2 evaluation of Building Respect

RACS has identified this as an advocacy priority. States and territories have separate policies determining eligibility for paid maternity leave, mostly requiring 12 months' continuous service in that jurisdiction. Harmonisation at a national level is required, and RACS has raised the issue with Federal and State Health Ministers.

Vic/Qld/NT: Have demonstrated significant support for leave portability.

NSW: a recent letter from the Health Minister confirms support for Trainees around leave entitlements across state boundaries.

Discussions continue with other states and territories via COAG.

This is not applicable in New Zealand.

TAS

Women in Surgery/International Women's Day event; March 2019

VIC

Medical Student's workshops x 3 each year; 2016, 2017, 2018, 2019

Developing a Surgical Career x 1 each year; 2017, 2018, 2019

Surgical Students Society of Melbourne Women in Surgery; 2019

MUMUS - Monash Uni Medical Careers Expo; 2018, 2019

AMA Medical Careers Expo; 2019

ISSC Conference; 2019

PMCV Expo; 2019

WA

WA Post Graduate Medical Council Careers Expo; 2016, 2017, 2018, 2019

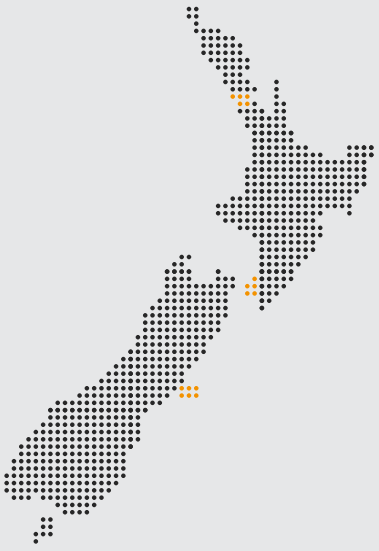
UWA Surgical Society WIS Event; 2016, 2017, 2018, 2019

Notre Dame Surgical Society Careers Expo: 2016, 2017, 2018, 2019

AIDA Conference; 2018, 2019

AMSA Convention; 2018

WIS International Women's Day Cocktails; 2019



NEW ZEALAND

2016-2019: NZ Medical Students Association annual conferences: Promoting surgery as a career (approx. half of NZ medical students are female)

2016-2019: Career evenings in several District Health Boards for prevocational doctors

2016-2019: NZAGS annual conferences: Promoting surgery as a career to prevocational attendees

2016-2019: NZAPS annual conferences: Promoting surgery as a career to prevocational attendees

2016-2019: NZSOHNS annual conferences: Promoting surgery as a career to prevocational attendees

2016-2019: Te Ohu Rata o Aotearoa (Te ORA) annual conferences: Promoting surgery as a career to prevocational Māori attendees

2016, 2018, 2019: NZOA annual conferences: Promoting surgery as a career to prevocational attendees

2019: International Women's Day Breakfast

2019: Presentation within Surgery 2019 related to women in surgery: Promoting surgery as a career to prevocational indigenous attendees

INDIGENOUS PEOPLES: ABORIGINAL AND TORRES STRAIT ISLANDER AND MĀORI HEALTH

RACS Diversity and Inclusion Plan provides a useful framework to ensure our work to progress and report on the representation and participation of Indigenous peoples from Australia and New Zealand in surgery is a college-wide responsibility.

RACS is committed to Indigenous health and focused on the most appropriate and effective ways to achieve the vision of health equity for Aboriginal, Torres Strait Island and Māori people, as well as increasing the representation of Indigenous peoples in surgery.

RACS Indigenous Health Committee (IHC) oversees the College's work in Indigenous health. It oversees the implementation of the RACS Position Statement and ensures our strategic commitments in Indigenous health in Australia and New Zealand are met. The IHC guides the ongoing review and development of RACS Indigenous health portfolio, to ensure that it continues to meet our aim to improve the health of Aboriginal and Torres Strait Islander peoples in Australia and Māori in New Zealand, in partnership with those communities. The IHC's current focus is on the Aboriginal and Torres Strait Islander Health Curriculum and training project, the Māori Health Curriculum and training package project, the Reconciliation Plan for Australia and Te Rautaki Māori, the Māori Health Strategy and Action Plan for New Zealand.

Another priority is examining how better to collaborate and bring together our work to increase diversity and inclusion of Indigenous peoples in surgery. The IHC, supported by RACS Indigenous Health Project Officers, also have a wider role in helping apply an indigenous lens to other College projects.

Australia

RACS strong commitment to promoting Aboriginal and Torres Strait Islander peoples' health and participation in surgery continues.

We are moving into the next phase of our Reconciliation Action Plan, and continue to work with Reconciliation Australia to ensure our program is nationally aligned with Australia's wider community effort.

Our effort to address the devastating problems of indigenous ear health continue. The RACS-led, profession-wide Ear Health for Life Consortium is hoping to soon progress to a research phase and has prepared an application for Medical Research Future Fund support for this work. RACS's prioritisation of this Indigenous health issue was affirmed by the World Health Organisation's (WHO) decision to create a new category to describe the egregious state of Australian Indigenous ear health, as it fell outside the previous WHO classification system.

Our efforts to increase the number of Aboriginal and Torres Strait Islander surgical Trainees continues. While we are not yet at parity with the wider indigenous population, there has been an increase in Indigenous Trainee numbers in the last two years.

We are also exploring new pathways to increase the participation of Aboriginal and Torres Strait Islander doctors in surgery. We are in active discussions with the Royal Darwin Hospital in the Northern Territory to try to think more laterally about how to address this recruitment challenge. Currently, while applications for RACS traineeships are over-subscribed, there is limited interest from Aboriginal and Torres Strait Islander doctors in surgery as a career.

New Zealand

The RACS Indigenous Health Committee oversights the work of the Māori Health Advisory Group (Advisory Group), which is responsible for providing advice on the implementation of the Māori Health Action Plan and on other key Māori health initiatives, projects and content in RACS position statements and policies. The Māori Health Action Plan 2016 – 2018 sets out the College's priorities that address Māori health inequity. It aims to achieve a culturally safe and competent surgical workforce and advocate for health equity. The Māori Health Action Plan has been reviewed and extensive consultation is underway to inform further development of Te Rautaki Māori, Māori Health Strategy and Action Plan 2020 - 2023. A consultation meeting in November 2019 brought together the Māori community from different organisations across the health sector to provide feedback and comment on Te Rautaki Māori. It is important that the needs and aspirations of the Māori community are heard and considered for planning and Māori health development. A final draft is expected by March 2020.

Significant advances toward achieving the 2016 - 2018 vision for equitable health outcomes for Māori, have occured. RACS now has a Māori name, 'Te Whare Piki Ora o Māhutonga' which is mainly used in New Zealand and a Māori motif which is being included in RACS branding. Ensuring Te Ao Māori is present and visible in college activities, image and culture is another way of demonstrating RACS commitment to addressing Māori health inequities and Māori representation in surgery.

OBJECTIVE 3. PARTICIPATION OF ALL DIVERSITY GROUPS

Ensure the profession of surgery is accessible to all people regardless of their minority group status.

Action	Task	Administrative responsibility	Measurable target	Status
3.1 Improve and extend our relationships with Aboriginal and Torres Strait Islander peoples and organisations to enable us to better equip the surgical workforce to meet the needs of all Australian Communities	3.1.1 Complete Action Plan Goal 1: Relationships, as outlined in the RACS Reconciliation Action Plan 2016-2017	IHC, Fellowship Services Relationships and Advocacy	• Developing a RAP Steering group. • Establishing strong partnerships with key stakeholders. • Inviting an Elder in residence as a formal role within the College. • Raising awareness about reconciliation.	Ongoing
3.2 Engender respect and enhance cultural competency amongst the surgical workforce	3.2.1 Complete Action Plan Goal 2: Respect, as outlined in the RACS Reconciliation Action Plan 2016-2017.	IHC, Fellowship services	• Developing appropriate Aboriginal and Torres Strait Islander protocols. • Communicate and advocate for improvements in Aboriginal and Torres Strait Islander health. • Develop and implement cultural competency and Aboriginal and Torres Strait Islander health training.	In progress
3.3 Promote an increase in the number of Aboriginal and Torres Strait Islander Fellows, Trainees and staff by creating an organisational culture that values and encourages opportunities for Aboriginal and Torres Strait Islander Peoples	3.3.1 Complete Action Plan Goal 3: Opportunities, as outlined in the RACS Reconciliation Action Plan 2016-2017.	IHC, Fellowship Services People and Culture	• Establish a network of Fellows interested in supporting Aboriginal and Torres Strait Islander health. • Develop Aboriginal and Torres Strait Islander recruitment strategies. • Facilitate an increase in Aboriginal and Torres Strait Islander Trainees by guaranteeing a training post. • Promote reconciliation through our business relationships and considering supplier diversity.	Ongoing
3.4 Tracking progress and reporting	3.4.1 Complete Action Plan Goal 4: Tracking and Progress Reporting.	Fellowship Services	• Disseminate the RAP. • Report on RAP implementation.	Complete

Progress commentary/metrics

- RACS relationship with the Australian Indigenous Doctors' Association (AIDA) has continued to grow. AIDA is formally represented on the Indigenous Health Committee. RACS has been a gold sponsor and RACS President has attended AIDA's annual scientific meeting for the last four years. AIDA President regularly attends RACS ASC. The organisations collaborate leading initiatives in support of Aboriginal and Torres Strait Islander pathways into specialty medicine and in advocacy for key health issues. RACS immediate past President Mr Phil Truskett was invited to serve as AIDA Patron.
- RACS has strengthened ties with the National Aboriginal Community Controlled Health Organisation (NACCHO). Presenting at their annual meeting in 2017/18 and incorporating them as a partner in RACS ear health for life advocacy.
- Professor Martin Nakata was appointed as an Education Advisor to provide strategic advice relevant to RACS indigenous health programs. Professor Nakata has addressed Council and the Board for Surgical Education and Training, presented as part of the 2018 ASC program and is an active contributor through RACS Indigenous Health Committee.

