

FATES 1 – Rural Accreditation Final Report

Addressing barriers to rural specialist training

2025

Royal Australasian College of Surgeons (RACS)

Final Report

Title	Rural accreditation – addressing barriers to rural specialist training Final Report
Affiliation	RACS
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ABBREVIATIONS

Shortened forms

ABiGS	Australian Board in General Surgery
ACCHOs	Aboriginal Community Controlled Health Organisations
ACD	Australasian College of Dermatologists
ACEM	Australasian College for Emergency Medicine
ACRRM	Australian College of Rural and Remote Medicine
ACSEP	Australasian College of Sport and Exercise Physicians
Ahpra	Australian Health Practitioner Regulation Agency
AIDA	Australian Indigenous Doctors' Association
AMC	Australian Medical Council
AMA	Australian Medical Association
AMS	Antimicrobial Stewardship Academy
ANZCA	Australian & New Zealand College of Anaesthetists
ANZSVS	Australian and New Zealand Society for Vascular Surgery
AOA	Australian Orthopaedic Association
AoNZ	Aotearoa New Zealand
ASMOF	Australian Salaried Medical Officers Federation
ASOHS	Australian Society of Otolaryngology, Head and Neck Surgery
ASPS	Australian Society of Plastic Surgeons
BOHNS	Board of Otolaryngology, Head & Neck Surgery
BOU	Board of Urology
BPT	Basic Physician Trainees
CICM	College of Intensive Care Medicine
CPD	Continuing professional development
CPMC	Council of Presidents of Medical Colleges
CSET	Committee of Surgical Education and Training
Department, the	The Australian Department of Health, Disability and Ageing
ED	Emergency Department
EM	Emergency medicine

FACEM	Fellow of the Australasian College for Emergency Medicine
FATES	Flexible Approach to Training in Expanded Settings
FRACS	Fellow of the Royal Australasian College of Surgeons
FRAME	Federation of Rural Australian Medical Educators
FTC	Federal Training Committee
FTE	Full-time equivalent
GACM	General and Acute Care Medicine
GP	General Practitioner
GRiD	Global/Remote/Rural/Regional/Deployable
GSA	General Surgeons Australia
GSET	General Surgery Education and Training
HDU	High Dependency Unit
HTP	Hospital Training Post
ICU	Intensive Care Unit
IRTP	Integrated Rural Training Program
KPI	Key performance indicator
MBA	Medical Board of Australia
MM	Modified Monash
NHPO	National Health Practitioner Ombudsman
NMWS	National Medical Workforce Strategy
NSA	Neurosurgical Society of Australasia
NSQHS	National Safety and Quality Health Service
NZAGS	New Zealand Association of General Surgeons
NZOA	New Zealand Orthopaedic Association
NZAPS	New Zealand Association of Plastic Surgeons
NZSOHNS	New Zealand Society of Otolaryngology, Head and Neck Surgery
OHNS	Otolaryngology Head & Neck Surgery
PBE	Place-based education
PRH	Palmerston Regional Hospital
PRS	Plastic and Reconstructive Surgery

RACGP	Royal Australian College of General Practitioners
RACMA	Royal Australasian College of Medical Administrators
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainees' Association
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RANZCR	Royal Australian and New Zealand College of Radiologists
RDH	Royal Darwin Hospital
RESP	Rural Education and Support Program
RHMT	Rural Health Multidisciplinary Training Program
RRIPM	Rural and Remote Institute of Palliative Medicine
RRR	Remote, rural and regional
RRTP	Regional and Rural Training Pathway
RUFUS	Rural Focused Urban Specialist
SEM	Sport and exercise medicine
SET	Surgical Education and Training
SIMG	Specialist international medical graduate
SSTS	Standardised Supervisor Training System
STB/C	Specialty training board/committee
STP	Specialist training program
TKWK	Te Kāhui Whakamōhou Kiri
USANZ	Urological Society of Australia and New Zealand
VR	Vocationally registered
WACHS	WA Country Health Service

Terms

AMA Doctors in Training Committee

AMA Medical Training Survey

AMC model procedures

AMC model standards

Australian Commission on Quality and Safety in Healthcare, NSQHS Standards

FATES 1 Rural Accreditation – Addressing Barriers to Rural Specialist Training project

FATES 1 Rural Accreditation – Addressing Barriers to Rural Specialist Training: Final report

FATES 2 Rural Training Models Final Report

FATES 3 National Accreditation Portal IT Requirements project

FATES 4 RACP Workforce Mapping and Accreditation Renewal Project

Health Workforce Data Intelligence Unit (Department of Health, Disability and Ageing)

HTP accreditation Part A application form

HTP accreditation Part B application form

HTP Accreditation project

Miller Blue Group Model Standards Implementation project

NHPO Processes for Progress Review – a roadmap for greater transparency and accountability in specialist medical training site accreditation

RACMA Rural-Ready Medical Workforce Policy

RACMA Securing Australia's Medical Workforce Policy

RACS Hospital Training-Post Accreditation project

RACS Rural Accreditation workshop (6 August 2022)

RACS Rural Context Profile

RACS Rural Health Equity Strategic Action Plan

RACS Rural Professional Skills curriculum

DEFINITIONS

Geographic classification

This paper uses the Modified Monash (MM) Model¹ to classify whether a location in Australia is urban, rural, remote, or very remote. MM1 to MM7 locations are classified according to remoteness and population size.

- MM1 Metropolitan/urban
- MM2 Regional centres
- MM3 Large rural towns
- MM4 Medium rural towns
- MM5 Small rural towns
- MM6 Remote communities
- MM7 Very remote communities

For binational training committees, the Geographic Classification for Health² is recommended in Aotearoa New Zealand (AoNZ).

Remote, rural and regional (RRR) and Rural

The term *rural* and the acronym *RRR* are used in this document to collectively refer to remote, rural and regional areas, unless otherwise specified. Note that while some colleges and training committees use the term 'regional' to describe state or territory training areas, in this paper the term regional specifically refers to MM2 Regional centres.

Remote has 2 meanings

As the term 'remote' can apply to both MM6-7 communities as well as to digitally enabled communication, when the latter definition is intended, the term will be remote/virtual. For example, remote/virtual mentoring and remote communities.

Australian Medical Council (AMC) Model Standards for medical specialist college accreditation of training sites standards³ (model standards) hierarchy

An explanation of the AMC model standards hierarchy is presented below:

Table 1. AMC model standards hierarchy explanation³

Domain	Type of matters addressed by the standards.
Standard	The outcome that must be achieved at the training setting.
Criterion	The measurable component of a standard.
College-specific requirements (optional)	Requirements that are specific to each college and training program that supplement a criterion (e.g. specific equipment needs).

Australian Health Practitioner Regulation Agency (Ahpra) levels of supervision

The definitions contained in the Ahpra supervised practice framework⁴ are adopted in this document for levels of supervision.

- Direct supervision: supervisor physically present at all times to observe the supervisee
- Indirect
 - a. Indirect 1 (present): supervisor physically present at the workplace
 - b. Indirect 2 (accessible): supervisor accessible by phone or other means and available to physically attend the workplace
- Remote supervisor is not present at the workplace

Models of supervision

Flexible and sustainable models of supervision include any model that does not fit the current most common model, including

- direct and indirect supervision only.
- supervisor to Trainee ratios as the measure of training quantity and quality.
- all supervisors are Fellows from the same specialty/subspecialty as the Trainee.
- supervisory requirements are uniform for all years of the training program, with no change in supervision requirements as Trainees progress.

Flexible and sustainable models of supervision may include:

- remote supervision, either in addition to direct and indirect supervision (hybrid) or in remote-only supervision models. The remote supervisor needs to understand the Trainee's context, and this can be assisted by periodic onsite visits or past experience in the setting.
- alternative measurement of supervision quantity (expressed in number of hours or sessions or activities e.g. consultations and/or procedures, rather than number of supervisors or supervisor to Trainee ratios).
- multidisciplinary/interdisciplinary supervision: supervisors outside the same specialty/subspecialty as the Trainee, for example an Otolaryngology Head & Neck surgeon supervising a general surgical Trainee, a rural generalist supervising an emergency physician Trainee, or in another discipline, for example a nurse practitioner or physiotherapist supervising a Trainee.
- supervision from specialist international medical graduates (and/or vocationally registered internationally trained specialists in AoNZ) who have not achieved Australian/AoNZ Fellowship.
- supervision requirements on a 'sliding scale', with more hours of direct and indirect supervision in earlier years of training and fewer hours in later years of training and/or emphasis on direct supervision early in training, transitioning through more indirect supervision in mid years and remote supervision in later years.
- supervision defined for outreach training experiences.

Place-based selection and training

Fuller et al. 2025 defines place-based approaches to health professional education: 'Growing your own' emphasizes the recruitment of students already embedded in rural communities and providing them with access to training opportunities, ideally in the local area. 'Place-based' approaches recognize that education is inexorably grounded in the place and context in which it occurs. Place-based education (PBE) seeks to strengthen students' connections with their location and community through the context, content, and pedagogy of curriculum delivery.⁵

The following definitions and supervisor role taxonomy were agreed within the Flexible Approach to Training in Expanded Settings (FATES) 3 Standardised Supervisor Training System (SSTS) project, led by the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) with consortium partners the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), RACS, the College of Intensive Care Medicine (CICM), RACMA and the Royal Australian and New Zealand College of Radiologists (RANZCR).⁶

Networks definition 1 (RANZCO SSTS)

Network

'An interconnected group or system...a cooperative structure where interconnected groups or individuals coalesce around a shared purpose on the basis of trust and reciprocity.'⁶

Training network

'A structured system facilitating medical Trainees' training and professional development. It involves a collaborative group of accredited training sites, including hospitals and other healthcare facilities, where Trainees gain practical experience and learn from experienced professionals. These networks are designed to provide a comprehensive and diverse training experience, ensuring Trainees are exposed to various medical specialties and healthcare settings. They also often include support systems such as mentoring programs, resources, and guidelines to assist Trainees throughout their training journey.'¹⁶

Networks and Integrated Training Program definitions 2 (Royal Australasian College of Physicians [RACP] Training Network Principles)

An Integrated Training Program:

- delivers the competency-based training curriculum
- aligns Trainee development with the curriculum and training requirements
- offers a full range of high-quality training experiences
- offers a fair, positive, and supported training experience
- assesses Trainee autonomy and preparedness for independent practice
- provides continuity in training.

A Training Network is a group of Training Settings delivering one or more Integrated Training Programs in multiple workplaces that:

- provides a training governance framework
- delivers appropriately diverse training experiences
- coordinates the training offered by each Training Setting
- supports the delivery of a Network-wide formal learning program
- provides Trainees with continuity of training
- engages with the Training Settings, supervisors and Trainees.

Rural training networks – FATES 2 Rural Training Models Project

Rural training networks involve a network of RRR facilities providing comprehensive training experience, with training occurring entirely within the network and/or majority within the network with rotations to urban hospitals, and a formal learning program. Place-based models of training enable equivalent training outcomes compared to urban training models, while using a more diverse range of training sites. Rural training networks provide comprehensive training supplemented by the use of technology to access resources and professional networks remotely, and by links between urban and rural centres, to enable urban Trainees to access rural experience and rural Trainees to access subspecialty experience.

Orientation

The AMC model standards Standard 2.2.4 states: 'Trainees are provided with effective orientation for each training setting/rotation.'³ The notes to the standard include '...orientation covers matters that are unique to each training setting/rotation, or significantly different to previous settings/rotations. The information Trainees need for an effective orientation will differ depending on the size and nature of the setting...'³

RANZCO SSTS definition of orientation:

'Orientation programs are comprehensive initiatives designed to facilitate the smooth transition of clinicians into training environments and requirements.'

The orientation programs provide a detailed overview of training requirements, encapsulated in comprehensive Trainee handbooks, and introduce Trainees to a network of support systems, including mentoring programs and online resources. Orientation should also include clarification of expectations of the program, training site and development of Trainee learning goals. Furthermore, they brief Trainees on essential college and training site policies, procedures, and guidelines and provide information on accessing college and training site facilities, tools, and other resources. They foster community and networking opportunities through orientation events and introductions to Trainee associations and interest groups, equipping new clinicians with the knowledge, skills, and resources needed to integrate effectively into the hospital environment, provide safe care, and navigate their professional journey.⁶

Note: this definition of orientation relates largely to orientation to the training program and to the context of training at each training site. It does not encompass other necessary elements of orientation, including orientation and onboarding to the healthcare facility, employment context and community. Orientation programs need to be comprehensive and include professional as well as sociocultural elements.

Supervision

AMC

The AMC defines a supervisor as ‘An appropriately qualified and trained medical practitioner, senior to the Trainee, appointed, approved or accredited by a college, who guides the Trainee’s education and/or on-the-job training on behalf of the college. The supervisor’s training and education role will be defined by the college, and may encompass educational, support and organisational functions. Colleges may or may not appoint the main supervisory role. Colleges frequently define a number of supervisory roles.’⁷

The *Standards for Assessment and Accreditation of Specialist Medical Programs* 8.1.1 state: ‘The education provider ensures there is an effective system of clinical supervision to support Trainees to achieve the program and graduate outcomes.’⁷

In the notes to the standard, a team-based approach to supervision is described, including ‘medical practitioners senior to the Trainees who have day-to-day involvement with the Trainee’ and ‘other members of the healthcare team may also contribute to supervising, assessing and providing feedback to the Trainee’.⁷

The AMC model standards, Domain 2: Supervision, management and support structures, requires Trainees to have input into how supervision is delivered, and that supervision is effective and timely to meet the dual goals of patient safety and training outcomes.³ Domain 2 appears as follows:

2.1 Clear governance structures support the delivery of effective education and training.

2.1.2 Trainees and the training provider engage constructively about how training is delivered at the training setting and Trainees can provide input and feedback into how their local training is delivered.

2.2 Trainees receive appropriate and effective supervision.

2.2.1 There is effective and timely clinical supervision of Trainees to support them to achieve the training program outcomes and to protect patient safety.³

SSTS

The combined college SSTS project holds that supervisors ‘...have a critical guiding role and provide oversight of Trainees to ensure Trainees meet required training standards and adhere to protocols.’⁶

The definition is expanded upon as follows:

‘Supervisors understand and implement the requirements detailed in the relevant curriculum and handbooks, helping Trainees navigate all aspects of their training, as well as the intricacies of the healthcare organisation. They facilitate the setting of individualised learning goals and learning opportunities to meet those goals. They contribute to the maintenance of a safe and supportive learning and training environment for Trainees. They guide Trainees from novices to competent practitioners, encouraging participation in research and professional development activities. Supervisors provide regular constructive feedback and guidance, which is crucial for Trainees’ clinical, professional, and personal development. Supervisors regularly assess Trainees’ knowledge, skills, behaviour and readiness to progress, coordinating learning experiences and maintaining precise assessment records.’⁶

Taxonomy of medical supervision – SSTS

Table 2. Three suggested groups for medical supervision⁸

Education and Training Director/Coordinator for Region/Site/Network/Program	Provides educational leadership and support to learners and Supervisors in the region, site or program. They liaise with the College, hospital authorities and educational supervisors on educational issues to ensure education and training is delivered in accordance with the College’s accreditation standards, curricula, policies and procedures. The role may be responsible for confirming learners’ readiness to progress to the next stage of training. The Director/Co-ordinator may also co-ordinate and oversee support for learners experiencing difficulty. The role may also involve program administration including organising learners’ training rotations, and in some cases overseeing contractual requirements, reporting and invoicing.
Department/Term/Rotation Supervisor	Plans and co-ordinates learners’ education and educational supervision to meet learners’ learning needs in a department/term/rotation. Provides on-site clinical supervision, teaching and feedback on personal, professional, and educational development and patient care. Conducts work-based assessments which confirm learners have achieved required learning outcomes and provide information for progression decisions.
Clinical/Surgical Instructor	Provides clinical supervision, teaching, work-based assessment, and feedback on personal, professional, and educational development and patient care.

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* policy¹⁵ 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 assist 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 project²⁰, 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 resources²¹ 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.

PART 2: BARRIERS TO RURAL ACCREDITATION – SUMMARY

INTRODUCTION

Where we are starting from

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 subspecialised.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

While 28% of Australians live in RRR areas, the Australian NMWS reported that just 5% of Australian specialists work in RRR areas.¹¹ The specialist to population ratio declines sharply with increasing remoteness, from 143 per 100,000 in cities to 22 per 100,000 in very remote areas. Seven per cent of metropolitan patients reported no access to a specialist, compared with 60% of patients in remote areas. The RACS 2023 Activities Report²³ found that only 14.1% of surgeons live and work in these areas. For 5 surgical specialties, less than 10% of the workforce is based outside metropolitan/urban cities (MM class 1).²³ All of Tasmania and the Northern Territory is classified MM2–7, so 100% of surgeons in those areas practice in MM2–7 locations. South Australia (95.7%) and Western Australia (93.2%) had the most urbanised surgical workforces, apart from the ACT, which has no hospitals beyond the national capital. In Queensland, 20% of surgeons are based outside MM1 locations.²³

The 2022 RACS workforce census²⁴ (24.0% response rate: 20.4% of Australian Fellows, 32.4% of AoNZ Fellows) found the overall percentage of surgeons based in RRR areas was 18% in Australia and 18.2% in AoNZ, well below population parity.

For some surgical specialties, there are no surgeon respondents based outside cities (Table 1).

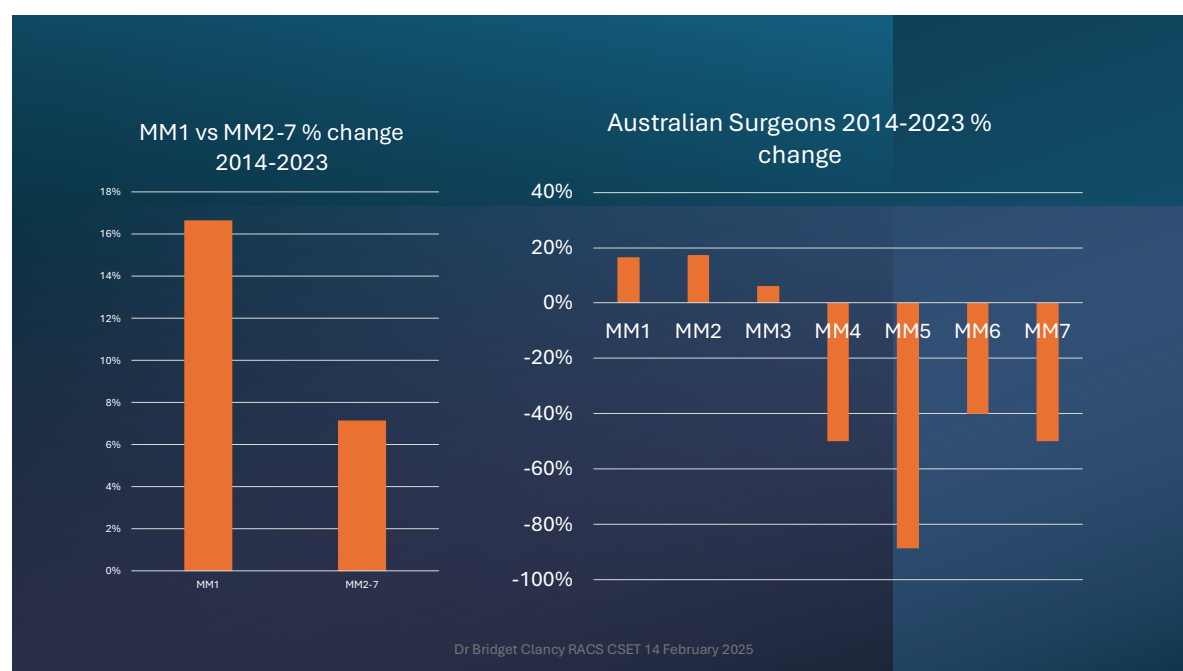
Table 3. Surgical specialties based in major cities

Specialty	Cardiothoracic Surgery	General Surgery	Neurosurgery	Orthopaedic Surgery	OHNS	Paediatric Surgery	PRS	Urology	Vascular Surgery
Australia urban	98%	73%	96%	78%	82%	93%	89%	72%	90%
AoNZ urban	100%	69%	100%	76%	86%	100%	96%	64%	95%

AoNZ = Aotearoa New Zealand; OHNS = Otolaryngology Head & Neck Surgery; PRS = Plastic and Reconstructive Surgery

Maldistribution is getting worse over time. Medical schools' graduate outcomes data for Australia over the last 10 years shows the surgical workforce in cities grew by 2.5 times the rate of that in RRR areas (Figure 1).²⁵ More granular data shows that the growth in the rural workforce occurred almost entirely in regional areas (MM2), with a 40–90% reduction in the surgical workforce in MM4–7 areas (medium rural towns–very remote communities) (Figure 1). This imbalance is only likely to increase.

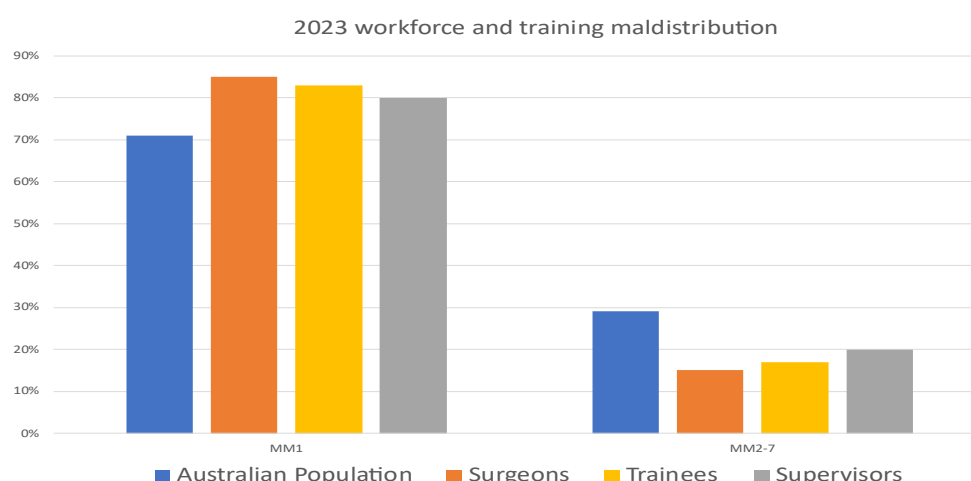
Figure 1. Changes in the surgical workforce, 2014-2023



MM = Modified Monash

While rural training is well established for some specialties, training posts are maldistributed and there are barriers to accreditation of rural training posts. Surgical supervisors and Trainees are also maldistributed. Both the supervisors and Trainees are over-represented in cities and under-represented in rural areas, although rural surgeons contribute more SET supervision per capita compared to urban surgeons (Figure 2).

Figure 2. Maldistribution of the surgical workforce



Dr Bridget Clancy MBBS FRACS GAICD RACS 2023 PSA

MM = Modified Monash¹,

Rural hospitals experience cultural and procedural barriers when applying for training-post accreditation. Unnecessary variability exists between specific surgical specialty accreditation standards and wider healthcare standards and hospital accreditation frameworks, creating

disconnection. Standards, criteria and evidentiary requirements do not align with national and jurisdictional systems for role delineation, facility capability levels (i.e. for surgery, anaesthetics, paediatrics, critical care) or safety and quality standards (e.g. the Australian Commission on Quality and Safety in Healthcare, National Safety and Quality Health Service [NSQHS] Standards).²⁶

The application process lacks transparency and efficiency, with duplication and repetition. Hospitals seeking accreditation for more than one surgical training program need to complete separate applications for up to 9 surgical specialties, in addition to the multiple other primary and postgraduate health professional education accreditation processes hospital must engage in. There is no system to allow hospitals to complete a single application form which includes most of the RACS accreditation standards and criteria in conjunction with separate smaller applications for the individual surgical programs. Accreditation imposes a significant resource burden on rural surgeons and administrative teams who are already working with limited resources and smaller teams.

Stakeholders report that current processes can feel more suited to urban subspecialist contexts, and that rural sites sometimes experience higher evidentiary expectations. Opportunities exist to strengthen partnership-based workforce planning with rural sites.

Stakeholders perceive that STB/Cs exhibit bias towards urban subspecialist training posts, preferencing subspecialist over generalist experience in decision-makers, training pathways and curricula. A perception of double standards exists, with a higher bar for rural training sites, requiring them to meet every standard—including access to a minimum number of ‘major’ cases skewed towards subspecialty scope of practice—while allowing accreditation of ‘special’ training posts in subspecialties that provide a necessary but narrow scope of practice and do not meet all accreditation criteria (e.g. paediatrics, trauma).

Where we need to get to

The AMC Standards⁷ require specialist medical colleges to contribute to developing a workforce that meets community needs and offer a diverse range of experiences including those in rural and Indigenous healthcare settings. The AMC encourages colleges 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.

Rural residents have a variety of health problems, requiring access to the full breadth of specialist and subspecialist care. They receive healthcare close to home, as well as in cities and via telehealth. Most patients can have their conditions and procedures managed safely close to home via dispersed models of care; however, highly complex patients and procedures, and rare conditions must be managed in highly complex, subspecialist and multidisciplinary units at quaternary referral centres in a centralised model of care.

Healthcare delivered by Aboriginal and Torres Strait Islander and/or Māori healthcare workers and/or in Indigenous healthcare settings is associated with increased cultural safety and better health outcomes for Indigenous people. Culturally safe training and practice environments, and access to the cultural determinants of health including Country and community, enhance cultural safety for medical specialist Trainees. Enabling training close to home, Country and community in Indigenous healthcare settings is key to growing the Indigenous specialist medical workforce. Training experiences in Indigenous healthcare settings and caring for Indigenous people, and combined curricula and learning resources, enables non-Indigenous Trainees to develop cultural competence and provide culturally safe care. Culturally safe care improves health outcomes.

An ideal health system would provide equitable access to culturally safe care by a medical specialist workforce with appropriate geographic distribution, a balance of centralised and dispersed place-based models of care, and a balance of generalists and subspecialists in each medical specialty.

Some Trainees intend to enter urban practice, while nearly 40%^{25 27} intend to practice rurally, and some are undecided and open to formative experiences during training.

Rural training experience enables the development of rural contextual competence, generalist skills and the development of 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.

While the range of services provided and the resources available in RRR hospitals differ from urban hospitals, they reflect the healthcare needs of rural communities. Rural experience is an essential component of a complete training program for medical specialists.

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 community need. Rural training posts should be valued for learning experiences unavailable to urban subspecialists, including a generalist and broad scope of practice, multiage patient cohort, rural contextual analysis and rural contextual decision-making, as well as multidisciplinary and collaborative skills in local and geographically dispersed teams.

The FATES 2 Rural Training Models project recommendations include the development of 3 models of rural training: urban hub–rural spoke models, rural training networks and RUFUS models.

Trainees need curricula and training experiences to enable the development of contextual competence in diverse settings and with diverse models of service delivery, including RRR practice, whole-of-patient care for RRR patients travelling to cities for care, outreach, virtual healthcare, and collaborative care in virtual and geographically dispersed healthcare teams. Trainees need rural training experiences aligned with the RACS Rural Professional Skills curriculum²⁸ to develop the skills to care for rural patients and to collaborate with each other through rural or RUFUS practice. Training in a range of settings and healthcare models will ensure they receive comprehensive training and a broader skill set.

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 *RACS Rural Health Equity Strategic Action Plan*¹⁴, the *RACMA Securing Australia's Medical Workforce* policy¹⁵ and Rural-Ready Medical Workforce policy¹⁶ and the National Medical Workforce Strategy (NMWS).¹¹

FATES 1 PROJECT GRANT

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 assist rural hospitals to assess their performance against hospital training-post accreditation standards within a rural context, and document compliance

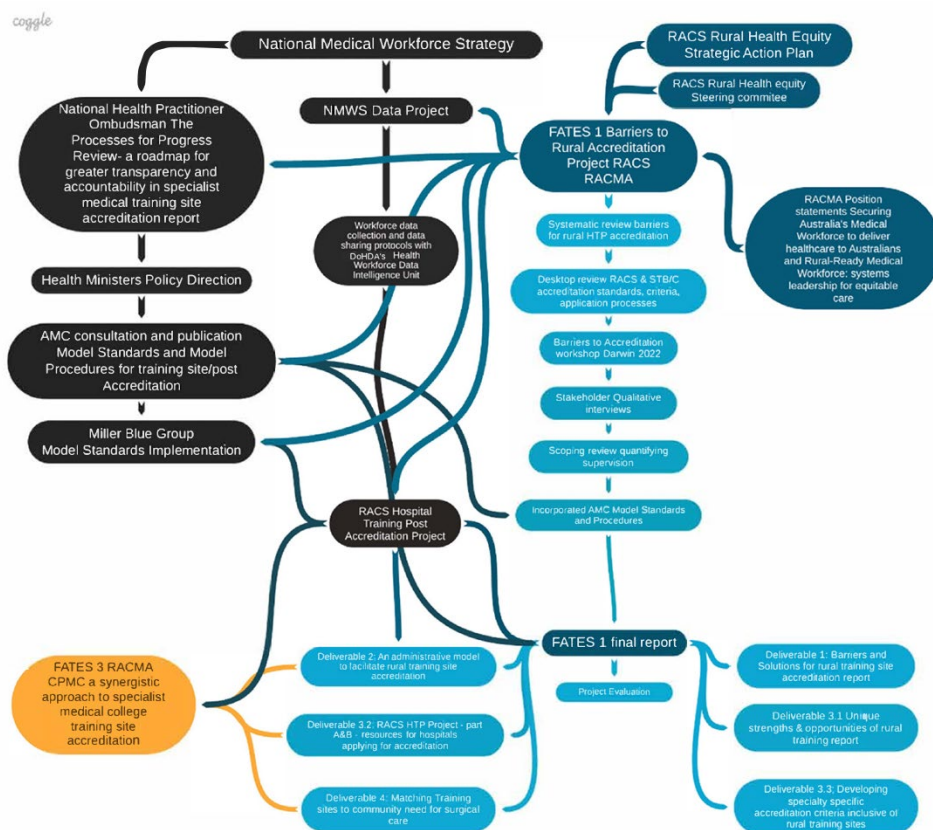
- establish a foundation for the design of a system that distributes training posts based on community need through health and workforce data-sharing partnerships with jurisdictions.

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 NHPO *Processes for Progress Review – a roadmap for greater transparency and accountability in specialist medical training site accreditation* 2023,¹⁸ the Australian Medical Council's (AMC) *Model Standards for specialist medical college accreditation of training settings* ³ (model standards) and *Model Procedures for specialist medical college accreditation of training settings*¹⁹ (model procedures) and the RACS Hospital Training-Post (HTP) Accreditation project.

GRANT ACTIVITIES AND DEPENDENCIES

Figure 3 shows grant activities and deliverables and all interactions between the FATES 1 project and internal/external reviews, consultations, publications and projects.

Figure 3. Representation of interactions and activities for execution of FATES 1



AMC = Australian Medical Council; DoHDA = Department of Health, Disability and Ageing; HTP = Hospital training post; NMWS = National Medical Workforce Strategy; RACMA = Royal Australasian College of Medical Administrators; RACS = Royal Australasian College of Surgeons; STB/C = Specialty training board/committee

The project was informed by the NMWS priority areas and cross cutting themes, the FATES program objectives, the Aphra/AMA Medical Training Survey²⁷ the *RACS Rural Health Equity Strategic Action Plan*¹⁴, and completed and in-progress Specialist Training Program (STP) and FATES projects by RACS, consortium partners and other medical specialist colleges.

A financial acquittal and final evaluation report will be submitted to the Department. The project summary, recommendations and outputs will be submitted to the Department and published on the RACS website at the conclusion of the project in early 2026.

Grant activities included a systematic review addressing the questions: What are the unique opportunities rural training posts can provide? How can barriers impeding Australian rural surgical training-post accreditation be overcome? A review of RACS accreditation standards and the 9 specialty specific accreditation criteria and application processes was conducted with a rural lens, in addition to a workshop in Darwin and qualitative interviews with subject matter experts, a scoping review examining the relationship of quantitative measures of supervision to training outcomes and patient safety, and extensive consultation with the NHPO Accreditation review, the development of the AMC model standards and procedures, the internal RACS HTP Accreditation project and the Miller Blue Group Model Standards Implementation project.

Outcomes of the FATES 1 project will inform RACS's engagement with the RACMA/CPMC FATES 3 National Accreditation Portal IT Requirements project.²⁰

There have been significant changes to the external regulatory environment since the project commenced.

