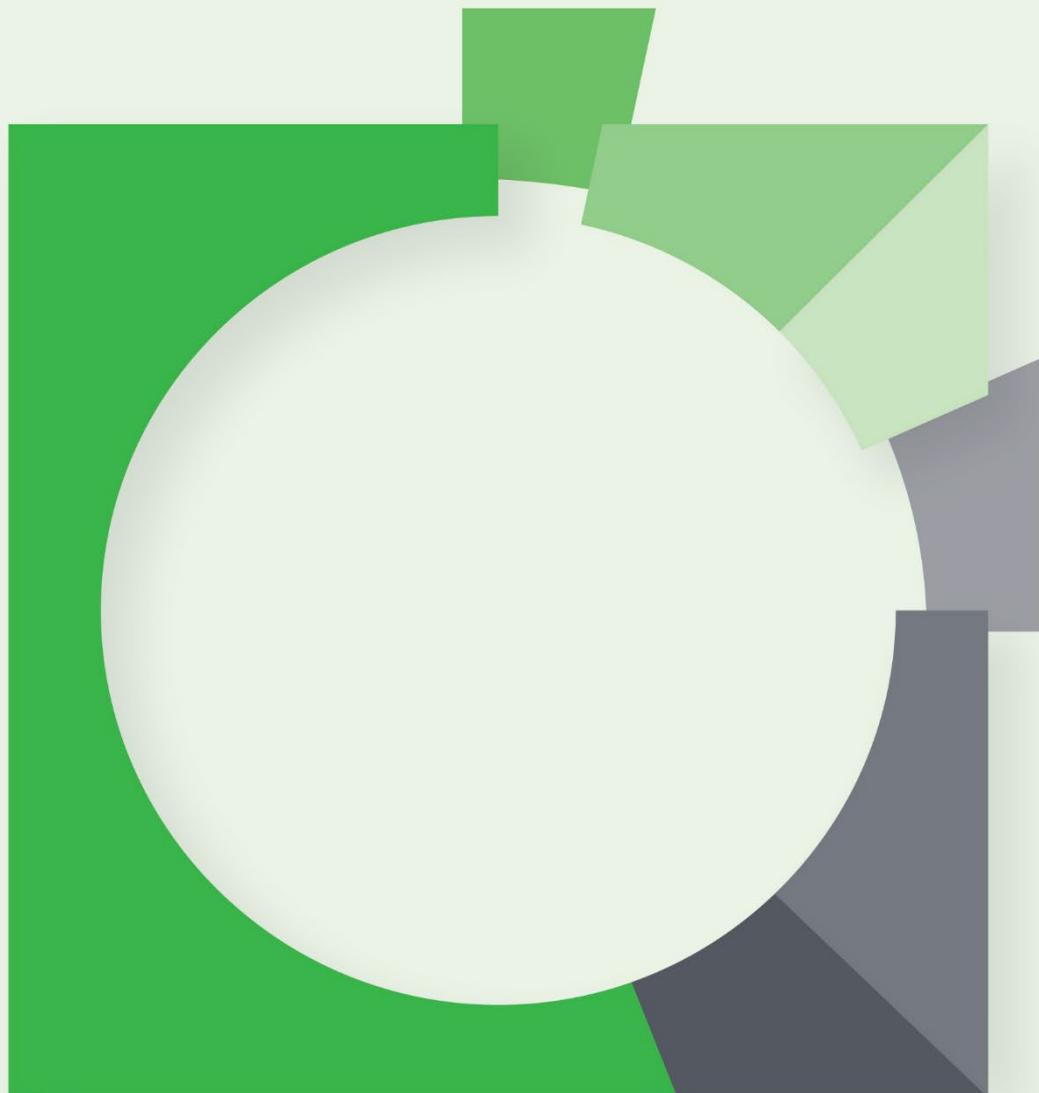


2024 Monitoring Submission to the Specialist Education Accreditation Committee

Royal Australasian College of Surgeons



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Australian
Medical Council Limited

Specialist Education Accreditation Committee

Monitoring submissions by accredited specialist medical colleges

Once the AMC has accredited programs and their providers, under the *Health Practitioner Regulation National Law* it must monitor the program and provider to ensure that they continue to meet the accreditation standards.