- Acknowledgement and welcome to country protocols have been established.
- Commissioning of the Aboriginal and Torres Strait Islander Motif has increased the visibility of Aboriginal and Torres Strait Islander health in the College and is prominently displayed during RACS Indigenous health activities.
- RACS has partnered with the Koorie Heritage Trust in Melbourne to deliver cultural competency training for staff. Training has been offered to all Melbourne based staff with programs investigated in the Australian states.
- Aboriginal and Torres Strait Islander Health and Cultural Competence e-modules have been promoted to Fellows through the CPD program. RACS is working with the Australian Indigenous Doctors' Association with respect to their roll-out of a face to face Aboriginal and Torres Strait Islander Health in Clinical Practice training program that would be tailored for the needs of surgeons.
- In partnership with ASOHNS, the College has led a three year ear health for life campaign in support of reducing the burden of ear disease in Aboriginal and Torres Strait Islander communities.
  - o Wins to date have included a new $30 million investment in hearing assessments over four years
  - o Federal Government support for the $7.9 million program addressing otitis media in the Northern Territory
  - o the establishment of a Hearing Health Sector Committee led by Minister Wyatt and development of national KPIs as part of the COAG process.
  - o Aboriginal Ear Health prioritised as part of a $160 million Medical Research Future Fund Mission.
- In September 2018, RACS secured a 2.5 year $460,000 grant from the Australian Department of Health to support a review of needs across nine surgical specialties in terms of Aboriginal, Torres Strait Islander health and cultural safety.

- The Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative has been implemented by 8 of 9 training boards. The first Trainee selected as part of the initiative started training in 2019.
- Aboriginal and Torres Strait Islander Health Network launched to connect Fellows interested in supporting Indigenous health initiatives.
- Formalised a list of Aboriginal and Torres Strait Islander suppliers and promoted to encourage the use of indigenous suppliers.
- RACS scholarships in support of Aboriginal and Torres Strait Islander medical students and doctors have increased from $15,000 in 2016 to $77,500 annually in 2020 funded by RACS, the Foundation for Surgery and with support from industry.

- RACS reports annually to Reconciliation Australia.
- In addition RACS has presented public updates on RAP progress and educational support projects in:
  - o 2016 and 2018 at the Australian Indigenous Doctors' Association Conference
  - o 2017 and 2019, to the Leaders in Indigenous Medical Education Conference
  - o 2018 to the National Aboriginal Community Controlled Health Organisation
- RACS Indigenous Health Committee is currently chaired by a RACS Councillor and from 2019 will report directly to College Council.
- RACS staff presented with an introduction to RACS Reconciliation aims and strategies including a brief introduction to cultural context.

OBJECTIVE 3. PARTICIPATION OF ALL DIVERSITY GROUPS

Ensure the profession of surgery is accessible to all people regardless of their minority group status.

Action	Task	Administrative Responsibility	Measurable target	Status
3.5 Provide advocacy for equity of Māori health	Goal 1, Maori Health Action plan.	IHC, Fellowship Services NZ office	• Develop a communications plan • Information provided in college publications. • Meetings with internal and external stakeholders.	In progress
3.6 Implement strategies to increase Māori representation in surgical workforce:	Goal 2 as outlined in the Māori Health Action Plan.	IHC, Fellowship Services NZ office	• Promote surgical careers at TeORA conferences. • Develop and promote scholarships. • Identify mentors and build links between surgeons and Māori doctors/medical students • Collect ethnicity data from New Zealand Fellows. • Investigate options for including Māori representation on selection panels.	Ongoing
3.7 Promote research and conduct audit in relation to Māori health disparities:	Māori Health Action Plan, Goal 3. Research and Audit	IHC, Fellowship Services NZ office	• Undertake cross sectoral analysis on state of Māori health • Provide financial support for Māori health research. • Ensure ethnicity data is collected as part of surgical research.	Complete/ In progress
3.8 Increase Māori cultural presence within the College:	Māori Health Action Plan, Goal 4. Cultural competence	IHC, Fellowship Services NZ office	• Develop a Māori name for the College. • Develop a Māori motif for the College. • Strengthen Māori health governance within organisational structure. • Identify appropriate karakia and identify meetings where this should be included. • College representatives and senior staff are familiar with tikanga and trained where appropriate.	Complete/ In progress
3.9 Provide support for people from culturally and linguistically diverse backgrounds (CALD) seeking to apply for IMG assessments and following their acceptance of a pathway to Fellowship	3.9.1 Provide induction or support to assist with understanding AU/NZ culture and working within these health systems.	IMG Assessment Dept Clinical Director, IMG	Number of induction sessions provided, frequency of contact with Clinical Director.	Complete
	3.9.2 Create opportunities for active inclusion of IMGs on pathway to fellowship	IMG Assessment Dept; Clinical Director, IMG	No of times these opportunities are taken up	In progress
	3.9.3 Develop a responsive support program for those IMGs assessed for Specialist Areas of Need pathways and placed in remote geographical areas	IMG Assessment and Support, STANZ	Increased participation of CALD groups within College as reported against the baseline	To do

Progress commentary/metrics

- Māori health is regularly highlighted through Surgical News with articles appearing in at least of issues annually from 2016. The September 2018 edition featured the Māori name and motif.
- New Zealand media have shown strong support for promoting RACS work in supporting Māori health highlighting ASC Award winners, scholarship recipients and Māori Health Medal Recipients.

- A meeting with the Chairs of the NZ training Boards/Committees was led by Indigenous Health Committee and Māori Advisory Group. Its purpose to collaborate and develop a framework to progress the development of appropriate and successful selection processes, as well as cultural competency for Trainees and selectors.
- Several selection committees for NZ-based surgical training have altered their selection systems to acknowledge applicants' knowledge / skills in te ao Māori.
  - All selection committees for NZ-based surgical training interested in furthering activities in this area
  - From 2018 selections processes, seven Māori selected for training.
  - From 2018 two NZ based selection panels included Māori representation
- RACS is a gold sponsor of the Te Ora (Māori Medical Practitioners Association) annual meeting. In 2016 RACS also provided gold sponsorship for the Pacific Region Indigenous Doctors Conference in Auckland and the Leaders in Indigenous Medical Education Conference in 2017 and 2019.
- Te Ora has a seat on RACS Indigenous Health Committee and President or delegate regularly attends RACS ASC.
- RACS scholarships in support of Māori medical students and doctors have increased from $15,000 in 2016 to $76,000 in 2020 funded by RACS, the Foundation for Surgery and with support from industry.

- New Zealand Annual Scientific Meeting and RACS ASC 2016, 2017, 2018 and 2019 programmes included presentations / sessions on Māori Health.
- Māori health research is featured as part of the ASC Indigenous Health program and the New Zealand annual meeting from 2016 onward including Surgery 2018: Planning For Change featured Dr Matire Harwood and Associate Professor Suzanne Pitama speaking on improving Māori health outcomes and working alongside Māori patients and whanau.

- Te Whare Piki Ora o Māhutonga was adopted as the Māori name for the College, the name broadly equates to the school of ascension to health under the Southern Cross, encapsulating RACS' commitment to excellence in learning, good health and the College's bi-national history.
- RACS has commissioned the Māori motif. These initiatives are highlighting the importance of Māori language and culture within the organisation and reinforcing this importance with Fellows, Trainees, IMGs and external stakeholders.
- Māori surgeons are active contributors and have formalised links on RACS Council and the New Zealand National Board.
- A Māori welcome is included at the opening of appropriate meetings. RACS Fellows and staff have worked together to identify appropriate welcome options and to provide support for Fellows with appropriate understanding and pronunciation.
- RACS New Zealand staff undertook training in the Treaty of Waitangi with specific regard to current health outcomes for Māori.
- Māori health medal was established and awarded annually at ASC to acknowledge and promote work undertaken in support of Māori health

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All IMGs are required to complete RACS IMG Orientation eLearning module prior to commencement of supervision.

All IMGs are required to attend RACS IMG Induction Workshop within first six month of commencement of supervision. The workshop is held three times per calendar year (in a different state/territory each time).

All IMGs are provided with a Welcome Pack upon commencement of supervision. The pack includes a welcome letter from RACS Clinical Director, a personalised id card, a BRIPS fact sheet, a Converge fact sheet, STANZ information and a list of available skills and professional development courses.

IMG Committee is engaging with Specialty Training Boards requesting inclusion of IMGs in Fellowship Examination preparation study groups and courses.

The monitoring of participation data has been flagged as an area to address.

To Do

Women's representation on committees and other leadership roles: 20% by 2018 and 40% by 2020

DIVERSE REPRESENTATION

We are pleased to note steady, if slow, improvement in the representation of women in surgery. Last year, 31 per cent of applications for a training place were from women, and 33 per cent of Trainees accepted onto our training program were women. The representation of women on RACS Council and Committees is also increasing. After the Council elections for 2020, 40 per cent of RACS Councillors will be female. Given the proportion of women in the surgical profession generally is 13 per cent, this is a significant achievement and reflects the substantial contribution women make to our profession.