The AMC standards⁷ require colleges to respond to community need, to provide a diversity of training experience, to select applicants more likely to work in rural and Indigenous healthcare settings and to expand access to training experiences in rural and Indigenous healthcare settings. The 2021 *AMC Accreditation Report: the training and education programs of the Royal Australasian College of Surgeons*²⁹ imposed conditions on RACS including several of particular relevance to rural training:

Condition 1: Demonstrate within the College governance structure that accountability is shared by RACS Council, the Education Board, the Board of SET, and STB/Cs to enable each of the 13 training programs meet AMC standards and conditions. Evidence of alignment and robust reporting mechanisms, between the College and STB/Cs in developing education and training policies consistently, is needed. (Standard 1.2)

Condition 2: Provide evidence of effective implementation, monitoring and evaluation of the *Rural Health Equity Strategic Action Plan*¹⁴ (Standards 1.6 and 1.7)

Condition 4: Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available, reflecting community needs and mapped to the 10 RACS competencies (Standards 2.2 and 2.3)

Condition 6: As it applies to the specialty training program, expand the curricula to ensure Trainees contribute to the effectiveness and efficiency of the healthcare system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective healthcare across a range of settings within the Australian and/or New Zealand health systems (Standard 3.2.6)

The updated standards for assessment and accreditation of specialist medical programs by the AMC⁷ came into effect at the beginning of 2024. Standards for accreditation of training sites/posts are addressed by Standard 8: Implementing the program – delivery of education and accreditation of training site; 8.2 Training sites and posts.

The NHPO conducted an accreditation review, publishing the *Processes for Progress Review – a roadmap for greater transparency and accountability in specialist medical training site accreditation report* in 2023.¹⁸ Health Ministers issued a policy direction on 1 September 2023, including the requirement that the AMC work with jurisdictions and colleges on the implementation of recommendations for reform.

The AMC published new model standards³ and model procedures¹⁹ for specialist medical college accreditation of training settings for implementation by all colleges commencing February 2026. The model accreditation standards are standardised across all colleges and can be supplemented by optional college-specific (and/or specialty specific) requirements where needed. The AMC *Key messages for specialist medical colleges 2025* communique states that the AMC intends to publish 'guidance on accreditation in rural/regional, general practice and small private or community-based services'.³⁰

All stakeholders in specialist medical training are focused on training outcomes and patient safety. The new model standards and 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—to develop 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 project²⁰, led by RACMA and CPMC, will deliver these outcomes.

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 relocation burden for Trainees, stakeholders need to combine to find novel solutions in the context of wider rural healthcare professional education, training and recruitment strategies.

Concurrent with the NHPO review and report, and the AMC consultation and publication of model standards and procedures, RACS is developing a new model of accreditation through the RACS HTP Accreditation project, for implementation in 2026. Both the FATES 1 project and the RACS HTP Accreditation project evolved in response to changes in the external regulatory environment. Although this resulted in delays to both projects, the outputs are now aligned to the new AMC model standards and procedures and will be fit for purpose.

The RACS HTP Accreditation project has been discussed with CPMC and aligns with the development of the FATES 3 National Accreditation Portal IT Requirements project²⁰, led by RACMA in collaboration with CPMC. The FATES 3 project aims to assess the feasibility and define the requirements for a potential shared accreditation IT platform for specialist medical colleges. This project aims to create efficiencies that will reduce the administrative and regulatory burden on accreditation processes, increase transparency and enable more rapid accreditation and expansion of rural training. The project has the potential to significantly streamline the accreditation processes and reduce the burden on rural hospitals when engaging with accreditation processes.

STRATEGIC ALIGNMENT

Reducing barriers to rural training-post accreditation aligns with the RACS *Rural Health Equity Strategic Action Plan*¹⁴ the RACMA *Securing Australia's Medical Workforce* policy¹⁵ and its *Rural-Ready Medical Workforce* policy¹⁶, and the NMWS.¹¹

Government

Reforming the specialist training pathway, growing the RRR and Aboriginal and Torres Strait Islander specialist workforce and increasing generalist skills and practice are key priorities of the NMWS.¹¹ The longstanding RHMT program³¹, the AMC standards⁷, and the new AMC model standards³² are aligned with these priorities.

RACS Rural Health Equity Strategic Action Plan

The RACS *Rural Health Equity Strategic Action Plan – Train for Rural*³³ includes actions to equip all Trainees with generalist skills; offer all Trainees the opportunity for rural training, either through rural training time or through RUFUS activities (inreach, outreach, telehealth, collaboration in dispersed teams); and increase accreditation of rural training sites via rural-specific accreditation approaches and the development of rural training networks for General and Orthopaedic surgery. The FATES 2 Rural Training Models project investigated and will make recommendations for best practice models of orientation, supervision and mentoring in a rural training context, and the development of rural training networks.

RACMA Position Statements

The RACMA Position Statement *Rural-Ready Medical Workforce: System Leadership for Equitable Care* notes the following:

‘RACMA envisions a health system in which rural, regional, and remote communities in Australia and Aotearoa New Zealand receive safe, continuous, and culturally responsive care delivered by a supported, skilled, and locally embedded medical workforce. This workforce must be shaped not only by workforce numbers but also by medical leadership, community connection, and structural reform. Remote, rural, and regional settings are not peripheral to the health system—they are foundational. A rural-ready workforce strategy must centre on place-based leadership, population health, and the unique dynamics of rural service delivery. It must address the maldistribution of clinicians, opportunity, investment, and training.’¹⁶

RACMA’s position statement describes elements of place-based medical leadership, which include governing and credentialing systems reflective of the realities of rural practice, and which should advocate for equitable models of education, training, and succession planning. Key priorities for reform include the reshaping of generalist pathways, and investment in place-based models of medical education, training and research responsive to community need.

RACMA’s Position Statement *Securing Australia’s Medical Workforce to Deliver Healthcare to Australians* holds that:

‘Australia’s medical workforce faces sustained pressures that are impacting service delivery, clinician wellbeing, and patient outcomes. Persistent workforce maldistribution, inflexible training pathways, and overdependence on locum and international medical graduates (IMGs) are contributing to practitioner burnout and destabilising health service delivery. RACMA calls for urgent, system-level reform to ensure we have the right workforce and support in the right places.’¹⁵

RACMA calls for a systemic response to medical workforce challenges: ‘a nationally coordinated, jurisdictionally delivered approach to workforce reform—one that integrates data insights, policy levers, training design, and clinical governance at the local level. A resilient and sustainable medical workforce must be deliberately planned, data-informed, and responsive to national goals and local realities.’¹⁵

Medical and surgical training pathways must be reformed to better match community needs and provide specialists with the generalist, procedural and leadership skills needed in RRR settings:

‘Priority 5 Plan Nationally, Implement Locally: Getting Distribution and Accountability...A nationally agreed medical workforce strategy with accountability mechanisms across governments; stronger clinical governance frameworks in rural and regional systems are tailored to the context and are not copied from metro hospitals; funding for Medical Administrators and clinical leaders to lead workforce development within health services;

investment in local medical workforce units or networks within regions to coordinate placements, training, and planning, similar to jurisdictional training hubs, but with stronger clinical governance leadership; Contractual mechanisms (e.g. National Health Reform Agreements) to embed reform actions within health system architecture.’¹⁵

Priority 6 (*Culture and Wellbeing – Creating the Conditions to Stay*) of RACMA’s *Position Statement: Securing Australia’s Medical Workforce to Deliver Healthcare to Australians*¹⁵ calls for a systemic approach to ensuring cultural safety via the implementation of the Better Culture Curriculum³⁴ and management of wellbeing risks with the same discipline as clinical and financial risk.

‘Clinician wellbeing has become one of the most significant—and least systematically managed—risks to workforce sustainability. Across the system, doctors are facing unsustainable workloads, limited career visibility, and inconsistent access to peer support. These pressures are particularly acute in rural and regional settings, but they affect clinicians in all contexts. Cultural and structural change is essential...RACMA supports embedding wellbeing and safety into the performance metrics of boards, executives, and training programs; investment in medical leadership development at all stages of the workforce pipeline, with emphasis on team-based care and psychological safety; creation of psychologically safe learning and working environments, with transparent escalation pathways and structured support; expansion of funded peer support, debriefing, and supervision training programs grounded in safety science and inclusive of all disciplines; strengthening governance capability so that culture and wellbeing risks are managed with the same discipline as clinical and financial risks.’¹⁵

CROSS UTILISATION OF STP AND FATES PROJECTS

RACS STP and FATES projects

The following completed and in-progress RACS STP projects informed FATES 1:

1. Gap analysis of barriers and incentives to Trainees preferencing rural placement and new Fellows rural career uptake.³⁵
2. RRR Professional Skills Curriculum and eLearning course²⁸ 2021–2026
 - a. Phase 1: Investigation and Development of a rural-facing surgical curriculum framework. Developed key domains of professional skills where urban and rural practice diverge. Identified need to train for analysis of rural context, rural contextual decision-making and RUFUS (rural focused urban surgical skills including inreach/whole-of-person care, telehealth, outreach and collaboration in dispersed teams) 2021–2022.
 - b. Phase 2: Rapid review of evidence for efficacy and acceptability of professional skills training in a virtual environment, and stakeholder needs analysis, confirming that rural and urban surgeons and Trainees agree with the priority domains and support the need for the curriculum to be developed 2023.
 - c. Phase 3: RACS RRR professional skills eLearning course 2024–2026. Rural professional skills curriculum refined and learning modules created to support Trainees in developing rural and RUFUS professional skills.
3. Asynchronous video coaching in rural settings 2022. This work was relevant for remote supervision and involved asynchronous video coaching in non-technical or professional skills, initially for surgeons, with the intention that the findings can be used to develop programs for remote asynchronous coaching for Trainees, expanding their access to quality supervision during rural training placement.
4. *Towards Culturally Safe and Effective Training Pathways for Aboriginal and Torres Strait Islander Medical Specialist Trainees* April 2025 by Professor Yin Paradies, BSc, MMedStats,

The FATES 2 Rural Training Models project (led by RACS in partnership with the Australian & New Zealand College of Anaesthetists [ANZCA], RACMA, RACP, RANZCOG) provided best practice models for orientation, supervision and mentoring in the rural context, as well as culturally safe practice in an outreach context and best practice models for implementation of rural training networks.

Specialist medical colleges FATES projects relevant to RACS FATES 1 project

The range of FATES projects shows that many colleges are researching, piloting and implementing novel and flexible solutions to increase rural training sites, develop supervisory capacity and flexible models of supervision, and create rural training pathways.

A consortium of colleges comprising RANZCO, RANZCR, RANZCOG, RACS, RACMA and CICM (FATES 3) have developed the SSTS and investigated models of remote supervision.

The RACMA (FATES 3) National Accreditation Portal IT Requirements project²⁰ builds on the work undertaken by the AMC to develop model accreditation standards and procedures. This revised FATES 3 project will focus on developing IT specification requirements and investigating the feasibility for a shared hospital accreditation portal. The portal would support both health service settings and specialist medical colleges by addressing longstanding inefficiencies and duplication in accreditation processes. It would also enable better data coordination, enhance transparency, and reduce the administrative burden across the accreditation lifecycle.

The RACP (FATES 4) Workforce Mapping and Accreditation Renewal project links the RACP rural workforce strategy with accreditation processes.³⁷

Flexible models of supervision are being developed, piloted and implemented: hybrid supervision (CICM onsite and remote), rotatory supervision (Australasian College of Dermatologists [ACD] continuity of supervision provided by shifts of visiting supervisors), blended supervision (Australasian College for Emergency Medicine [ACEM] onsite, multidisciplinary/interdisciplinary and remote supervision) and remote supervision (Australasian College of Sport and Exercise Physicians [ACSEP]).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) and ACD are proactively increasing supervisory capacity to enable accreditation of rural training sites (RANZCP Rural Director of Training pilot program, ACD re-establishing training in Tasmania).

RACP and RANZCR have developed resources for RRR supervisors for culturally safe supervision and medical education (RACP resource to support culturally safe supervision, Upskilling RANZCR Regional Rural and First Nations Clinical Supervisors in Medical Education)³⁸

Several colleges are working towards digitally enhanced supervision (ACD Towards a New Paradigm for Specialist Training – Harnessing digital technologies to optimise national supervisory capacity and efficiency; ACSEP Sport and Exercise Medicine Supervisor Support Scheme³⁷).

There are multiple projects to increase access to resources for Trainees in rural training sites: online application portals for rural prevocational doctors (RANZCR Reducing Application Barriers for Specialist Training for Regional, Rural and Indigenous Doctors – A centralised application solution), simulation facilities (ANZCA simulation collaboration), national networked formal learning, support and orientation to rural practice and orientation to each training site programs (RANZCR Rural Education and Support Program [RESP], RANZCP Rural Readiness project).

Colleges are proactively developing training positions in rural sites (e.g. RACP Rural Physician Training Pathway, RACP Rural Paediatric Training Pathway, RANZCP WA Rural Psychiatry Training Pathway, ACSEP Regional and Rural Training Pathways in Expanded Settings), overcoming 'generalisable barriers' to accreditation of rural training sites (e.g. ACD Towards a Homegrown Workforce project), creating rural-specific accreditation pathways (e.g. ANZCA Developing Flexible Accreditation Pathways for Pain Medicine Training in Rural Settings), developing rural outreach and virtual healthcare training posts (e.g. RACP Diabetes Alliance Program, Remote and Aboriginal Cancer Care), proactively linking smaller sites to larger sites to form rural networks (e.g. RACP Rural Palliative Care Medicine Network, ACEM Piloting an Integrated System of Regional and Rural Accredited Emergency Medicine [EM] Training Networks), and creating rural specialist training pathways (e.g. RANZCOG Rural O&G Specialist Pathway, RACP Remote and Aboriginal Cancer Care).

OUTCOMES AND RECOMMENDATIONS

While the project was focused on barriers to the accreditation of rural training sites, wider concepts and themes emerged that are key to the success of rural training models. These 4 key themes are

1. Collaborative workforce planning
2. A new paradigm for the SET program
 - a. accountable STB/Cs delivering on the dual purpose of the SET program
 - b. diversity not uniformity – firm on standards, flexible on criteria, focused on outcomes for Trainees and patients
 - c. supervision – measuring what matters
 - d. making it count – effective and efficient delivery of courses and assessment
3. Streamlining the accreditation process
4. Realising the benefits of rural training while reducing the burden of relocation on Trainees and their families

A flexible approach to accreditation is required to enable Trainees to access the benefits of rural training. A proactive approach to workforce planning, including distributing training sites/posts in response to community need for surgical services, combined with dedicated RACS resources to assist rural and remote administrators and supervisors, were identified as key activities to enable expansion of rural training.

GRANT DELIVERABLES

Grant deliverables appear in part 3 of this report. A summary follows:

Deliverable 1: Barriers and solutions for rural training site accreditation report

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

Deliverable 3.1: Strengths and opportunities of rural training report

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

PART 3: BARRIERS TO RURAL ACCREDITATION GRANT AGREEMENT, ACTIVITIES AND OUTCOMES

GRANT AND GOVERNANCE

COMMONWEALTH STANDARD GRANT AGREEMENT

Grant Activity Name: FATES 1 Rural Accreditation – Addressing Barriers to Rural Specialist Training

Organisation ID 1-VFUOMQ, Agreement ID 4-GQ3U2MV, Schedule ID 4-GQ3U2MX

Dates: 14 February 2022 to 31 Dec 2025

GRANT ACTIVITY

The Grantee and the Royal Australian College of Medical Administrators will undertake a review of Royal Australasian College of Surgeons (RACS) accreditation criteria and processes, including extensive engagement with internal and external stakeholders to:

- Identify barriers to rural hospitals in both applying for and meeting surgical hospital training-post accreditation standards.
- Design an administrative model that provides support and engagement for rural hospitals during the hospital training-post accreditation process.
- Create a 'supporting evidence' resource to assess performance against hospital training-post accreditation standards within a rural context.
- Establish a foundation for the design of a system that distributes training posts based on community need through Trainee workforce data.
- Evaluate deliverables for their effectiveness and relevancy to addressing community needs.

The Grantee will evaluate this activity and develop a series of summary reports to be published on the Grantee's website and provided to the Department at the time identified in the annual activity workplan including:

- Study report on barriers rural hospitals face for training-post accreditation in the surgical context, and provide recommendations for improvement, to be published on RACS website.
- A proposal for a model which identifies required personnel and systems to overcome barriers for rural hospitals as identified in the study report.
- A literature review that interrogates the evidence base for surgical training core requirements, to be published on RACS website.
- A report of training performance indicators against hospital post core requirements, to inform the accreditation standards of STB/Cs.
- A report that identifies a list of unique training opportunities that rural hospitals can provide, to assist in developing rural training networks and ensuring accreditation standards are met, to be published on RACS website.
- A report that provides a set of generic recommendations and measurable examples of how rural training posts can meet accreditation standards, to be published on RACS website.

DELIVERABLES

Deliverables – defined as goods or services that must be provided/produced upon completion of a project.

Activities under the Grant will include comprehensive project planning leading to the development of an annual Activity Work Plan. Activities should include:

- Stakeholder consultation and engagement
- Monitoring project performance
- Monitoring risk management

The Grantee is required to measure the impact of the project against the FATES objectives through a project Evaluation to be published on the College's website at the conclusion of the Project. An evaluation plan is to be provided to the Department for consideration prior to the evaluation commencing. Activities, actions, outputs, outcomes and key performance indicators (KPIs) are outlined below.

Table 4. Agreement ID 4-GQ3U2MV, Schedule ID 4-GQ3U2MX: Deliverables

Activity	Actions, outputs, outcomes
Stakeholder consultation and engagement	
Identify barriers to rural hospitals in both applying for and meeting surgical hospital training-post accreditation standards.	A literature review that interrogates the evidence base for surgical training core requirements, to be published on RACS website. KPI: Study report on barriers rural hospitals face for training-post accreditation in the surgical context, and provide recommendations for improvement, to be published on RACS website
Design an administrative model that provides support and engagement for rural hospitals during the hospital training-post accreditation process.	KPI: Develop a proposal for a model which identifies required personnel and systems to overcome barriers for rural hospitals as identified in the study report.
Create a 'supporting evidence' resource to assess performance against hospital training-post accreditation standards within a rural context.	KPI: A report that identifies a list of unique training opportunities that rural hospitals can provide, to assist in developing rural training networks and ensuring accreditation standards are met, to be published on RACS website. KPI: A report of training performance indicators against hospital post core requirements, to inform the accreditation standards of Specialty Training Boards. KPI: A report that provides a set of generic recommendations and measurable examples of how rural training posts can meet accreditation standards, to be published on RACS website
Establish a foundation for the design of a system that distributes training posts based on community need through Trainee workforce data. System mapping of RACS Trainee workforce data, and allocation of Trainees.	KPI Establish consortium of stakeholders who hold Trainee and service registrar workforce data and negotiate data-sharing protocols. KPI Develop a system map of the workforce data that RACS holds and how it is collected and demonstrates how RACS allocates its Trainees by specialty.
Evaluate deliverables for their effectiveness and relevancy to addressing community need	KPI measure the impact of the project against the FATES objectives through a project Evaluation to be published on the College's website at the conclusion of the Project. An evaluation plan is to be provided to the Department for consideration prior to the evaluation commencing.

PERFORMANCE INDICATORS

Performance Indicators – defined as a type of performance measure. Performance Indicators evaluate an organisation or a particular activity.

The Activity will be measured against the following Performance Indicators

Table 5. Agreement ID 4-GQ3U2MV, Schedule ID 4-GQ3U2MX: Performance Indicators

Performance Indicator Description	Measure
All of the requirements in the Grant Agreement have been met.	Information is provided to an acceptable standard in Annual Performance Reports, Activity Work Plans and financial reports, including budgets.
Activities are completed according to the scope, timeframes and budget defined in the Activity Work Plan.	The Department and your organisation agree that the requirements outlined in the Activity Work Plan have been completed as specified.
Department agreed project performance indicators are achieved.	Reporting on progress against the Department agreed project performance indicators within agreed timeframes.
The project evaluation identifies achievements and outcomes against the FATES objectives and outcomes.	Project Evaluation analysis measures the impact of the project against the FATES objectives and outcomes.
Identify barriers to rural hospitals in both applying for and meeting surgical hospital training-post accreditation standards.	Deliverable 1 Barriers and solutions report: Study report on barriers rural hospitals face for training-post accreditation in the surgical context and provide recommendations for improvement.
Design an administrative model that provides support and engagement for rural hospitals during the hospital training-post accreditation process.	Deliverable 2 Administrative model to facilitate rural training site accreditation: Develop a proposal for a model which identifies required personnel and systems to overcome barriers for rural hospitals as identified in the study report.
Create a 'supporting evidence' resource to assess performance against hospital training-post accreditation standards, within a rural context.	Deliverable 3 Identify core surgical training-post requirements, report on unique rural hospital post training opportunities, and how, with evidence, rural training meets core hospital training-post accreditation standards. 3.1 Unique strengths and opportunities of rural surgical training 3.2 RACS HTP Accreditation project – Part A and Part B accreditation application forms/supporting evidence resource to assist hospitals in applying for accreditation 3.3 Developing specialty specific accreditation criteria inclusive of rural training sites
Establish foundation for design of a system that distributes training posts based on community need through Trainee workforce data. System mapping of RACS Trainee workforce data, and allocation of Trainees.	Deliverable 4 Matching training sites to community need: Model for distributing training posts based on community need: Establish consortium of stakeholders who hold Trainee and service registrar workforce data and negotiate data-sharing protocols. Develop a system map of the workforce data that RACS holds and how it is collected and demonstrates how RACS allocates its Trainees by specialty.

KPIs are presented in this report under the following headings:

Deliverable 1: Barriers and solutions for rural training site accreditation report

The report synthesises findings from qualitative research and subject matter experts. A majority of recommendations have already been communicated to internal and external stakeholders and incorporated into NHPO, AMC and RACS HTP Accreditation consultations, projects and reports.

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

In collaboration with the RACS Pathways to Fellowship portfolio, a proposal for processes and personnel to facilitate rural training site accreditation has been developed and is currently being assessed by the RACS executive.

Deliverable 3.1: Strengths and opportunities of rural training report

The report adds findings from FATES 1 qualitative research to the existing RACS evidence base, including the STP barriers and levers to rural training project, the STP rural professional skills curriculum and eLearning course, and the Ahpra Medical Training Survey.

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

The RACS HTP Accreditation project team produced 2 documents, with extensive consultation from the RACS Rural health equity steering committee, the RACS Rural surgery section committee and FATES 1 investigators. The documents are included in this report to highlight changes made to existing accreditation standards to reduce barriers to rural hospital training-post accreditation.

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

RACS and its STB/Cs are required to commence implementation of the AMC model standards and procedures from 2026. There is a risk that the flexibility provided in both the standards and procedures, and the HTP accreditation Part A and Part B application forms, will be lost as STB/Cs develop specialty specific criteria. The report provides guidance to assist STB/Cs to develop criteria that do not present unnecessary barriers to rural hospital training post accreditation.

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

RACS is collaborating with the Department's Health Workforce Data Intelligence Unit, via workforce data collection and data-sharing protocols. This work is ongoing. The FATES 1 report will include an aspirational model for STBs and their Colleges to consider in matching training sites to community need for surgical care.

REQUIREMENTS OF FINAL REPORT

Final Report for the period of the Activity as per the requirements at Item E.5 due 2 February 2026.

The Final Report for the Activity is to contain information on the performance of the Activity for the entirety of the Activity period, including:

- the extent to which the objectives of the Activity described in Item B of the Schedule have been met
- a description of the specific Activity Milestones or other outcomes completed during the Activity period
- an explanation as to how the Grantee addressed any issues, problems or delays identified with the Activity
- project Evaluation report, to be published on the College website, which will include analysis of:
 - feasibility and recommendations for ongoing suitability without FATES funding, scalability of the project in other locations and for other colleges/specialties, and effectiveness for rural recruitment and retention
 - impact of the project against the FATES objectives and outcomes
 - experiences of participants to determine what worked well and where additional support is required.

ALIGNMENT WITH NATIONAL MEDICAL WORKFORCE STRATEGY

The NMWS¹¹ aims to address medical workforce issues by exploring actions that fall under the 5 key priorities of.

- collaborating on medical workforce planning and design
- rebalancing the supply and distribution of doctors across specialties and locations
- reforming medical training pathways
- building the generalist capability of the medical workforce
- building a flexible and responsive medical workforce.

The strategy also includes 3 overarching contextual priorities that aim to:

- grow the Aboriginal and Torres Strait Islander medical workforce and improve cultural safety
- adapt to, and better support, new models of care
- improve doctor wellbeing – Australian Department of Health, Disability and Ageing

The FATES 1 Rural Accreditation – Addressing Barriers to Rural Specialist Training project supports the priorities of the NMWS in the following ways:

Priority 1 Collaborating on medical workforce planning and design: partnership with RACMA, collaborating with Government on models of data sharing and collaborative workforce planning.

Priority 2 Rebalancing the supply and distribution of doctors across specialties and locations: accreditation of rural training sites to build contextual skills and connection to place, with long-term increase in rural workforce; accrediting more remote and rural sites and rural training networks for Orthopaedic Surgery and General Surgery, accrediting rural training sites in specialties with smaller rural presence (OHNS, PRS, Urology and Vascular Surgery) and accreditation of outreach sites for RUFUS specialties/skills in all 9 specialties, but especially Cardiothoracic Surgery, Neurosurgery and Paediatric surgery).

Priority 3 Reforming medical training pathways: improved and increased accreditation of rural training sites and/or rural training networks, to enable all Trainees to have the opportunity for rural work experience, to enable rural origin and/or rural interested/intention Trainees to spend most of their training time in their chosen RRR area and to accredit RUFUS training/outreach sites.

Priority 4 Building the generalist capability of the medical workforce: providing Trainees access to the generalist experience associated with RRR training; advocating for generalist skills and experience to be as equally valued as subspecialist training experience; working towards balance of generalist and subspecialists in medical specialist workforce; building professional networks and collaborative practice between generalists and subspecialists.

Priority 5 Building a flexible and responsive medical workforce: ensuring training is responsive to community need; enabling all Trainees to have the opportunity to work in a variety of settings including RRR and Aboriginal and Torres Strait Islander health services and communities, fostering skills in contextual analysis, and the ability to assess and adapt to new practice contexts, practice contextual decision-making and optimise outcomes in limited resource environments.

Cross cutting theme 1 Grow the Aboriginal and Torres Strait Islander medical workforce and improve cultural safety: enabling RRR Aboriginal and Torres Strait Islander Trainees to train close to Country and community; increasing access to RRR training experiences that include caring for RRR Aboriginal

and Torres Strait Islander communities, aligned with the RACS Rural Professional Skills Curriculum (includes lessons on RRR Aboriginal and Torres Strait Islander people).

Cross cutting theme 2 Adapt to, and better support, new models of care: evidence and practice informed advocacy to ensure Trainees have access to training experiences involving diverse settings and diverse models of care, including place-based remote and rural surgical practice, communication (especially clinical handover) and collaborative practice in geographically dispersed teams, virtual healthcare, outreach services.

Crossing cutting theme 3 Improve doctor wellbeing: enable RRR origin/intention Trainees, including RRR Aboriginal and Torres Strait Islander Trainees, to train closer to home; ensure specialty specific criteria provide necessary flexibility for Trainees from different specialties to share on-call, to facilitate safe hours and fatigue mitigation; reduce the burden on Trainees and their families of frequent relocation through longer rural rotations and collaboration with stakeholders to find novel solutions for relocation, accommodation and personal and professional support. Innovate, collaborate, and improve supervisor and Trainee wellbeing and work life balance in regional, rural, and remote areas.

GOVERNANCE WITHIN RACS

The project was part of the RACS Pathways to Fellowship and Operations and Partnerships Portfolios, and managed by the Manager Accreditation, Research and Scholarships; the Manager STP and FATES; and the General Manager, Research, Audit and Academic Surgery. Fellowship governance was provided by the RACS Rural Health Equity Steering Committee.

PROJECT TEAM

Principal Investigator

Associate Professor Kerin Fielding FRACS, Orthopaedic surgeon, immediate past President, RACS, Chair RACS Rural Health Equity Steering Committee 2021–2025

Co-Principal Investigator

Dr Bridget Clancy FRACS, Otolaryngologist Head and Neck surgeon, Chair RACS Rural Surgery Section, Deputy Chair Rural Health Equity Steering Committee 2021–2025

Leading Fellows from RACMA

(in alphabetical order)

Dr Joe McGirr MP

Associate Professor Alan Sandford AM

Coordinating Principal Investigators

(In alphabetical order)

Prof Wendy Babidge PhD, RACS, Adjunct Professor Adelaide Medical School, Faculty of Health and Medical Sciences 2025

Dr Joanna Duncan PhD, Head of Accreditation, Research and Scholarships 2022–2024

Dr Erika Polman PhD, Manager, STP, FATES 1 and FATES 2 2023–2025

Application, initial supervision and project management, stakeholder engagement:

(in alphabetical order)

Angela Burden, Head of Rural and Education Operations, 2022–2023

Dr Bridget Clancy (grant application, supervision and guidance, scoping review, final report writing and recommendations) 2021–2025

Christine Cook, Executive General Manager, Education Partnership RACS 2022–2023

A/Prof Kerin Fielding (grant application, supervision and guidance, scoping review, final report writing and recommendations) 2021–2025

Kate Fisher, Executive Officer, Rural Health Equity Strategy 2021–2025

Dr Tamsin Garrod PhD, Executive General Manager, Education, Development & Delivery 2022–2023

Olivia Hartles, Program Manager, Rural Health Equity Strategy 2021–2022

Jacky Heath, General Manager, Accreditation, Rural Health Equity, Research 2024–2025

Donna Lehmann, Program Manager, Rural Health Equity Strategy, 2023–2023

Sean Lomas, Program Manager FATES 2025

Fiona McAllister, Chief Operations and Partnerships Office, 2025

Deborah Paltridge Executive General Manager, Education Pathways, RACS Principal Educator FRACS (Hon) 2023–2024

Etienne Scheepers, Executive General Manager, Fellowship Engagement RACS 2022–2024

Alexandra Wilson, Executive General Manager, Pathways to Fellowship, 2025

Research team

(In alphabetical order)

Dr Alun Cameron PhD, Senior Research Team Leader, RAAS, ASERNIP–S 2022–2025

Steph Claridge, Project and Research Officer, 2023–2025

Dr Danniella Dougherty PhD, RESS Team Leader, RAAS, ASERNIP–S 2022–2023

Dr Joanna Duncan PhD, Head of Accreditation, Research and Scholarships 2022–2024

Kirsty Grove, RACMA Specialist Training Project Senior Coordinator 2022–2025

Dr Jonathan Henry Jacobsen PhD, Senior Research Officer, RAAS, ASERNIP–S 2022–2023

Anastasia Lavrentyeva, Research Assistant 2022–2025

Tindal Magnus, Amplexa Consulting, 2022–2022

Nikki Manolakis, Project and Research Officer, 2025

Anne Mooney, Project Lead 2022–2022

Fiona Morrow, RACMA Specialist Training Project Manager 2022–2025

Deborah Paltridge, Executive General Manager, Education Pathways, RACS Principal Educator, FRACS (Hon) 2023–2024

Prof Yin Paradies BSc, MMedStats, MPH, PhD, FASSA, FAHA, Deakin Distinguished Professor and Chair in Race Relations 2024–2025

Dr Adriana Parrella PhD, Senior Research Lead FATES 2025

Georgina Peate, Hospital Training-Post Accreditation Program Coordinator 2023–2025

Dr Erika Polman PhD, Manager, STP, FATES 1 and FATES 2 2023–2025

Dr Penny Williamson PhD, Senior Qualitative Research Officer 2023–2025

STAKEHOLDER ENGAGEMENT STRATEGY

The project activities included ongoing partnership with RACMA, collaboration with the RACS HTP Accreditation project team, consultation with training managers from the 13 STB/Cs, and consultation with the Department's Health Workforce Data Intelligence Unit.

PROGRAM EVALUATION

The report will be provided to government and published on the College website. The report will include the final report, deliverables 1–4 and the project evaluation.

