Royal Australasian
College of Surgeons

FATES 1 – Rural Accreditation Executive Summary & Recommendations

Addressing barriers to rural specialist training

2025

PART 1: EXECUTIVE SUMMARY AND RECOMMENDATIONS

EXECUTIVE SUMMARY

More than 7.5 million people—28% of Australians—live in remote, rural and regional (RRR) areas. People living in RRR areas experience worse health outcomes and have poorer access to healthcare including specialist care than people living in metropolitan areas [9] [10] The medical specialist workforce is maldistributed and becoming more.[11] Health inequity is compounded for Aboriginal and Torres Strait Islander people in RRR areas.[12] Aboriginal and Torres Strait Islander doctors are under-represented in medical specialties.[13]

An ideal health system would provide equitable access to a medical specialist workforce, with appropriate geographic distribution and a balance of generalists and subspecialists in each medical specialty.

Rural training experience is different to urban experience. Competence is contextual. Urban experiences are insufficient to develop a well-rounded surgeon or a workforce that meets RRR community need. Rural training experience enables the development of rural contextual competence, generalist skills and connection to place. Longer periods of rural experience and community immersion and cumulative periods of experience are strongly associated with future rural practice. Prevocational and vocational experience are emerging as the strongest individual factors: specialists with experience at these training stages are 11 times more likely to become rural practitioners.

Increasing rural experience for surgical Trainees will contribute to growing the rural surgical workforce and delivering a geographically distributed surgical workforce with an appropriate balance of generalists and subspecialists. Accreditation of more RRR training sites/posts is a key element of the Royal Australasian College of Surgeons (RACS) *Rural Health Equity Strategic Action Plan*[14] the Royal Australasian College of Medical Administrators (RACMA) *Securing Australia's Medical Workforce* policy[15] and *Rural-Ready Medical Workforce*[16] policy and the *National Medical Workforce Strategy* (NMWS).[11]

The FATES 1 Rural Accreditation – Addressing Barriers to Rural Specialist Training project was funded by the Australian Department of Health, Disability and Ageing (the Department) as part of the Flexible Approach to Training in Expanded Settings (FATES) program.[17] The Department is a passive funder and does not conduct or direct the input, execution of research activities, analysis, final report or recommendations. The project was conducted by RACS in partnership with RACMA.

The purpose of the project was to:

- identify barriers to rural hospitals in both applying for and meeting surgical hospital training post accreditation standards
- design an administrative model that supports rural hospitals to apply for accreditation, develop resources to assists rural hospitals to assess their performance against hospital training-post accreditation standards within a rural context, and document compliance
- establish a foundation for the design of a system that distributes training posts based on community need through health and workforce data-sharing partnerships with jurisdictions.

The FATES 1 project commenced in 2022. The regulatory environment for training-post accreditation dynamically changed over the course of the project. A collaborative and adaptive approach to the project enabled early findings and recommendations to be communicated to stakeholders and considered and/or incorporated into the National Health Practitioner Ombudsman's (NHPO) *Accreditation Processes for Progress Review – a roadmap for greater transparency and accountability in specialist medical training site accreditation*[18] the Australian Medical Council's (AMC) *Model Standards for specialist medical college accreditation of training settings* (model standards)[3]

and *Model Procedures for specialist medical college accreditation of training settings* (model procedures)[19] and the RACS Hospital Training-Post (HTP) Accreditation project.

All stakeholders in specialist medical training are focused on training outcomes and patient safety. The new AMC model standards and model procedures reinforce existing AMC standards for specialist medical programs. Colleges must provide Trainees with diverse experiences, including in rural and Indigenous healthcare settings, and are encouraged to take a flexible rather than restrictive approach to accreditation of training sites to enable the full capacity of the health system to be utilised for training. The new standards present an opportunity to streamline training-post accreditation, internally and in collaboration with all medical specialist colleges and hospitals, by developing efficient processes, systems and digital tools to reduce the burden on all stakeholders of the accreditation process. The FATES 3 National Accreditation Portal IT Requirements project [20], led by RACMA and the Council of Presidents of Medical Colleges (CPMC), will deliver these outcomes by assessing the feasibility and defining the requirements for a potential shared accreditation IT platform for specialist medical colleges.[1]

Rural training experience is often associated with relocation for Trainees and their families. The model standards do not include support for relocation, accommodation or preservation/portability of workplace entitlements. To realise the benefits of rural training experience while reducing the burden of relocation for Trainees, stakeholders need to come together to find novel solutions in the context of wider rural healthcare professional education, training and recruitment strategies.