In 2017, RACS committed to a Panel Pledge which aims to ensure that women are better represented at conferences, seminars and other leadership opportunities. The Panel Pledge was initiated by Chief Executive Women, Women's Leadership Institutes Australia and Male Champions of Change. It recognises that conferences and panels provide a platform to share experiences and perspectives, and that lack of diversity limits the quality of the conversation and potential outcomes. RACS Panel Pledge commits us to making every effort to ensure women leaders are represented on all RACS panels and explicitly asking other conference organisers that we work with to pay attention to this issue. As Elizabeth Broderick, Sex Discrimination Commissioner, Australian Human Rights Commission notes: '..if you don't intentionally include, the system unintentionally excludes…'.

Invited speakers in 2018/2019 for main conferences:

Percentage of women – invited speakers/ chairs/presenters		
Meeting	**2018**	**2019**
RACS ASC	22%	32.6%
ACTASM	39%	28%
NZ Surgery (ASM)	30%	38%
QLD ASM	N/A	37.5%
SA/WA/NT ASM	26%	21%
Tasmanian ASM	39%	33%
Victorian ASM	29%	27%


Increasing representation of women in SET from 29% in 2016 to 40% by 2021

OBJECTIVE 4. DIVERSE REPRESENTATION ON BOARDS AND IN LEADERSHIP ROLES

Increase diversity and in particular, representation of women, on training boards and in all College leadership roles.

Action	Task	Administrative Responsibility	Measurable target	Status
4.1 Set targets for women's representation on Training Boards and College Boards including in leadership positions	4.1.1 Develop targets for women's representation on each Training Board	EGM Education	20% by 2018 40% by 2020	Complete
	4.1.2 Develop targets for women's representation in Committees and other leadership roles	EGM Education	20% by 2018 40% by 2020	Complete
	4.1.3 Develop targets for women's representation as Examiners	EGM Education	To do	Not achieved
	4.1.4 Publicise the set targets and issue a statement of expectation and intent to fulfil these targets	EGM Education	Targets publicised	Complete
4.2 Achieve greater diversity on Training Boards and within RACS Boards and committees	4.2.1. Create and implement a plan to achieve the desired board composition including adjusting terms of reference	CEO and EGMs	More diverse Board membership reported against the baseline benchmark.	In progress
	4.2.2 Appoint community, non-surgeons and education professionals	CEO and EGMs	More appointments against the baseline benchmark	Ongoing
4.3 Encourage potential candidates to participate in leadership roles (RACS Boards and committees)	4.3.1. Promote opportunities for involvement and encourage diversity in applications (e.g. Council elections and regional committees)	CEO and EGMs	Increasing participation of women and other diversity groups in leadership roles, as reported annually.	Ongoing
4.4 Provide support for diversity groups to improve their pathways to involvement in leadership roles through mentoring resources and support	4.4.1 Promote the use of current mentoring resources	EGM Education Fellowship services	2 x *Surgical News* annually, monthly Fax Mentis, RACSTA, other newsletters. Feedback via surveys shows	Ongoing
4.5 Reduce the barriers to participation in various leadership processes and events	4.5.1 Make greater use of electronic and online technology for meetings e.g. video-conferencing	All EGMs	Greater participation of women, other diversity groups and greater representation of regional areas in RACS events	Achieved
	4.5.4 Provide training to chairs of teleconferences to promote participation.	All EGMs	Training provided	Ongoing
	4.5.2 Consider selecting venues for professional development activities that provide child minding and/or breastfeeding facilities for the parent	Conference and Events (set standard)	Family friendly facilities provided	Ongoing

Progress commentary/metrics
Target agreed: Women's representation on Training Boards, College Boards and major committees, in other leadership roles, 20% by 2018 and 40% by 2020
As above
To do
Completed via *Surgical News*, Building Respect Improving Patient Safety Progress Updates
Rationalisation of the RACS governance structure will include review of all committee terms of reference. The Governance Committee will also review the College's committee membership application process, ensuring transparency. Both aspects will include consideration of community, non-surgeon and education professional involvement.
External co-opted members are engaged in multiple committees and boards of the College including College Council, Board of Surgical Training and Education, Education Board, Professional Development and Standards Board, Governance Committee, Resources Committee, Risk Management and Audit Committee, Investment Committee, Information Technology Governance Committee and Foundation for Surgery Board. Seven of 13 Specialty Training Boards have external members appointed as of November 2019.
The Governance Committee will review the College's committee membership application process, ensuring transparency.
The Younger Fellows Committee has established a mentoring program for Younger Fellows interested in advancing their careers, academic and research interests. Cohorts of up to 20 pairs of mentees and mentors have been matched and introduced at RACS ASC from 2017 through 2019. RACS mentoring resources are made available on the website and booklets are provided at relevant professional development courses.
Will be further supported through implementation of the "RACS One College Transformation" Plan
As above
Breastfeeding facilities provided at all RACS offices. Consideration given to this regarding use of external facilities in the planning of conferences and events.

AN ONGOING COLLEGE-WIDE COMMITMENT

We have adopted an integrated delivery model for our work to support diversity and inclusion. Accountability and responsibility for this is shared across the college.

The Executive Committee of Council oversees the plan's overall implementation and reports to Council on progress, changes and updates; benchmarking and reporting are the responsibility of the CEO; RACS Governance Committee oversees the work we are doing to support diverse representation on Boards and in leadership roles; and the Indigenous Health Committee oversees our work on indigenous diversity. Administrative responsibilities for specific actions in the plan are detailed in the tables in this report.

In allocating responsibility for action in this manner, we aim to ensure our commitment and accountability for progression of this work remains a college-wide focus into the future.

OBJECTIVE 5. BENCHMARKING AND REPORTING

Be transparent and accountable for increasing diversity and making progress against the Diversity and Inclusion Plan, by gathering data and reporting publicly on progress.

Action	Task	Administrative Responsibility	Measurable target	Status
5.1 Collect data and report on representation of women on Boards and Committees	5.1 Develop data gathering mechanisms	Vice President	Gender split of Board/ Committee memberships regularly reported	Complete
	5.2 Collect data on various representation criteria including gender split	Vice President	Annual reporting as minimum	Ongoing
	5.3 Prominently report each Board's composition levels at least annually	Vice President	Annual reporting as minimum	Ongoing
5.2 Collect data and report on offerings and uptake of flexible training options and deferments for each Specialty	5.2.1. Develop data collection protocols and mechanisms for uptake of various aspects of flexible training covering all Boards	Surgical Training Services	Data capture methods established	Complete
	5.2.2 Collect data relating to flexible training offered by each Board	Surgical Training Services	Data collection occurs on a regular basis	Complete
	5.2.3 Report each Board's flexible training offering	Surgical Training Services	Detailed measures of flexible training uptake regularly reported	Complete
5.3 Collect robust data on CALD status of RACS membership	5.3.1 Develop and introduce a set of data collection items relating to CALD status	Fellowship Engagement	CALD membership status known and reported	Complete
	5.3.2 Capture data relating to CALD status of Trainees at SET registration process	Surgical Training Services	To Do	-
	5.3.3 Report the levels of participation of CALD members within surgery and in RACS activities	Fellowship Engagement	Reporting on an annual basis	In progress
5.4. Creation of sustainable structures to ensure accountability, measurement of results and reporting for all aspects of the Diversity and Inclusion Plan	5.4.1 Allocate clear organisational structure for implementation of the Diversity and Inclusion Plan and reporting of its progress	Vice President	Clear organisational governance for Diversity and Inclusion established	Complete

Progress commentary/metrics
Data gathering mechanisms identified
Data collected biannually
Reported on website and via *Surgical News*
STB reports to BSET now include a standing item for flexible training. Boards report on how many Trainees are in flexible training positions. Training Boards also advise the SET team each time a Trainee is approved for a flexible training post and the information is recorded Hospitals provide information as to whether flexible training posts can be accommodated. This information is collected as part of the accreditation reports when posts are inspected (standard 5) and the provision of flexible employment options are a minimum requirement for hospitals.
CALD data collected as part of RACS members profile via RACS portfolio.
To do
To be highlighted as part of RACS 2019 Activities Report (published 2020) this report captures and reports key demographic data of Fellows, Trainees and IMGs annually.
Regular reporting via CEO report to Council on Diversity and Inclusion is provided by Executive Lead, Building Respect Improving Patient Safety. Governance Responsibility is held by Vic President. AMC conditions also require reporting on Diversity and Inclusion commitments.