GRANT ACTIVITIES AND MILESTONES

The activities undertaken include

- Documenting the internal and external regulatory environment, responding to changes, participating in consultation.
- Investigation of RACS accreditation standards and processes, mapping specialty specific accreditation requirements and criteria to RACS accreditation standards and assessing ease of completing applications and consultation with RACS HTP Accreditation Project.
- Literature Review and Scoping review. The systematic review investigated 2 research questions: What are the unique opportunities rural training posts can provide? and How can barriers impeding Australian rural surgical training-post accreditation be overcome? The scoping review examined the relationship of quantitative measures of supervision on training outcomes and patient safety.
- Cross utilisation of STP and FATES projects.
- Rural accreditation workshop and stakeholder engagement, Darwin 2022.
- Qualitative interviews with stakeholders.
- Assessing the impact of the 2025 AMC Model Standards and Procedures for accreditation.
- Producing deliverables
 - Deliverable 1: Barriers and solutions for rural training-post accreditation report
 - Deliverable 2: An administrative model to facilitate rural training site accreditation
 - Deliverable 3.1: Strengths and opportunities of rural training report
 - 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

EXTERNAL REGULATORY ENVIRONMENT FOR ACCREDITATION OF TRAINING SITES

All stakeholders in specialist medical training are focused on training outcomes and patient safety.

The National Registration and Accreditation Scheme was implemented in 2010 to ensure public safety through one overarching scheme for registered health professionals and is administered by Ahpra.³⁹ The Medical Board of Australia (MBA) is responsible for approving accreditation standards and courses of study to ensure that medical practitioners are suitably trained and qualified, with the AMC being appointed as the MBA's accreditation authority.⁴⁰ In this role, the AMC accredits specialist medical colleges and their education and training programs and produces the standards and procedures for the accreditation of specialist medical training sites, which is carried out by the respective medical colleges.¹⁸

There have been significant changes to the external regulatory environment since the project commenced in 2022.

The standards for assessment and accreditation of specialist medical programs by the AMC came into effect at the beginning of 2024.⁷ Standards for accreditation of training sites/posts are addressed by *Standard 8 Implementing the program – delivery of education and accreditation of training site; 8.2 Training sites and posts.*⁷

In 2023 the NHPO conducted an accreditation process review, the *Processes for Progress Review – a roadmap for greater transparency and accountability in specialist medical training site accreditation report*.¹⁸ In response to the report, health ministers issued a policy direction on 1 September 2023, including the requirement that the AMC work with jurisdictions and colleges on the implementation of recommendations for reform.

The AMC published new model standards and model procedures in 2025 for implementation by all colleges commencing February 2026.^{3 19} The model accreditation standards are standardised across all colleges and can be supplemented by optional college-specific (and/or specialty specific requirements) where required. The AMC *Key Messages for specialist medical colleges 2025 communique* states the AMC intends to publish 'guidance on accreditation in rural/regional, general practice and small private or community-based services'.³⁰

The new 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, to develop 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 project²⁰, led by RACMA and CPMC, will deliver these outcomes.

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.

2022 ANALYSIS OF AMC STANDARDS FOR ASSESSMENT AND ACCREDITATION OF SPECIALIST MEDICAL PROGRAMS BY THE AUSTRALIAN MEDICAL COUNCIL 2023

8.2 TRAINING SITES AND POSTS

This standard is currently in place and will be replaced by the AMC model standards from 2026.

The standard appears below, with phrases particularly relevant to accreditation of rural training posts in bold. These include providing training in diverse settings, including rural and regional locations and settings; providing experience of caring for Aboriginal and Torres Strait Islander peoples and/or Māori; flexible rather than restrictive approaches to accreditation, utilising the capacity across the whole health system for training; collaborating with other specialist medical colleges to streamline the accreditation process; training being a shared responsibility between colleges and health facilities/hospitals.⁷

8.2 Training sites and posts

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

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

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

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

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

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

Notes:

Since training and education in most specialties takes place in health services, specialist medical training is a **shared responsibility** between the education providers and these training sites. The quality of the learning experience depends on the support the unit or service provides. Education providers have formal processes to select and accredit training sites, and the process and requirements for accreditation vary depending on the medical specialty. Many commonalities exist between education providers' processes but so do inconsistencies. The AMC recognises the significant interest of training sites and education providers in ongoing quality improvements in and

streamlining of these processes, including where relevant, greater sharing of information or processes between providers. The AMC endorses work to **develop tools to support consistent approaches to accreditation, such as the Accreditation of Specialist Medical Training Sites Project**. The accreditation standards under 8.2.2 draw on the domains for accreditation in that report and education providers are encouraged to use these standards. Education providers define the range of experience to be gained during training. Education providers should make as explicit as possible the expectations of training sites seeking accreditation, including clinical and other experience, education activities and resources, and expectations for flexible training options. Education provider accreditation processes must verify that this experience is available in training sites seeking accreditation and once accredited must evaluate the Trainees' experience in those sites. The accreditation process should result in a report to the training site. Where accreditation criteria are not met, the report should give guidance so that the training site may address any unmet requirements. Trainees are likely to **gain experience in multiple locations each providing a varying range of experiences of the specialist discipline**. For this reason, education providers are increasingly accrediting networks of training sites rather than expecting a single training site to provide all the required training experience, and while all training sites should satisfy the education provider's accreditation criteria, **the AMC encourages flexible rather than restrictive approaches that enable the capacity of the health care system to be used most effectively for training.**⁷

RACS HOSPITAL TRAINING-POST ACCREDITATION STANDARDS AND PROCEDURES

RACS has a distributed or devolved model of selection, training, accreditation and Fellowship services, in partnership with speciality societies and associations. The following information sets out the governance of SET within RACS.

Governance

RACS, as the overarching surgical college, governs the Committee of Surgical Education and Training (CSET) that provides oversight for Australia and AoNZ's SET programs, which are in turn regulated and delivered by the surgical speciality's respective STB/C.⁴¹⁻⁴⁴ While there are 9 surgical specialities, there are binational STB/Cs for 5 specialties and separate Australian and AoNZ STB/Cs for 4 specialties, resulting in 13 STB/Cs in total. The surgical specialities, affiliated specialty societies and the respective STB/Cs are as follows.⁴⁵

Table 6. Accreditation governance structure

Surgical Speciality	Associated Speciality Society	STB/C	Accreditation process executed by
Orthopaedic Surgery	Australian Orthopaedic Association (AOA)	AOA Federal Training Committee (FTC)	AOA
	New Zealand Orthopaedic Association (NZOA)	AoNZ Orthopaedic Training Board	NZOA
Cardiothoracic Surgery	The Australian & New Zealand Society of Cardiac & Thoracic Surgeons	Cardiothoracic Surgery Training Committee	RACS
General Surgery	General Surgeons Australia (GSA)	Australian Board in General Surgery (ABiGS)	GSA

	New Zealand Association of General Surgeons (NZAGS)	Aotearoa New Zealand Committee in General Surgery	NZAGS
Otolaryngology Head & Neck Surgery	Australian Society of Otolaryngology, Head and Neck Surgery (ASOHNS)	Board of Otolaryngology, Head & Neck Surgery (BOHNS)	ASOHNS
	New Zealand Society of Otolaryngology, Head and Neck Surgery (NZSOHNS)	BOHNS (New Zealand Training Subcommittee)	NZSOHNS/ RACS
Paediatric Surgery	Australian and New Zealand Association of Paediatric Surgeons	Committee of Paediatric Surgery	RACS
Plastic and Reconstructive Surgery	Australian Society of Plastic Surgeons Inc. (ASPS)	Australian Board of Plastic & Reconstructive Surgery	ASPS
	New Zealand Association of Plastic Surgeons/Te Kāhui Whakamōhou Kiri (NZAPS/TKWK)	New Zealand Board of Plastic & Reconstructive Surgery	NZAPS/ TKWK
Neurosurgery	Neurosurgical Society of Australasia (NSA)	Board of Neurosurgery	NSA
Vascular Surgery	Australian and New Zealand Society for Vascular Surgery (ANZSVS)	Board of Vascular Surgery	ANZSVS
Urology	Urological Society of Australia and New Zealand (USANZ)	Board of Urology (BOU)	USANZ

Accreditation standards

RACS publishes overarching accreditation standards and processes, aligned with the AMC Standards.^{18 44} The STB/Cs may use these standards, with additional specialty specific criteria, or may publish their own accreditation standards and processes, providing the RACS standards are met.
18 44 46 47

The RACS policy Training-Post Accreditation and Administration ETA-SET-043⁴⁶ includes the following statements:

3.1.1. Posts submitted by hospitals for accreditation are assessed in accordance with the standards established by the Specialty Training Board. These standards will assess:

- a culture of respect
- education facilities and systems required
- quality of education, training and learning
- surgical supervisors and staff
- support services and flexibility for Trainees
- clinical load and theatre sessions
- equipment and clinical support services
- clinical governance, quality and safety.

3.1.2. Posts must achieve each of the standards listed in 3.1.1, but do not need to meet every criterion within each standard.

The hospital training posts are required to meet each standard, but it is not necessary for every criterion specified by an STB/C to be met.^{44 46} Instead, RACS holds that the accreditation team should decide if 'enough criterion are met to demonstrate that the standard is achieved' overall.^{44 46}

Accreditation assessment

RACS accredits hospital training posts on behalf of Cardiothoracic Surgery and Paediatric Surgery in Australia, and Cardiothoracic Surgery, Paediatric Surgery and OHNS in AoNZ.⁴⁸ Responsibility for accreditation for training sites for the remaining specialties and SET programs is delegated to partner STB/Cs.

Standards and processes are highly variable

When a hospital (or consortia of hospitals in the case of a shared or network training post) wishes to gain accreditation for a new surgical training post, they contact the organisation that is responsible for supporting the accreditation process for the relevant speciality directly to obtain the necessary application forms and accreditation standards and criteria.^{44 49} This process is the same for hospitals that are applying for their first surgical training post, and for hospitals that wish to apply for training posts for any additional surgical specialties.⁴⁴ While specific application procedures, timelines and assessment processes vary between STB/Cs, the general process follows a similar format. Steps can involve the submission of an initial Expression of Interest form at any point in the accreditation cycle (AOA FTC)⁵⁰, may necessitate that the hospital first email the Speciality Society to gain access to an online application form (ABiGS)⁵¹ or may simply involve downloading and completing the necessary application form (BOHNS).⁵² In all cases, the official application must be received before a designated date – generally in the year prior to the desired accreditation cycle – for the hospital to be eligible for accreditation in that particular period, as this allows for the assessment process to be completed and for surgical Trainees to be assigned to the post.⁵³

The specific procedures for hospital training-post assessment following the official application varies between the STB/Cs, but the overall process is similar. The relevant STB/C will first undertake an initial review of the application to determine if the information provided indicates that the accreditation criteria are satisfied.^{53 54} If it appears that accreditation standards and criteria are met, then the STB/Cs' relevant accreditation panel or committee will determine the means by which the accreditation inspection should be conducted – this may occur via a document-based review of the application, a technology-assisted remote inspection, a physical site visit, or a hybrid review encompassing both virtual and onsite inspection.^{50 53-57} Following the review, the designated accreditation committee or panel will, in line with their assessment of the training post and their governance policy frameworks, advise the hospital of the accreditation outcome.^{50 53-57} Depending on the STB/C, this may take the form of full accreditation of a post, provisional accreditation or conditional approval, or the withdrawal or rejection of the accreditation application.^{50 53-57}

For most surgical specialties, accreditation is generally granted for a period of 5 years, the expiry of which necessitates the reaccreditation of the training post. In the case of reaccreditation of a training post due to either impending expiry or because of concerns raised about the hospital's ability to appropriately meet accreditation standards, the relevant STB/C will contact the hospital directly to initiate the process.⁴⁴ Reaccreditation procedures are not uniform, and the specific reaccreditation process is highly dependent on the specific surgical speciality – for example, ABiGS follows a state-based reaccreditation cycle, reaccrediting hospital training posts in particular states and territories in specific years.⁵³

2022 ANALYSIS OF BARRIERS TO RURAL ACCREDITATION, RACS AND SPECIALTY SPECIFIC ACCREDITATION STANDARDS

Two spreadsheets (Attachments 1 and 2) were created to map the training-post accreditation standards for all SET programs to the RACS accreditation standards for hospitals and posts for SET(63). Attachment 1 is the initial review; Attachment 2 is the more comprehensive review incorporating findings from the 2022 Rural Accreditation workshop and the AMC 2023 standards.

The data and analysis occurred in 3 phases.

1. 2022: non-clinical researchers conducted a desktop review of the accreditation standards, criteria, regulations and accreditation assessment processes for each surgical speciality. Standards, criteria and processes for application for accreditation for each training program were taken from the published standards and/or application forms on RACS or specialty society websites, or by contacting relevant STB/Cs via email if information was unclear or difficult to obtain (Attachment 1).
2. 2023: updated spreadsheet created incorporating work from the initial spreadsheet. Barriers to accreditation of rural training posts were mapped to each criterion, using insights from participants at the 2022 Rural Accreditation workshop and qualitative interviews (Attachment 2).
3. 2024: rural clinician subject matter experts reviewed the updated table, modifying as necessary (Attachment 2).

Specialty specific accreditation standards and criteria may not meet RACS and AMC Standards

Adherence to the RACS accreditation standards by STB/Cs (specialty specific standards and criteria) is not universal. There are certain omissions as well as additional specialty specific criteria.

Duplication, repetition and disconnection from healthcare standards and accreditation

Hospitals seeking accreditation for more than one surgical training program must complete separate applications for up to 9 surgical specialties. There is no system to allow hospitals to complete one application form covering most of the RACS accreditation standards and criteria, and separate smaller applications for individual surgical programs. Standards, criteria and evidentiary requirements do not correspond with national and jurisdictional systems for role delineation, facility capability levels (for surgery, anaesthetics, paediatrics, critical care) or safety and quality standards (e.g. the Australian Commission on Quality and Safety in Healthcare NSQHS standards).²⁶

The application process lacks transparency and efficiency

Some training programs have online applications with tick boxes and areas for text entry. Others require hard copy applications or require evidentiary documents to be attached/uploaded. While accreditation standards for each program are easily accessible, for some programs additional, sometimes extensive, criteria are discoverable only once inside the application portal. Application forms do not always reference standards or match standards. Applicants need to access both sources of information (standards and application form) to understand the full spectrum of accreditation requirements, the nature and extent of evidence required, and to estimate the time to complete the application.

STB/C specific insights

RACS oversees hospital training-post accreditation for Cardiothoracic Surgery and Paediatric Surgery; therefore, the standards and criteria for these specialties are identical to the RACS

accreditation standards. The application form for these programs includes a list of documents required to substantiate each standard and/or criterion.

General Surgery incorporates all of the minimum RACS accreditation standards, in order, plus additional specialty specific requirements and a specific standard for trauma training posts. The online application process is efficient, with a narrative summary of required evidence for each standard.

Neurosurgery uses the RACS accreditation standards, with some omissions (e.g. 24-hour remote access to IT systems and private study areas, National Association of Testing Authorities/Royal College of Pathologists of Australasia/International Accreditation New Zealand accreditation). It has additional specialty specific criteria and allows for accreditation of primary (urban) and secondary (regional) training sites, where a Trainee spends time in both units consecutively and concurrently during a period of training.

The AOA has developed standards independent of the RACS accreditation standards.

PRS uses the RACS standards plus specialty specific criteria, which are only visible in the application form.

Urology uses the RACS standards with a few differences, mainly comprising variations in terminology.

OHNS has some flexibility to enable accreditation of rural or regional training posts, for example, allowing outpatient experience to occur in private practice if a public hospital outpatient clinic is not available (a common occurrence in Victoria and New South Wales where most consultations occur in private practice), a reduction in supervisor per Trainee ratio of 2:1 (rather than 3:1 for urban training posts) and the addition of a remote supervisor, and the removal of the requirement for the roles of supervisor of training and director of the unit to be held by two separate surgeons rather than by one surgeon.

Vascular Surgery stipulates that RACS hospital accreditation criteria must be satisfied. However, terminology varies between the RACS and Vascular Surgery standards, with several RACS criteria omitted.

2023–2025 RACS HOSPITAL TRAINING-POST PROJECT

Concurrent with the NHPO review and report and the AMC consultation and publication of the model standards and model procedures, RACS is developing a new model of accreditation through the RACS HTP Accreditation project, for implementation in 2026. Both the FATES 1 project and the RACS HTP Accreditation project evolved in response to changes in the external regulatory environment. Although this resulted in delays to both projects, the outputs are now aligned to the new AMC standards and procedures and will be fit for purpose.

The RACS HTP Accreditation project team produced 2 documents: The HTP accreditation Part A application form, and the HTP accreditation Part B application form. These application forms also function as a 'supporting evidence' resource to assist hospitals in applying for accreditation by providing information on the kinds of evidentiary documents hospitals can include in their submission to demonstrate minimum accreditation requirements have been met. The HTP Accreditation project team consulted extensively with the RACS Rural health equity steering committee, RACS Rural surgery section committee and FATES 1 investigators. The documents are included in this report to highlight changes made to existing accreditation standards for reducing barriers to rural hospital training-post accreditation. These appear under 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.

The RACS HTP Accreditation project has been discussed at the CPMC and aligns with the development of the FATES 3 National Accreditation Portal IT Requirements project²⁰, led by RACMA in collaboration with CPMC and all specialist medical colleges. The project has the potential to significantly streamline accreditation processes and reduce the burden on rural hospitals of engaging with accreditation processes.

RACS SPECIALTY SPECIFIC INITIATIVES TO INCREASE RURAL TRAINING-POST ACCREDITATION

The following section highlights specialty specific initiatives to reduce barriers to rural training-post accreditation, as part of the RACS *Rural Health Equity Strategic Action Plan*.¹⁴

General Surgery

The ABiGS shared the *Review of Hospital Accreditation from 2013–2025 General Surgery Report*. Board Chair Robert Whitfield provided the following summary:

‘Fifty new posts have been accredited since 2013. The majority of the increase occurred in 2015 and 2016 when the board actively reviewed the then SET1 training posts and converted those that met the standards to SET2+ posts.

Since 2017, whilst the number of training posts has fluctuated slightly, they have remained relatively steady. The net difference between 2016 (407 training posts) and 2025 (413 training posts) is 6.

From 2013 to 2025 there has been **an increase of 20 (20.83% increase) training posts accredited in rural–remote areas (MM2–MM6)**. The majority of increases occurred in MM3 designated areas. This increase however occurred in hospitals that already contained accredited training posts. From 2013 to 2025 there have been 2 new sites in an MM4 area.

As of 2025, the percentage of training posts in rural–remote areas in General Surgery is 28.09%, with 71.67% in metro areas and 0.24% overseas. As of 2025, the percentage of training sites in rural–remote areas is 34.38%, with 64.84% in metro and 0.78% overseas. As per the Australian Institute of Health and Welfare, 28% of Australians live in rural and remote areas, signifying that for General Surgery **the number of accredited training posts in MM2–7 is in line with the population and the number of hospitals is slightly higher.**

The board will continue to review all hospitals that submit an application for accreditation of training posts and is open to flexible arrangements in regard to setup of posts as well as supervision that ensure the Trainees obtain the required training, education and experience in a supportive environment.”

Otolaryngology Head & Neck Surgery

The BOHNS introduced the *Hospital Accreditation Requirements for Otolaryngology, Head and Neck Surgery Australian Regional Accreditation Criteria* ⁵⁸

‘BOHNS is committed to addressing the shortage of regional surgical services and increasing regional training exposure within the OHNS Surgical Training Program. The BOHNS has introduced a Regional Accreditation initiative in line with the RACS *Rural Health Equity Strategic Action Plan* with the aim of increasing interest and participation in regional & remote practice.’

The regional accreditation criteria allow for a flexible model of supervision. The BOHNS accreditation criteria require a training post to have 3 surgeons; most rural and regional OHNS units have 1 or 2

surgeons. The regional accreditation criteria allow for 2 onsite surgeons with additional support from a remote supervisor and a remote mentor. Training posts accredited under this model may only host each Trainee for 6 months and are inspected every 12 months rather than every 3 years.

Plastic and Reconstructive Surgery

The Darwin Workforce Project ⁵⁵ is part of the ASPS rural and regional strategy. The project has successfully enabled accreditation of Royal Darwin Hospital (RDH) for training:

'Patients in the Top End in need of plastic surgery treatment will no longer need to travel interstate, thanks to a new partnership between ASPS and NT Health bringing specialist plastic surgeons to the region. ASPS has been concerned with the shortage of high-quality plastic surgery services in parts of regional Australia for many years, forming a Rural and Regional Committee in 2019. The partnership, which commenced in 2020, sees some of Australia's most highly skilled plastic surgeons work and live in the Top End in a rotation system involving Royal Darwin Hospital and Palmerston Regional Hospital. In addition to undertaking specialist plastic surgery procedures during their time on rotation, the placements also enable local surgeons to further develop their skills through training opportunities with the specialists.' ⁵⁵

The goal was to increase services for the community and to provide specialists to supervise SIMGs on a pathway to Fellowship. The outcome is a sustainable service that has grown from less than 1.0 FTE consultants to 5 local surgeons, an accredited training position, new outreach services and collaborative care with other surgical specialties, enabling more cancer and trauma reconstructive surgery to be provided locally. ASPS publishes project impact reports.

The project provides an example of collaboration and leadership by medical specialists to increase services and supervisory capacity in an area of need.

Neurosurgery

The Neurosurgery accreditation criteria enables accreditation of secondary sites provided they are linked to a primary training site, and allows Trainees employed in a primary training site to spend time in secondary training sites.⁵⁹ The Board of Neurosurgery defines primary and secondary units as follows

'For accreditation as a training network, which includes multiple neurosurgical units, there must be one neurosurgical unit nominated as the primary unit for the training network, which must satisfy the primary unit requirements as outlined in these regulations. The remaining units will be classified as secondary units and must satisfy the secondary unit requirements as outlined in these regulations. Secondary units must be located near the primary unit, except for secondary units in an RRR location...Trainees are only allocated to primary units. Where secondary units are accredited as part of a training network, Trainees may spend no more than 25% of their time in the rotation at the secondary units combined. Where a training network includes a secondary unit in an RRR location...the board determines the length of time the Trainee spends in the rotation in the secondary unit.'⁵⁹

Accreditation criteria for secondary sites allow for fewer resources and supervisors. Examples of primary-secondary pairs include large tertiary hospitals paired with adjacent private hospitals and tertiary adult hospitals paired with children's hospitals. The sole regional pairing is Townsville and Darwin.

The accreditation standards further reduce barriers to regional training-post accreditation by enabling Trainees in secondary sites to participate remotely in formal learning programs and/or research and/or quality assurance (e.g. audit, morbidity & mortality meeting) provided by the primary site,

enabling non-Fellow surgeons (vocationally registered or limited registration in an area of need) to participate in training surgeons in RRR units, and no requirement for highly subspecialised resources (e.g. onsite neuropathology and neuropsychiatry) in secondary sites where these services would usually be accessed remotely.

Orthopaedic Surgery

Rural training posts may not be able to meet all accreditation criteria that urban hospitals meet, but this does not necessarily mean the training experience for these registrars is inferior.

The AOA accreditation standards state: 'It is recognised that not every training post can provide Trainees with exposure to learn all aspects of the AOA curriculum. Therefore, accreditation reviews assess that training posts can contribute effectively to each Trainee achieving general orthopaedic surgery expertise and the ability to provide quality patient care on their first day of independent practice.'⁶⁰

RACS NORTHERN TERRITORY STAKEHOLDER ENGAGEMENT

RACS convened the Rural Accreditation workshop on 6 August 2022 in partnership with RACMA, as part of their collaborative work on rural accreditation. The one-day workshop was facilitated by Tindal Magnus from Amplexa Consulting. Amplexa consulting has expertise in vocational medical training and application of the AMC standards. The Amplexa workshop report is attached (Attachment 3), along with a shorter summary report (Attachment 4).

The workshop formed part of a multi-day visit by senior RACS representatives, including then President Sally Langley, then Chief Executive Officer John Biviano, then Executive General Manager Fellowship Engagement Etienne Scheepers, then Executive General Manager Education Partnerships Christine Cook, Associate Professor Kerin Fielding and Dr Bridget Clancy.

The workshop was held in Darwin as part of RACS's commitment to increasing access to surgical care in the Northern Territory and the remote northern and central areas of Australia. Identifying barriers to accreditation of remote and rural training sites is a key step towards increasing access to surgical training for remote and rural doctors in Australia. RACS and the NT Government signed a memorandum of understanding in April 2022 to facilitate the establishment of an environment and structures to support the training of an Australian qualified workforce that is locally trained within the NT; identify and develop opportunities for the training of Indigenous surgeons; explore ways in which Indigenous health outcomes can be improved within the NT; and develop strategies to enable the retention of the workforce within the NT.

RACS representatives met with NT Chief Minister and Health Minister the Hon. Natasha Fyles; Dr Frank Daly, Chief Executive Officer NT Department of Health; Adjunct Professor Joanne Norton, Deputy Chief Executive Officer NT Department of Health and Professor Marco Briceno, Chief Medical Officer NT Department of Health, to discuss the memorandum of understanding.

The RACS team toured the RDH, the Palmerston Regional Hospital (PRH), the Menzies School of Health Research and the Flinders Medical School NT Clinical School Rural Clinical School.

The team met with local and visiting surgeons from all specialties at RDH including Dr Matthew Sharland, Head of Orthopaedics; Dr Mark Hamilton, Head of Vascular Surgery; Dr Manimaran Sinathamby, Head of General Surgery; Dr Mahiban Thomas, Director of Surgery; Drs Hemi Patel and Graeme Crossland, OHNS Department; Drs Ravi Mahajani and Shiby Ninan, PRS Department; Dr Johnny Efendi, Neurosurgery Department; and Drs Henry Duncan and Suzanne Brady, Urology Department.

The team met with Top End Health executives, including Allison Grierson, Executive Director RDH and PRH; Sara Watson, Director Medical Services RDH and PRH; Helen Mason, Executive Director RDH and PRH and Dr Kanakamani Jeyaraman, Director of Clinical Training RDH. The team also met with medical educators from the Flinders Medical School NT Clinical School (Dr Emma Kennedy) and Charles Darwin University (Prof Dianne Stephens), eminent researchers from the Menzies School of Health Research, Trainees and junior doctors.

The RACS team gained insights regarding SIMG pathways to RACS Fellowship and assessments in dedicated meetings that included RACS NT committee members, Heads of Departments and Directors of Clinical Training (Professor Phil Carson, Dr Richard Bradbury and Dr Patrick Bade).

The RACS team visited the National Critical Care and Trauma Response Centre with RACS surgeon and Director of Trauma Dr Annette Holian. The visit highlighted the opportunities for trauma training for RACS Trainees in the Top End.

FATES 1 RURAL ACCREDITATION WORKSHOP

There were 33 participants present at the Rural Accreditation workshop, including Trainees, surgeons, anaesthetists, physicians and medical administrators from Katherine, Alice Springs and Darwin; RACS and RACMA; the NT training hub; and the Territory and Federal governments.

After Dr Richard Fejo welcomed participants to Country, Kim Hanna, CEO of ASPS, presented the ASPS rural and regional strategy, including the Darwin Workforce Project.⁵⁵

In small groups, participants critically examined the RACS hospital training-post accreditation standards, focusing on barriers and possible solutions for RRR hospitals in both applying for hospital training-post accreditation and meeting accreditation standards. Insights from small groups were presented to the main group, with discussion and consensus building.

NT stakeholders, including surgeons, administrators and government, discussed the challenges in working with the RACS accreditation standards and the missed opportunities to provide place-based training in the Territory, including in single-surgeon services.

For all barriers identified, creative and thoughtful proposals were presented that could be achieved with adaptable approaches and support.

A workshop evaluation was undertaken.

Outcomes:

A flexible approach to accreditation is required to enable Trainees to access the benefits of rural training. Key activities were identified to enable the expansion of rural training: a proactive approach to workforce planning, including distributing training sites/posts in response to community need for surgical services, combined with dedicated RACS resources to assist rural and remote administrators and supervisors.

Theme 1: A new paradigm

RACS must be proactive in providing rural training experience for Trainees to achieve graduate and workforce outcomes.

Workshop participants challenged the assumptions and closely linked biases that the current system of surgical training was delivering excellence for all communities, that rural training experience was inferior to urban training experience, and that rural healthcare is inferior to urban healthcare. The current system of training is not delivering equity of outcomes for RRR patients and there is a need to realign surgical training with community need. The persistent linking of rural training with the risk of

compromising the quality and safety of outcomes for Trainees and patients needs to be challenged. All stakeholders in medical speciality training and in the delivery of healthcare services are working to deliver effective training and safe, quality outcomes for patients and their families.

Flexible accreditation will enable diverse training sites and experiences.

Rural and remote training sites face barriers in meeting RACS and specialty specific accreditation criteria, in particular rigid 3:1 supervisor to Trainee ratios, a focus on a specified number of major or subspecialty operative procedures rather than a holistic assessment of Trainee experience (including emergency department [ED], outpatient/consulting experience and professional skills), exclusive use of resources that could feasibly be shared between specialties (wards, tutorial rooms, office space etc.), and onsite or physical access to resources that are now accessed in a virtual or digital environment (formal learning programs, libraries, radiology and pathology meetings, multidisciplinary meetings etc.).

STB/Cs must understand that a key element of rural contextual competence is the development of strategies that result in the best outcome for patients in an environment of resource limitation or variability. While all rural facilities would appreciate more funding for recruitment and infrastructure, accreditation standards should enable Trainees to access a diversity of training contexts.

RACS, via STB/Cs, must enhance its support for rural supervisors and Trainees, incorporate new ways of working (virtual, networked) and incorporate place-based solutions into accreditation standards:

- Shift the focus to development of competence in both technical and professional skills, not rigid case number requirements.
- Measure supervision quality directly, not via number of supervisors.
- Adopt team-based supervision including novel, multidisciplinary and hybrid models. Enabling multidisciplinary/interdisciplinary supervision will allow a rural general surgical Trainee to benefit from working with and being supervised by a PRS Surgeon, an OHNS Surgeon and a Urologist, in addition to 1 or 2 General Surgeons, delivering a richer training experience and access to the extended scope of practice many rural general surgeons engage in.
- Build supervisory capacity: Provide appropriate time/remuneration for the role, adopt novel solutions to supervision (e.g. ASPS Darwin Workforce project), adopt team-based/virtual/network approaches of support for supervisors (ASOHNS regional accreditation), virtual communities of practice and reflective practice.
- Adopt virtual, networked formal learning programs, libraries, radiology and pathology meetings, multidisciplinary meetings and research (e.g. teleclinic trials), including the utilisation of local public and private facilities, and distant sites within or between healthcare and training networks.
- Consider the impact on rural Trainees of compulsory in-person courses and examination; provide as many locally or virtually as possible and provide support when travel is necessary.
- Recognise that diagnostic and critical care services in rural and remote areas may be provided differently (e.g. High Dependency Unit [HDU] instead of Intensive Care Unit [ICU], virtual radiology and anatomical pathology services).
- Share physical resources between surgical and medical specialties (e.g. inpatient wards, tutorial rooms, office spaces).
- Advocate for technology and connectivity such as simulation facilities for rural training and healthcare delivery.

Theme 2: Streamlining accreditation

- Recognition of the significant administrative burden on smaller teams of administrators and surgeons in rural training sites, and the need to streamline processes and provide resources.

- Leveraging existing systems of accreditation of health services, including national hospital peer classifications, jurisdictional role delineation and capability frameworks and regular monitoring and accreditation against the Australian Commission on Quality and Safety in Healthcare NSQHS Standards.²⁶

Theme 3: maximising upsides/minimising downsides for Trainees

- Minimum 12-month rural placements to foster community integration for Trainees and reduce the burden of frequent relocation.
- Operationalising the Operating with Respect program: Tools to support a positive workplace culture (e.g. 360-degree reviews, transparent complaints processes, whole-of-hospital surveys, exit interviews and root-cause analysis that identify and address issues and problematic behaviours such as bullying), alongside mechanisms to build effective supervision and clinical leadership (e.g. skills training in business management, leadership and performance management, and offering the RACS Operating with Respect resources to all disciplines).

FATES 1 LITERATURE REVIEW: RURAL ACCREDITATION – ADDRESSING BARRIERS TO RURAL SPECIALIST TRAINING⁶¹

Authors: Alun Cameron, Dannii Dougherty, Joanna Duncan

The following information is compiled from the executive summary (full report supplied as Attachment 5).

People in RRR communities in Australia have poorer health outcomes compared with those in metropolitan areas. Coupled with this inequity are medical workforce shortages in non-metropolitan areas. Having surgical Trainees in RRR centres has been shown to improve workforce numbers and can be associated with broader improvements to the health service. However, accreditation requirements for postgraduate training posts have been developed in the context of large metropolitan tertiary hospitals and it is difficult for RRR services to meet these requirements.