Key reports arising from the FATES 1 project include:

Deliverable 1: Barriers and solutions for rural training site accreditation

Deliverable 2: An administrative model to facilitate rural training site accreditation

Deliverable 3.1: Strengths and opportunities of rural training

Deliverable 3.2: RACS HTP Accreditation project – Part A and Part B accreditation application forms/supporting evidence resource to assist hospitals in applying for accreditation

Deliverable 3.3: Developing specialty specific accreditation criteria inclusive of rural training sites

Deliverable 4: Matching training sites to community need for surgical care

Note: RACS has a distributed or devolved model of selection, training, accreditation and Fellowship services, in partnership with speciality societies and associations. As this shows, within RACS, multiple bodies are involved in the accreditation process. In this report, the term RACS is used to refer to one or many areas of the College.

RECOMMENDATIONS

The following recommendations are for hospital training-post accreditation standards and processes that:

- are firm on standards, flexible on criteria and focused on outcomes for Trainees and patients
- provide Trainees with experience of diverse training settings and models of healthcare and the skills to care for RRR people in rural practice or rural focused urban specialist (RUFUS) practice

[1] This project was initially titled ‘Create a Synergistic Approach to Specialist Medical College Training Site Accreditation’. Updates to the title and scope of the project were provided by RACMA representatives for inclusion in this report (email, December 09/12/2025). All references to the FATES 3 National Accreditation Portal IT Requirements project within this report reflect the updated title and scope.

- provide a specialist workforce with appropriate geographic distribution and balance of generalist and subspecialist skills
- contribute to equitable access to specialist care and health outcomes for rural people.

Several of these recommendations have already been implemented by RACS via specialty training boards/committees (STB/Cs). The following recommendations have been divided into four overarching themes: workforce planning, Surgical Education and Training (SET) administration, the accreditation process and support for rural surgical training.

THEME 1: COLLABORATIVE WORKFORCE PLANNING

RACS continues to work with the Department and other stakeholders on shared data and workforce strategies.

THEME 2: A NEW PARADIGM FOR THE SURGICAL EDUCATION AND TRAINING PROGRAM

Accountable STB/Cs – delivering on the dual purpose of the SET program

STB/Cs develop specialty specific rural health equity and workforce strategies, including timed targets for rural selection, RRR and RUFUS training posts and surgical workforce distribution.

STB/Cs assign accountability for rural health equity and workforce strategies (e.g. to the STB/C chair or by creating a specialty director of rural training).

STB/Cs develop rural training coordinator roles to coordinate rural recruitment and training pathways and collaborate with internal and external stakeholders to implement rural workforce strategies.

STB/Cs monitor, evaluate and report progress towards objectives on accessible websites.

STB/Cs ensure diversity of decision-makers in policy, standards and implementation of the SET program. STB/Cs ensure diversity in selection and training of Trainees, accreditation of training posts, assessment and leadership. This should include rural and generalist surgeons and set targets for representation (e.g. population parity 28%).

STB/Cs proactively identify, partner and develop rural training sites for accreditation, linking workforce strategy, workforce mapping, community need and accreditation.

RACS, via STB/Cs, engage with and integrate rural surgical training initiatives into the Rural Health Multidisciplinary Training (RHMT) program, including university departments of rural health, regional training hubs and the Federation of Rural Australian Medical Educators (FRAME).

Diversity not uniformity – firm on standards; flexible criteria; focused on outcomes for Trainees and patients

STB/Cs consider the following FATES 1 reports before finalising specialty specific accreditation criteria as part of the RACS HTP Accreditation project: 3.1 Strengths and opportunities of rural training report, 3.2 RACS HTP Accreditation project, 3.3 Developing specialty specific accreditation criteria inclusive of rural training sites.

STB/Cs preserve the flexibility embedded in the AMC standards and procedures for accreditation, and design flexible accreditation criteria focused on outcomes rather than prescribing specific case-mix or caseload, allowing for multidisciplinary and interdisciplinary collaboration and shared/virtual access within training networks or via urban–rural partnerships to resources (including formal teaching and learning resources, simulations, clinical resources including pathology, radiology and multidisciplinary meetings, quality assurance and improvement activities including audit morbidity and mortality meetings, and research).