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Royal Australasian College of Surgeons

Governance Structure

Foundation Board
Mr John Batten
Jessica Redwood

ANZ Journal of Surgery
Prof Julian Smith
Abderazzaq Noor

Council
Mr Tony Sparnon
John Biviano

Appeals
Dr John Quinn

Awards Committee
Mr Tony Sparnon
Pernette Wijnen

NZ National Board
Miss Philippa Mercer
Justine Peterson

Board of Council
Mr Tony Sparnon
John Biviano

Professional Conduct C'tee
Dr Sally Langley
Rebecca Clancy

ACT C'tee
Prof Paul Smith
Tess Green

NSW State C'tee
A/Prof Payal Mukherjee
Allan Chapman

Finance, Audit & Risk Mgt C'tee
Dr Greg Witherow
Emily Wooden

Governance C'tee
A/Prof Julie Mundy
Rebecca Conning

NT C'tee
Mr Mahiban Thomas
Angela D'Castro

Qld State C'tee
Prof Deborah Bailey
David Watson

Investment C'tee
Ms Siobhan Blewitt
Adam Shepard

Property C'tee
Dr Christine Lai
Emily Wooden

One College Transformation Steering Group
Mr Richard Perry
John Biviano

SA State C'tee
Mr David King
Daniela Ciccarello

Tas State C'tee
Mr David Penn
Di Cornish

Indigenous Health C'tee
Dr Maxine Ronald
Paul Cargill

Vic State C'tee
Mr Matthew Hadfield
Katherine Walsh

WA State C'tee
Dr Mary Theophilus
Angela D'Castro

Education Board
A/Prof Phillip Carson
Julian Archer

Professional Development & Standards Board
Dr Sally Langley
Etienne Scheepers

Int'l Engagement C'tee
A/Prof Julie Mundy
Emily Wooden

Pre-Vocational & Skills Education C'tee
Dr Jennifer Chambers
Philippa Davis

- ANZ Surgical Skills Education and Training (ASSET)
- Care of the Critically Ill Surgical Patient (CCrISP)
- Critical Literature Evaluations and Research (CLEAR)
- Early Management of Severe Trauma (EMST)
- JDocs
- Operating With Respect (OWR)
- Training in Professional Skills (TIPS)

Court of Examiners
Prof Christopher Pyke
Philippa Davis

- Executive C'tee
- Cardiothoracic Surgery
- General Surgery
- Neurosurgery
- Orthopaedic Surgery
- Otolaryngology Head & Neck Surgery
- Paediatric Surgery
- Plastic & Reconstructive Surgery
- Urology
- Vascular Surgery

Board of Surgical Education & Training
Mr Adrian Anthony
Julian Archer

- Board of Cardiothoracic Surgery
- Australian Board in General Surgery
- New Zealand Board in General Surgery
- Board of Neurosurgery
- New Zealand Board of Orthopaedic Surgery
- Board of Otolaryngology Head & Neck Surgery
- Board of Paediatric Surgery
- Australian Board of Plastic & Reconstructive Surgery
- New Zealand Board of Plastic & Reconstructive Surgery
- Board of Urology
- Board of Vascular Surgery
- Surgical Science & Clinical Examinations C'tee
- Australian Orthopaedic Association Federal Training C'tee
- International Medical Graduates Committee

Professional Standards C'tee
Prof Andrew Hill
Rebecca Clancy

- CCRTPET
- ACCRTGE
- NZCCRTGE
- RCCC
- SGEC
- LEPRC
- Trauma Committee
- Trauma Verification C'tee
- Trauma Quality Improvement C'tee
- Road Trauma Advisory C'tee
- DSTC C'tee

Professional Development C'tee
Dr Lawrence Malisano
Amanda Christie

- Academy of Surgical Educators C'tee

Fellowship Services C'tee
Ms Ruth Bollard
Paul Cargill

- Younger Fellows C'tee
- Sections:

- ANZ Chapter of American College of Surgeons
- Colon & Rectal Surgery
- Endocrine Surgery
- History, Heritage & Archives
- Medico-Legal
- Military Surgery
- Pain Medicine & Surgery
- Rural Surgery
- Senior Surgeons
- Surgical Directors
- Surgical Oncology
- Transplant Surgery
- Upper Gastrointestinal and Hepato-Pancreato-Biliary and Obesity Surgery
- Women in Surgery

Research & Academic Surgery C'tee
Prof Mark Frydenberg
Wendy Babidge

- Research & Evaluation incorp ASERNIPs C'tee
- Academic Surgery C'tee
- Aust & NZ Scholarship & Grant C'tee
- Scholarships Evaluation & Monitoring C'tee

Surgical Audit C'tee
Mr John Crozier
Helena Kopunic

- ANZASM
- Morbidity Audit C'tee

ASC Planning & Review C'tee
Prof Owen Ung
Lindy Moffat

Global Health Programs Stg Group
Dr Annette Holian
Philippa Nicholson

- Global Health Section

RACSTA Committee
Dr James Churchill
Veronica Vele

IMG Assessments
A/Prof Kerin Fielding
Ria Fanourakis

● CEO ● Operations ● Education ● People & Culture ● Fellowship Engagement

CEO Office 8 July 2020

Division:	**Office of the CEO**	**Ref. No.**	**REL-PCS-037**
Department:	**President & Council Support**		
Title:	**Conflict of Interest**		

1. PURPOSE

This policy is part of the Royal Australasian College of Surgeons (RACS) commitment to good governance and ethical conduct. It emphasises freedom from any conflicts of interest which may result in personal gain and those related to any disclosable relationships like close associates, such as friends, family, and other businesses or organisations. Outside engagements or work commitments like paid or voluntary work also need to be disclosed. When working with, and representing RACS, the interests of the organisation are paramount.

The following framework is designed to support RACS to effectively identify, disclose, and manage any actual, potential, or perceived conflicts of interest in order to protect the integrity of RACS. It supports RACS to manage risk and safeguard the organisation's reputation and the trust placed in it by stakeholders and the public. The policy also supports RACS's compliance with its legislative and statutory obligations, and good governance standards.

2. SCOPE

Managing perceived, potential, and real conflicts of interest is the responsibility of all **RACS people** that participate in the work of RACS and/or represent RACS, including:

- Councillors and committee members (including members of the Specialty Training Boards);
- RACS staff, Fellows, Trainees, Specialist International Medical Graduates (SIMGs) and volunteers; and
- consultants and contractors.

3. DEFINITIONS

Conflict of Interest: Any situation where an individual stands to, or may be perceived to actually or potentially, benefit or alternatively be disadvantaged by a particular decision, either personally or professionally, to the extent it is reasonably possible that the decisions of the person affected may be influenced. Such benefit or detriment may be financial or non-financial, direct, or indirect. A conflict of interest based upon a relationship can also exist if a relative, family member, close associate or related business entity has the potential to derive a benefit or suffer a detriment from a particular decision.

Disclosable relationship: Relationships including those with close associates, such as friends, family, and other businesses or organisations that could be perceived to/could potentially create a conflict of interest between an individual's personal interests (connected to these relationships) and the best interests of RACS.

Outside engagement or work commitments: Any external paid or voluntary engagement or commitments that could be perceived/could potentially create a conflict of interest between an individual's commitment to RACS and to fulfilling the agreed scope of their work with RACS, and to meeting their external commitments.

4. LEGISLATIVE FRAMEWORK AND STANDARDS

RACS people will act with reasonable care and transparency when disclosing any conflicts of interests. RACS complies with the following legislation and standards noting that Councillors of RACS are Directors:

- Corporations Act 2001 (Cth),
- the New Zealand Companies Office,
- Australian Securities Investment Commission (ASIC),

- Australian Charity and Not-for-profit Commission (ACNC) under their Standards 5: *'Duties of Responsible Persons'*,
- Australian Council for International Development (ACFID) Code of Conduct, and
- the Australian Medical Council (AMC) accreditation standards.

5. POLICY STATEMENT

It is the policy of RACS, as well as a responsibility of the Council, that ethical, legal, financial, education and training, or other conflicts of interest be avoided and that any such conflicts (where they do arise) do not conflict with the obligations to RACS. All conflicts and potential conflicts must be disclosed.

6. POLICY IN ACTION

6.1 Council and Governance Committees

The Council's role is to establish a system to identify, disclose and manage conflicts of interest pertaining to all Councillors and committee members within RACS. The CEO and Council/Board Secretary will ensure that Councillors and committee members are aware of the ACNC governance standards, and that they disclose any actual or perceived material conflicts of interests as required by ACNC governance Standards 5.

On appointment to Council or a committee, and each year of membership, all Councillors and committee members will complete the **Conflict of Interest Disclosure Form** provided in Appendix 2 of the Conflict of Interest Procedure, this will include any relationships and work commitments that could potentially impact on their role with RACS**.**

6.1.1. Identifying, and Disclosing Conflicts of Interest

The Chair of any RACS Council and Committee, prior to the deliberation of that Council or Committee, as a standing agenda item, seeks confirmation from everyone present that none of the matters being considered or about to be considered create a conflict of interest for any person in that meeting.

A useful way to decide whether or not a conflict of interest exists is to apply the impartial observer test, which involves asking the question: "Would a reasonable person (properly informed about the nature of your personal interests) believe that you might be influenced by your personal interests when making decisions on behalf of RACS?" If the answer is yes, you are likely to have a conflict of interest that needs to be disclosed."[1]

6.1.2. Managing and Documenting Conflicts of Interest

Once a conflict of interest has been identified, the Council or committee must decide what needs to be done to address the conflict. They will consider whether the conflicted Council or committee member should:

- vote on the matter (exclusion from voting is the minimum measure),
- have access to related documentation
- participate in any debate, or
- be present in the room during the debate and the voting.

[1] *'Managing Conflicts of Interest: A Guide for Charity Board Members'*, ACNC website.

In exceptional circumstances, such as where a conflict is very significant or likely to prevent a Council or committee member from regularly participating in discussions, the Council or committee may consider it appropriate for the person conflicted to resign from the relevant Council or committee. The approval of any such action requires the agreement of at least a majority of the Council or committee (excluding any conflicted member/s) who are present and voting at the meeting. The action and result of the voting will be recorded in the minutes of the meeting and in the **Conflict of Interest Register** provided in Appendix 3 of the Conflict of Interest Procedure. This register is maintained by the Council/Board Secretary in consultation with the Council and Committees. The register must include the nature and extent of the conflict of interest and any steps taken to address it.