This literature review is one part of the FATES-funded project: *Rural Accreditation – Addressing Barriers to Rural Specialist Training*. The review of published literature aims to investigate and address the barriers facing RRR hospitals when attempting to gain accreditation for surgical training posts.

Systematic searches of MEDLINE and Embase were performed using a search strategy including terms related to 'surgery', 'accreditation and components', 'rural', and 'barriers and incentives'. Grey literature was also investigated. Studies were selected based on reference to the research questions. No restrictions were placed on study or publication type. The search retrieved 91 studies: 23 narrative reviews, 21 observational or retrospective series, 10 surveys, 1 non-randomised comparative study and 3 systematic or scoping literature reviews, with website searches identifying 33 documents or webpages. Overall, little formal research is available on this topic. Evidence was drawn from narrative reviews and retrospective studies. A thematic analysis was undertaken and results were described narratively.

Large geographical distances, the nature of postgraduate medical STP needs, and training-post accreditation requirements each create unique challenges in providing RRR specialty training in Australia compared to other countries. There were relatively few publications explicitly on barriers and solutions to the accreditation of training posts in RRR centres. However, retrospective analyses and narrative reviews did provide information on various aspects of training and accreditation.

Increased subspecialisation and its effects, particularly in rural areas, is an issue in many countries. The case-mix and case volume in RRR hospitals is clearly different to that seen in metropolitan centres. Training solely based on numbers of specific types of operations can thus be a problem for some RRR training sites. Training to competency was not specifically investigated as part of this literature review, but it should be considered in line with the requirements of each specialty and applied to training programs and accreditation standards as needed.

The RRR setting provides other valuable opportunities to the training experience, such as increased independence, a broad scope of practice, a mix of experiences, and interactions with First Nations people. While accreditation and training can be a burden in an RRR setting, the literature showed that benefits of training-post accreditation can flow to the broader workforce and health service. These include access to infrastructure, improved (cross-specialty) collaboration and interprofessional learning, increases in services and workforce capacity, and the recruitment and retention of specialists.

Rather than accept the limitations of a small RRR site, accreditation standards should be flexible enough to recognise the value of the broader experience and the more general and varied scope of practice that RRR training posts provide compared to a traditional metropolitan teaching hospital. The current AMC accreditation standards allow for a flexible approach.

Conclusions

Unique opportunities for the Trainee: RRR training posts are different to training in a metropolitan setting. They are nevertheless valuable, with a positive Trainee experience, varied scope of practice and more first-hand operator experience. Unlike training in metropolitan hospitals, rural training enables Trainees to develop rural practice capability and rural self-efficacy, increasing their confidence to work rurally in future.

Unique opportunities for the health system: RRR training posts help attract and maintain senior clinicians. Trainees, particularly senior Trainees, can enhance the local workforce and receive relevant experience. The greater the number of training posts, the easier it is to attract a specialist workforce. Rural training experience is positively correlated with future rural practice. Increasing rural training is one lever to reduce workforce maldistribution.

Caseload, case-mix and training opportunities: Surgical demands at RRR hospitals vary, and differ from those at large metropolitan hospitals. This is reflected in the scope of the RRR training experience. There is a need to recognise the strengths of the case-mix and other aspects of the scope and opportunities that RRR training can provide. The accreditation standards and training requirements should be flexible to allow for this, rather than be metro-focused and based on case numbers. There must be a recognition of the more generalist scope of practice and interdisciplinary benefits of an RRR placement. While there may be less exposure to some procedures (i.e. more complex cases or more specialised procedures), for other procedures the numbers of cases and the exposure to training opportunities can be greater. Trainees need a broad experience of conditions and procedures. Specialty collaborations and training networks can help in this regard.

Supervision requirements: Supervisors should be provided with support, training and effective advocacy. The number of specialists at RRR centres can be low. A key barrier in achieving hospital training-post accreditation in Australia is the requirement to provide for each Trainee 2–3 supervisors who are Fellows of RACS (FRACS). Flexibility in the number of supervisors could be based on total FTE supervisor hours of direct FRACS supervision. Partnerships with other specialties or subspecialties, and offsite, remote (e.g. telementoring) or network

supervision models would be helpful. Younger Fellows, locums or SIMGs could also play a role. The role of supervisors as mentors should be acknowledged and developed, as well as the value of peer support.

Infrastructure and workforce requirements and administrative burden on the health service: RRR hospitals must balance the workforce requirements of healthcare delivery, supervision and training. Senior Trainees can provide additional workforce support to an RRR hospital. However, the demands of the accreditation process (and training delivery) can be a burden, particularly for less experienced RRR centres. Transparent information would be valuable to understand and clarify what is needed to comply with the accreditation standards. A more flexible approach to gathering and presenting the evidence needed for accreditation could be beneficial, including coordinating and sharing information and activities across specialties and colleges. Standardising terminology and definitions would also be helpful. Tools and support (such as centralised hubs or networks for administrative support) could be valuable. As part of the accreditation process, ensuring rural knowledge within the accreditation assessment team and providing good-quality feedback is essential. RRR sites may need help to develop the necessary training infrastructure, including IT support. These facilities can also benefit the broader workforce. Financial support or partnerships with larger centres may also be helpful for RRR units to gain accreditation.

Lack of transparency of accreditation standards: It is a significant commitment for an RRR site to apply for an accredited training post. The accreditation standards need to be transparent, so the site is properly informed and understands the requirements.

Other issues: Research in an RRR site is often difficult, due to distance from other units and a lack of infrastructure. Linkages with rural universities and medical schools, as well as funding for conference attendance, would support this aspect of the accreditation requirements. Other aspects of the broader rural experience should be recognised as being valuable to the Trainee as an alternative to the research requirement. The process of preparing for accreditation and providing training can be costly. Support should be provided for RRR sites to meet the costs for seconded Trainees and for Trainee entitlements to be preserved across all sites.

FATES 1 SCOPING REVIEW: IMPACT OF THE QUANTITY OF SUPERVISOR OVERSIGHT ON SPECIALTY TRAINING OUTCOMES⁶²

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The following information is compiled from the introduction, discussion, and conclusion (full review supplied as Attachment 6).

Research question: What is the evidence supporting quantity of supervisor oversight on specialty training outcomes?

Quality supervision is required for Trainees to achieve the learning and graduate outcomes of specialty medical training. Supervision can be direct (direct observation), indirect (within the same facility or able to attend within a specified time) or remote (not at the same facility, available by phone or video, not available to attend).⁴

The quality of supervision can be measured in several ways, including Trainee outcomes, patient safety and quality of care, Trainee surveys and multisource feedback for supervisors. A common proxy is the quantity of supervision. Quantitative measures include: the number of supervisors, the number of hours of supervision, the number of patient encounters or procedures directly supervised, or a combination of one or more of these. The evidence

supporting the ideal quantity of supervision (including number of supervisors and number of hours of supervision) for the best training outcomes is uncertain.

The RACS training committee/board standards for accreditation of hospital training posts include a requirement for a minimum number of FRACS surgeons per Trainee. Seven of 9 STBs have a quantified supervisor requirement (2 or 3 FRACS to supervise each Trainee) in their training-post accreditation standards. Supervisors must be available to attend on site when needed. That is, they must provide direct and indirect rather than remote supervision. The standards do not include a minimum requirement for number of hours of direct and indirect supervision per Trainee per week.

In the context of rural surgical specialty training, RRR hospital surgical units tend to have fewer FRACS surgeons with higher per-surgeon FTE compared to urban surgical units with more FRACS surgeons and lower per-surgeon FTE. As a result, many RRR hospitals are unable to reach and maintain the requirements of training-post accreditation of specialist medical colleges and specialty societies.^{39 63}

Current AMC accreditation standards are flexible and allow for remote and alternative models of supervision.^{7 48} Remote supervision cannot completely replace direct and indirect supervision for surgical training but presents a solution to expanding the number of supervisors available to a Trainee. The RACS *Rural Health Equity Strategic Action Plan* recommends that supervision be based on total FTE hours of direct consultant supervision rather than on the total number of FRACS employed, to preserve quality and remove the barrier to accreditation of the rural post.^{29 64 14 33} An example is, rather than having 3 surgeons providing a total of 4 sessions of onsite supervision per week, there could be 2 surgeons providing a total of 8 sessions.⁶⁴

The objective of this scoping review is to identify and describe evidence that supports quantifiable supervisor requirements for specialty training (e.g. number of individual supervisors, number of hours or number of sessions of supervision per week) and how this relates to training outcomes and patient safety.

The scoping review identified a small number of studies, commonly examples of local specialty training programs with limited objective outcomes reporting. A small number of comparative studies were available, which provide insights into training programs over time and across different groups.⁶⁵⁻⁶⁸ None of the studies provide direct evidence on the impact of any single aspect of specialty training or supervision on the training program. Due to the variability in study design and reporting, no synthesis was possible. However, the studies provide an understanding of perceptions and outcomes of various training programs.

There was no published evidence on any quantitative aspect of supervision or other single component of postgraduate specialty training. Specifically, there was no evidence for the current practice of requiring defined supervisor to Trainee ratios. Studies suggest that specialty training programs, training terms and training sites are inherently variable, providing different experiences. Where reported, the training outcomes are perceived to be highly satisfactory, but commonly with areas for improvement. Tailoring the training to individual Trainee requirements and allowing an appropriate level of autonomy is needed.

Specialty training is a complex activity involving a number of different variables. In any defined training program, the impact of any single element on the quality of training is not well understood. Allowing time for teaching, having an appropriate workload and good-quality supervision are commonly reported. Particularly with less experienced Trainees, more direct oversight can lead to improved outcomes, but the manner in which this is best provided per placement is not clear.

Future research to quantify the quality of training and supervision in Australia would further inform aspects of local training and help identify any points of improvement.

CROSS UTILISATION STP AND FATES PROJECTS

RACS STP projects—the FATES 2 Rural Training Models (led by RACS) and the FATES 3 SSTs (led by RANZCOG)—were revisited and a desktop analysis of all FATES-funded projects was conducted to identify relevant projects, implementation evaluations and outputs.

SPECIALIST TRAINING PROGRAM

The STP aims to:

- improve the specialist workforce by providing quality training posts in different settings to broaden participants' experiences
- increase the number of specialists working in RRR areas.¹⁴
- Apart from funding rural training posts, STP project grants are available for rural training projects.

The following completed and in-progress RACS STP projects informed FATES 1:

1. Gap analysis of barriers and incentives to Trainees preferencing rural placement and new Fellows rural career uptake.³⁵
2. RRR Professional Skills Curriculum and eLearning course. 2021–2026
 - a. Phase 1: Investigation and Development of a rural-facing surgical curriculum framework. Developed key domains of professional skills where urban and rural practice diverge. Identified need to train for analysis of rural context, rural contextual decision-making and RUFUS (rural focused urban surgical skills including inreach/whole-of-person care, telehealth, outreach and collaboration in dispersed teams) 2021–2022.
 - b. Phase 2: Rapid review of evidence for efficacy and acceptability of professional skills training in a virtual environment, and stakeholder needs analysis, confirming that rural and urban surgeons and Trainees agree with the priority domains and support the need for the curriculum to be developed 2023.
 - c. Phase 3: RACS RRR professional skills eLearning course 2024
 - d. –2026. Rural professional skills curriculum refined and learning modules created to support Trainees in developing rural and RUFUS professional skills.
3. Asynchronous video coaching in rural settings 2022. This work was relevant for remote supervision and involved asynchronous video coaching in non-technical or professional skills, initially for surgeons, with the intention that the findings can be used to develop programs for remote asynchronous coaching for Trainees, expanding their access to quality supervision during rural training placement.
4. *Towards culturally safe and effective training pathways for Aboriginal and Torres Strait Islander medical specialist Trainees* April 2025 by Professor Yin Paradies, BSc, MMedStats, MPH, PhD, FASSA, FAHA, Deakin Distinguished Professor and Chair in Race Relations 2024–2025.³⁶

FLEXIBLE APPROACH TO TRAINING IN EXPANDED SETTINGS

There have been 4 rounds of FATES grant funding.

The FATES projects of most relevance to FATES 1 include:

1. FATES 2 Rural Training Models (RACS, ANZCA, RACMA, RACP, RANZCO)

2. FATES 3 Promoting Health equity in RRR communities, a cross-college consortium's vision for supervisor excellence, yielding the SSTs (RANZCO, RANZCR, RANZCOG, RACS, RACMA, CICM)
3. FATES 3 RACMA project: National Accreditation Portal IT Requirements project.²⁰ Building on the work undertaken by the AMC to develop model accreditation standards and procedures, the revised FATES 3 project will focus on developing the IT specification requirements and investigating the feasibility for a shared hospital accreditation portal. This portal would support both health service settings and specialist medical colleges by addressing longstanding inefficiencies and duplication in accreditation processes. It would also enable better data coordination, enhance transparency and reduce the administrative burden across the accreditation lifecycle.
4. FATES 4 RACP Workforce Mapping and Accreditation Renewal Project, linking rural workforce strategy with accreditation.
5. Models of hybrid supervision (CICM onsite and remote), rotatory supervision (ACD continuity of supervision provided by shifts of visiting supervisors), blended supervision (ACEM onsite, multidisciplinary/interdisciplinary and remote supervision), remote supervision (ACSEP)
6. Increasing supervisory capacity in rural training sites (RANZCP Rural Director of Training pilot program, ACD re-establishing training in Tasmania)
7. Increasing resources for RRR supervisors (RACP resource to support culturally safe supervision, Upskilling RANZCR Regional Rural and First Nations Clinical Supervisors in Medical Education), digitally enhanced supervision (ACD Towards a New Paradigm for Specialist Training – Harnessing digital technologies to optimise national supervisory capacity and efficiency, Diabetes Alliance program) ACSEP Sport and Exercise Medicine Supervisor Support Scheme)
8. Increasing resources for Trainees in rural training sites, including:
 - a. online application portals for rural prevocational doctors (RANZCR Reducing Application Barriers for Specialist Training for Regional, Rural and Indigenous Doctors – A centralised application solution)
 - b. simulation facilities (ANZCA simulation collaboration)
 - c. national/networked formal learning, support and orientation for rural practice and orientation to each training site programs (RANZCR RESP, RANZCP Rural Readiness Project)
9. Colleges proactively seeking to develop training positions in rural sites:
 - a. RACP Rural Physician Training Pathway, RACP Rural Paediatric Training Pathway, RANZCP WA Rural Psychiatry Training Pathway, ACSEP Regional and Rural Training Pathways in Expanded Settings)
 - b. overcoming 'generalisable barriers' to accreditation of rural training sites (ACD Towards a Homegrown Workforce; college-led consortium approach to co-designing and establishing transferable and sustainable accredited rural-centric specialist training)
 - c. creating rural-specific accreditation pathways (ANZCA Developing Flexible Accreditation Pathways for Pain Medicine Training in Rural Settings)
 - d. Rural outreach and virtual healthcare training posts (RACP Diabetes Alliance program)
10. Colleges proactively linking smaller sites to larger sites to form rural networks (RACP Rural Palliative Care Medicine Network, ACEM Piloting an Integrated System of Regional and Rural Accredited EM Training Networks) and rural training pathways (RANZCOG Rural O&G Specialist Pathway, RACP Remote and Aboriginal Cancer Care).

FATES 2 RURAL TRAINING MODELS RECOMMENDATIONS

The following recommendations from the FATES 2 Rural Training Models report provide insight into the role of accreditation within the wider context of rural health equity and rural workforce strategies.

1. Colleges develop and publish rural health equity, rural training and rural workforce strategies.
2. Colleges evaluate the effectiveness of rural health training and workforce strategies and publishing annual reports.
3. Colleges engage with and integrate rural training initiatives into the RHMT program, including university departments of rural health, regional training hubs and FRAME.
4. Colleges develop strategic collaboration with regional training hubs and/or existing rural training networks in areas of community need as informed by health workforce data.
5. Colleges formalise inter-college collaboration on rural health training and workforce initiatives, sharing of resources/developing shared resources and the development of rural training models.
6. 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.
7. Colleges engage stakeholders to facilitate relocation support for Trainees and their families and to ensure assistance occurs in a systematic way for all Trainees relocating for rural training.
8. Colleges to engage stakeholders to develop systemic and place-based solutions to assist Trainees to secure suitable accommodation within RRR areas.
9. Colleges develop a collaborative strategy, with the AMA Doctors in Training Committee and 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.
10. Colleges 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 regional, rural and remote hospitals and communities.
11. Colleges incorporate RUFUS skills into curricula and RUFUS experience into training program requirements, including outreach, virtual healthcare and collaboration in dispersed teams/virtual teams.
12. Colleges foster culturally safe training environments for Aboriginal and Torres Strait Islander Trainees and/or Māori, provide resources for all Trainees to develop cultural competence and cultural safety skills, and support 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.
13. RACP to consider providing access to the Culturally Safe Supervision resource to all colleges and supervisors. Colleges to promote the module to all supervisors.
14. Colleges develop place-based training programs and accreditation policies to enable Trainees to access a diverse range of training experiences, including rural, generalist and Indigenous models of care.
15. Colleges combine place-based training with place-based curricula and learning resources; colleges share and/or collaborate on the development of rural readiness, rural professional skills and generalist curricula and resources.
16. Colleges to implement digital/virtual policies and processes to support rural training, including online application for selection, virtual interviews, digital competency and log-book applications, virtual access to training and supervision resources and professional development and networking events.
17. Colleges 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.
18. Colleges develop policies to facilitate equitable access to formal learning programs and examination preparation resources for rural Trainees via urban–rural partnerships, virtual access and annual or biannual in-person events.

19. Colleges consider accessibility of compulsory in-person courses for rural Trainees, including resources to support registration and travel and/or providing access to courses in rural and regional areas.
20. 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.
21. Colleges develop and deliver virtual orientation to rural practice and preparation for rural training programs for all Trainees undertaking a rural placement.
22. 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 and can be shared with colleges.)
23. Colleges implement the RANZCO SSTS to support selection, training, reflective practice and CPD for supervisors.
24. Colleges encourage supervisors to access the RACP Culturally Safe Supervision resources.²¹
25. Colleges develop shared resources for rural supervisors (e.g. RANZCOG and RACMA leadership development for rural and remote specialists).
26. Colleges assess and report on progress towards digital tools to map Trainee progress.
27. Colleges promote urban–rural partnerships to ensure all rural training sites are integrated into formal learning programs.
28. Colleges ensure equitable access to training resources for Trainees and supervisors, including virtual participation in tutorials, meetings and courses, and funding to support travel to in-person events when needed.
29. Colleges investigate and implement flexible, novel, place-based and digitally enabled models of supervision, including onsite, remote and hybrid models, interdisciplinary supervision and inclusion of SIMG specialists as clinical supervisors.
30. Colleges develop metrics for supervision quality focused on Trainee and patient outcomes and relevant to flexible models of supervision. Colleges move away from de facto measures of supervision quality including number of supervisors and supervisor to Trainee ratios.
31. Colleges, through their membership of the National Rural Health Alliance, continue to advocate for equitable access to virtual healthcare services and health professional education and training for rural communities, such as telephone, internet and GPS connections that are reliable, accessible, affordable and can support video services, and improvements in digital health literacy.

FATES 3 STANDARDISED SUPERVISOR TRAINING SYSTEM RANZCO – REMOTE SUPERVISION⁶⁹

This project was led by RANZCO, with consortium partners RANZCR, RANZCOG, RACS, RACMA and CICM.

Project outputs include agreed definitions for supervision, mentoring, orientation and training networks and a standardised taxonomy for medical supervisor roles and titles (included in the Definitions section of this report).

A grey literature review undertaken as part of the project, *Supervision, Mentoring and Orientation in Australian and New Zealand Medical Colleges*⁶⁹ revealed the following insights regarding remote supervision. The longstanding Royal Australian College of General Practitioners (RACGP) and Australian College of Rural and Remote Medicine (ACRRM) remote supervision models for rural general practice and rural generalist training provided the most experience and information. RANZCO effective remote supervision models include:

- **Pre-commencement Training:** Trainees and supervisors are required to spend 1–2 weeks together before the start of remote supervision, allowing for relationship-building and familiarisation with the Trainee's skill level and learning needs.
- **Regular Communication:** Remote supervisors allocate several hours each week to teaching, in-practice support, ad hoc communications and formal assessments to ensure continuous supervision despite physical distance.
- **Midterm Site Visits:** A site visit by the remote supervisor at the midpoint of the training period is mandated to assess progress and address any issues in person.
- **Team Meetings:** Onsite and remote supervisors meet regularly to discuss the Trainee's progress and coordinate their supervision efforts.

RANZCO challenges in implementing remote supervision in medical specialist training include:

- **Geographical Restrictions:** Many colleges impose geographical restrictions that limit the distance between the Trainee and the supervisor (e.g. 20 minutes), making remote supervision impractical in rural or remote settings. Other restrictions include stipulation that supervisors must be employed by the same hospital/network.
- **Limited Flexibility:** In many cases, remote supervision is only available to Trainees at higher levels of training, leaving early-career Trainees without access to these options.
- **Supervision Quality:** Concerns about the quality of supervision in remote settings persist, with some stakeholders questioning whether remote supervision can provide the same level of support and oversight as onsite supervision.

OTHER RELEVANT FATES PROJECTS

The following information and analysis is quoted and/or derived from the FATES webpage⁷⁰ and the publication *FATES Forum – Projects on a page*, distributed to attendees at a FATES forum.

Table 7. Summary of FATES projects, rounds 1-4

Funding round	Activities and outcomes
FATES 1¹⁷	
WA ICU training pathway CICM ⁷¹	The Pathway aimed to link rural health training settings to a centralised recruitment and allocation system to provide Trainees with streamlined access to rural training centres and increased education support, coaching and mentoring in WA. Included access to rural and metro training time, and mandatory training rotations, individual learner centred education. From 2023 model incorporated in WA Country Health Service (WACHS), with collaboration from metro directors of ICU and supervisors of training, with sustainable management and funding. Resulted in creation of multiple new training posts. Ongoing funding for administration and for relocation support is required for scaling/sustainability.
ACD An Innovative and collaborative model for hybrid supervision and education for specialist training in Townsville (blend of onsite and virtual supervisors) ¹⁷	The hybrid model was successful, increasing training capacity and service delivery in Townsville (reducing patient wait times) and reducing professional isolation. Virtual collaborative care models between Townsville University Hospital and Melanoma Institute Australia (Sydney) are ongoing.
ACD Implementation and evaluation of supervisory rotational system for specialist dermatology training in the Top End, NT (blend of permanent	Implementation and evaluation of a supervisory rotational system, using visiting supervising dermatology consultants from across the country, resulted in 0.5FTE increase in consultant capacity at RDH, increased outreach services including Trainees, resulted in expansion and stabilisation of training in Top End. Altruism helps in initial phases, but ongoing funding including for salaries, travel and accommodation are necessary for sustainability and scaling up.

and fly-in fly-out supervisors) ¹⁷	
ACEM pilot of blended supervision in EM training (blend of specialties providing supervision) ⁷²	Pilot for training in non-ACEM accredited EDs, with onsite supervision by Fellows of ACEM (FACEM), Fellows of RACGP, Fellows of RACP and virtual supervision by director of EM training, Southwest Victoria and Townsville. Evaluation showed the model was successful and made recommendations for scaling up and sustainability (enhanced use of digital tools, structuring training for non FACEM supervisors, streamlined assessment process, prioritising sites with strong existing training infrastructure).
ACSEP Remote clinical supervision model pilot ¹⁷	Remote supervision by ACSEP Fellow for 8 hours per week plus onsite visits for Trainees in MM2-7, with onsite supervision provided by Fellows from other colleges. 2 Trainees achieved Fellowship through this model and stayed in their communities as Fellows. Evaluation: remote supervision is feasible, scalable and effective, supporting rural recruitment without compromising patient care, increased access to care, recommendations for resources to support face-to-face interaction and measuring long-term impacts, to ensure remote supervision only for more experienced Trainees (e.g. year 3+). Note that the ACSEP supervision requirements are expressed in hours per week, with onsite supervisory hours highest in years 1 (20 hours), progressively reducing over the training program (8 hours in year 3+).
RANZCP Rural Director of Training pilot program ¹⁷	Established rural director of training positions specifically focused on supporting rural Trainees in rural training posts, manage training progression and advocate for rural Trainees, as an adjunct to the implementation of the Rural Psychiatry Training Pathway. Targeted investment increased services and training capacity in rural areas. This project will develop rural directors of training located in and cofounded with 3 state and territory governments. Evaluation pending.
FATES 2²²	
ACD Shaping Sustainable Specialist Dermatology Training and Services in Tasmania ²²	This project aims to build a sustainable dermatology service/training hub in Hobart, a rural transition pathway, and foster a homegrown workforce. Evaluation pending. Will re-introduce dermatology department and training in Hobart, previously stopped due to lack of consultants. Project funds salary of consultants, with focus on recruiting local origin consultants and Trainees.
ANZCA Tasmanian Anaesthetic Simulation, Education and Training Network ²²	This project aims to extend and develop resources for the delivery of anaesthetic education and training in Tasmania with a focus on simulation-based learning. Consortium with the Tasmanian Health Service, the Royal Hobart Hospital, the Launceston General Hospital, the North West Regional Hospital and the University of Tasmania Rural Clinical School. Evaluation pending. Addressing maldistribution of simulation training resources by training trainers and developing infrastructure/equipment/facilities, developing local education strategies for each hospital.
RACP Rural Physician Training Pathway ²²	This project will develop the Rural Physician Training Pathway, which will promote rural training for adult basic physician Trainees (BPT) and advanced physician Trainees (AT) in WA through a feasibility study. In order to become a Physician, Trainees must complete 3 years of basic training and 3+ years of advanced training under the RACP). In WA, physician training recruitment, selection and training is a centralised metro-centric model that requires rural Trainees to leave country WA for prolonged periods in order to successfully complete the RACP physician training requirements. The FATES-funded WA Rural Physician Training Pathway aims to deliver a high-quality rural-first physician training pathway, with a focus on the first 3 years of basic physician training being embedded in rural WA, employed by WACHS, with 'inreach' to metropolitan level-3 training centres to complete the necessary RACP training requirements.

	The pathway will connect rural medical students in rural prevocational training (intern and resident medical years) to rural vocational physician training, enabling rural doctors to stay connected and embedded in country practice. The pathway will be the first rural physician training network to be implemented in Australia, with successful implementation requiring RACP to reimagine physician training requirements through a rural lens, leaning towards outcomes-based accreditation and training rather than a centre-based approach. Partnership with WACHS. The WACHS employed project team consists of, Dr Lloyd Nash, Director Rural Physician Training Pathway, Dr Lee Fairhead, Clinical Educator and Joanne Scammell, Senior Project Officer. The project team is supported by the WACHS Medical Education Unit and the directors of physician education at the 5 WACHS regional level 1 physician training centres (Albany, Broome, Bunbury, Geraldton and Kalgoorlie). The project team has undertaken extensive stakeholder engagement, including consumer focus groups with rural medical students and rural early-career doctors plus ongoing regular engagement with RACP training and accreditation, WA Level 3 physician metropolitan centres, the WA BPT committee and the Department of Health, Office of the Chief Medical Officer. The project team has secured in-principal support for the pathway from local and national partners, including the level 3 WA-based metropolitan centres, which will provide 'inreach training' and the WA BPT committee. A pilot of the pathway was ready to launch in May 2024 for recruitment and selection of BPTs to commence on the rural pathway in February 2025, aligning with the registrar clinical year. The project team will continue to scope and enhance rural physician training opportunities by exploring Level 2 site accreditation for Bunbury Regional Hospital, investigation and implementation of a WACHS rural physician mentorship program and investigating rural General and Acute Care Medicine (GACM) Advanced Training recruitment, selection and retention opportunities with local and national stakeholders
RACP Rural and Remote Institute of Palliative Medicine (RRIPM) ²²	This project will establish the RRIPM to develop a training network for rural and remote palliative medicine training to provide a shared network and pathway to support training and work in these settings. Links smaller rural sites, sometimes solo consultant services, to share resources to create training posts and networks, starting with a pilot then expanding. There is a desire from Trainees for rural training but no current pathway.
RACP Culturally Safe Supervision resources ²²	This project will develop a suite of resources targeted at specialist medical college supervisors of Aboriginal and/or Torres Strait Islander Trainees to support culturally safe supervision. Online resources and webinar available to RACP members and external stakeholders(50). Non-RACP members can log in as a guest.
RANZCOG Rural O&G Specialist Advanced Training Pathway ²²	This project will develop a Rural O&G Specialist Advanced Training Pathway ⁷³ that will focus on supporting and encouraging RANZCOG Trainees to return to RRR locations to complete their training. The funding supported both the development of a dedicated curriculum and financial incentives of \$100,000 per Trainee for 4 Trainees. The first 2 Trainees commenced at rural sites in 2025. Funding time has been extended to support 2 Trainee placements in 2026. While only 4 financial incentive packages were originally available, demand for the program has been significant, highlighting the need for additional funding to expand this significant initiative. RANZCOG has a rural page(51) collating all their rural initiatives including the FATES projects, Obstetrics and Gynaecology Education and Training Project (providing training and CPD to rural generalists with advanced skills in O&G and their teams), rural and regional women's health strategy and O&G map. ⁷⁴ Explore O&G services across Australia, including population and workforce data, and service locations in RRR areas.