STB/Cs develop place-based training programs and accreditation policies to enable Trainees to access a diverse range of training experiences, including rural, generalist, Indigenous and RUFUS models of care.

STB/Cs combine place-based training with place-based curricula and learning resources. STB/Cs provide rural readiness, rural professional skills, generalist and RUFUS curricula and resources.

STB/Cs adopt the RACS Rural professional skills curriculum and recommend Trainees complete the RACS Rural professional skills eLearning course.

STB/Cs appraise training pathways and the diversity of accredited training sites/posts to ensure diversity of training experiences including rural and urban, generalist and subspecialist, outreach, virtual and collaborative healthcare, and Aboriginal and Torres Strait Islander communities and healthcare settings (e.g. Aboriginal Community Controlled Health Organisations [ACCHOs]/Antimicrobial Stewardship Academy [AMS]).

STB/Cs incorporate RUFUS skills into curricula and RUFUS experience into training program requirements, including outreach, virtual healthcare and collaboration in dispersed teams/virtual teams.

STB/Cs consider creating specialty specific criteria for urban and/or subspecialist training posts to provide outreach and virtual and collaborative healthcare experience for Trainees.

STB/Cs advocate for RRR outreach services to be incorporated into public hospital networks and for urban and larger regional hospitals to be accountable for developing outreach services to smaller RRR hospitals and communities.

Supervision – measuring what matters

The following recommendations also appear in the RACS FATES 2 Rural Training Models Final report:

STB/Cs develop metrics for supervision quality focused on Trainee and patient outcomes and relevant to flexible models of supervision. If qualitative measures of supervision are desired, the number of operating and outpatient sessions that are directly or indirectly supervised and/or the total full-time equivalent (FTE) of surgeons employed or surgeon to Trainee ratios should be considered.

STB/Cs enable flexible, novel, collaborative, place-based and digitally enabled models of supervision, including onsite, remote and hybrid models, interdisciplinary supervision and inclusion of specialist international medical graduates (SIMG)/vocationally registered (VR) surgeons as clinical supervisors.

STB/Cs collaborate with hospitals and surgeons in RRR areas of need to find innovative ways to increase capacity for supervision of Trainees.

STB/Cs develop policies, targets and reporting frameworks to ensure Trainees at all training stages can access rural training experience and that the supervisory load is equitably shared between rural and urban training sites.

Colleges implement the SSTS led by RANZCO with consortium partners RANZCR, RANZCOG, CICM, RACMA and RACS to support selection, training, reflective practice and continuing professional development (CPD) for supervisors.

Colleges develop shared resources for rural supervisors and/or provide access to resources from other colleges, for example, RACP Culturally Safe Supervision resources[21] and RANZCOG and RACMA Leadership Development for Rural and Remote Specialists.[22]

Making it count – effective and efficient delivery of courses and assessment

STB/Cs develop policies to facilitate equitable access to formal learning programs and examination preparation resources for rural Trainees via national or regional coordination and/or urban–rural partnerships to ensure all rural training sites are integrated into formal learning programs; provide virtual access to events; and provide courses in rural and regional locations.

STB/Cs critically appraise all compulsory courses, meetings/conferences and examinations, assessing the learning value, method of delivery and suitability for virtual synchronous or asynchronous delivery and the and cost to Trainees (including RRR Trainees) of travelling, accommodation and lost time from the workplace and the locum costs for training sites.

STB/Cs limit the number of compulsory in-person events for Trainees to 1–2 per annum, by reducing the number of events or clustering events together.

STB/Cs consider frameworks to nurture peer-to-peer networking for rural Trainees—including virtual and in-person events designed to connect rural Trainees with other rural Trainees and with urban peers—and to support attendance at in-person events via grants.

THEME 3: STREAMLINING THE ACCREDITATION PROCESS

RACS HTP Accreditation project:

RACS, via STB/Cs, standardise terminology and definitions used in the HTP accreditation Part A and Part B application forms, using the AMC model standards terms and definitions and Ahpra definitions for levels of supervision.