6.2 Impact of Policy on Quorum and Voting Requirements

Where a conflict of interest has been identified in accordance with clause 6.1, the removal, exclusion or inability to vote imposed on any member or members of the Council or committee shall not create the absence of a quorum for the meeting or any resolution at that meeting, where a quorum existed immediately prior to the decision to exclude any persons from the meeting or part thereof, or not permit any person(s) to vote, by reason only of the conflict of interests. This Policy shall override any provisions of Terms of Reference of any committee with respect to the existence of a quorum in circumstances addressed by clauses 6.1 and 6.2 of this Policy.

6.3 Fellows, Trainees, SIMGs, Staff, Volunteers, Consultants and Contractors

Fellows, Trainees, SIMGs, staff, volunteers, consultants and contractors of RACS must actively seek to avoid conflicts of interest. If this is unavoidable with respect to a particular issue, there is an obligation for the individual to declare the real, perceived or potential conflict of interest as soon as possible to management. RACS may take steps to manage the conflict of interest which may include ensuring the individual is not involved in decisions relating to themselves or another party, conflict does not lead to favouritism or disadvantages to others and or self-benefit.

6.4 Acceptance of Gifts or Benefits

Gifts or benefits arising by way of an individual's involvement with RACS that might in any way appear to compromise or influence them in their official capacity, must not be either solicited or accepted. The offer of gifts or benefits arising as a result of an individual's involvement with RACS must be reported as soon as reasonably practicable to an Executive Director of Surgical Affairs in the case of Fellows, Trainees and SIMGs or to their manager in the case of staff, volunteers, consultants and contractors. If RACS is engaged in a tender process, no gift or benefit, no matter how small or insignificant, should be accepted from the tenderers.

6.5 Disclosable Relationships

Disclosable relationships (defined in Section 1 of this Policy) should be effectively managed to avoid conflicts of interest. Decisions relating to the recruitment/appointment and management of RACS people must be transparent, based on merit, without any real, potential or perceived conflict of interest. A failure to disclose a disclosable relationship, during recruitment or while working with RACS may lead to disciplinary action including termination of employment or contract. Further detail is outlined in the **Recruitment and Selection Policy.** Staff members, volunteers, consultants or contractors must disclose disclosable relationship to their manager. Councillor and Committee members must disclose disclosable relationships to their relevant chairs. All other Fellows, Trainees and

SIMGs must disclose disclosable relationships to an Executive Director of Surgical Affairs. All disclosures will be recorded and treated confidentially in accordance with the **Privacy of Personal Information Policy**.

6.6 Outside Engagements and Working Commitments

It is important that RACS people's outside engagements and working commitments (defined in Section 1 of this policy) do not undermine an individual's ability to fulfil the reasonable requirements of their role at RACS, do not adversely impact on their endeavours to protect the interests and public image of RACS, or create a conflict between their personal interests and the best interests of RACS.

7. ASSOCIATED DOCUMENTS

- Constitution
- Governance Charter
- Conflict of Interest Procedure
- Conflict of Interest Disclosure Form
- Conflict of Interest Register
- Privacy of Personal Information Policy
- Purchasing of Goods and Services Policy
- RACS Code of Conduct
- RACS Workforce Conduct Policy
- Recruitment and Selection Policy
- Whistleblower Policy

Approver: **Council**

Royal Australasian
College of Surgeons

Transformation Program
‘Flight Board Template’

1 Dec 2020

Committed to Indigenous health

RACS Business Continuity Plan – 'Flight Board'

Scheduled	Flight	Destination	Airline	Gate (Group)	Status
March	**BCP 001**	Work from Home Guide +Go1.com Learning	BCP	Staff	Landed March 26
March	**BCP 002**	Remote Working Model (including Vendors)	BCP	Staff	Landed March 26
May	**SEC 001**	Multi-Factor Authentication (Security)	BCP	Staff	Early Landed March 27
May	**WRK 001**	MS Teams (Meeting/Chat/Screen/Files)	BCP	Staff	Early Landed March 27
April	**WRK 001**	MS Planner (MS Team Tasks/To Do)	BCP	IT Staff	Early Landed March 23
May	**WRK 001**	MS Planner (MS Team Tasks/To Do)	BCP	Staff	Early Landed April 15
May	**WRK 001**	Cloud Email (Independent of RACS Offices)	BCP	Staff	Early Landed April 15
May	**WRK 001**	MS Teams Meeting Recordings (MS Stream)	BCP	Staff	Early Landed April 15
May	**WRK 002**	Sharepoint365 (Files +Hybrid Search +Backup)	BCP	Staff	Delayed Expected Q1
Dec	**EDU 001**	MS Teams+ for Learning (Live Prototypes)	BCP	Education	Early May 30

RACS One College Transformation – 'Flight Board'

Scheduled	Flight	Destination	Airline	Gate (Group)	Status
Feb 20	**WEB 001**	Rebuild / New Website (Sitecore)	1CT	Staff	Landed / Nov
March 20	**SOE 001**	Windows 7 to 10 Rollout (PC/Laptops)	1CT	Staff	Landed March
March	**EXP 001**	Expense Management (Pilot)	1CT	Staff	Pause / Expected Nov
March	**S08 001**	Stabilise Infrastructure (~2008 Server Risk)	1CT	Staff	Delayed / Expected April
March	**TEL 001**	New Telephone System (Mitel w/ Software First)	1CT	Staff	Landed / October
March	**EE 001**	Experience Engine 1.0 (CRM Design Build)	1CT	RACS	Landed March
March	**RPT 001**	Insights & Analytics 1.0 (see Exp. Engine 1.0)	1CT	RACS	Changed (add to Exp. Engine1.0)
March	**SEC 001**	Security Mgmt. 1.0 (see MFA & Security 2.0)	1CT	Staff	Landed March
March	**SM 001**	IT Service Management 1.0 (Remote Working)	1CT	RACS	Pause / Expected May 31

RACS One College Transformation – 'Flight Board'

Scheduled	Flight	Destination	Airline	Gate (Group)	Status
April 20	**EE 002**	E-Hub Portal (see Exp. Engine 1.0)	1CT	RACS	Changed (re: Exp. Engine1.0)
April 20	**EE 003**	Hospital Inspection +Complaints	1CT	Staff	Changed (re: Exp. Engine2.0)
April 20	**AV 001**	New Audio/Visual (within Offices)	1CT	Staff	Delayed Expected Dec 20
May 20	**WRK 001**	Digital Workplace (Collaboration)	1CT	Staff/Volunteer	Landed March
May 20	**MET 001**	Meeting Room Manager (Office Rooms)	1CT	RACS	Changed Expected Q1 2021
May 20	**WRK 002**	Pulse (Intranet) 2.0 / Migrate to SharePoint365	1CT	RACS	Landed June
June 20	**EE 004**	Exp. Engine 1.0 (CRM +Cases +Rpt. +Forms +e-Pay +Bots)	1CT	Staff	New Flight Expected Q2 2021
Sept 20	**EE 005**	Exp. Engine 2.0 Sales/Mkting (Survey+Campaign+Website)	1CT	RACS	Changed Expected Q1 2021

RACS One College Transformation – 'Flight Board'

Scheduled	Flight	Destination	Airline	Gate (Group)	Status
Sept 20	**VOL 001**	Volunteer Management	1CT	RACS	Early Expected August 31
Dec 20	**EDU 002**	Edu. & Training 2.0 MS Teams+ Azure Moodle	1CT	Wforce/Students	Delayed Expected Q1
Dec 20	**SEC 002**	Security Mgmt. 2.0 (Remote @surgeons Learn)	1CT	RACS	Delayed Expected Q1
Dec 20	**EE 004**	E-Hub Portal 2.0 - Replacement of e-Portfolio	1CT	RACS	Delayed Expected Q1
Dec 20	**NET 002**	Network 2.0 (100% Remediation Complete)	1CT	RACS	Delayed Expected Q1
Dec 20	**CPD 001**	New CPD 1.0 [2021] (with Activity Log 1.0)	1CT	Fellowship	Delayed Expected Q1

Portfolio:	**Education**	**Ref. No.**	**ETA-SET-061**
Team:	**Training Services**		
Title:	**Reconsideration, Review and Appeal**		

1. PURPOSE AND SCOPE

This policy sets out the formal process for challenging a decision being via the process of Reconsideration, Review and Appeal (RRA Policy or Policy), by any person, organisation, or body corporate (an Applicant) affected by a decision related to the training and education functions of the Royal Australasian College of Surgeons (RACS).

The three-step process involved in formally challenging a decision is intended to minimise the need for Applicants to undertake an Appeal to resolve their issue. It is expected that many issues will reach a satisfactory outcome in the Reconsideration and Review steps.

The purpose of this Policy is to set out the three sequential steps that may be taken by an Applicant aggrieved by a decision related to the training and education functions of RACS, those being to apply for:

1.1. Reconsideration.

This step provides the Applicant with the opportunity to submit additional information to the original decision-maker. This additional information must have been available and known (or should have been known) at the time that the original decision was made.

1.2. Review.

This step provides the Applicant with the opportunity to provide the reasons (to a review panel) that they believe there has been an error by the original decision-maker.

1.3. Appeal.

This step provides the Applicant (also known as the Appellant at this step) with the opportunity to present their case for an Appeal of the decision (by the original decision-maker) to an independent appeals committee (Appeals Committee).