RANZCR RESP ⁷⁵	This project will develop the RESP, an initiative to better connect Trainees based in regional and rural sites who have been selected to pilot RANZCR's Clinical Radiology Regional and Rural Training Pathway (RRTP), and at the same time to strengthen relationships with existing regional hubs, schools, local councils, training networks and jurisdictions. Individual information packages for each of the sites of the RRTP pilot (to include information about the college training programs, training and practice environment, local area, schools, community centres and events, town maps etc.) have been developed and provided to RRTP Trainees. The information packs aim to assist Trainees to better assimilate into their selected regional/rural setting before embarking on their training, provide a clear overview of 'what to expect before you go' to aid assimilation to selected rural settings and regions.
RANZCR Reducing Application Barriers for Specialist Training for Regional, Rural and Indigenous Doctors – A centralised application solution ²²	This project will develop and implement an application process into the training program through an online IT application solution. The AMC requested the college to establish a more centralised recruitment process to improve selection and minimise bias and discrimination. The centralised application solution intends to broaden entry opportunities for RRR and Aboriginal and/or Torres Strait Islander applicants thereby reducing application barriers and bias in the varied selection processes currently in place between different jurisdictions across Australia.
FATES 3²⁰	
ACD Towards a Homegrown Workforce. College-led consortium approach to co-designing & establishing transferable & sustainable accredited rural-centric specialist training with implementation of a proof-of-concept dermatology training model in western NSW ²⁰	This project will demonstrate and document—through a structured collaboration, co-design and implementation process—how to overcome generalisable barriers to rural-centric training to create pathways where training and transition to specialty practice can occur locally. Targeted western NSW (WNSW) as identified as underserved area (especially in public vs private), with tertiary hospitals and medical schools. Consortium with WNSW local health district, WNSW regional training hub, University of Sydney School of Rural Health (Dubbo, Orange), Orange Aboriginal Medical Service, Pinnacle Dermatology (private practice Orange).
ACEM Piloting an Integrated System of Regional and Rural Accredited EM Training Networks to Build a Flexible and Responsive Rural EM Workforce ²⁰	This project will establish and pilot 2 accredited integrated EM training networks that will increase education and training opportunities for regional/rural based specialist Trainees. Pilot sites are SW Victoria (Barwon and SW Health) and WACHS. Like RANZCOG, ACEM has a rural page (RRR EM page) ⁷⁶ , rural health action plan ⁷⁷ and information about rural training ⁷⁸ and the Emergency Medicine Education and Training program. In 2021, the ACEM board endorsed the workforce planning strategy that included the recommendation of establishing a new integrated system of accreditation that includes a series of accredited training networks within each jurisdiction with an appropriate balance of metropolitan and RRR training sites to satisfy all training program requirements. All future FACEM Trainees (date to be determined) will also be required to undertake a minimum 6-month RRR training placement within an accredited training network. Each network will therefore be expected to facilitate and ensure the appropriate rotation of FACEM Trainees through their respective RRR training sites. The model will facilitate opportunities for regional/rural based specialist medical Trainees by establishing integrated EM training networks that (a) have regional/rural EDs as the core, with opportunities to access placements within the network that meet all EM training requirements and

	(b) provide training opportunities within unaccredited regional/rural EDs. These integrated EM training networks will provide a comprehensive training program experience that delivers safe, high-quality training and ultimately contributes to the development of a sustainable RRR EM workforce.
ANZCA Developing Flexible Accreditation Pathways for Pain Medicine Training in Rural Settings	This project seeks to understand the barriers within the Faculty of Pain Medicine accreditation standards impacting rural based pain medicine training and to identify flexible models of rural/regional training and accreditation pathways for consideration and pilot in several identified rural locations. The goal is to increase the number of RRR accredited training sites.
CICM Intensive Care Training for Aboriginal and Torres Strait Islander Health Practitioners – Improving health outcomes for First Nations people and supporting training of specialists in intensive care medicine	This project aims to develop and deliver training in intensive care for Aboriginal and Torres Strait Islander health practitioners to improve health outcomes for First Nations people and support training of intensive care specialists in the domains of Indigenous health and cultural safety. ²⁰
RACMA National Accreditation Portal IT Requirements project ²⁰	This project will focus on developing the IT specification requirements and investigating the feasibility for a shared hospital accreditation portal. It builds on the work undertaken by the AMC to develop model accreditation standards and procedures, the revised FATES 3 project delivered in partnership with CPMC. The portal will support both health service settings and specialist medical colleges by addressing longstanding inefficiencies and duplication in accreditation processes. It will also enable better data coordination, enhance transparency, and reduce the administrative burden across the accreditation lifecycle.
RANZCOG Health and Occupational Wellness Program ²⁰	This project will develop and implement the Health and Occupational Wellness program for Trainees and Fellows, with a focus on those in rural and remote areas. The program will consist of eLearning modules, practical toolkits and frameworks, and the engagement of wellbeing advocates to support the broader rollout across hospitals in Australia.
RANZCP Rural Readiness project – A three stage approach to rural readiness for psychiatry Trainees ²⁰	This project will enhance professional, clinical and social orientation required to practice in RRR areas of Australia for psychiatry Trainees. With a focus on establishing and expanding skills imperative for Trainees to engage in safe rural practice, the project will provide the opportunity for Trainees to network with Fellow Trainees early in their career to build connections to peers, regions and communities that will sustain their Fellowship journey. Improving and promoting a positive rural psychiatry education culture that reduces feelings of isolation and supports Trainees' wellbeing and work life balance from the first year to Fellowship, it will build an understanding of a career in rural health and enhance preparedness. The Rural Readiness project will include 3 stages of targeted learning for psychiatry Trainees: Stage 1: Successful completion of the RANZCP online Aboriginal and Torres Strait Islander mental health modules, already a requirement for Fellowship. Stage 2: Successful completion of online eLearning Professional Orientation to Rural Psychiatry Services modules. Stage 3: Attendance at a face-to-face Rural Readiness Workshop, delivering clinical and social orientation to working in RRR areas of Australia as a psychiatrist. Focused engagement with Trainees, Fellows, and project stakeholders will shape the design of 7 face-to-face Rural Readiness workshops to be conducted across Australia delivering clinical and social orientation to

	working in RRR areas. This collaboration will guide the design of 3 online eLearning modules on Professional Orientation to Rural Psychiatry Services including an overview of psychiatry services, an introduction to mental health in rural communities, and rural preparedness. The project builds on the rural psychiatry road map and other resources on the RANZCP rural page.⁷⁹The RANZCP Training in a rural area page⁸⁰ lists current rural training posts, the rural training orientation guide and Trainee support webinar series – rural training. Note that There are 2 entry points to rural training: whole of pathway method (start with intention of completing 75% training in rural), and stage 3 model (applicants enter rural training at stage 3 of their training/after completing at least 66% of the training program). The orientation guide also explains the RHMT program, RTH and STP program and how rural training was developed and a list of supports/resources for rural Trainees.
RANZCO Promoting Health Equity in Regional, Rural and Remote Communities, a cross-college consortium's vision for supervisor excellence ²⁰	This project will develop and deliver one innovative, rural focused, SSTS aligned to the AMC accreditation standards for postgraduate medical training and across medical colleges in the consortium. This will increase the number of non-GP specialist supervisors in non-metropolitan areas and increase the capacity to deliver specialist medical training in RRR areas. A National Supervisor's Curriculum and a Supervisor and Trainee Framework will be developed which will enhance the skills of existing supervisors and improve college systems to support them. The project will enhance supervisors' accreditation by implementing rigorous and transparent processes for selecting supervisors and providing them with individualised feedback on their supervisory performance that ensures that the highest standards of competence, professionalism and culturally safe supervision are achieved and maintained.
FATES 4³⁷	
ACD Towards a new paradigm for specialist training – Harnessing digital technologies to optimise national supervisory capacity and efficiency ³⁷	This project leverages national dermatologist consultant capacity through digitally enhanced supervision of Trainees and SIMGs. 1. Scoping review and stakeholder consultation to identify: current state of digital technology use in specialist training, supervision and service delivery; requirements, enablers for best practice clinical, educational and technology governance. 2. Development of a governance framework. 3. Model co-design and implementation to inform best practice and transform training capacity.
ACSEP Regional and Rural Training Pathways in Expanded Settings ³⁷	This project will investigate rural training pathway models using non-traditional sport and exercise medicine (SEM) training settings that are available in many MM2–7 areas, such as public/private hospitals, GP clinics, Aboriginal and/or Torres Strait Islander medical services and other community health services.
ACSEP Sport and Exercise Medicine Supervisor Support Scheme ³⁷	This project will develop a new suite of digital resources for SEM supervisors and practices for use in training and managing Trainees in non-GP, private practice settings. It will enable development of high-quality supervision skills and support SEM supervisor wellbeing in regional and rural areas via development of a professional learning community program.
RACP Workforce Mapping and Accreditation Renewal to inform and influence specialist General Medicine work force distribution to RRR settings ³⁷	This project will map and describe accredited GACM specialist training positions, Trainees and specialists in Australia. It will revise the GACM advanced training accreditation standards alongside the RACP to align with the curriculum renewal and recommendations of the NHPO accreditation review, particularly pertaining to the alignment and role of site accreditation with workforce reform priorities. It will establish a community of practice drawing together stakeholders currently contributing to activities seeking to positively influence specialist generalist training in Australia and particularly to the Modified Monash 2019 M2–M7 locations.
RACP WA Rural Paediatric Training Pathway ³⁷	This project will create a defined and secure pathway for paediatric Trainees wanting to pursue rural practice. The current training system requires Trainees to be metropolitan employed. While it provides short-term mandatory rural placements, these have been shown to have little

	influence on a specialist pursuing a rural career upon achieving Fellowship with the RACP. Approval of this project to scope a Rural Paediatric Training Pathway is the first step in enabling rural doctors to stay connected to country practice, creating attractive rural pathways and ultimately addressing the healthcare disparity between rural and metropolitan based patients by improving specialist case access closer to home.
RACP Diabetes Alliance Program Plus, Supporting General Medicine and Endocrinology Specialist Trainees to Improve Diabetes and Endocrinology Care ³⁷	This project will overcome geographic and social barriers to specialist training in RRR areas through innovative and flexible solutions. General medicine and endocrinology advanced Trainees will be supported by a large metropolitan teaching hospital and medical research institutes, while providing virtual and face-to-face care in RRR areas. Flexible training of general medicine and endocrinology specialists will include outreach, and inreach services, virtual telehealth clinics, face-to-face case conference clinics, mobile medical bus (Medibus), community and healthcare worker focused educational and networking events, and on-demand telephone and written advice provision.
RACP Remote and Aboriginal Cancer Care – Putting training at the Centre ³⁷	This project will implement a competency-based training program which includes generic competencies such as acute and chronic care. This project extends these competencies by developing a competency framework for remote cancer care, with associated knowledge guides and a mentoring and support program for remote Trainees. The project will be developed through a collaboration between Alice Springs Hospital, the SA oncology training network and remote communities. Training will be implemented through a named remote oncology training Fellowship and knowledge disseminated through a Capstone conference.
RACS Generalism and Global/Remote/Rural/Regional/Deployable (GRiD) Developing a flexible, generalist, broad and extended-scope surgical workforce to meet RRR community need ³⁷	The GRiD Faculty will enable a flexible, responsive, culturally competent, generalist, broad and extended-scope surgical workforce (across all surgical disciplines), with the skills and motivation to work collaboratively and effectively in areas of need and limited resource environments. RACS, RANZCO, RACP, RACMA, and ACRRM will partner to form a consortium to research and investigate the viability, feasibility and sustainability of a GRiD Fellowship faculty through evidence-based recommendations and extensive stakeholder engagement. The trend to subspecialisation is reducing the availability of surgeons capable and confident of working in RRR areas. Data (safety, outcomes, community need) will allow definition of clinical problems and procedures with better outcomes in urban or subspecialist settings, and those with equivalent patient outcomes between urban and RRR, and generalist and subspecialist settings. This will inform culture, training, workforce planning and resource allocation between urban, RRR and generalist and subspecialist services.
RANZCOG First Nations Health, Representation and Support Project ³⁷	This project will pilot a First Nations Elder in Residence to provide cultural guidance and mentorship to college leaders, the First Nations Health Advisor, and First Nations Trainees and Fellows. The First Nations Health Advisor will support Trainees' cultural safety and career growth, aligning with the AMC standards and Reconciliation Action Plan goals. This initiative also aims to increase First Nations representation by developing culturally safe educational resources, creating a First Nations recruitment framework, implementing a stakeholder engagement plan, and launching a formal mentoring program. RANZCOG will continue financial support to foster mentorship and networking within the Indigenous Network Group and at key conferences, working towards a culturally safe pathway for First Nations Trainees and Fellows in specialist healthcare.
Upskilling RANZCR Regional Rural and First Nations Clinical Supervisors in Medical Education ³⁷	This project will develop 12 scholarships to encourage and appropriately support existing and potential clinical supervisors, directors of training, and college committee members to develop their expertise in medical education. Particular focus will be given to regional and rural clinical supervisors, First Nations Fellows, members of RANZCR education and training committees, and new Fellow members.

QUALITATIVE INTERVIEWS

Thirty semi-structured qualitative interviews were conducted with FRACS and hospital administrators with experience in RRR practice across Australia. Interviews of 45–60 minutes were conducted online via Microsoft Teams between September 2023 and June 2024. With a rural setting in mind, the main focus of discussion centred on RACS and specialty specific accreditation standards, the hospital training-post application and accreditation process, barriers to hospitals completing the accreditation process and/or meeting the accreditation standards, possible solutions to barriers including specific support for the accreditation process for rural hospitals, surgeons and administrators, as well as participants' opinions on the benefit and unique opportunities of rural surgical training.

Thematic analysis revealed broad themes and subthemes. The researchers combined data from the interviews with data from the literature review, FATES 1 Rural Accreditation workshop, FATES 2 Rural surgeons training and retention workshop and the desktop review of RACS and specialty accreditation standards and processes. A synthesis of the qualitative research findings is provided (Attachment 7).

2025 ANALYSIS OF IMPACT OF AMC MODEL STANDARDS FOR ACCREDITATION ON RURAL TRAINING-POST ACCREDITATION

The new AMC model standards reduce barriers to rural training-post accreditation by delivering significant flexibility in models of supervision, caseload and case-mix, multidisciplinary teams, and virtual and networked access to training experiences and formal learning programs.

Potential barriers for rural training site accreditation around Trainees raising concerns, fatigue and safe hours, and cultural safety are addressed below, with solutions and recommendations from the FATES 2 Rural Training Models project accompanying each relevant criterion.

The new model standards do not allow for stakeholders to require rural hospitals and/or jurisdictions provide relocation allowances, accommodation or portability/preservation of entitlements for Trainees. Alternative mechanisms to address these issues are included from the FATES 2 Rural Training Models project recommendations.

Table 8. Summary the standards and criteria from the AMC model standards³

AMC Model standards for specialist medical college accreditation of training settings	
Final v1.0 August 2025	
FATES 1 Analysis of impact on accreditation of rural training sites/posts	
Domain 1 Trainee health and welfare	
Standard	Criterion
1.1 Training takes place in a learning environment that supports Trainee health and welfare.	1.1.1 Effective processes are implemented for Trainees to raise concerns, grievances and complaints about matters affecting their training. Trainees are informed of these and feel safe to use them.
	Barrier: It's difficult for Trainees working in small teams at a distant from peer/mentor support in rural sites to raise concerns, remain anonymous and/or continue working within the same team.
	Solutions: Provide rurally located Trainees with multiple ways of raising concerns including existing methods (anonymously via Medical Training

	Survey, RACS Trainees' Association (RACSTA) surveys, RACS annual Trainee survey, Trainee rotation survey and Trainee Fellowship exit surveys, confidentially discuss with RACS staff via RACS complaints process and/or training manager). RACS FATES 2 Rural Training Models recommendations: Consider role of RACS Rural Training Coordinator and/or mentors in helping Trainees raise concerns while staying safe. 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.
	1.1.2 Risks to Trainees regarding bullying, harassment, discrimination, racism and other unlawful or unacceptable workplace behaviours are identified, investigated, managed and recorded.
	1.1.3 There is a positive learning environment that fosters respect, diversity, inclusion, equity and cultural safety for Trainees of diverse backgrounds.
	1.1.4 Risks to the cultural safety of Aboriginal and/or Torres Strait Islander and/or Māori Trainees are identified, managed and recorded.
	Barrier: in RACS FATES 2 Rural Training Models research, Trainees recommended rural supervisors be upskilled in cultural competence and cultural safety. Solution and recommendations: RACS to implement recommendations made in the STP report <i>Towards Culturally Safe and Effective Training Pathways for Aboriginal and Torres Strait Islander Medical Specialist Trainees</i>.³⁶ Supervisors to engage with RACP Culturally safe supervision resources.²¹
	1.1.5 Risks to Trainees associated with fatigue and volume of work are identified, managed and recorded.
	Barrier: Rural Trainees and surgeons have higher total work hours and more frequent on-call hours compared to urban teams. Small teams in rural areas make 24/7 cover more challenging, especially for smaller surgical specialties. Accreditation criteria can prevent Trainees covering other surgical units when on call. This limits flexibility and the sharing of on-call shifts in rural sites. There is also variability in maximum hours and on-call frequency between training programs. RACS standards for safe hours recommend no more than 1:4 on-call for surgeons; specialty specific accreditation criteria allow for 1:2 and 1:3 on call for Trainees. There is a need to balance access to experience in managing emergency presentations with the health and welfare of Trainees.

	Solution: STB/Cs review current guidelines with a view to introducing consistent guideline 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 units (e.g. PRS, OHNS, General, Urology share on-call in rural).
	1.1.6 Trainees can access leave arrangements, including leave to fulfil community cultural obligations, in accordance with employment and/or appointment conditions.
	1.1.7 Trainees can access flexible working arrangements in accordance with employment and/or appointment conditions.
	1.1.8 Trainees who have had a break in training are supported in their return to training.
	1.1.9 Reasonable adjustments for Trainees with disabilities are provided, in accordance with legislative requirements and employment and/or appointment conditions.
	1.1.10 Trainees have access to resources that support their health and welfare.
	Provides more flexibility for multiple models including onsite/in-person and virtual.
Domain 2 Supervision, management and support structures	
2.1 Clear governance structures support the delivery of effective education and training.	2.1.1 There is an effective, transparent and clearly understood educational governance system that demonstrates a commitment to the training program and manages the quality.
	Provides more flexibility for supervision models compared to inflexible current RACS standards (e.g. that supervisor must not also be head of department).
	2.1.2 Trainees and the training provider engage constructively about how training is delivered at the training setting and Trainees can provide input and feedback into how their local training is delivered.
	2.1.3 Management and administrative resources, such as rostering and recruitment, effectively support the delivery of training.
	2.1.4 Trainees are provided with effective orientation for each training setting/rotation.
	Insights from FATES 2 Rural Training Models Project: Best practice orientation for rural training sites and networks:

	Each rural facility/community is unique in ways that impact healthcare and training. Rural healthcare facilities and rural communities are interdependent and rural training terms are often associated with relocation for the Trainee and their family. Trainees need orientation to rural practice in general as well as orientation on the specific training site and community. Trainees require a comprehensive orientation to rural training sites. Site-specific orientation includes 4 stakeholders (Trainees and their families, hospitals, supervisors and community), 4 phases (orientation-in-advance, onsite orientation at commencement of employment, onboarding over the first 6 weeks, and evaluation of orientation after 3 months), 4 components (community, health service/health system, specialist unit-service delivery and specialist unit-training orientation-in-advance). Solutions and recommendations: 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 and can be shared with colleges. 2.1.5 The training provider engages with the college to resolve issues raised about the training program and training setting. 2.1.6 The training provider/setting has been accredited by relevant accreditation bodies. Opportunity to reduce administrative burden/streamline application for accreditation. Provided hospital is accredited by Australian Commission on Quality and Safety in Healthcare, no further evidence required. (Optional for colleges with training networks) 2.1.7 The training provider engages with structures, such as training networks and programs, to ensure overall training program outcomes can be achieved. Supports formation of rural training networks. Supports rural training sites partnering with other rural sites and/or urban sites to share resources including formal learning programs, multidisciplinary meetings, pathology/radiology meetings etc. Supports flexibility and diversity in training sites/experiences.
2.2 Trainees receive appropriate and effective supervision.	2.2.1 There is effective and timely clinical supervision of Trainees to support them to achieve the training program outcomes and to protect patient safety.

	Supports flexible models of supervision, with focus on outcomes (Trainee and supervisor feedback/satisfaction surveys, training outcomes, patient outcomes/safety) RACS FATES 2 Rural Training Models recommendations: Colleges investigate and implement flexible, novel, place-based and digitally enabled models of supervision, including onsite, remote and hybrid models, interdisciplinary supervision, and inclusion of SIMG specialists as clinical supervisors. Colleges develop metrics for supervision quality focused on Trainee and patient outcomes and relevant to flexible models of supervision; colleges move away from de facto measures of supervision quality including number of supervisors and supervisor to Trainee ratios.
	2.2.2 Supervisors engage effectively with Trainees and provide regular and timely feedback on performance to guide Trainee learning.
	RACS FATES 2 Rural Training Models recommendation: Colleges assess and report on progress towards digital tools to map Trainee progress
	2.2.3 Trainees having difficulty in meeting the requirements of the training program are identified and appropriate support measures are available and promoted.
	2.2.4 A designated person is responsible for overseeing the training program and is provided with the time and resources necessary for the role.
	Supports provision of resources, rostered time and remuneration for rural supervisors
	2.2.5 Supervisors are supported in meeting their education and training responsibilities, including in providing culturally safe supervision and contributing to a culturally safe environment.
	FATES 2 Rural Training Models recommendations on rural supervision: Colleges implement the RANZCO SSTS to support selection, training, reflective practice and CPD for supervisors. Colleges encourage supervisors to access the RACP Culturally Safe Supervision resources.²¹ Colleges develop shared resources for rural supervisors (e.g. RANZCOG and RACMA leadership development for rural and remote specialists).

2.3 Trainees are supported in delivering quality patient care, including culturally safe care.	2.3.1 Trainees are supported in delivering quality patient care, including culturally safe care, to patients of diverse backgrounds.
	2.3.2 Trainees are supported in developing specific knowledge and skills to deliver quality patient care, including culturally safe care, to Aboriginal and/or Torres Strait Islander and Māori people.
	RACS FATES 2 Rural Training Program recommendations: Colleges foster culturally safe training environments for Aboriginal and Torres Strait Islander and/or Māori Trainees, provide resources for all Trainees to develop cultural competence and cultural safety skills, and 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.
	2.3.3 Trainees have the opportunity to reflect on critical incidents and engage with local clinical governance and quality improvement processes, including how to raise concerns about standards of patient care.
	Supports flexibility including virtual quality assurance and quality improvement activities (e.g. audit, morbidity and mortality)

Domain 3 Educational and clinical training opportunities

Standard	Criterion
3.1 Trainees are provided with the appropriate depth, volume and variety of clinical and other learning experiences.	3.1.1 Trainees are provided with a clinical caseload and case-mix to achieve the training program outcomes.
	Risk when specialty specific criteria created. This criterion must be implemented keeping certain features of the current standards for accreditation of medical specialist training programs in mind: Diversity of training experiences (including rural experience) should be considered, training program outcomes should be met over the course of the training program, not necessarily in every training post, specialty specific criterion related to caseload/case-mix is appropriate to the training site/needs of the community and is achieved via a competency-based framework rather than through inflexible numbers of specific operations, and outpatient consultation experience can occur in private practice. AMC Standards for Accreditation of medical specialist training programs 3.4.4 The specialist medical program provides flexibility for Trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with defined outcomes.⁷ 8.2.2 Support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of

	healthcare to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand.⁷ Notes to standard 8.2 Trainees are likely to gain experience in multiple locations each providing a varying range of experiences of the specialist discipline. For this reason, education providers are increasingly accrediting networks of training sites rather than expecting a single training site to provide all the required training experience, and while all training sites should satisfy the education provider's accreditation criteria, the AMC encourages flexible rather than restrictive approaches that enable the capacity of the healthcare system to be used most effectively for training.
	3.1.2 Trainees have the opportunity to engage in structured and unstructured learning activities to achieve the training program outcomes.
	Supports flexibility in delivery of formal learning programs, including local and distant, networked, in-person and virtual.
	3.1.3 Trainees are involved in clinical handovers during transitions of care.
	3.1.4 Trainees are given experience working and learning in multi-disciplinary teams and/or settings.
	Supports generalism and multidisciplinary care models in rural. Supports Trainees working with surgeons from other specialties in rural (e.g. general surgical Trainee working with PRS, OHNS, Urology, Vascular etc.) and sharing on-call with surgical Trainees from other specialties.
3.2 Learning opportunities are transparent, equitable and appropriate for the level of training.	3.2.1 Trainees are given an increasing degree of responsibility as their skills, knowledge and experience grow. Supports flexibility in closer/direct supervision and indirect/remote supervision as Trainees develop competence, entrustment and autonomy. 3.2.2 Training, learning and professional development opportunities are transparent and equitable for all Trainees. Supports flexible and virtual access to training opportunities and resourcing for rural sites for facilities (e.g. simulation). 3.2.3 Trainees are supported to complete their training program assessments in a timely manner.
Domain 4 Educational resources, facilities and equipment	
	4.1.1 Trainees have access to an appropriate quiet space with adequate computer and internet access for their learning.

4.1 Trainees have access to appropriate educational resources and facilities.	Supports flexibility for Trainees in rural sites to share spaces rather than have exclusive access.
	4.1.2 Trainees have access to educational resources that support their learning.
	Supports flexibility in access to educational resources (e.g. virtual rather than physical library on site).
4.2 Trainees have access to appropriate clinical equipment.	4.2.1 Clinical or other equipment needed for Trainees to achieve the training program outcomes are available, accessible and fit for purpose.
	RACS FATES 2 Rural Training Models recommendations: Colleges, through their membership of the National Rural Health Alliance, continue to advocate for equitable access to virtual healthcare services and health professional education and training for rural communities; telephone, internet and GPS connections that are reliable, accessible, affordable and can support video services, and improvements in digital health literacy.
Existing accreditation criteria no longer enabled in model standards, requiring RACS to develop collaborative solutions with other stakeholders	
Relocation assistance, provision of accommodation, portability of entitlements	RACS FATES 2 Rural Training Models recommendations: Colleges 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. Colleges engage stakeholders to develop systemic and place-based solutions to assist Trainees to secure suitable accommodation in RRR areas. Colleges develop a collaborative strategy, with the AMA Doctors in Training Committee and the 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.

2025 ANALYSIS OF IMPACT OF AMC MODEL PROCEDURES ON RURAL TRAINING-POST ACCREDITATION

The new AMC Model Procedures¹⁹ for specialist medical college accreditation of training settings address barriers to rural training-post accreditation in the following ways:

Table 9. Barriers to rural training-post accreditation present in the AMC model procedures and associated solutions

Barrier	Training committees as gate keepers, not developers of workforce in partnership with training sites
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Solution provided by model procedures	The model procedures describe a culture of collaboration with a shared goal of workforce development: Context of Accreditation: ‘Accreditation of training settings takes place in the context of a joint endeavour between colleges, training providers, their training settings, and governing health departments, in which all parties have the shared goal of achieving high-quality specialist medical training that is responsive to the needs of the communities of Australia and Aotearoa New Zealand. The context in which accreditation takes place is complex. It involves different legislative environments across Australia and in Aotearoa New Zealand, a variety of training settings, and parties that have multiple obligations. When engaging in accreditation, colleges, training providers and their settings, and health departments should acknowledge this complexity and respect each party’s wider obligations. These include the maintenance of high standards in specialist medical practice, as well as service delivery obligations to a diverse range of communities. Accreditation can foster communication and be the foundation for engagement, continuous quality improvement and innovation. The parties should approach accreditation in good faith, acknowledging that, in addition to its assessment role, accreditation provides an opportunity to discuss and resolve problems in a constructive manner and share information about issues for which both colleges and training providers have responsibilities. This will enhance outcomes for Trainees, patients and consumers and support the long-term sustainability of the specialist medical workforce.’¹⁹
Barriers	The accreditation process is complex and burdensome for rural hospitals and there is no support provided. Urban/subspecialist bias and inflexible or unfair application of criteria, with a higher bar for rural sites.
Solutions provided by model procedures	The model procedures¹⁹ set out responsibilities, conflicts of interest, flexible site assessments and training for assessors, relevant to Deliverable 2: An administrative model to facilitate rural training site accreditation, Deliverable 3.2 RACS HTP Accreditation project and Deliverable 3.3 Developing specialty specific accreditation criteria inclusive of rural training sites. ‘Where colleges accredit networks or programs, these criteria will apply, recognising that various settings may contribute to meeting the criteria overall. Accreditation committee responsibilities include provides advice and support to new training settings. College Accreditation secretariat responsibilities include: Advises the Accreditation Team on the application and interpretation of the Accreditation Standards and processes. Ensures reports have appropriately addressed the Accreditation Standards and are within the scope of the college’s accreditation function.’¹⁹ Section 3 relates to managing conflicts of interest. Accreditation teams should include rural surgeons/supervisors to ensure fair assessment of rural training posts. ‘Potential assessment team members must advise the College Accreditation Committee of any personal or professional interest that may, or may be perceived, to impact their ability to be an impartial assessor. The College may require the team member to step aside from a particular accreditation process. Where there is a perceived or potential conflict of interest, the college will disclose this to the training setting and training provider and seek their comments on the accreditation team membership. The Accreditation Committee will consider any

	declared interests as well as the training setting's comments when finalising the appointment of the team.'¹⁹ Section 6 site visits allow for physical, virtual and hybrid site visits. Section 19 relates to Training 'All Accreditation Committee and Accreditation Team members will receive training from the college to ensure accreditation processes and policies are understood and delivered appropriately.'¹⁹
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DELIVERABLE 1: BARRIERS AND SOLUTIONS FOR RURAL TRAINING-SITE ACCREDITATION REPORT

The report synthesises findings from qualitative research and subject matter experts. Most recommendations have already been communicated to internal and external stakeholders, and incorporated into the NHPO, AMC and RACS HTP accreditation consultations, projects and reports.

Table 10. Domain 1: Health systems: Collaborative workforce planning

Barriers	The purpose of training is to develop a workforce with the right skills in the right places to meet community need for surgical care. There are multiple stakeholders in workforce development. Data sources, strategies and accountability are dispersed among the multiple stakeholders involved in employing and training surgeons. Surgeons work in teams with nurses, anaesthetists, physicians, paediatricians, allied health professionals, administrators and GPs. Shortages in other medical disciplines and health professions impact surgical services and surgical training. Rural workforce strategies need to include the whole perioperative team.
Solutions	Collaboration and shared data to inform and develop models of surgical training to match/meet community needs, including distribution of training sites. All stakeholders need visibility of surgical workforce data, strategies, targets and accountabilities. Workforce strategies for the whole team required to deliver surgical services in rural areas.
Recommendation	RACS continues to work with the Department and other stakeholders on shared data and workforce strategies.

Table 11. Domain 2: RACS and specialty societies: A new paradigm for the SET Program

Theme 1: Accountable STB/Cs – delivering on the dual purpose of the SET program. The AMC model procedures sets out the context of accreditation as follows: 'Accreditation of training settings takes place in the context of a joint endeavour between colleges, training providers, their training settings, and governing health departments, in which all parties have the shared goal of achieving high-quality specialist medical training that is responsive to the needs of the communities of Australia and AoNZ. The context in which accreditation takes place is complex. It involves different legislative environments across Australia and AoNZ, a variety of training settings, and parties that have multiple obligations. When engaging in accreditation, colleges, training providers and their settings, and health departments should acknowledge this complexity and respect each party's wider obligations. These include the
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maintenance of high standards in specialist medical practice, as well as service delivery obligations to a diverse range of communities.¹⁹

The summary below describes barriers to rural training-post accreditation created by or resulting from the internal culture, standards and processes of the RACS SET program. Extensive consultation with internal stakeholders throughout the project, including the Education Committee, CSET, the STB/Cs and the specialty societies, enabled barriers and solutions to be incorporated into the RACS HTP Accreditation project and the accreditation policies and procedures of the STB/Cs. While describing all identified barriers existing when the project commenced, the report also describes the significant changes already made by internal stakeholders.

Barriers	Stakeholders perceive STB/Cs act as gatekeepers rather than strategic developers of surgical workforces to meet community needs. Rural hospitals, surgeons and administrators perceive they need to 'earn' accreditation rather than be partners in providing training experiences relevant to community need and workforce strategies. Stakeholders perceive STB/Cs exhibit positive bias towards urban subspecialist training posts, preferencing subspecialist over generalist experience in decision-making, training pathways and curricula. There is a perception of negative bias towards rural and generalist training sites. This perception is reinforced by members of STB/Cs, for example: 'we're doing the rural units a favour by letting them have Trainees', 'we support rural training, but we won't compromise on the quality of surgical training', 'we need to maintain quality; we won't lower standards to accredit rural training posts'. There is inconsistent application of standards, or double standards, with 'the bar set higher' for rural training sites, requiring rural training sites to meet every specialty specific criterion, including access to a minimum number of 'major' cases skewed to subspecialty scope of practice, while allowing accreditation of 'special' urban training posts (e.g. paediatric, trauma, subspecialty and private hospital posts) that provide a necessary but narrow scope of practice and do not meet all accreditation criteria.
Solutions	STB/Cs need to foster a culture of collaboration with training settings and approach their work with a dual purpose—that of individual graduate outcomes plus developing a workforce that meets community needs, with appropriate geographic distribution and balance of generalists and subspecialists in each specialty.
Recommendations	STB/Cs develop specialty specific rural health equity and workforce strategies, including timed targets for rural selection, rural 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 SET programs, including selection, training, accreditation of training posts, assessment and leadership including rural and generalist surgeons, and setting 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 engage with and integrate rural surgical training initiatives into the RHMT program, including university departments of rural health, regional training hubs and FRAME.
Theme 2: Diversity not uniformity – firm on standards, flexible criteria, focused on outcomes for Trainees and patients. The AMC standards⁷ require colleges to provide Trainees with a diverse range of training experiences, including rural and Indigenous healthcare settings. A diverse range of training experiences collectively enables Trainees to meet the requirements of the training program over time, and the specialist workforce to collectively meet the needs of communities. The AMC standards for accreditation of training sites further facilitate program flexibility so that Trainees can access a diverse range of settings. Interpretation and implementation of the AMC standards for accreditation of training sites varies between and within colleges. Some colleges accredit sites (hospitals, practices) or networks, while others accredit specialty specific training posts or rotations. Some programs interpret consistent standards as meaning consistent experiences, so specialty specific criteria include every possible resource and experience a Trainee may need. These criteria are designed for large well-resourced urban settings and, for surgery, include defined types and numbers of procedures, including subspecialised procedures. In attempting to standardise training, the risk of ubiquity or uniformity in experiences is present, when what Trainees need is exposure to a variety of practice settings. The context of specialist medical training in RRR settings differs from urban training in significant ways, including training-post accreditation, supervision, orientation and digitally enabled collaboration. It is possible, and desirable, to enable flexibility in healthcare and in training programs, with multiple place-based and technology-enabled models of delivery of healthcare services and training, while setting uniform training standards and achieving equivalent outcomes for patients and for Trainees.	
Barriers	Stakeholders perceive the STB/Cs focus narrowly on activities rather than outcomes—and on uniformity rather than diversity of Trainee experiences—rather than using the flexibility that the AMC standards allow, to provide diverse training experiences while remaining focused on training outcomes and patient safety. Lack of diversity of training experiences: The AMC requires diversity in training experiences. However, STB/Cs' application of specialty specific criteria to achieve uniformity in every training rotation—rather than diversity of experiences that collectively contribute to graduate outcomes—prevents this diversity. Trainees work towards training outcomes over several years and in several contexts. It is not necessary or desirable for every training post to deliver exactly the same experience or all required experiences. Failure to recognise the importance of diversity in training, and failure to incorporate into curricula and training pathways diverse training experiences and generalist, rural and Indigenous healthcare settings, experiences and curricula, does not result in favourable outcomes for Trainees. Narrow focus on one element of surgical practice and depth rather than breadth of scope of practice: Current standards often focus narrowly on meeting a minimum number of major and minor operations or categories of highly subspecialised procedures. Instead, standards should reflect case-mix and caseload that match the reality of surgical service provision, along with a more holistic assessment of the experiences training sites provide. This includes responding to community needs, effectively conducting outpatient consultations for a wide variety of presentations and patients of all ages, communicating with referrers, assessing and managing emergency presentations, handling patient transfers, delivering virtual healthcare, and ensuring safe clinical handover and collaboration within dispersed teams.