RACS, via STB/Cs, develop resources for applicants (including a guide to examples of evidence that can be used to demonstrate a criterion is being met) and a liaison team within the College to support rural training sites. (e.g. FATES 1 Deliverable 2 – an administrative model has been developed by the RACS HTP Accreditation project team, and FATES 1 Deliverable 3.2, RACS HTP Accreditation project).

RACS continues collaboration with RACMA and CPMC for the FATES 3 – A Synergistic Approach to Specialist Medical College Training Site Accreditation project to further streamline the accreditation process, including the development of an efficient online portal.

RACMA considers how the RACMA FATES 3 project might be developed into an accreditation system for all health professional education and training.

STB/Cs set reasonable criteria reflecting real-world surgical practice in RRR areas.

STB/Cs include rural surgeons in developing accreditation criteria and assessing applicants/sites.

STB/Cs adopt a collaborative, flexible problem-solving approach to rural training site accreditation, working with training sites to develop place-based ways to meet criteria and/or sharing of resources with training networks and/or partnerships with larger sites.

STB/Cs partner with rural training sites to advocate for capital investment/resources.

STB/Cs introduce consistent guidelines, in alignment with guidance provided by RACS, on maximum weekly work hours and on-call frequency for Trainees while also enabling Trainees to share on-call load with those from other surgical specialties within the same facility (e.g. Plastic and Reconstructive Surgery [PRS], Otolaryngology Head & Neck Surgery [OHNS], General Surgery and Urology share on-call in rural).

THEME 4: REALISING THE BENEFITS OF RURAL TRAINING WHILE REDUCING THE BURDEN OF RELOCATION ON TRAINEES AND THEIR FAMILIES

The following recommendations are also included in the FATES 2-Rural Training Models report:

RACS, via STB/Cs, develop improved urban hub–rural spoke models and rural training networks that foster connection to place while reducing the burden of frequent relocation during training, including place-based selection, advanced notice of rural placements (at least 12 months), longer duration of each placement (at least 12 months, aligned with school year) and/or multiple placements to the same hospital/region to enable families to move with Trainees and integrate into the community.

RACS, via STB/Cs, engage stakeholders to facilitate relocation support for Trainees and their families and ensure assistance occurs in a systematic way for all Trainees relocating for rural training.

RACS, via STB/Cs, engage stakeholders to develop systematic place-based solutions to assist Trainees to secure suitable accommodation in RRR areas.

RACS, via STB/Cs, develop a collaborative strategy, with the Australian Medical Association (AMA) Doctors in Training Committee and the Australian Salaried Medical Officers Federation (ASMOF), to advocate for jurisdictions to implement mechanisms for portability and/or preservation of leave entitlements (parental, carers, personal, long service, sabbatical) for Trainees who move between states, territories or countries during training.

Colleges develop and deliver virtual orientation to rural practice and preparation for rural training programs for all Trainees undertaking a rural placement.

Colleges provide a summary of FATES 2 research findings to all rural training sites, and supervisors to assist them in designing and delivering site-specific orientation programs for specialist Trainees. The RACS Rural Context Profile provides a comprehensive list of community, hospital and unit information for Trainees, which can be shared with colleges.

The following recommendations also appear in the FATES 2 Rural Training Models Project Final Report:

Colleges implement the SSTS to support selection, training, reflective practice and CPD for supervisors.

Colleges develop shared resources for rural supervisors (e.g. RANZCOG and RACMA leadership modules).

Colleges encourage supervisors to access the RACP Culturally Safe Supervision resources.[21]

Colleges foster culturally safe training environments for Aboriginal and Torres Strait Islander Trainees and/or Māori and provide resources for all Trainees to develop cultural competence and cultural safety skills.

Colleges to develop training for Supervisors to provide culturally safe supervision and ensure contextually relevant cultural information and engagement is provided in orientation programs for rural and outreach training sites.

Colleges develop frameworks to nurture peer-to-peer networking for rural Trainees—including virtual and in-person events designed to connect rural Trainees with other rural Trainees and with urban peers—and to support attendance through grants and agreements with training sites.

Colleges consider developing shared mentoring resources and a microlearning activity.

Colleges develop rural-specific formal mentoring programs to support rural workforce strategies, with flexibility, minimum requirements for participation, mentor–mentee matching algorithms and programmatic evaluation.

Colleges develop rural training coordinator and director of rural training roles to coordinate rural recruitment and training pathways and collaborate with internal and external stakeholders to implement rural workforce strategies.