2. GENERAL PRINCIPLES

2.1. Fees

2.1.1. No fee is required for Reconsideration or Review.

2.1.2. An Applicant will be required to pay a fee for an Appeal:

a. The relevant fee is available on the RACS website;

b. This fee must be paid at the time a request for an Appeal is lodged;

c. Where the Appellant is successful (i.e. where the decision is revoked) 50% of the Appeal fee will be refunded.

2.2. Appointment and Delegation

The Reconsideration, Review and Appeal Officer ("RRA Officer") will be appointed by the CEO. The RRA Officer may delegate their powers and duties in respect of this Policy and any procedures made under it.

2.3. Matter Progression

2.3.1. Generally, Applicants will have their matter considered in accordance with the three-step mechanism in the stated sequence, that is, they will commence at the Reconsideration step before continuing to a Review and then Appeal.

2.3.2. The Reconsideration and/or Review steps may be bypassed if approved by the CEO.

2.4. When applications will be accepted

2.4.1. Any person, organisation or body corporate whose interests are directly and adversely affected by an original decision (as detailed in clause 3.1) that is inconsistent with an approved regulation or policy may, within the specified timeframe set out in this policy, apply to have that original decision reconsidered, reviewed and/or considered at a hearing of the appeals committee where there is demonstrable evidence, provided at the time of the application, of one or more of the grounds (set out in clause 3.2) relating to the decision that is the subject of the application.

2.4.2. The onus of establishing the relevant grounds of a request falls upon the Applicant.

2.4.3. Applications submitted under this Policy will not be accepted where the Applicant is seeking an exemption from any approved policy or regulation.

2.4.4. In the absence of manifest error in the scoring of examination results, challenges to examination results are limited. Examinations will not be "re-scored" or "re-assessed", and a candidate cannot be elevated to a pass except in accordance with the Special Consideration for an Examination Policy.

2.4.5. Applications will not be accepted where the application relates to matters that fall under the remit of the Special Consideration for an Examination Policy, and where that policy was not utilised within the timeframe outlined therein and results of the examination have been published, regardless of the reasons cited for not submitting an application under that policy.

2.5. Applicant's request for documents

2.5.1. An Applicant may, prior to requesting a Reconsideration or Review, request from the original decision-maker copies of documents on which the decision was based. The original decision-maker must respond to this request within fourteen (14) days of receipt of a written request. The original decision-maker will not provide any documents to the Applicant where to do so may waive privilege, or breach privacy and confidentiality obligations.

2.5.2. Failure to receive copies of documents on which the decision was based, from the original decision-maker, shall not be accepted as a reason for failure to lodge an application on time. The Applicant must meet all timing requirements in this Policy, even if the documents requested have not been provided by the original decision-maker.

2.6. Reporting

RACS will publish annually an Activities report including the number of Applicants using this Policy and the relevant outcomes.

3. DECISIONS ABLE TO BE RECONSIDERED, REVIEWED OR APPEALED

3.1. Decisions subject to this Policy

An Applicant may apply for a Reconsideration, Review or Appeal of the following decisions related to the training and education functions of RACS:

3.1.1. Selection, training, or admission to Fellowship.

3.1.2. Specialist assessment and clinical assessment of International Medical Graduates (IMGs).

3.1.3. The accreditation of training posts or IMG clinical assessment posts.

3.1.4. Accreditation of Post Fellowship Education and Training programs and Accreditation of courses.

In addition to the above the following other decisions may be challenged in accordance with this Policy:

3.1.5. Decisions relating to termination of Fellowship (Appeal only).

3.1.6. Decisions of the Professional Conduct Committee (Appeal only).

3.1.7. Such other decisions of RACS, its Boards or Committees (including conjoint Committees), or surgical specialty societies in performing RACS functions under delegation and/or contract as the CEO may determine from time to time.

3.2. Grounds for Reconsideration, Review and Appeal

The grounds under which an application for a Reconsideration Review and Appeal can be made are:

3.2.1. That an error in law or in due process occurred in the formulation of the original decision;

3.2.2. That relevant and significant information, whether available at the time of the original decision or which became subsequently available, was not considered or not properly considered in the making of the original decision;

3.2.3. That irrelevant information was considered in the making of the original decision;

3.2.4. That the original decision was made for an improper purpose;

3.2.5. That procedures that were required to be observed by RACS policies and/or Surgical Education and Training (SET) board regulations in connection with the original decision were not observed;

3.2.6. The original decision was made in accordance with a rule or policy without consideration to the merits of the particular case;

3.2.7. The original decision was clearly inconsistent with the evidence and arguments put before the original decision-maker.

Any application which does not meet these requirements may be rejected.

4. STEP ONE – RECONSIDERATION

4.1. Initiation of Reconsideration

4.1.1. Any Applicant who is directly affected by and is dissatisfied with a decision of RACS referred to in clause 3 of this Policy may apply to have the original decision-maker reconsider its decision.

4.1.2. The application for Reconsideration must be made in writing and may include any additional material or documentation not previously considered

by the original decision-maker (if applicable), but only where such material was available and known (or should have been known) to the original decision-maker at the time the decision was made. Additional material or documentation cannot be considered for decisions relating to:

a. selection to the surgical education and training program; and

b. examinations where special consideration ought to have been sought.

4.1.3. The Applicant is entitled to provide written submissions at the time of application. The original decision-maker may also require the Applicant to provide written submissions if they consider it may assist in this process.

4.2. Timeframe

4.2.1. The application for Reconsideration of a decision must be received by RACS within twenty-eight (28) days of the date of the original decision unless it is a decision relating to selection to the surgical education and training program, which must be received by RACS within seven (7) days.

4.2.2. If the decision is provided in writing, the date of the written notification shall be taken to be the date of the decision for this purpose. Failure to receive documents requested under clause 2.5.1 shall be noted by the Applicant on their application and shall not be accepted as a reason for late lodgement of an application. The Applicant must comply with clause 2.5.2.

4.2.3. RACS will acknowledge receipt of the application within seven (7) days of receipt.

4.3. Conduct of Reconsideration

4.3.1. The original decision-maker shall reconsider the decision together with all original material previously before the original decision-maker, any additional materials provided by the Applicant and their submissions (if applicable).

4.3.2. Unless requested by the original decision-maker, the Applicant does not have the right to attend any meetings with the original decision-maker or make any oral submissions to the original decision-maker, either personally or through any other party.

4.3.3. The original decision-maker may inform itself as it sees fit, subject to the rules of procedural fairness.

4.4. Outcome of Reconsideration

4.4.1. RACS aims to complete the Reconsideration process within twenty-eight (28) days of receipt of the complete Reconsideration application received pursuant to this Policy. Following completion of the Reconsideration, RACS will notify the Applicant in writing of the decision (Reconsideration Decision). In the event the original decision is upheld, the communication to the Applicant shall contain the Reconsideration Decision and information relating to the further options available to the Applicant.

5. STEP TWO – REVIEW

5.1. Initiation of Review

5.1.1. An Applicant who remains dissatisfied with the decision of the original decision-maker and maintains that the decision-maker erred in making that decision, may apply to have that decision reviewed by a Review Panel.

5.1.2. The Applicant is entitled to provide written submissions for the Review Panel at the time of application, which they consider may assist in this process.

5.2. Timeframe

5.2.1. The application for Review of a decision must be received by RACS within fourteen (14) days of the date of the written notification of the Reconsideration Decision.

5.2.2. RACS will acknowledge receipt of the application within seven (7) days of receipt.

5.3. Conduct of Review

5.3.1. RACS shall convene a Review Panel, which shall comprise of people approved by the CEO or their delegate for this purpose. The Review Panel shall not include a member who participated in the making of the original decision or the Reconsideration Decision or who otherwise has, or may be perceived to have, a conflict of interest.

5.3.2. The Review Panel shall consider and conduct the Review on the basis of:

a. all the material and documentation considered by the original decision-maker when making the original decision or reconsidering it under this Policy;

b. the application for Review;

c. any new information obtained by it which is relevant to the decision of the original decision-maker;

d. any submissions made by the Applicant under clause 5.1.2;

e. whether the principles of procedural fairness and natural justice were followed when the original decision was made and when it was reconsidered; and

f. any RACS regulations, policies and procedures relevant to the decision.

5.3.3. Unless requested by the Review Panel, the Applicant does not have the right to attend any meetings of the Review Panel or to make any oral submissions to it, either personally or through any other party.

5.3.4. The Review Panel may inform itself as it sees fit, subject to the rules of procedural fairness.

5.4. Outcome of Review

5.4.1. The Review Panel may only make one of the following decisions (Review Decision):

a. affirm the original decision or Reconsideration Decision;

b. set aside the original decision or Reconsideration Decision and require that an alternative process be undertaken to arrive at a decision; or

c. vary the original decision or the Reconsideration Decision to arrive at a different decision.

5.4.2. The decision of the Review Panel is binding on the original decision-maker who must comply with any directions.

5.4.3. RACS aims to complete the Review process within twenty-eight (28) days of receipt of the complete Review application received pursuant to this Policy. Following completion of the Review process, RACS will notify the Applicant in writing of the Review Decision and, if relevant, will advise the Applicant of their right to appeal this Review Decision.

6. STEP THREE - APPEAL

6.1. Initiation of Appeal

6.1.1. An Applicant (also known as the Appellant) who remains dissatisfied with the outcome of the Review process may submit an Appeal in accordance with the allowable grounds of Appeal at clause 3.2for determination by an independent Appeals Committee. The Appellant will carry the burden of proof to establish the specific grounds relied upon in the application.