	Rural stakeholders also perceive that Trainees based in urban sites are not provided with access to teaching and learning environments to care for rural people, that is, for RUFUS practice, including inreach, outreach, virtual healthcare and communication and collaboration in virtual and geographically dispersed teams. Narrow focus on well-resourced urban models of healthcare and lack of awareness of strengths and opportunities in rural settings. One-size-fits-all specialty specific accreditation criteria designed for well-resourced urban tertiary and quaternary centres. The impact is that training is confined to these settings, preventing access for Trainees to experience working in clinical settings with resource limitation or variability. Trainees without experience in developing strategies to optimise outcomes in resource-limited settings lack confidence to practice in these settings, contributing to workforce maldistribution with a shortage of services in RRR and outer metropolitan settings where a large proportion of services are required. Criteria are not evolving with contemporary models of education, healthcare, research and collaboration. Narrow interpretation of accreditation standards and criteria limit Trainees' access to teaching and learning environments in multiple models of healthcare delivery and health professional education, including virtual healthcare, communication, and collaboration in virtual and geographically dispersed teams and outreach. Specific examples include: • Inflexible on-call criteria: while safe hours are non-negotiable, requiring Trainees to be exclusively on-call for their specialty is a barrier for rural hospitals. The AMC standards require Trainees to experience multidisciplinary and interdisciplinary models of care. For General Surgery Trainees, the only way to access the full scope of the General Surgery Education and Training (GSET) curriculum is to work with local and visiting surgeons from other specialties during RRR training terms (PRS, OHNS, Urology, Vascular etc.). For smaller specialties in RRR, on-call is shared between General Surgery, PRS, OHNS, Urology etc., enabling Trainees to work safe rosters, support each other, and engage in multidisciplinary and interdisciplinary care. • Requiring exclusive use of resources that could feasibly be shared between specialties (e.g. tutorial rooms, offices, study spaces). • Requiring access to 24/7 highly subspecialised resources that are centralised and accessed remotely in contemporary health systems (e.g. onsite interventional radiology and Monday–Friday anatomical pathologists, achievable only in urban tertiary and quaternary settings). • Criteria requiring or referencing supervision by Fellows of other specialist medical colleges rather than enabling place-based models endorsed by those same specialist medical colleges in rural and remote hospitals (e.g. requiring CICM Fellow-led rather than physician-led ICU/HDU, a FACEM rather than rural generalist-led ED). Remote and rural settings have different models of service delivery including generalist physicians and rural generalists with extended scopes of practice working in dispersed teams with visiting and/or remote support from specialist medical colleagues. • Requiring onsite or physical access to resources that are now accessed in a virtual or digital environment (formal learning programs, libraries, radiology and pathology meetings, multidisciplinary meetings, simulation etc.). For example, most specialties have weekly state or national video tutorials, with opportunity for interaction with educators and peers, and online libraries of past tutorials, allowing asynchronous access for
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	Trainees on call or operating when a tutorial is scheduled, reducing duplication of effort by supervisors and freeing supervisors to focus on other elements of supervision including reflective practice. Requiring onsite and/or exclusive resources for specialty specific research, for example, personnel such as a nominated consultant in charge or research, secretarial support, and a research nurse, when these resources may not be feasible, or may be shared with other teams, or may be accessible virtually or via university departments of rural health and regional training hubs; and limiting multidisciplinary and interdisciplinary collaborative research.
Solutions	STB/Cs have already considered and responded to feedback provided by the FATES 1 project team to the RACS HTP Accreditation project team. The result is that many of the barriers identified above are already being addressed in the HTP Accreditation project, with significant flexibility included in the new RACS standards for accreditation. The next phase of the project, where STB/Cs will develop specialty specific criteria, may re-introduce barriers. There is significant potential for deeper collaboration, resource sharing and innovation impacting surgical training, including in a virtual environment between urban and rural training sites, supervisors and Trainees, and multidisciplinary and interdisciplinary collaboration within rural and remote regions between training sites, educators and researchers in university departments of rural health and regional training hubs.
Recommendations	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 through 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 program 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 (AMS/ACCHOs).

	STB/Cs incorporate RUFUS skills into curricula and RUFUS experience in 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, virtual and collaborative healthcare experience for Trainees. STB/Cs advocate for RRR outreach services to be incorporated into public hospital networks, for urban and larger regional hospitals to be accountable for developing outreach services to smaller regional, rural and remote hospitals and communities.
Theme 3: Supervision – measuring what matters. Ahpra defines 3 levels of supervision: direct (on site, in the same room), indirect (within the same facility or able to attend within a specified time) or remote (not at the same facility, available by phone or video, unavailable to attend on site).⁴ Quality supervision is required for Trainees to achieve the learning and graduate outcomes of specialty medical training. The quality of supervision can be directly measured in several ways, including Trainee outcomes, patient safety and quality of care, Trainee surveys and multisource feedback for supervisors. A commonly used indirect measure for assessing supervision quality is the quantity of supervision. Quantitative measures include the number of supervisors, the number of hours of supervision, the number of patient encounters or procedures directly supervised, or any combination of these. All STB/C specialty specific accreditation criteria include quantification of supervision via a defined quantity of supervisors or supervisor to Trainee ratio in combination with the number of operating sessions and outpatient clinics per week, with a combination of direct and indirect supervision. A small minority of STB/Cs allow for remote supervision in addition to but not in place of direct and indirect supervision. Quality of supervision is measured through Trainee surveys and successful progression of Trainees through the training program. The FATES 1 scoping review found no published evidence on any quantitative aspect of training. Specifically, there was no evidence for the current practice of requiring defined supervisor to Trainee ratios. Specialty training is a complex activity involving several different variables. The impact of any single element of a training program on the quality of training is not well understood. With less experienced Trainees, more direct oversight can lead to improved outcomes, and with more experienced Trainees, increasing levels of entrustment and autonomy are required. Studies suggest that specialty training programs, training terms and training sites are inherently variable and provide diverse experiences. The <i>Supervision, Mentoring and Orientation in Australian and New Zealand Medical Colleges – grey literature review</i>,⁶⁹ completed as part of the RANZCO FATES 3 SSTS project, found ‘The absence of a strong evidence base for supervision practices is a significant concern. In an era where medical training is increasingly driven by competency-based education and measurable outcomes, the reliance on outdated or non-evidence-based supervision models poses risks to both Trainees and patients. Few colleges have undertaken comprehensive reviews of their supervision practices to determine their effectiveness or to explore alternative models and there, particularly, remains a gap in research related to the impact of supervision on Trainee outcomes, especially in rural and remote settings where traditional supervision models may not be feasible.’⁶⁹ Most medical specialist colleges allow for direct and indirect supervision. RACGP and ACRRM have well established models of remote supervision or team-based supervision, which include the remote supervisor and Trainee working together before the period of remote supervision begins, regular communication (several hours per week scheduled and ad hoc communication), midterm site visits and regular supervisor team meetings, including onsite and remote supervisors. The review recommends ‘a more nuanced approach to remote supervision, one that balances the need for quality supervision with the realities of providing education in geographically dispersed settings.’⁶⁹	

Barriers	Inflexible criteria for supervision—number of supervisors, supervisor to Trainee ratios and models of supervision—is the most significant barrier to the accreditation of rural training posts. The combination of smaller specialist teams available to provide supervision, lack of flexibility to enable team-based models of supervision, and higher working hours and on-call hours adds pressure to individual supervisors, who may already have insufficient local support, quarantined and remunerated time to supervise and insufficient distance support from larger centres and STB/Cs. Surgeon to Trainee ratios: Requiring 2 or 3 FRACS supervisors at the training site is not workable for many rural training posts, does not take into consideration the FTE surgeon hours available for direct and indirect supervision, is not based on evidence, and is not consistent with the AMC requirement to enable flexible models of supervision. The number of supervisors does not adequately measure the quantity (hours or sessions per week) or quality of supervision (training outcomes, Trainee and supervisor experiences of supervision, patient outcomes). The requirement for 3 operating sessions, 1 outpatient clinic and 3:1 supervisor to Trainee ratio, may provide as few as 4 sessions of direct and indirect supervision per week in an urban unit where each supervisor has a low FTE appointment. Rural surgeons tend to have higher FTE commitments to public hospital work. A rural training post with 1 or 2 surgeons working a much larger FTE fraction results in greater hours per week of direct and Trainee supervision. Trainees in rural training posts report more direct surgeon supervision, higher first operator rates, more responsive supervision (more direct when less experienced, more indirect when entrustment and autonomy achieved), broader scope of experience and exposure to conditions not seen in urban practice. Flexible models of supervision: Accreditation criteria requiring FRACS-only supervision is not workable in many rural and remote hospitals where vocationally registered (AoNZ) or SIMG surgeons make up a large proportion of the workforce. Remote supervision cannot completely replace direct and indirect supervision for surgical training but presents a solution to expanding the number of supervisors available to a Trainee, and a sharing of the load of supervision, particularly in rural training sites with fewer than 3 surgeons. Flexible, collaborative, place-based models of supervision, including multidisciplinary/interdisciplinary, hybrid direct/indirect/remote and FRACS/VR/SIMG teams are required. Valuing rural training and rural supervisors: When rural training is recognised as valuable, it is considered by STB/Cs to be suited to less experienced Trainees, missing the opportunity for experienced Trainees to benefit from transition to practice years after exam attainment later in training. Stakeholders perceive rural surgeons to have a higher and/or unequal burden of supervision over less experienced Trainees. The unequal burden of supervision of less experienced Trainees is exacerbated by the practice of urban hospitals assigning annual leave during rural rotations, with more junior prevocational doctors/unaccredited registrars sent to cover annual leave for SET Trainees. Proactively developing rural supervisory capacity: helps to grow the rural surgical workforce, but there is an insufficient number of surgeons to conduct rural training. Stakeholders expect STB/Cs to proactively develop rural supervisory capacity through novel programs like the RACS Darwin Project, RANZCP Rural Directors of Training Project and the ACD hybrid supervision model.
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Solutions	Measure what matters: measure quality directly rather than using supervisor to Trainee ratios as a de facto measure of quality Enable flexible, collaborative models of supervision including hybrid models (combining direct, indirect and remote supervision from a team of local and distant surgeons), multidisciplinary/interdisciplinary models (including surgeons from another specialty), and supervision by IMGs (under level 3 or 4 supervision in Australia or vocationally registered non-FRACS surgeons in AoNZ) provided there is one FRACS surgeon supervisor on site. Use technology to enable teams of supervisors and rural and urban sites to share teaching and learning resources, formal education programs and examination preparation. STB/Cs ensure equity of access to rural training experience at all training stages, and equity of supervisory burden, setting and monitoring targets for equitable distribution of Trainees between urban and rural training sites. STB/Cs collaborate with hospitals and supervisors in areas of need to develop supervisory capacity (e.g. ASPS).
Recommendations	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, consider the number of operating and outpatient sessions that are directly or indirectly supervised, and/or the total FTE equivalent of surgeons employed in the unit instead of the number of surgeons or surgeon to Trainee ratios. 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 SIMG/VR surgeons as clinical supervisors. STB/Cs collaborate with hospitals and surgeons in remote and rural 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 RANZCO SSTS to support selection, training, reflective practice and CPD for supervisors. Colleges develop shared resources for rural supervisors and/or provide access to resources from other colleges, for example, RACP's Culturally Safe Supervision resources²¹, RANZCOG and RACMA leadership development for rural and remote specialists.²²
Theme 4: Making it count – effective and efficient delivery of training, courses and assessment. SET programs combine experience in health settings with formal teaching and learning programs and assessment. In-person, hybrid and virtual delivery of teaching, learning and assessment are validated methods in postgraduate medical programs.	
Barriers	Compulsory courses, conferences and examinations requiring in-person attendance in a capital city impose a significant burden on RRR Trainees and those in national and binational training programs where interstate or cross-Tasman travel may be required. A recent RACSTA investigation estimated RRR Trainees incur 150% of the financial cost of attending compulsory commitments compared to urban Trainees. Costs are even higher for those with caring responsibilities who need to travel with children or pay for alternative after hours

	care while away. There is a significant secondary burden imposed on RRR training sites. RRR Trainees are absent for the duration of the course/exam plus at least one travel day either side of the event, requiring training sites to employ locums in their absence for multiple days. An urban Trainee takes less time off work, has lower travel costs and fewer locum days are required. While Trainees and training sites accept the need for in-person attendance for some courses (e.g. skills courses) and examinations (e.g. clinical/viva), and Trainees value the opportunity to meet colleagues face-to-face, there is a desire for STB/Cs to consider the value of each event and the number of events per year per training program, and the higher travel time, cost and absence from the workplace for RRR Trainees, and associated locum costs for rural hospitals. Trainees are perplexed by the requirement to travel long distances to participate in online examinations. There are significant resources—including infrastructure and proctors—available in rural training sites to support virtual examinations via university departments of rural health, regional training hubs and FRAME. Trainees desire that STB/Cs integrate more virtual options into training programs, combined with a more seamless digital experience when interacting with STB/Cs and RACS, to improve access and to deliver efficiencies and cost savings for Trainees.
Solutions	Specialty specific accreditation criteria are evolving to enable formal teaching and learning programs to be shared within hospital networks and between urban and rural training sites to reduce the burden on small teams of surgeons and supervisors at rural training sites to independently deliver comprehensive local programs. Stakeholders identified opportunities for STB/Cs to take a more active role in coordinating and providing access to a formal learning program, to share the load between training sites, to include a diversity of surgeons and teaching styles and to ensure a consistent and comprehensive program for both urban and rural Trainees. Stakeholders also expect STB/Cs to lead the provision of virtual mentoring programs, peer-to-peer networking and examination preparation events, and consider that responsibility for these activities should be shared between training sites and STB/Cs. Stakeholders identified solutions including review of low value courses, opportunities for virtual delivery of courses and examinations (e.g. multichoice, written, online examinations), remote access to events, hybrid delivery with virtual pre-learning and a shorter onsite session, provision of courses in larger regional centres closer to rural Trainees, and clustering multiple in-person components together once or twice a year rather than dispersed through the year to reduce travel time and cost, time away from the workplace and locum costs. Suggestions include a rotating schedule of regional and rural courses, similar to the RACS Annual Scientific Congress and society annual scientific meetings. Regional and rural courses (e.g. in Darwin or Townsville), would also reduce barriers for rural prevocational doctors to attend and prepare for application for the SET program. Stakeholders proposed novel solutions to provide access to simulation facilities for rural training sites, including mailing Trainees simulation kits to be used in conjunction with local operating theatre equipment with virtual instruction, and for more complex simulation equipment such as provision of a mobile simulation unit, to be shared between multiple sites in a state/territory or region.
Recommendations	STB/Cs develop policies to facilitate equitable access to formal learning programs and examination preparation resources for rural Trainees through national or regional coordination and/or urban–rural partnerships to ensure all rural training sites are integrated into formal learning programs, by providing virtual access to events, and by providing 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 cost to Trainees, including rural and remote Trainees, of travelling, accommodation and lost time out of the workplace and the locum costs for training sites. STB/Cs limit the number of compulsory in-person events for Trainees to one or two 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.
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Table 12. Domain 3: Rural Hospitals, surgeons and administrators: Streamlining the accreditation process

Theme 1 Accreditation processes The NHPO <i>Processes for Progress Review – a roadmap for greater transparency and accountability in specialist medical training site accreditation</i> states: ‘Accreditation is at the heart of the registration of health practitioners seeking to work in Australia’s National Registration and Accreditation Scheme...Robust accreditation processes help ensure health practitioners are suitably trained and qualified to practise a regulated profession in Australia.’¹⁸ The 2025 AMC model standards and model procedures deliver substantial flexibility to enable accreditation of training sites/posts in rural hospitals and Indigenous healthcare settings.	
Barriers	While accreditation of training sites is an essential component of specialist medical education, current accreditation procedures impose a significant resource burden on rural surgeons and administrative teams, who are already working with fewer resources and in smaller teams. Rural hospitals experience cultural and procedural barriers when applying for training-post accreditation. There is unnecessary variability between surgical specialty specific accreditation standards and a disconnection from wider healthcare standards and hospital accreditation frameworks. Standards, criteria and evidentiary requirements do not correspond with national and jurisdictional systems for role delineation, facility capability levels (for surgery, anaesthetics, paediatrics, critical care) or safety and quality standards and accreditation processes, for example the Australian Commission on Quality and Safety in Healthcare, NSQHS Standards.²⁶ STB/Cs do not uniformly apply AMC terminology and definitions (e.g. using induction in place of orientation) or Ahpra definitions of supervision (onsite/offsite supervision in place of direct, indirect and remote supervision). The application process lacks transparency and efficiency, with duplication and repetition. There is no system to allow hospitals to complete one application form including most of the RACS accreditation standards and criteria, and separate smaller applications for individual surgical programs. Hospitals seeking accreditation for more than one surgical training program need to complete separate applications for up to 9 surgical specialties, in addition to the multiple other primary and postgraduate health professional education accreditation processes that hospital engage in, all with differing requirements, timeframes and application processes. Stakeholders perceive the resources invested in accreditation by training sites has not been rewarded with a commensurate increase in rural training-post accreditation, rural workforce recruitment and retention or services to patients.

	Stakeholders desire an improved medical specialist hospital training site/post accreditation process.
Solutions	While RACS is concerned primarily with surgical education and training-post accreditation, rural hospitals manage accreditation across multiple medical specialist colleges. It is recommended that RACS consider the wider medical specialist training environment. More uniform standards across all medical specialist colleges, with less repetition and duplication of work, combined with a central rural liaison team with knowledge of all medical specialist accreditation standards and application processes, would be an ideal solution. A central rural liaison team could be shared between colleges or hosted/supported by CPMC. Stakeholders recommend accreditation standards remains as close to the structure and intent of the AMC model standards as possible, with lean specialty specific accreditation criteria focused on training outcomes and quality and safety of patient care. Accreditation assessment processes should allow flexibility in how criteria are met and use efficient digital systems to minimise the burden on colleges and training sites of participating in accreditation procedures. Stakeholders recommend STB/Cs sets reasonable benchmarks for the burden (time, cost, frequency) of accreditation activities for hospitals. RACS is already responding to the new AMC model standards. While the RACS HTP Accreditation project will streamline accreditation to some degree and the RACMA FATES 3 National Accreditation Portal IT Requirements project²⁰ will deliver further collaboration, synchronisation and efficiencies, significant resources will still be required to be invested by training site administrators and surgeons. Stakeholders proposed the following solutions: STB/Cs standardise terminology and definitions, using the AMC model standards terms and definitions and the Ahpra definitions of levels of supervision. An ideal streamlined accreditation process with 4 levels: 1. Ahpra overseeing hospitals being accredited once every 3 years for all health professional primary and postgraduate education programs, for a core set of accreditation standards linked to the Australian Commission on Quality and Safety in Healthcare NSQHS Standards²⁶ and accreditation processes, and for all health professional education programs. 2. CPMC overseeing accreditation for the core set of accreditation standards unique to specialist medical training, as set out in the AMC model standards and procedures, once every 3 years via an efficient online portal (encompassed by RACMA FATES 3 National Accreditation Portal IT Requirements project²⁰) 3. RACS HTP accreditation Part A application form: uniform Part A standards for all STB/Cs (FATES 1 Deliverable 3.2) once every 3–5 years 4. RACS HTP accreditation Part B application form: STB/Cs undertaking accreditation for a small set of specialty specific criteria. (FATES 1 Deliverable 3.3) once every 3–5 years, with an agreed maximum burden on training committees and hospital accreditation teams.

	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 and/or STB/Cs to support rural training sites. (Encompassed by FATES 1 Deliverable 2 – Administrative model, and FATES 1 Deliverable 3.2 – RACS HTP Accreditation project). Training for accreditation assessors, diversity of assessor teams including rural surgeons involved in assessment of rural training sites, and combination of virtual and in-person accreditation visits.
Recommendations	RACS HTP Accreditation project: 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 of 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 to support rural training sites (FATES 1 Deliverable 2 – Administrative model, and FATES 1 Deliverable 3.2 – RACS HTP Accreditation project). RACS continues collaboration with RACMA and CPMC for FATES 3 National Accreditation Portal IT Requirements project²⁰, to further streamline the accreditation process, including the development of an efficient online portal. RACMA considers how the RACMA FATES 3 project could coordinate with an accreditation system for all health professional education and training.
Theme 2: Accreditation standards and criteria	
Barriers	Inflexible specialty specific criteria, solutions and recommendations were addressed in Domain 2. There is significant variability in resources between rural training sites, with some surgical units being very well-resourced and others having fewer resources including perioperative teams (nurses, anaesthetists, critical care, diagnostic radiology and anatomical pathologists), infrastructure and equipment. Meeting specialty-specific STB/C accreditation criteria can require investment by training sites. Some training sites noted that accreditation requirements can be challenging to align with existing financial frameworks, budget cycles and competing priorities within public hospital systems. Stakeholders identified an opportunity for RACS, via STB/Cs and through its engagement with rural training sites, to further strengthen advocacy for the resources required to support high-quality training. Assessors and assessments do not always demonstrate understanding of rural context. Criteria written and rigidly applied by assessors without rural contextual knowledge leads to missed opportunities for flexible solutions to meeting criteria. Using on-call for surgical emergencies as an example: All stakeholders are in staunch agreement about safe hours. No-one wants Trainees and surgeons to work unsafe hours with associated risks to patient and surgeon health, burnout and reduced retention. RACS standards for safe hours and STB/Cs specialty specific criteria set the maximum on-call frequency for Trainees. Several programs do not allow a Trainee to be on-call for another surgical specialty, although the AMC requires colleges to provide

	Trainees with experience in multidisciplinary and interdisciplinary settings and the GSET curriculum includes significant crossover in scope of practice with other surgical specialties. Rural Trainees and surgeons have higher total work hours and more frequent on-call hours compared to urban teams. Small teams in RRR settings makes 24/7 cover more challenging, especially for smaller surgical specialties. Providing 24/7 cover for surgical emergencies requires flexibility, for example, one SET registrar covering multiple surgical specialties while on call. Accreditation criteria can prevent Trainees covering other surgical units when on call, thereby limiting flexibility and sharing of on-call hours at RRR sites. There is variability in maximum hours and on-call frequency between training programs. RACS standards for safe hours recommend no more than 1:4 on-call for surgeons, with specialty specific accreditation criteria allow for 1:2 and 1:3 on call for Trainees. There is a need to balance access to experience in managing emergency presentations with the health and welfare of Trainees.
Solutions	Stakeholders expect accreditation assessors to understand rural context, place-based models of care and resource limitations in rural settings, and the variability between rural settings.
Recommendations	STB/Cs set reasonable criteria reflecting real-world surgical practice in rural and remote 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. RACS, via STB/Cs, provide a framework to support consistent guidelines on maximum weekly work hours and on-call frequency for Trainees, while allowing shared on-call models across surgical specialties within the same facility (e.g. PRS, OHNS, General Surgery and Urology in rural contexts).

Table 13. Domain 4: Trainees: Maximising the upsides and minimising the downsides of rural training.

Trainees value rural training experience and community integration during rural training terms. Rural training is often associated with relocation for Trainees and their families and, for some Trainees, isolation from peers. It is possible to provide Trainees with the benefits of rural training experience while reducing the burden of relocation on Trainees and their families and reducing professional and social isolation.

Barriers	Relocation during training has upsides and downsides for Trainees and their families. Short-notice and short-term placements mean Trainees live separately from their partners and families with duplication in housing costs, increased stress and reduced wellbeing. Multiple short-term placements also increase the burden on rural hospitals with smaller workforces, of orienting and onboarding multiple Trainees every year, rather than one Trainee for 12 months. Trainees need resources to assist with relocation, including information, relocation grants or entitlements, and concierge services. There are multiple steps and stakeholders involved in relocation assistance. A collaborative effort is required to join these steps and ensure assistance occurs in a systematic way for all Trainees relocating for rural training. The steps include college rural training pathways and advanced notice of placement; preorientation information to assist relocation, provided by the training site and community organisations; regional and jurisdictional relocation services resources; and state and territory health and public service employment agreements. A key challenge for rural workforce strategies is the issue of accommodation in rural areas. Securing accommodation suitable for Trainees and their partners and families is increasingly stressful. Accommodation challenges in rural areas occur throughout the health professional education and training pathway, including medical students (placement poverty) and prevocational doctors, specialist Trainees and recruitment, and retention of all rural healthcare professionals. Rural industries and employers are investing in housing projects to assist in the recruitment and retention of workers. The National Rural Health Alliance has proposed provision of accommodation and childcare as key actions to recruit and retain healthcare professionals in rural areas. In the past, nurses homes attached to rural and regional hospitals provided flexible and inexpensive accommodation for health professional students and Trainees. Few of these now exist. Some hospitals provide subsidised accommodation to Trainees on short-term placement (6 months or less) and some jurisdictions provide short-term accommodation (4–12 weeks) at the start of longer-term placements. The STP and Integrated Rural Training Program (IRTP) provide funding to support rural training; however, there is low visibility to Trainees on how these funds support relocation and accommodation. Existing STB/C specialty specific accreditation criteria have included relocation, travel and accommodation support, with the cost borne by rural hospitals, who may have no allocation of budget from their jurisdiction. There is no universal system for rural public hospitals to build and maintain accommodation and/or subsidise private rental accommodation. While the STP and IRTP programs contribute to funding rural training posts, RACS Trainees have no visibility of this funding. Other colleges apply this funding to assist with relocation support, paid directly to the Trainee. No STB/C requires an urban hospital to provide similar benefits to a rurally based Trainee relocating to an urban training site. While the new AMC model standards for accreditation of training sites deliver more flexibility to enable the accreditation of rural training sites, there is no provision for colleges to include accommodation for Trainees in training site accreditation. ASMOF advises relocation and accommodation are not part of industrial or employment agreements. Relocation allowances are sometimes provided through public service awards although are not universally applied or accessible for doctors in training.
Solutions	The FATES 2 Rural Training Models project recommends advance notice of RRR placements (preferably at least 12 months, noting that some programs already provide 2–4 years advance notice), longer placements (at least 12

	months and aligned with the school year to enable Trainees with children to relocate with their families) and extended and/or multiple placements to the same hospital/region to enable Trainees and their families to integrate into the community. Training sites can coordinate to ensure Trainees have an adequate number of days off duty at the start and end of rotations for relocation. Collaboration with external stakeholders: To realise the benefits of rural training experience while reducing the burden of relocation for Trainees, stakeholders need to combine to find novel solutions in the context of wider rural healthcare professional education, training and recruitment strategies. Relocation allowances belong within industrial and public sector employment agreements; collaboration with ASMOF and jurisdictions is required. Collaboration, creativity and resources are required to develop novel solutions for accommodation. For example, redesign of the STP and IRTP programs to more directly benefit Trainees, partnerships between rural hospitals and rural universities/regional training hubs that may have excess student accommodation that could be made available to Trainees, investment in buying or building accommodation for health professional students, Trainees and staff, and negotiating industrial agreements that include relocation and accommodation allowances. There is an opportunity for colleges to lead the development of solutions in collaboration with Trainee organisations (within colleges and the AMA Doctors in Training Committee), the National Rural Health Alliance, governments and jurisdictions, rural hospitals and communities, and the Rural Health Multidisciplinary program/regional training hubs.
Recommendations	The following recommendations are also included in the FATES 2-Rural Training Models Report: RACS, working through the STB/Cs, supports the development of improved urban hub–rural spoke models and rural training networks that foster connection to place while reducing the burden of frequent relocation during training. This includes place-based selection, advanced notice of rural placements (at least 12 months), longer placement durations (at least 12 months, aligned with the school year), and/or multiple placements to the same hospital or region to enable families to relocate and integrate into the community. RACS, working through the STB/Cs, engages with stakeholders to support the facilitation of relocation assistance for Trainees and their families, and to promote a more systematic approach to relocation support for all Trainees undertaking rural training. RACS, working through the STB/Cs engage stakeholders to develop systemic and place-based solutions to assist Trainees to secure suitable accommodation in RRR areas. RACS, working through the STB/Cs, supports the development of a collaborative advocacy strategy with the Australian Medical Association Doctors in Training Committee and the Australian Salaried Medical Officers Federation (ASMOF) to encourage jurisdictions to implement mechanisms for portability and/or preservation of leave entitlements (including parental, carers, personal, long service and sabbatical leave) 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 and can be shared with colleges.
Barriers	The geographic distance from peers and/or family combined with the smaller surgical teams in rural training sites can make speaking up about concerns harder for rural Trainees. The culture of bullying, discrimination and harassment in surgery is well documented. The impact of a psychosocially unsafe workplace can be felt more keenly by rural Trainees and anonymity is impossible. It is difficult for Trainees working in small teams at a distant from peer/mentor support in rural sites to raise concerns, remain anonymous and/or continue working within the same team.
Solutions	New legislation imposes a positive duty on workplaces to prevent gendered discrimination and harassment and to provide psychosocially safe workplaces, rather than just respond to issues as they arise. The <i>A Better Culture Curriculum</i>³⁴ will guide practical actions for organisations, managers and individuals to provide culturally safe workplaces. RACMA recommends psychosocial risks be incorporated into existing quality systems for people and culture and clinical systems within hospitals, and that Trainees are provided with multiple avenues to raise concerns. The Operating with Respect program, Foundation for Surgical Educators and Keeping Trainees on Track courses provide surgeons with skills to provide safe training spaces. RACP has online modules for Culturally Safe Supervision. RACS, working through the STB/Cs, supports the provision of multiple, accessible avenues for rurally located Trainees to raise concerns, including existing mechanisms (such as anonymous feedback via the Medical Training Survey, RACSTA surveys, the RACS annual Trainee survey, Trainee rotation surveys and Trainee Fellowship exit surveys, as well as confidential discussions with RACS staff through the RACS complaints process and/or training managers). This may be complemented by the implementation of rural career or training coordinator and/or director of rural training roles, and dedicated mentoring programs for rural Trainees.
Recommendations	The following recommendations also appear in the FATES 2 Rural Training Models Project Final Report. Colleges implement the RANZCO 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 and/or Māori Trainees, provide resources for all Trainees to develop cultural competence and cultural safety skills, and support 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 program 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.
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DELIVERABLE 2: AN ADMINISTRATIVE MODEL TO FACILITATE RURAL TRAINING-SITE ACCREDITATION

In collaboration with the RACS Education Portfolio, a proposed administrative model to facilitate rural training site accreditation has been developed and will be provided to the Commonwealth.

An accreditation coordinator would have high-level knowledge of the AMC model standards and model procedures for accreditation of training sites, the RACS HTP Accreditation project, the HTP accreditation Part A and Part B application forms and relevant evidentiary examples used to illustrate satisfaction of accreditation requirements. The accreditation coordinator would have knowledge of the RACS *Rural Health Equity Strategic Action Plan*¹⁴, STP projects relevant to rural training (Rural professional skills curriculum, Asynchronous video coaching), and the FATES 1 Rural Accreditation – Addressing Barriers to Rural Specialist Training and FATES 2 Rural Training Models final reports and recommendations.

An accreditation coordinator would engage with:

- existing internal stakeholders including CSET, the HTP Accreditation project team, the Rural Health Equity Steering Committee and the Rural Surgery Section
- the proposed RACS roles of rural career/training coordinator and director of rural
- external stakeholders:
 - rural training sites, surgeons and administrators
 - FATES 3 RACMA National Accreditation Portal IT Requirements project²⁰
 - RHMT program
 - Regional Training Hubs
 - National Rural Health Alliance.