6.1.2. To constitute a valid application for Appeal, the application must contain all of:

a. The prescribed Appeal fee;

b. Details of the specific decision that is being appealed;

c. The grounds of Appeal based on the allowable grounds of Appeal as described in clause 3.2;

d. A summary of the facts or other means by which the matter falls within the stated ground(s); and

e. A statement that evidence exists that supports the grounds of Appeal.

6.2. Timeframe

6.2.1. The application for Appeal must be received by RACS within fourteen (14) days of the date of the written notification of the Review Decision (in the case of decisions referred to in clause 3 e. to f. of this Policy, within fourteen (14) days of the date of the written notification of those decisions).

6.2.2. RACS will acknowledge receipt of the application within fourteen (14) days and will advise the Appellant and the original decision-maker that an Appeal will be heard. This advice will include a timeline of the Appeal process and information about the rights of the Appellant.

6.2.3. Unless otherwise advised in writing by RACS, the decision under Appeal remains in effect until the Appeal is heard and determined.

6.2.4. The Appellant and the original decision-maker will provide to RACS written submissions and copies of any documents and records upon which they wish to rely, within the time specified in any communication from RACS. The Appellant and the original decision-maker shall have no less than

twenty-eight (28) days to undertake this. The written submissions of the original decision-maker and the Appellant will be provided to the other party and to the Appeals Committee. Following receipt of the original decision-maker's submissions, the Appellant cannot introduce new grounds of Appeal.

6.2.5. The Appellant and the original decision-maker may lodge a rebuttal within the time specified by RACS which cannot be less than fourteen (14) days before the Appeal hearing. The rebuttals will be provided to the other party and to the Appeals Committee. No further material will be accepted after this time.

6.3. Conduct of Appeal

6.3.1. RACS will convene an Appeals Committee, which will comprise the following members approved by the CEO or their delegate:

a. three persons who are not Fellows of RACS, one of whom shall chair the Appeals Committee (Chair);

b. the Vice President of RACS or a delegate who is a Fellow of RACS; and

c. one Fellow of RACS.

6.3.2. The Appeals Committee shall not include members who have been involved in the decision to which the Appeal relates or who otherwise have, or may be perceived to have, a conflict of interest.

6.3.3. Council has delegated the appointment of persons to the pool of Appeals Committee members, including the Chair, to the CEO.

6.3.4. A quorum for meetings of the Appeals Committee will be a Chair and three other members. All members of the Appeals Committee shall be entitled to vote on decisions and the outcome of the Appeal shall be decided on the basis of a majority vote if consensus cannot be achieved. In the event of a tied vote the Chair will have a casting vote.

6.3.5. The Appeals Committee must act according to the rules of procedural fairness. The Appeals Committee is not bound by the rules of evidence and, subject to the rules of procedural fairness, may inform itself on any matter and in such manner as it thinks fit.

6.3.6. The Appeals Committee shall be entitled to consider all relevant information which it thinks fit and may invite any person to appear before it, or to provide information. Witnesses are not compellable. However, the Appeals Committee is limited to considering the grounds of Appeal as pleaded by the Appellant in their application for Appeal.

6.3.7. The CEO, or their delegate, will appoint a person to be the legal advisor to the Appeals Committee.

6.3.8. The Appellant is expected to appear before the Appeals Committee at their own cost and may seek leave to be represented by a legal practitioner and where such leave is sought, it must be sought at the time of application. An Appellant may be excused from attending where attendance would cause undue hardship to the Appellant or for another reason acceptable to the Appeals Committee. Where an Appellant is excused from attending in person, their legal advisor may exercise all the

rights and shall bear all the obligations of the Appellant at the hearing. The Appellant may also be accompanied by a support person.

6.3.9. A representative of the original decision-maker is expected to attend and address the Appeals Committee on matters relevant to the Appeal. The original decision-maker may seek leave to be represented by a legal practitioner. If leave is sought, the Manager of the RACS legal department will appoint a legal advisor.

6.3.10. The RRA Officer may request or permit other persons to attend meetings of the Appeals Committee.

6.4. Outcome of Appeal

6.4.1. An Appeals Committee may, upon considering all submissions, make one of the following decisions:

a. affirm the decision under Appeal;

b. set aside the original decision and recommend that an alternative process be undertaken to arrive at a decision; or

c. revoke the original decision under Appeal and refer the decision back to the original decision-maker and make any other recommendations for the further consideration of the decision that the Appeals Committee considers appropriate.

6.4.2. The Appeals Committee cannot make a recommendation in relation to a matter that the original decision-maker could not have made and cannot make an order in relation to costs. In addition, the Appeals Committee may not:

a. elevate an Appellant above others in a competitive assessment for selection to the SET program without reference to the scoring process; or

b. recommend a pathway to Fellowship for an IMG without reference to a new IMG Assessment Panel; or

c. revoke the clinical or examination assessment of a trainee and replace the assessment with an assessment of its own; or

d. award a Fellowship to any Appellant.

6.4.3. The Appeals Committee will issue a written decision, with reasons for the decision, as soon as practicable, but aims to complete its decision within twenty-eight (28) days from the date of the Appeal hearing.

6.4.4. The Appeals Committee's decision takes effect from the date of the written decision which will be forwarded on the same date to the Appellant and the relevant decision-maker.

7. COMPLIANCE WITH LAWS AND REGULATIONS

Nothing in this Policy authorises an Appeals Committee to direct that an act be done or a process be undertaken by any decision-maker which is unlawful or outside the terms or authority of the regulations or policies of RACS as they existed at the time of the original decision.

Portfolio:	**Education**	**Ref. No.**	**ETA-SET-061**
Team:	**Training Services**		
Title:	**Reconsideration, Review and Appeal**		

8. ASSOCIATED DOCUMENTS

Approver Education Board
Authoriser Council

Policy

AOA
AUSTRALIAN ORTHOPAEDIC ASSOCIATION

RECONSIDERATION REVIEW AND APPEAL OF TRAINING DECISIONS

AOA 21™ Excellence in Orthopaedic Surgical Education and Training

Reconsideration, Review and Appeal of Training Decisions

AOA Education & Training	Document created	September 2018
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Purpose and Scope

This policy outlines the mechanism by which a trainee in the AOA training program (Trainee) may request reconsideration, review or appeal of a training related decision.

A Trainee adversely affected by a decision of AOA outside the parameters of this policy (i.e. a decision other than a training related decision) should refer to the *AOA Reconsideration, Review and Appeals policy* (*Appeals Policy*). The Appeals Policy does not apply to training related decisions covered by this policy.

Training Decisions

1. From time to time, a Trainee may believe they have been adversely affected by a Training Decision.

2. *Training Decisions* may be categorised as Formative Decisions or Summative Decisions.

3. Formative Decisions are those decisions intended to provide a Trainee with feedback. This includes decisions pertaining to Workplace-Based Assessments and Feedback Entries.

4. *Formative Decisions* are not eligible for reconsideration, review or appeal under this policy or the Appeals Policy.

5. *Summative Decisions* are those decisions that may affect a Trainee's progression. This includes decisions pertaining to Quarterly Assessment Reports, Performance Appraisals, Progress Reviews, Stage Reviews and Dismissal.

6. A Trainee adversely affected by a Summative Decision may request a copy of the written reasons for the decision. If such a request is made, written reasons are to be provided within 14 days of receipt of the Trainee's request.

7. A Trainee adversely affected by a summative training decision may request reconsideration, review or appeal of such a decision in accordance with this policy.

8. Requests for reconsideration, review or appeal of a training related decision pertaining to an assessment conducted by the Royal Australasian College of Surgeons (RACS) are not managed under this policy and should be directed to RACS.

9. AOA staff will assist a Trainee to lodge a request for reconsideration, review or appeal and refer the Trainee to the appropriate policy or procedure to be followed.

Reconsideration of a Training Decision

10. A reconsideration of a Summative Decision may be made as the Federal Training Committee (or delegate) may determine from time to time.

11. A Trainee adversely affected by a Summative Decision may, within 14 days of receipt of notice of such a decision, apply to the AOA to have the decision reconsidered by the original decision makers.

12. Where the Trainee has sought a copy of the written reasons of the decision, time elapsed between the request for, and subsequent provision of, written reasons will not contribute to the 14-day period outlined at section 11.

13. A reconsideration of a decision may be made on the following grounds:

    13.1. The original decision was the result of an error of law or error in due process.

    13.2. That relevant and significant information, available at the time of the original decision, was not considered or not properly considered in the making of the original decision.

    13.3. That the original decision was clearly inconsistent with the evidence and arguments put before the body making the original decision.

    13.4. That irrelevant information was considered in the making of the original decision.

    13.5. That procedures that were required by AOA to be observed in connection with the making of the decision were not observed and this could have had a material impact on the decision.

    13.6. That the original decision was made in accordance with a rule or policy without regard to the merits of the particular case.

    13.7. That the original decision was made for an improper purpose.

14. All applications for reconsideration are to be made in writing and accompanied by all relevant information or grounds upon which the Trainee seeks to rely in respect of the reconsideration.

15. The Trainee will bear the onus of proof to establish the grounds of the reconsideration upon application. If AOA determines in its absolute discretion that grounds have not been established, or that information provided in order to establish grounds is not relevant to the decision or policy, the reconsideration will not proceed.

16. AOA may offer the Trainee the option of proceeding directly to review, omitting reconsideration where deemed appropriate. In these cicumstances, clauses 17-21 will not apply.

17. The original decision makers will form a Reconsideration Panel and will reconvene to reconsider the original decision and material associated with that decision. The Reconsideration Panel will also consider information the Trainee provides to establish grounds for reconsideration.

18. The reconsideration will be conducted with as little formality as possible, but otherwise the Reconsideration Panel shall have full power to regulate its conduct and operation.

19. The reconsideration of the decision by the Reconsideration Panel must be undertaken in accordance with the rules of natural justice and each reconsideration will be reviewed on its merits.

20. Minutes of the meeting shall only record the decision, the reasons for the decision, and any recommendations made.

21. The outcome of the reconsideration and the reasons for the outcome will be provided to the Trainee in writing.

Review of a Training Decision

22. A review of a Summative Decision may be made as the Federal Training Committee (or delegate) may determine from time to time.

23. A review of a decision may be made on the same grounds as a reconsideration (outlined in Section 13) once a reconsideration process has been undertaken, the outcome communicated to the Trainee and if the Trainee is not satisfied with the outcome or in accordance with section 16.

24. A Trainee adversely affected by a Summative Decision and having had the decision reconsidered by the original decision makers by the process outlined in this policy may, within 14 days of receipt of notice of such a decision, apply to the AOA to have the decision reviewed by an AOA internal independent review panel (Review Panel).

25. The Trainee will bear the onus of proof to establish the grounds of the review upon application. If AOA determines in its absolute discretion that grounds have not been established, or that information provided in order to establish grounds is not relevant to the decision or policy, the review will not proceed.

26. All applications for review are to be made in writing and be accompanied by all relevant information or grounds upon which the Trainee seeks to rely in respect of the review.

27. The Trainee must pay a fee, which shall be the current fee as published by the Board at that time.

28. A Review Panel will be established. The AOA will provide administrative and procedural assistance. The Review Panel will be made up of at least three (3) Fellows of AOA with no previous involvement in the decision.

29. The Review Panel will convene to review the original decision and material associated with that decision and will also consider information the Trainee provides to establish grounds for review.

30. The review will be conducted with as little formality as possible, but otherwise the Review Panel shall have full power to regulate its conduct and operation.

31. The review of the decision by the Review Panel must be undertaken in accordance with the rules of natural justice and each review will be considered on its merits.

32. The Review Panel may uphold or overturn the decision. Where the decision is overturned, the Review Panel may not make a determination as to the competence of the Trainee. The Panel may only:

    32.1. Require a new decision to be made via a defined alternative process, or

    32.2. Refer the matter back to the original decision maker with directions, terms or conditions regarding the process for the making of a new decision

33. Minutes of the meeting shall only record the Review Panel's decision, the reasons for the decision, and any recommendations made.

34. The outcome of the review and the reasons for the outcome will be provided to the Trainee and the original decision maker in writing.

Appeal of a Training Decision

35. An appeal of a Summative Decision may be made as the Federal Training Committee (or delegate) may determine from time to time.

36. An appeal of a decision may be made on the same grounds as reconsideration (outlined in Section 13) once a review process has been undertaken, the outcome communicated to the Trainee and if the Trainee is not satisfied with the outcome.

37. A Trainee adversely affected by a Summative Decision and having had the decision reviewed by the process outlined in this policy may, within 14 days of receipt of notice of such a decision, apply to the AOA to have the decision appealed.

38. Applications for appeal of a Summative Decision where a review has not been undertaken according to this policy will not be accepted. Reconsideration and/or Review shall not, and does not, constitute an appeal under this policy.

39. Appeal of dismissal decisions will be referred to the RACS Appeal Mechanism.

40. Appeal of all other Summative Decisions will be referred to an AOA Appeal Committee in accordance with this policy.

41. The Trainee will bear the onus of proof to establish the grounds of the appeal upon application. If AOA determines in its absolute discretion that grounds have not been established, or that information provided in order to establish grounds is not relevant to the decision or policy, the appeal will not proceed.

42. All applications for appeal are to be made in writing and be accompanied by all relevant information or grounds upon which the Trainee seeks to rely in respect of the appeal.

43. The Trainee must pay a fee, which shall be the current fee as published by the Board at that time.

Appeal Committee

44. Unless the matter is being referred to the RACS Appeal Mechanism, an Appeal Committee will be convened by the AOA Dean of Education (or delegate) and shall be comprised of:
    - One Fellow of AOA;
    - One member of AOA, who may be any category of member;
    - Up to two appropriately qualified or interested persons who are not required to be Fellows of AOA, one of whom shall be an appropriately qualified legal practitioner.

45. A member of the Appeal Committee, who is not a Member of AOA, shall be appointed Chair of the Appeal Committee.

46. The Appeal Committee will not comprise any person who was a party to the decision of AOA to which the appeal relates.

47. A quorum of the Appeal Committee will be the Chair and two other members.

48. Each member of the Appeal Committee shall be entitled to one vote. In the event of an equality of votes, the Chair may exercise a casting vote, whether or not the Chair has previously voted.

Appeal Hearing

49. AOA will convene the Appeal Committee within 3 months of an appeal having been lodged, and shall hear the appeal as soon as practicable.

50. The Appeal Committee will not, except in exceptional circumstances and with AOA Board approval, consider a matter de novo.

51. A Trainee shall have the right to appear and address the Appeal Committee in relation to his or her written submissions. The Trainee shall be entitled to have a support person attend the hearing with him or her. That support person may be the Trainee's legal representative. The support person may, with leave of the Appeal Committee, act as an advocate.

52. At least 28 days before convening the Appeal Committee hearing, the AOA will advise the parties in writing of:
    - The time, date and place of the hearing;
    - The right of the parties to appear before the Appeal Committee; and
    - The right of the parties to seek leave of the Appeal Committee to have legal representation at the hearing.

53. The parties will be asked to provide written submissions to the Appeal Committee not less than 14 days before the date of the hearing. The Appeal Committee may, in its discretion,

receive written and/or oral submissions at any time during the course of a hearing.

54. The Appeal Committee is not bound by the rules of evidence and it may inform itself of any matter and in such manner as it thinks fit.

55. The Appeal Committee shall conduct its affairs with as little formality as possible, but otherwise shall have full power to regulate its conduct and operation.

56. The Appeal Committee must act in accordance with the rules of natural justice and decide each appeal on its merits.

57. The proceedings of the Appeal Committee will be recorded and the proceedings transcribed.

58. The transcript of proceedings shall be kept confidential (except as required by law).

Hearing Procedures

59. The Appeal Committee will meet prior to each hearing to consider the matter before it.

60. The hearing is to be conducted with all parties present, however, the Appeal Committee may, in its absolute discretion, hear the parties separately.

61. All questions must be directed to the Chair.

62. The Chair may invite the Trainee, then any other party appearing before the Appeal Committee, to summarise his or her position.

63. The Chair will then invite the Trainee to present his or her submission and may direct the Trainee, at any time, to any point of that submission or invite questions on any point of that submission.

64. The Chair will then invite members of the Appeal Committee to seek clarification from the Trainee of any matters raised.

65. The Chair will then invite any person attending to provide information to the Appeal Committee.

66. The Trainee will then be asked to respond or make submissions in relation to the material presented by the other parties or participants.

67. The Trainee and other parties will then be asked to withdraw from the meeting while the Appeal Committee discusses the matter. The Trainee and other parties will be asked to remain available to clarify any further matters if required.

68. If further clarification is sought, all of the parties will reconvene before the Appeal Committee and clarify those further matters. The Trainee will then be asked to make any final submissions.

69. If the Appeal Committee decides, in its absolute discretion, that the Trainee ought to be given an opportunity to provide further written submissions, leave will be granted in relation to same.

70. Minutes of the hearing shall only record the Appeal Committee's decision, the reasons for the decision, and any recommendations made.

71. All information made available to the Appeal Committee is to be made available to the Trainee.

Decision of the Appeal Committee

72. The Appeal Committee may uphold or overturn the decision, Where the decision is overturned, the Appeal Committee may not make a determination as to the competence of the Trainee. The Panel may only:

    72.1. Require a new decision to be made via a defined alternative process, or

    72.2. Refer the matter back to the original decision maker with directions, terms or conditions regarding the process for the making of a new decision.

73. The Appeal Committee may make a recommendation to the Board as to whether any or all of the fee paid by the Trainee should be reimbursed by AOA;

74. The Appeal Committee will reach a determination within 3 weeks of the hearing, or receipt of final written submissions, whichever is the latter. A copy of the Appeal Committee's written decision with reasons is to be provided to all parties by the AOA no later than 7 days after the decision has been made.

75. The decision of the Appeal Committee will be final.

Non-Assessment Period

76. Where a Trainee has submitted a request for reconsideration, review or appeal and:
    - Is still allocated to the training site where the contested assessment was completed, and
    - Either the Trainee or their Director of Training considers the process may be having an impact on the ability for training to continue productively,

    the Trainee or their Director of Training may apply to the Chair, Education and Training for the Trainee to complete a non-assessment period until such time as the matter is resolved.

77. Where a Trainee has submitted a request for reconsideration, review or appeal and safety concerns are reported to AOA, the Trainee may be required to undertake a non-assessment period until such time as the matter is resolved.

78. During a non-assessment period, the Trainee may continue to work (at the discretion of the training site) but will not be considered to be in active training. No assessments will be conducted, and training time will not be recognised/accredited.

79. AOA will formally notify the training site where a non-assessment period is triggered and when completed.