An accreditation coordinator would implement a strategy to increase the number of accredited rural training sites, with distribution informed by workforce mapping and community need, and monitor and report progress towards targets.

DELIVERABLE 3.1: STRENGTHS AND OPPORTUNITIES OF RURAL TRAINING REPORT

The following report adds findings from FATES 1 qualitative research to the existing RACS evidence base, including the STP barriers and levers to rural training project, the STP rural professional skills curriculum and eLearning course, and the Ahpra Medical Training Survey.

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 community need. Rural training experience enables the development of rural contextual competence, generalist skills and the development of connection to place.

The strengths and opportunities of rural surgical training include:

1. increased access to health services for RRR communities
2. building the rural and Aboriginal and Torres Strait Islander surgical workforce and reducing workforce maldistribution
3. enabling Trainees to develop adaptability and flexibility, and to practice in multiple contexts and in multiple models of healthcare including generalist, rural contextual and RUFUS skills
4. community integration
5. training outcomes.

To realise the benefits of rural training experience, Trainees need:

6. orientation to rural practice and rural context
7. rural training experience paired with the RACS Rural professional skills curriculum and eLearning course

INCREASED ACCESS TO HEALTH SERVICES FOR RURAL COMMUNITIES

Rural people have poorer access to healthcare. Rural health professional education and training is associated with an increase in access to health services for rural communities.

The benefits of training-post accreditation can flow to the broader workforce and health service. These include access to infrastructure, improved (cross-specialty) collaboration and interprofessional learning, increases in services and workforce capacity, and the recruitment and retention of specialists.

Rural industries, businesses, services, organisations and families are interdependent. Changes in one sector always impacts other sectors. Integration and cooperation across sectors increases the sustainability and resilience of all sectors and the community.

Healthcare has an impact beyond direct patient care. Healthcare facilities are 'anchor institutions' in rural communities.

The Australian Healthcare and Hospitals Association, Deeble Institute for Health Policy Research report, *Policy Alignment for Place-Based Solutions for Better Health Outcomes in Rural and Remote Communities* stated: 'The inextricable link between health services and the wellbeing of their communities is often not explicitly recognised in decision-making. The impact of health services is more than just the provision of healthcare. They also have influence (e.g. on employment, investment and purchasing decisions within the local community). The decisions that are made about the way healthcare is provided thereby impacts the safety, vibrancy, and stability of those communities.'⁸¹

Healthcare is a multiplier of built, human and social capital for rural communities. Investments in healthcare and health workforce in rural communities delivers social and economic benefits beyond

healthcare. The presence of health services and health career pathways are incentives for people and businesses to remain in, or move to, a rural or remote area. Poor health service access is a disincentive to live in rural areas, and poorer health outcomes limit the potential of rural industries by reducing the workforce's efficiency through increased absenteeism and decreased productivity. Loss of healthcare services or staff impacts the whole community and economy. The AoNZ *Rural Health Strategy 2023* describes this issue in the following way:

'The sustainability of rural communities and the availability of health services within these communities are intrinsically linked. As well as economic growth, maintaining and enhancing health and social infrastructure is important to attract people and businesses to communities. In particular, the loss of key services, such as banks, health clinics, retirement homes, schools, or supermarkets, can be a 'tipping point' for a town reducing the viability of remaining organisations, including those that rely on volunteers. As health and social services lessen, people are dissuaded from living in certain areas and may choose to move – particularly those looking to start a family, older people, or those with specific health needs. Struggling health services and communities can also find it hard to recruit health workers, compounding the problem – as schooling, digital connectivity and wider employment options (for family members) all contribute to the decision to live rurally...More work is needed on attracting young people to employment options in rural communities that support their life aspirations, which could include health careers.'

⁸²

Similarly, Vaughan et al state: 'Research into the closure of smaller hospitals, especially those in rural and remote areas, has found major impacts on local communities, with evidence of cascade effect. Hospital closure tends to trigger an exodus of local general practitioners, allied health and other community-based staff, following increases in the burden of work for those remaining. Low-skilled workers who lose their hospital jobs frequently have difficulty in finding alternatives, further stretching sparse local resources. Lack of health services makes it unlikely that people, especially those with younger families, will relocate to the town and will be a factor in others leaving, especially those with chronic health problems. Hospital closure can rapidly lead to whole towns becoming unviable, resulting in social isolation and deprivation for those who stay.'

⁸³

Local options for training in health careers is also a significant multiplier:

'Encouraging careers in healthcare and providing supportive training pathways benefits those in rural communities. The RHMT program is underpinned by a commitment to community investment and contributes to the social capital of the communities in which it is embedded. It is important to recognise the economic, social and employment value of rural training sites to their rural communities and the contribution communities and health professionals make to student training.'

⁸⁴

BUILDING THE RURAL AND ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE AND REDUCING WORKFORCE MALDISTRIBUTION

Selecting applicants with rural experience and providing rural vocational training experience with an aligned curriculum are key levers to growing the RRR specialist workforce.

Fuller et al. defines place-based approaches to health professional education in the following way:

'Growing your own' emphasizes the recruitment of students already embedded in rural communities and providing them with access to training opportunities, ideally in the local area. 'Place-based' approaches recognize that education is inexorably grounded in the place and context in which it occurs. Place-based education (PBE) seeks to strengthen students' connections with their location and community through the context, content, and pedagogy of curriculum delivery'.⁵

Beccaria et al⁸⁵ investigated the importance of attachment to place in growing a sustainable Australian workforce, via a systematic rapid review. Place attachment includes attachment to both the physical and social environment:

'Place attachment factors varied across disciplines and included (a) intrinsic place-based personal factors; (b) learning experiences enhancing self-efficacy and rural health work interest; (c) relational, social and community integration; and (d) connection to place with lifestyle aspirations...An attachment to place might develop through placement experiences or from a strong rural upbringing. The importance of the relational interactions within a work community and the broader community is seen as an important factor in attracting, recruiting, and sustaining a rural health workforce.'⁸⁵

Rural origin and/or rural-experienced Trainees are many times more likely to practice rurally, compared to Trainees with no connection or experience with rural communities. Longer periods of rural experience and community immersion, and cumulative periods of experience, are strongly associated with future rural practice.⁸⁶⁻⁸⁸ Rural origin, rural medical school and early-career positive rural exposure are strongly and independently associated with future rural practice, with rural immersion during vocational training emerging as the strongest independent factor. Urban-origin doctors with rural experience are also more likely to become rural doctors.

Compared to urban-origin graduates with no rural experience during medical school, prevocational or vocational training, the following factors increase the relative chance an Australian graduate will become an RRR doctor: rural origin 2.7–3.7 times; one year of rural clinical experience 2.4 times, two years 2.7 times; prevocational work experience 3.8 times for general practice, 2.8 times for non-GP specialist practice. A combination of factors and longer duration of exposure is even more powerful: rural origin plus 12 months rural clinical school, 4.4 times; rural origin plus 24 months rural clinical school 7.1 times. Urban-origin doctors with rural experience are also more likely to become rural doctors: urban origin plus 12 months rural clinical school, 2.4 times; urban origin plus 24 months rural clinical school, 2.7 times.⁸⁶⁻⁸⁸

Prevocational and vocational rural training experiences have the most impact on future rural practice. Graduates with prevocational and vocational rural work experience are 40 times more likely to become rural GPs and 11 times more likely to become rural specialists. The proportion of 2011 graduates working rurally increased between 5–8 years post-graduation, due to early-career training not being available in rural areas.⁸⁸ Rural- and urban-origin doctors who had rural clinical school, prevocational or vocational rural training experience were more than twice as likely to move from metro to rural areas during and after completion of training⁸⁷

The CPMC and the National Rural Health Commissioner presented guidance on implementing rural selection for entry to medical specialist training in 2025. 'Recognising and supporting rural applicants at college entry is a proven step towards addressing persistent rural workforce gaps.'⁸⁹

Some Trainees intend to enter urban practice, nearly 40% intend to practice rurally,^{25 27} and some are undecided and open to formative experiences during training. Increasing rural experience for surgical Trainees will contribute to growing the rural surgical workforce and deliver 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 RACS *Rural Health Equity Strategic Action Plan*⁷⁷ the RACMA *Securing Australia's Medical Workforce* policy¹⁵ and *Rural-Ready Medical Workforce*¹⁶ policy and the NMWS.¹¹

Training on Country

Health careers for remote and rural Indigenous people have a positive multiplier effect for remote and rural Aboriginal and Torres Strait Islander communities.¹³ Increasing educational attainment is

associated with better health outcomes for Indigenous people and their children and increased access to employment opportunities in rural and remote communities. Care delivered by First Nations people results in better health outcomes for Indigenous communities. Aboriginal and Torres Strait Islander healthcare workers understand the cultural context of their community and how to work within a culturally safe framework.

In 2016, Aboriginal and Torres Strait Islander people represented only 1.8% of the health workforce, despite comprising 3.3% of the total Australian population and 3.1% of the working age population. Aboriginal and Torres Strait Islanders make up 0.7% of all employed medical practitioners and 0.15% of specialists(14). The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–31 (Health Workforce Plan) aims for Aboriginal and Torres Strait Islander people to represent 3.43% of the national health workforce by 2031.¹³

‘A strong Aboriginal and Torres Strait Islander workforce is a powerful driver of change and evidence clearly shows that an Aboriginal and Torres Strait Islander health workforce delivers better outcomes for Aboriginal and Torres Strait Islander peoples. The National Workforce Plan has a vision that Aboriginal and Torres Strait Islander people enjoy long, healthy lives that are centred in culture, with access to services that are prevention-focussed, responsive, culturally safe, and free of racism and inequity. Co-designed with Aboriginal and Torres Strait Islander people, this plan's target is for First Nations people to be fully represented in the health workforce by 2031. It includes actions to attract, recruit and retain workers across all roles, levels and locations within the health sector.’ – National Aboriginal and Torres Strait Islander Health Workforce strategic framework¹³

First Nations students, especially remote and rural students, have lower course completion rates due to a lack of cultural safety in the way training is delivered and contextualised, cultural obligations and community expectations. It is hard to study off Country, away from family, community and culture, particularly for long degrees like medicine. It is difficult to take sufficient leave at short notice, when needed, for cultural reasons and sorry business; there are cost pressures—it is more expensive to travel and live away from home while studying.

Focused co-designed programs of recruitment and support for Indigenous students are attempting to reduce these barriers:

- The Indigenous Education and Research Centre at James Cook University trebled graduation rates over 10 years. There are 20 current medical students.
- The Australian Indigenous Doctors' Association (AIDA) conducted the *Specialist Trainees in the Medical Workforce project: a partnership and collaboration to grow the Aboriginal and Torres Strait Islander medical specialist workforce*.⁸⁹ In 2017, the Department commissioned AIDA to work with specialist medical colleges to increase recruitment and retention of Aboriginal and Torres Strait Islander doctors into specialties and provide culturally safe work and learning environments with support to achieve Fellowship.

RACS aims to increase recruitment and attainment of Fellowship by Aboriginal and Torres Strait Islander doctors through the Aboriginal and Torres Strait Islander Selection Initiative and the Indigenous Scholarship Program. The RACS Indigenous Health Committee and the Mina Advisory Group advise RACS and provides mentoring and support for Trainees and Fellows.⁹⁰ The RACS Rural Health Equity Strategic Action Plan¹⁴ aims to increase opportunities for RRR Aboriginal and Torres Strait Islander Trainees to complete more of their training on, or close, to Country and community.

GENERALISM, CASELOAD AND CASE-MIX

Rural practice incorporates the philosophy and practice of generalism.⁹¹

Generalist skills can be applied in any specialty and across many settings and are particularly effective in caring for patients with undifferentiated illness, multisystem disease and in rural areas with smaller teams of specialists. Generalism encompasses 3 concepts: broad scope of practice, responding to community need, and advocacy.

The key elements of rural generalism in surgical practice are:

- Broad scope of practice—
 - broad spectrum of patients, from infants to elderly
 - flexible, adaptable problem-solving in an environment of resource limitation or resource variability
 - knowledge of limits; having an established network of colleagues to call for help
 - engaging in CPD and reflective practice to ensure quality and maintenance of skills in generalism and multiple subspecialist areas
- Responding to community need including expanding skills, extending scope of practice, building team capacity, getting more resources
- Patient system navigation, coordination and advocacy

RRR surgeons see every patient referred to them. They are unable to pick and choose. While they may not provide definitive care for every patient they see, they are responsible for deciding the best course of treatment and assisting patients to access care that cannot be provided locally. While many RRR surgeons have subspecialist training and practice, this sits alongside their generalist practice. Many RRR surgeons are generalists with at least 2 subspecialty interests. For example, Rural OHNS surgeons are generalists with subspecialist practice in paediatrics, otology, rhinology and OHNS. RRR surgeons need broad professional networks within each subspecialty, and must carefully plan their CPD to stay up to date with all the subspecialty areas of surgery their community requires of them. Few rural surgeons can choose to focus solely on a subspecialist interest—that option is open only to surgeons practising in proximity to multiple other surgeons who can collectively meet the need for care across the spectrum of their specialty scope of practice.

Rural training posts are busy. There are many patients in need of surgical care. Trainees value the opportunity to develop their skills in diagnosing and managing a wide variety of presentations in emergency and outpatient clinics, the broad scope of operative and nonoperative experience, and being able to manage patients of all ages (urban hospitals are often siloed between adult and children, with limited paediatric experience available during training programs). While there may be less exposure to some procedures (i.e. more complex cases or more specialised procedures), for other procedures the numbers of cases and the exposure to training opportunities can be greater. Trainees need a broad experience of conditions and procedures. Trainees report that rural training experience provides a higher proportion of emergency to elective operating compared to urban training posts. In line with this, rural training also enables better access to large volumes of common procedures that are often displaced by cancer surgery or complex subspecialty procedures, or performed by physicians in urban hospitals (e.g. endoscopy for general surgery).

RURAL CONTEXTUAL COMPETENCE

Rural practice is place-based practice, that is, responsive to context. Rural contexts differ from urban contexts, and each rural context is unique. Expert rural practice involves understanding the unique rural context of practice, including resource limitation or variability, situating the health service within the wider health network, and the social, economic and cultural determinants of health and applying contextual decision-making to optimise patient outcomes. Rural practitioners are both providers for and members of their community and need to balance community immersion with boundaries and privacy, and balance responsibility to the community with safe hours, health and wellbeing.

Competence is contextual. Rural practice requires an additional skill set compared to urban practice, including generalism, responsiveness to community need, and ability to make good contextual decisions to optimise outcomes for patients, including strategies to manage resource variability or limitation. Rural experience facilitates the development of rural practice self-efficacy rural practice^{92 93} capability⁹⁴ and rural clinical courage.⁹⁵ Rural surgeons use professional networks to access information and resources to benefit their patients locally. Communication (especially clinical handover) and collaborative models of practice in geographically dispersed teams and/or virtual environments are core skills for rural surgeons.

Collaboration in geographically dispersed teams and in virtual environments, and developing and maintaining professional networks, enables rural specialists to deliver more care locally for rural patients. Collaboration includes shared decision-making (e.g. virtual multidisciplinary cancer meetings), quality assurance and quality improvement meetings (e.g. audit, pathology, radiology meetings), and CPD. Virtual healthcare and virtual teams offer new ways for Trainees to access supervision, including remote supervision of telehealth and multidisciplinary meeting presentations and reflective practice, and the delivery of virtual tutorials and exam preparation shared within and between networks. Virtual environments also enable professional networking and peer support for supervisor and Trainees. Participants strongly support medical specialist training adapting to virtual healthcare and virtual collaboration in healthcare teams.

In addition to delivering formal learning and experiences aligned with the national training curriculum, rural supervisors are expected to support the Trainee to develop the unique contextual and collaborative skills required for rural practice. While Trainees are experts in adapting to new training contexts, rural training fosters rural-specific skills with the ability to assess and adapt to new rural practice contexts, practice rural contextual decision-making, communicate and collaborate in virtual and geographically dispersed teams, and optimise outcomes in limited resource environments.

MULTIPLE MODELS OF HEALTHCARE

Rural people have a diversity of health problems and need all types of specialists. All specialists need skills to care for rural people in RRR practice, in RUFUS practice, in virtual healthcare and in collaborative models of care in geographically dispersed teams. Rural training experience provides exposure to multiple models of healthcare delivery, as distinct from the model of care experienced in well-resourced urban tertiary or quaternary subspecialist practice. Differing models of healthcare delivery are explored below:

1. Resource-limited environments and place-based models of care: a key element of rural contextual competence is developing strategies to get the best outcome for patients in an environment of resource limitation or variability. While all rural facilities would appreciate more funding for recruitment and infrastructure, accreditation standards should enable Trainees to access a diversity of training contexts.
2. Holistic models of care: RUFUS skills include whole-of-patient care for patients travelling to cities for care, virtual healthcare/telehealth, outreach, communication and collaboration in geographically dispersed and/or virtual teams. RUFUS skills also encompass design and delivery of health pathways and systems to enable equitable access and outcomes for rural people.
3. Collaborative, virtual and multidisciplinary models of care: When more members of the workforce have RRR experience, they will be better able to engage in models of collaborative care where urban and RRR specialists work together in geographically dispersed or virtual teams. Participants identified rural experience as key to developing skills in collaborative care, especially local collaborative multidisciplinary and/or interdisciplinary models of care and collaborative care in geographically dispersed teams and/or virtual environments. Rural

training experience brings Trainees into proximity with surgeons from other surgical specialties, enabling interdisciplinary supervision, training and learning.

RURAL COMMUNITY INTEGRATION

Rural community integration is associated with improved Trainee wellbeing and progression through training programs. Trainees value living and working in rural communities, and being integrated into community, social and professional networks. Trainees cite the benefits of rural community integration being the rural lifestyle, proximity to the natural environment and outdoor sports, and the rewarding nature of providing care for a community you live in. Trainees desire more information and involvement with local Aboriginal and Torres Strait Islander communities, healthcare teams and organisations.

A selection of comments from interviews conducted with FATES 1 participants between September 2023–June 2024 follows:

‘I think it also gives them unique training opportunities outside of the hospital, sort of being able to be tied to their local community, to be involved in the local community and looking after the community, which I think is one of the appealing things in recruiting people for rural long term’ – participant 3

‘An experience outside of the competition of big city traffic, costs, pollution. Time in a regional area that has different types of attractions can be a nice break or change from city-living’ – participant 22

‘They get the benefit of being in a rural community. Some Trainees take that on and get involved a lot, reaching out to community events and sport things’ – participant 29

‘You actually learn about a career that’s awesome. Because if you actually stay on and you go on to perform surgery in a rural community and become part of that community, it’s one of the most rewarding things you can do. It’s a lifestyle and a direction that increasingly our surgical Trainees don’t ever get exposed to or understand. I would count that as a super benefit’ – participant 14

‘When they see what their consultants do within the community, they see that their consultants are not just surgeons, that they also need to have a role within the local community as well. And they can actually see how that benefits the community as a whole by [surgeons being] involved in organisations and volunteering their time and all those sorts of things that they may not necessarily understand when they’re in a bigger centre’ – participant 10

TRAINEE EXPERIENCES

Trainees value rural training experience. The Ahpra Medical Training Survey consistently reports that RACS SET Trainees are more satisfied with their rural training experience than their urban training experience, and more likely to recommend their current rural training position to their peers, compared to Trainees in urban posts.²⁷ Hippolyte found that SET Trainees value rural training, provided their sociocultural needs are met and they can prepare for their exams.³⁵ Respondents cited more first operator experience, more direct consultation supervision or autonomy as needed, and a broader case-mix, as incentives to choosing rural training.⁹⁶ Almost half of all doctors in training (46%) and 42% of SET Trainees, are interested in RRR practice.

Strengths and opportunities for Trainees in rural training sites (as follows) are accompanied by representative quotes from FATES 1 interview participants:

Positive experiences of supervision

Quantity of supervision: more direct contact with supervisors and other surgeons in the unit per week, compared to urban training sites.

Individualised training: more scope to tailor the training experience to the needs of the Trainee. Negotiating a Trainee's personal learning and development plan is a key action to match the Trainee's needs and expectations to the scope of practice, resources and unique opportunities available in the training context.

Flexible supervision: closer/more direct supervision when required, while also enabling more indirect supervision as entrustment and autonomy develops. Supervisors facilitate access to experience with other surgical and medical specialties.

'Broad experience, which is often personalised, because there's smaller units where they get to know a surgical team' – participant 13

'There's no Fellows, there's no senior registrars. It's just the one registrar working closely with the consultants, they will get one-on-one instruction and supervision, which I think helps them develop their basic skills' – participant 29

'Better exposure to patient care in terms of fewer barriers between them and consultants, which results in better individualised training' – participant 4

Caseload and case-mix

Less competition for experiences, smaller teams of Trainees, fewer Fellowship positions leading to more hands-on experience, and higher first operator rates can lead to attainment of competence earlier in the training program.

Positive experiences with varied caseload and case-mix, is tempered by anxiety around meeting specialty specific caseload and case-mix targets.

'In the city, you're fighting for the opportunity to get into theatre. There is no fight here. They're in every theatre, in every theatre session they're allocated. So they get lots of opportunities to cut' – participant 28

'We have attracted good Trainees, because they get hands-on, they know there's less competition against Fellows for getting cases and it's all about those, but they enjoy the better access to doing cases and the more flexibility we have in training them' – participant 19

'I would absolutely second that the quality, the breadth and the depth of experience you get in regional and rural is, I would argue, better than metro' – participant 11

'Greater exposure, the ability for the Trainee to actually lead, to actually do the work because there's a lot of work; to actually do the job that they would do when they become a consultant effectively; to actually get more hands-on work' – participant 11

'Rural trauma is different to urban.....you can have an opportunity of working with RFDS [Royal Flying Doctor Service] and retrieval services, which is a good experience' – participant 24

'Our rural clinicians are very good at identifying a patient who is critically unwell. Identifying what they're likely to need in that diagnostic realm and knowing that they don't have it; in stabilising people for transport and working with the coordinators of that transport, be it flying doctor service or you know, a statewide coordination service' – participant 16

Continuity of care

Rural surgical training allows for continuity of care. Trainees gain experience in caring for patients from the outpatient clinic, through to surgery and recovery, allowing them to undertake holistic and patient-centred care.

‘They’re often following patients from clinic through to operating, to the ward and postoperative care clinic afterwards as well, so they get good continuity and perioperative care as well as the operating’ – participant 29

‘You get to see your patients, generally preoperatively. Generally, you do the operation and then they get to see them in the outpatient clinic as well. They may also get to see them in the community situation. So they actually get to see not just the sick patient but often the well patient afterwards, functioning within their community’ – participant 10

Aboriginal and Torres Strait Islander colleagues and communities

More opportunities to work with and provide care for Aboriginal and Torres Strait Islander people in some rural training sites, where more than 50% of patients and a significant proportion of healthcare staff are Indigenous (e.g. Darwin).

‘Given the fact that we have, at any point in time, more than 80% of the patients here Aboriginal and/or Torres Strait Islander, we actually have some amazing opportunities here to learn more about Aboriginal and Torres Strait Islander health’ – participant 21

Teamwork and collaboration

Rural surgical training allows for stronger relationships and teamwork, more recognition within the team, and the opportunity to develop better working relationships with senior staff. There are more opportunities for multi-/interdisciplinary teamwork and collaboration, including with other surgical specialities and with pre-hospital, primary care, and smaller and larger hospitals along referral pathways.

‘A smaller workforce, that means that they often feel more recognised as individuals, more recognised part of the team’ – participant 7

‘We have a really dedicated team of staff that work at the hospital. There's a lot of collaboration between the units. It's less siloed than...metropolitan hospitals’ – participant 21

‘They have the opportunity to really become very important members of the team’ – participant 28

‘I enjoy working in a small team that I see consistently day-in, day-out and enjoy that environment more than working in a very large hospital with a team that changes from day to day. Working as a small, close-knit team, I think it's one of the benefits of working in rural areas’ – participant 29

‘They’re on a first name basis with all the allied health staff and the anaesthetists and the nursing staff in theatre. So, they actually become part of a team very, very, very quickly’ – participant 10

An understanding of rural context

A deeper understanding of rural context and resource-limited environments enhanced a Trainee’s practice. These transferrable skills assist Trainees in urban settings when they care for rural people

who have travelled for care, aid communication with rural colleagues who are requesting advice, and allow for the support or transfer of patients.

‘When you’ve been at [a rural training site] for 6 months and you’re back in the big city and you get a call from them, you understand why they haven’t got a vascular surgeon, an MRI machine, access to a stoma therapist— all of these things—because you’ve been there and you know it’ – participant 17

Transition to practice

More visibility of the whole professional, personal and community life of a surgeon, leading to an understanding of the breadth and depth of responsibilities and the skills and resources required for consultant practice, combined with increasing clinical autonomy in ‘transition to practice’ year at the end of training.

‘[Trainees] very quickly get exposed to what the professional responsibilities are of the surgeons, so they can see what they are actually going to need to be when they’re a consultant and what opportunities there are beyond just being a surgeon’ – participant 10

ORIENTATION TO RURAL PRACTICE AND UNIQUE RURAL CONTEXTS

To realise the benefits of rural training, Trainees need orientation to rural practice in general, as well as contextual orientation to their rural training location.

The following describes the best practice model for orientation to rural training developed by the FATES 2 Rural Training Models project.

Trainees need to rapidly adapt to new contexts to become effective members of the healthcare team and meet the requirements of their training program. Trainees require orientation to the training program, to hospitals and to specific training posts. Urban tertiary hospitals all have similar structures, systems and resources. Orientation in a rural context has additional requirements. Because rural contexts differ from urban contexts and from each other, rural practice requires an additional skillset compared to urban practice, and rural rotations are often associated with relocation for Trainees and their families.

Rural contexts are highly variable and place-based orientation is essential. Effective orientation programs contribute to patient safety, Trainee wellbeing and success, and long-term retention of the rural health workforce.

A best practice model of orientation for RRR training sites includes the following elements of place-based orientation: 4 stakeholders, 4 phases, 4 components:

The 4 stakeholder groups comprise Trainees and their families, hospitals, supervisors, and community.

The 4 phases of orientation are:

- orientation-in-advance – providing information in advance, in a virtual format
- onsite orientation at commencement – providing essential information, resources and safety skills with protected non-clinical time to participate
- ongoing onboarding over first month – iterative orientation with ongoing support for the first 4–8 weeks to fill gaps, address issues and deliver non-time critical information, and for the supervisor and Trainee to negotiate a personal learning and development plan

- orientation evaluation – iterative cycle of improvement and evaluation by Trainees.

The 4 components for rural orientation include community, health service/health system, specialist unit service delivery, and specialist unit training.

RURAL TRAINING EXPERIENCE PAIRED WITH RACS RURAL PROFESSIONAL SKILLS CURRICULUM AND ELEARNING COURSE

The AMC standards require colleges to respond to community need.⁷ Rural people have a diversity of health problems and need access to all types of specialists and subspecialists. Rural people receive healthcare close to home, as well as in cities and via telehealth. Most patients, conditions and procedures can be managed safely close to home in dispersed models of care. Highly complex patients and procedures and rare conditions need to be managed in highly complex subspecialist and multidisciplinary units in quaternary referral centres in a centralised model of care. 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.

Trainees need curricula and training experiences to enable the development of contextual competence in diverse settings and with diverse models of service delivery, including RRR practice and RUFUS. RUFUS skills include whole-of-patient care for RRR patients travelling to cities for care, outreach, virtual healthcare and collaborative care in virtual and geographically dispersed healthcare teams.

The FATES 2 Rural Training Models project recommendations include the development of 3 models of rural training: urban hub–rural spoke models, rural training networks and RUFUS models.

The RACS Rural Professional Skills Curriculum and eLearning course will be available for Trainees and surgeons from February 2026, at no cost to participants, and covers all of the elements in this section.

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

Concurrent with the NHPO review and report and the AMC consultation and publication of the model standards and model procedures, RACS is developing a new model of accreditation through the RACS HTP Accreditation project, for implementation in 2026. Both the FATES 1 project and the RACS HTP Accreditation project evolved in response to changes in the external regulatory environment. Although this resulted in delays to both projects, the outputs are now aligned to the new AMC standards and procedures and will be fit for purpose.

The RACS HTP Accreditation project team produced 2 documents:

- HTP accreditation Part A application form
- HTP accreditation Part B application form

These application forms also function as a ‘supporting evidence’ resource to assist hospitals in their accreditation applications by providing information on the kinds of evidentiary documents hospitals can include in their submission to demonstrate minimum accreditation requirements have been met.

The HTP Accreditation project team consulted extensively with the RACS Rural Health Equity Steering Committee, the RACS Rural Surgery Section committee and FATES 1 investigators. The documents are included in this report to highlight changes made to existing accreditation standards to reduce barriers to rural hospital training-post accreditation.

RACS HOSPITAL TRAINING POST ACCREDITATION PART A APPLICATION FORM.

A summary of Part A instructions follows (complete form provided in Attachment 8):

This application form is to be used to apply for a Hospital Training Post for all surgical specialties. Once the Part A accreditation is achieved, specialty accreditation and additional posts can be applied for using Part B application forms. For both Part A and B, an accreditation team/inspection panel will conduct an onsite/paper-based inspection.

To complete this form please complete the ‘Evidence uploaded or comment’ column. A Reflective question and evidence suggestions have been provided to guide you to provide responses which demonstrate your hospital’s ability to meet the standard/criteria. It is not necessary to use any or all the evidence suggestions if you can demonstrate meeting the criteria in another way. Rather than uploading documents for every criterion, it may be appropriate to add a comment instead. The inspection team will be verifying evidence in the site inspection, and the more a hospital can provide in this application, the better.

ANALYSIS OF IMPACT OF PART A APPLICATION FORM ON ACCREDITATION OF RURAL TRAINING SITES

The form includes reflective questions, evidence suggestions and options to describe evidence or upload documents. There are multiple examples and options, with evidence linking to existing jurisdictional and clinical governance frameworks and accreditation practices.

The form presents a clear and transparent process for the first stage in applying for accreditation, which is common to all RACS training programs, thereby removing duplication of effort by STB/Cs and variability in standards. The form also provides useful and extensive prompts, resources and examples of evidence to assist applicants.

The standards reference the RACS standards for safe working hours and on-call frequency.

The form is organised into 6 principles, which do not align with the 4 domains in the AMC model standards. The form uses terms that are not aligned with AMC and/or Ahpra standardised terms (e.g. *induction* in place of *orientation*).

Future iterations could:

1. Start with the AMC model standards as a template, while preserving the RACS accreditation principles. This would facilitate both hospital accreditation processes as well as the AMC assessment of RACS adherence to the model standards and the RACMA FATES 3 National Accreditation Portal IT Requirements project.²⁰ The most streamlined accreditation system would enable hospitals to meet the AMC model standards by using a standardised form for all specialist medical college programs, then utilise a shorter college and specialty specific form for each individual training program.
2. Standardise terminology and definitions using AMC standards and Ahpra levels of supervision (e.g. induction vs orientation, onsite vs direct supervision).
3. Ensure forms are openly accessible from a centralised accreditation hub on the RACS webpage for all RACS training programs.

RACS HTP ACCREDITATION PART B APPLICATION FORM – SURGICAL SPECIALTY

A summary of Part B instructions follows (complete form provided in Attachment 9):

HTP Accreditation Application Form Part B – Surgical Specialty

This form can be modified by each surgical specialty to meet their needs. The criteria identified as Part B have been isolated and asked generically if they have been met. Space to provide evidence or comment after each principle is given, particularly if the response is 'no'. A specialty can add details to criteria that supports them and copy yes/no boxes if they wish. The comment boxes can also be a space where specialties can ask for more specific details. Opportunities for specialties to add specific details have been highlighted in blue, with some examples provided.

There are 4 columns on the application form: 'Standard', 'Criteria', 'Factors assessed', and 'Assessment'. Factors assessed are posed as questions (e.g. 'Do Trainees have 24-hour onsite access to the appropriate digital technology that enables them to perform their clinical duties and to access the required training and education resources?'). The assessment column includes a tick box yes/no.

The form provides opportunities for STB/Cs to insert specialty specific criteria ('opportunity for specialty specific information') and provides examples which appear reasonable. For example, 'participation in a specialty specific national quality registry'.

ANALYSIS OF IMPACT OF PART B APPLICATION FORM ON ACCREDITATION OF RURAL TRAINING SITES

There has been substantial improvement to enable flexibility in how individual sites meet accreditation criteria, removing many of the inflexible criteria identified as barriers for rural training sites. Examples of this include:

- access to shared facilities rather than exclusive use
- virtual/networked and geographically dispersed healthcare teams
- virtual/networked/national formal learning programs rather than requiring every site to provide a comprehensive onsite program
- improved flexibility for small rural units where the head of unit may be from another specialty and/or where the supervisor may also be head of unit

- removing the criteria related to hospital grand rounds and whole-of-hospital formal education programs
- improved flexibility for outpatient experience in private rooms, for hospitals without public outpatient clinics
- improved flexibility around caseload and case-mix
- improved flexibility around surgical beds, requiring 'sufficient beds' rather than dedicated specialty wards
- improved flexibility in ED and ICU experience, not specifically requiring FACEM or CICM supervision
- flexible access to imaging, pathology and multidisciplinary meetings including virtual.

The form prompts each STB/C to include maximum allowable on-call frequency.

The form includes options for flexible models of supervision (e.g. Is supervision provided during work hours, on-call and after hours? Is supervision on site or, where necessary and appropriate, is there a process for remote supervision?). Clarity could be improved by using the Ahpra levels of supervision (direct/indirect/remote) rather than onsite, to standardise terminology across all colleges.

The following criterion could be edited for clarity:

Criteria 15.1 There are credentialed staff qualified to carry out surgical training and supervision. Factors assessed: Do the surgical trainers satisfy the generic requirements, including mandatory training, in the RACS Surgical Trainers Policy and satisfy the relevant specialty specific regulations? Opportunity for specific information (e.g. must have completed the SAT SET, Keeping Trainees on Track, Foundation Skills for Surgical Educators and the Operating with Respect course).

'Credentialed staff' should be clarified to mean 'staff credentialed by the facility to practice as a surgeon in the specialty scope of practice'.

The generic requirements of the RACS Surgical Trainers Policy also need clarification. Does this mean vocationally registered and SIMG surgeons without FRACS will be permitted to be surgical Trainers? RACS surgical trainers policy Surgical Trainers Policy 2020 ⁹⁷ does not specify that surgical trainers must be FRACS, only that they are CPD compliant, do have level 2-4 complaints within 2 years, behave in accordance with RACS code of conduct and complete Operating with respect and Foundation skills for surgical educators course, with optional Keeping Trainees on track course.

DELIVERABLE 3.3: DEVELOPING SPECIALTY SPECIFIC ACCREDITATION CRITERIA INCLUSIVE OF RURAL TRAINING SITES

RACS and the RACS STB/Cs are required to commence implementation of the AMC model standards and procedures from 2026. There is a risk that the flexibility provided in the AMC model standards and procedures, and the RACS HTP accreditation Part A and Part B application/supporting evidence forms will be lost as STB/Cs develop specialty specific criteria. The report provides guidance to assist STB/Cs to develop criteria that do not present unnecessary barriers to rural hospital training post accreditation.

STB/CS are urged to:

- preserve the flexibility the AMC model standards and procedures and the HTP accreditation Part A and Part B application/supporting evidence forms in determining specialty specific accreditation criteria
- manage conflicts of interest and blind spots
- include rural surgeons in decision-making groups and accreditation teams and provide training for decision-makers on the new standards and procedures.

Three criteria from the AMC Model Standards 2025 are of particular importance to any specialty specific accreditation criteria:

3.1 Trainees are provided with the appropriate depth, volume and variety of clinical and other learning experiences.

3.1.4 Trainees are given experience working and learning in multidisciplinary teams and/or settings.

3.2.1 Trainees are given an increasing degree of responsibility as their skills, knowledge and experience grow.

The AMC Standards 2023 note that training posts collectively build Trainee experience over the course of a training program *rather than expecting a single training site to provide all the required training experience*.⁷

The RACS HTP accreditation Part B application form criteria 18.1 and 19.2 (relating to caseload and case-mix) are the areas of most concern for stakeholders. Trainees value rural training for, among other things, the varied and broad caseload and case-mix, with little competition for access to cases, more direct consultant supervision and higher first operator rate, *tempered by anxiety around meeting specialty specific caseload and case-mix targets*. STB/Cs are urged to consider the information and recommendations in the Barriers and solutions for rural training site accreditation report (Deliverable 1 of the FATES 1 – Rural Accreditation project) and the strengths and opportunities of rural training report (Deliverable 3.1 of the FATES 1: Rural Accreditation project). Imposing inflexible caseload or case-mix criteria better suited to urban subspecialist units will miss opportunities for Trainees to experience the generalist, broad scope, multiage and multidisciplinary operative caseload in rural surgical units.

Table 14. RACS HTP accreditation Part B application form, criterion 18.1 and 19.2

18.1 Trainees have access to a range and volume of clinical and operative experience which will enable them to acquire the competencies required to be a surgeon.	Do Trainees have access to appropriate case volumes and case-mixes as required by the relevant specialty specific regulations? Opportunity for specific information
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19.2 The workforce of the surgical unit allows for Trainees to access the sufficient clinical and operative experience to support Trainee development and progress through the program.	Is Trainee workload monitored to ensure they have access to the necessary operative cases, training and learning opportunities as specified by the relevant specialty specific regulations. Opportunity for specific information, such as consideration of added Fellows etc. Are there no conflicting service demands which interfere with the required operative experience?
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See Attachment 9 for full RACS HTP accreditation Part B application form

DELIVERABLE 4: MATCHING TRAINING SITES TO COMMUNITY NEED FOR SURGICAL CARE

RACS is collaborating with the Department's Health Workforce Data Intelligence Unit through workforce data collection and data-sharing protocols. This work is ongoing.

The FATES 1 report will include an aspirational model for RACS to consider in aligning training sites with community need.

RACS is supporting the development of data collection and reporting approaches, including dashboards that describe the impact of rural selection initiatives, the geographic distribution of accredited training sites, and the geographic distribution of the surgical workforce

To develop a workforce with the right skills in the right places to deliver health equity for all Australians, RACS will combine rural selection initiatives with an increase in rural training-post accreditation and develop the 3 models for rural training recommended within the FATES 2 report (improved rural hub–urban spoke model, rural training networks and RUFUS).

The RACS *Rural Health Equity Strategic Action Plan* includes an action to distribute training posts according to community need.¹⁴ Data sharing (community need for surgical services, areas of undersupply of services and surgeons, population distribution) and collaborative workforce planning between internal and external stakeholders is the foundation. Several measures of success are required:

1. Training sites are distributed first according to population distribution then, as data matures, to community need for surgical care and equitable access to care.
2. Training in RUFUS skills, including virtual healthcare and outreach services, for Trainees at urban training sites and/or in specialties with limited feasible options for rural training sites (e.g. Cardiothoracic Surgery, Neurosurgery, Paediatric Surgery).
3. The collective rural training experience provided by the SET program will be a factor of the number of rural and/or outreach accreditation training sites, as well as the duration of placements.

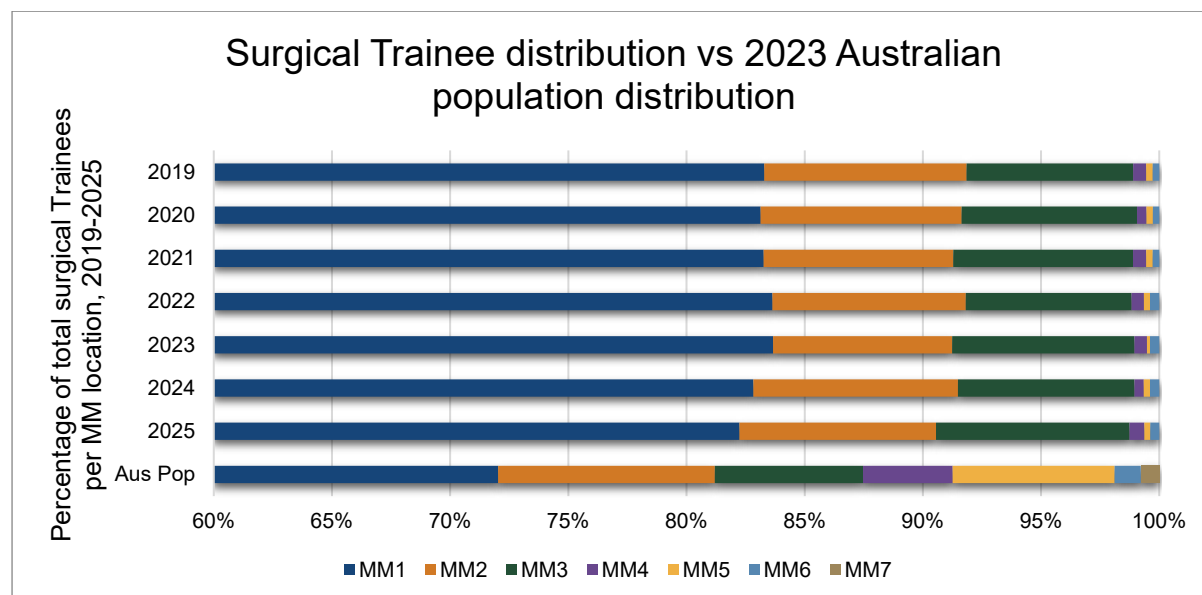
In the long term, an equitable model of distribution of training sites could consider the following targets:

- geographic distribution of training sites according to population distribution, with 28% of training sites in MM 2–7
- urban-based Trainees and urban-based training programs ensure 28% of training time includes RUFUS (and outreach) experience
- 28% of the SET pathway is spent at rural and outreach training sites, allowing for some Trainees to have more rural experience than others (e.g. rural origin/rural interested/rurally located Trainees in rural training networks or those experiencing multiple rural rotations in an urban hub–rural spoke training model).

Figures 4-12 illustrate surgical Trainee distribution for each MM location in 2019–2025, compared to the 2023 Australian population distribution.¹⁰ All surgical specialties except Orthopaedic Surgery are represented (these Trainee data are held by AOA, not RACS). For detailed numbers of Trainee distribution, see Attachment 10.

DATASET 1: Total surgical Trainees for each MM location per year (2019–2025) vs Australian population (2023)

Figure 4. Surgical Trainee distribution by year

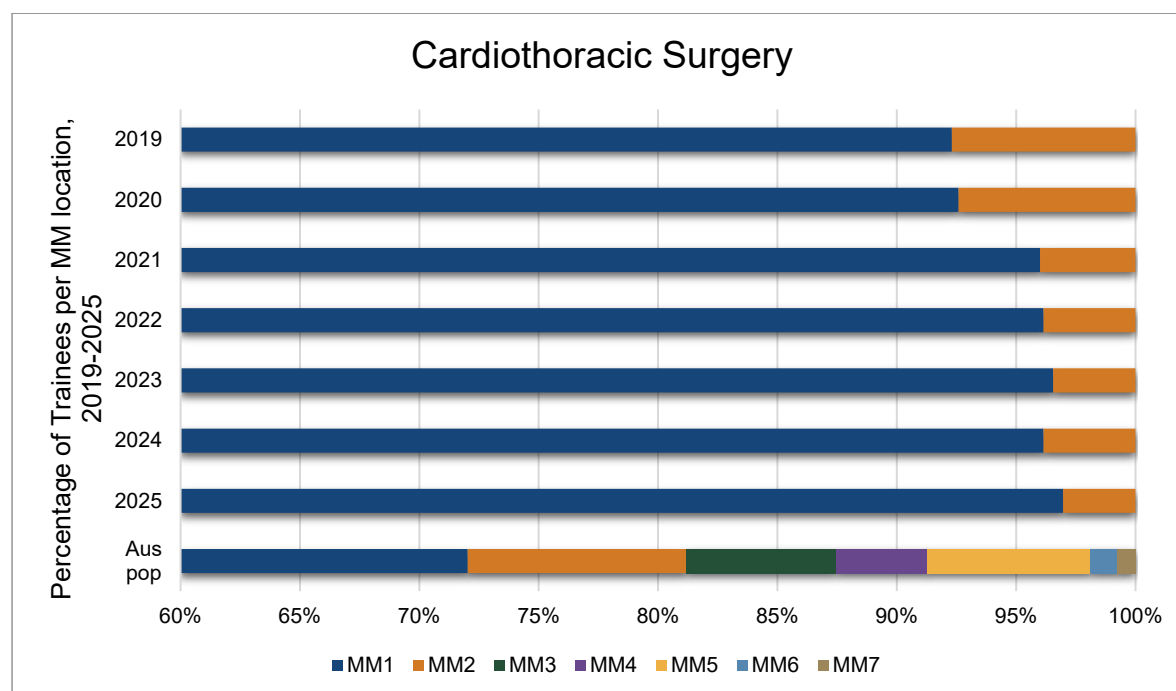


MM = Modified Monash

For the purposes of graph readability, location data presented on the x-axis begins at 60% to better portray the lower distribution of surgical Trainees compared to the Australian population in RRR locations.

DATASET 2: Trainee distribution by surgical specialty for each MM location per year (2019–2025) vs Australian population (2023)

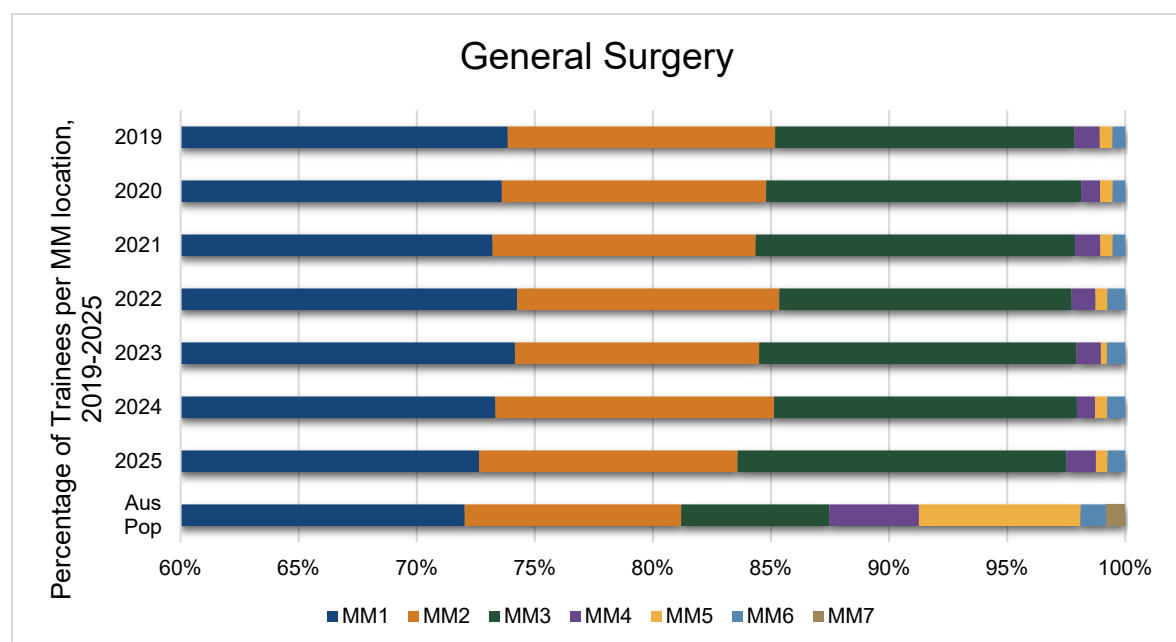
Figure 5. Cardiothoracic Surgery Trainee distribution



MM = Modified Monash

For the purposes of graph readability, location data presented on the x-axis begins at 60% to better portray the lower distribution of surgical Trainees compared to the Australian population in RRR locations.

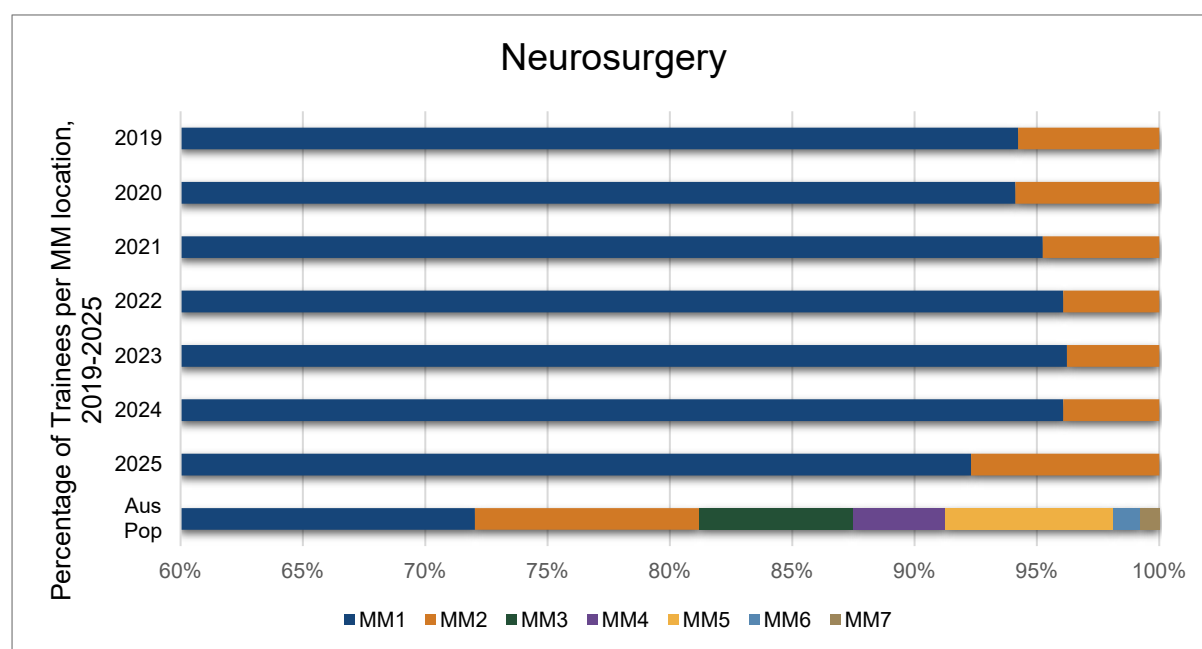
Figure 6. General Surgery Trainee distribution



MM = Modified Monash

For the purposes of graph readability, location data presented on the x-axis begins at 60% to better portray the lower distribution of surgical Trainees compared to the Australian population in RRR locations.

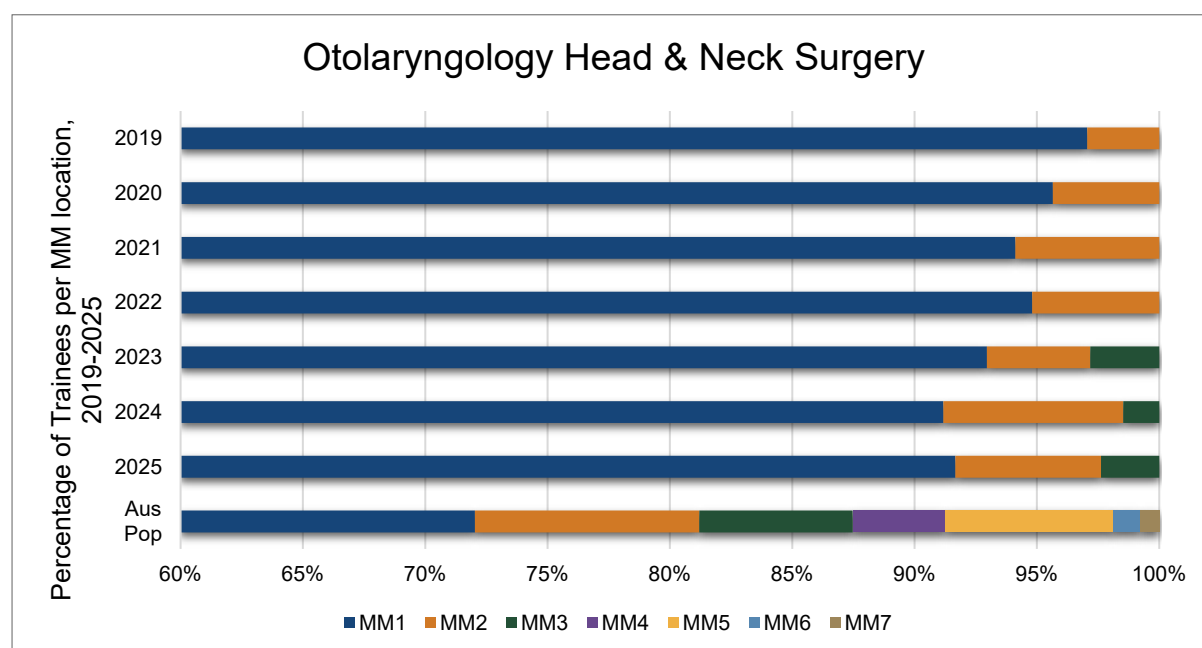
Figure 7. Neurosurgery Trainee distribution



MM = Modified Monash

For the purposes of graph readability, location data presented on the x-axis begins at 60% to better portray the lower distribution of surgical Trainees compared to the Australian population in RRR locations.

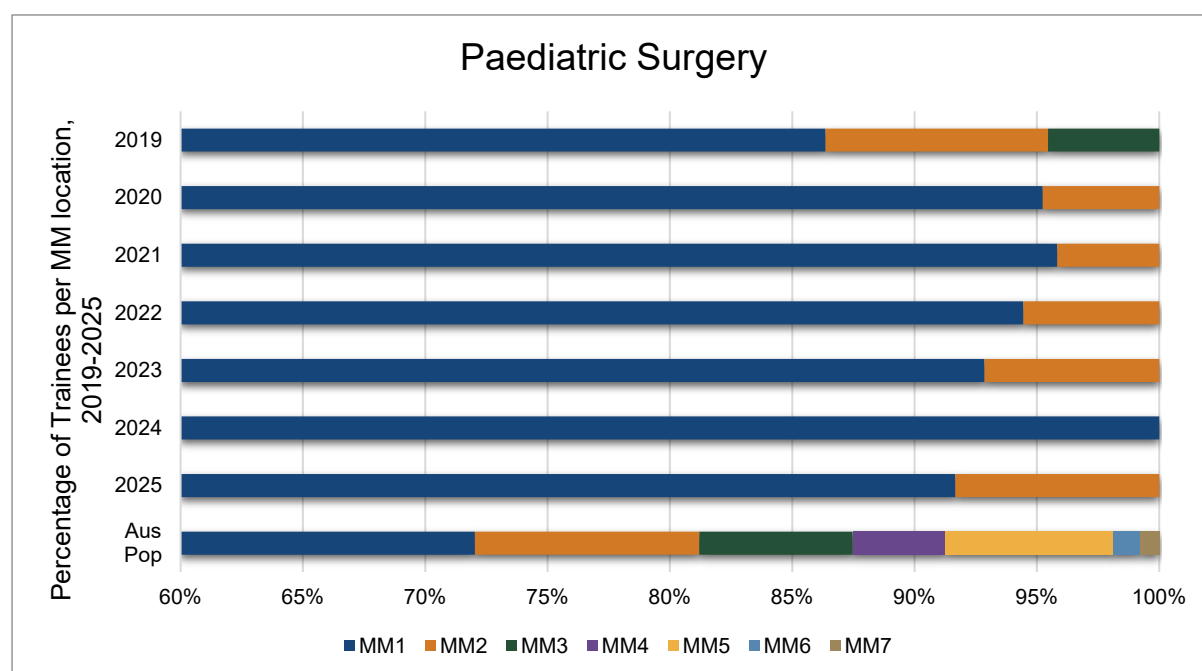
Figure 8. Otolaryngology Head & Neck Surgery Trainee distribution



MM = Modified Monash

For the purposes of graph readability, location data presented on the x-axis begins at 60% to better portray the lower distribution of surgical Trainees compared to the Australian population in RRR locations.

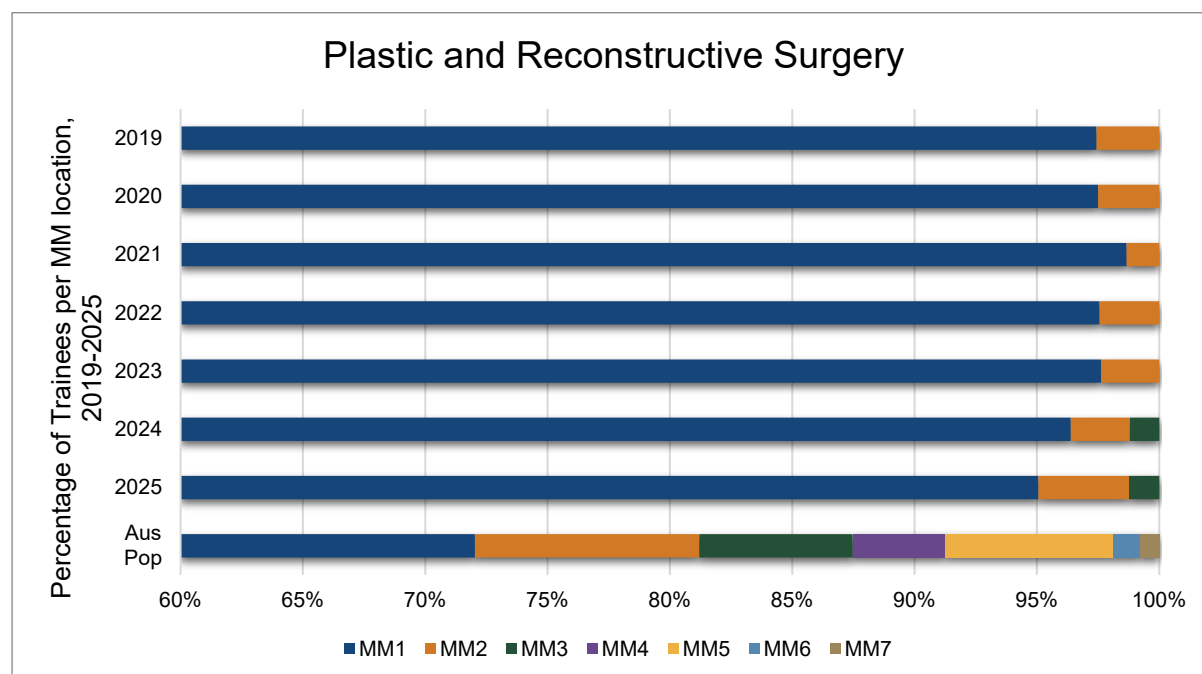
Figure 9. Paediatric Surgery Trainee distribution



MM = Modified Monash

For the purposes of graph readability, location data presented on the x-axis begins at 60% to better portray the lower distribution of surgical Trainees compared to the Australian population in RRR locations.

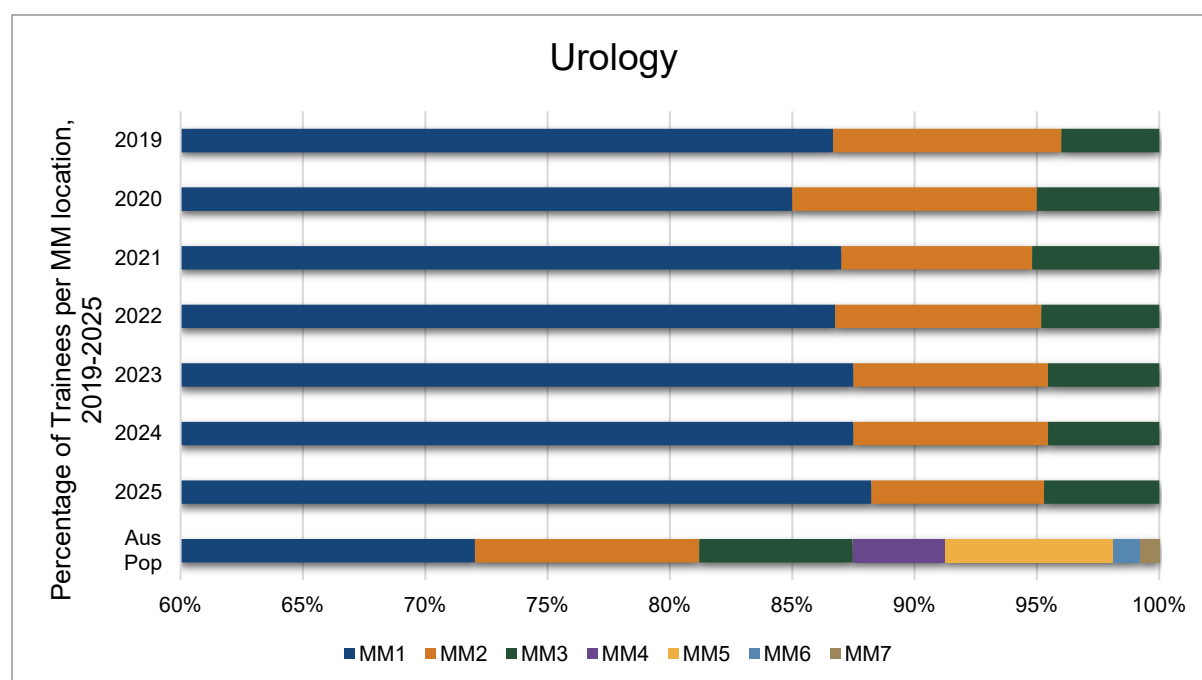
Figure 10. Plastic and Reconstructive Surgery Trainee distribution



MM = Modified Monash

For the purposes of graph readability, location data presented on the x-axis begins at 60% to better portray the lower distribution of surgical Trainees compared to the Australian population in RRR locations.

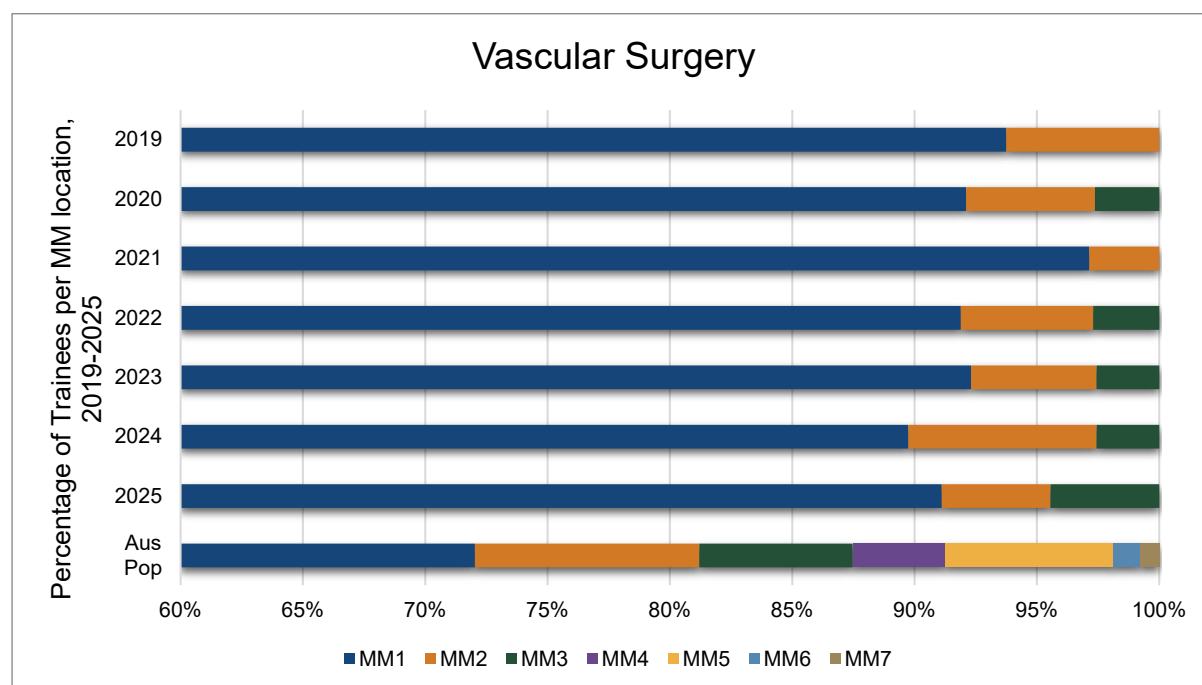
Figure 11. Urology Trainee distribution



MM = Modified Monash

For the purposes of graph readability, location data presented on the x-axis begins at 60% to better portray the lower distribution of surgical Trainees compared to the Australian population in RRR locations.

Figure 12. Vascular Surgery Trainee distribution



MM = Modified Monash

For the purposes of graph readability, location data presented on the x-axis begins at 60% to better portray the lower distribution of surgical Trainees compared to the Australian population in RRR locations.

DELIVERABLE 5: EVALUATION

The FATES 1 Rural Accreditation – Addressing Barriers to Rural Specialist Training project will be evaluated in early 2026. The evaluation report will be provided to government and published on the RACS website.

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