The AMC seeks submissions from accredited specialist medical colleges to satisfy this monitoring requirement. Monitoring submissions ensure that the AMC is informed of developments within individual colleges and of responses to recommendations and conditions in colleges' accreditation reports.

Monitoring submission procedures

The Specialist Education Accreditation Committee considers monitoring submissions in the following way:

- AMC staff seek commentary on the submissions from an experienced AMC reviewer.
- AMC staff may ask the college to clarify information in the submission at the request of the reviewer.
- The Specialist Education Accreditation Committee's, Progress Monitoring Subcommittee, considers the monitoring submission and the commentaries on them.
- The Subcommittee reports to the Specialist Education Accreditation Committee on its findings in relation to each college. Any matters that may affect the accreditation status of a college are reported in full to the Committee for a decision.
- The Committee needs to decide if, on the information available, it is substantially satisfied that the program(s) and the provider continue to meet the accreditation standards. It takes account of both the submission overall and the provider's response to any conditions on accreditation.
- The Committee makes one of the following decisions:
 - 1 the submission indicates that the program and provider continue to meet (or substantially meet) the accreditation standards, or
 - 2 further information is necessary to make a decision, or
 - 3 the provider and program may be at risk of not satisfying the accreditation standards.
- After the Committee has made its decision, AMC staff send the AMC's findings and feedback on the monitoring submission to the provider including:

- Whether standards are met, substantially met or not met.
- Conditions which are satisfied and do not need to be addressed again.
- Any questions concerning the submission or supplementary information required.
- Any issues that the provider should address in the next report.
- If the Committee considers that the provider may be at risk of not satisfying the approved accreditation standards, then the issue is referred to the AMC Directors, as per the *AMC Unsatisfactory Progress Procedures*. Providers are also advised if any major changes require assessment via correspondence and/or site visit.

For bi-national colleges, [the monitoring submission is also provided to the Medical Council of New Zealand to be considered by its Education Committee.](#)

The *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2023* are available on the AMC's website [here](#).

The *Procedures for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2023* are available on the AMC's website [here](#).

Guidance on how to provide the requested information

Section A: Reporting against the standards and accreditation conditions

The following should be addressed for each standard:

1. Significant developments undertaken or planned since the last report and requests for additional information from the AMC response to the 2023 monitoring submission (if applicable).
2. College activity towards satisfying AMC conditions or otherwise addressing the accreditation standards are rated as 'substantially met'.
3. Statistics and annual updates, if requested.

Please append documents, such as policy or discussion papers as evidence of changes or plans described.

1. Summary of significant developments

This section gives the AMC information on the continuing evolution of the College's programs and assists the AMC to determine if these programs are continuing to meet the approved accreditation standards.

Please provide a summary of significant developments completed or planned and resources under each standard.

- Provide a brief summary of the developments, including the rationale.
- Indicate if the College's development plans, as described at the time of the most recent AMC assessment have changed over the monitoring period.
- Colleges with multiple training programs, are to indicate which training programs are covered by the planned or implemented developments. If policy and process vary from program to program, please ensure that significant variations are explained.

The AMC also expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the submission.

The AMC may have requested the College provide an update on a development reported in the College's 2023 submission. If so, it will be included in this section.

2. Addressing accreditation conditions

The [AMC Accreditation Report](#) on the College's programs includes a series of commendations, quality improvement recommendations, and conditions on the accreditation. The AMC sets conditions when a program and provider substantially meet the accreditation standards but do not fully meet the all the requirements. Conditions are intended to lead to the program meeting the standard in "a reasonable time"¹.

Please provide a summary update of the College's responses to the AMC accreditation conditions in the last AMC Accreditation Report. If you are unsure of the meaning of a condition, please review the relevant section of the AMC accreditation report. AMC staff can organise advice to a college on specific conditions, if necessary.

- The AMC has included each condition on the accreditation which **must** be addressed in this submission.

Please explicitly address each of these conditions individually providing: a summary of the action(s) taken to address the condition, and details of the outcome(s) of that action. Where applicable, include a summary outlining the reasons for a particular course of action, along with any available evidence that the college considers demonstrates that the action(s) have or are likely to satisfy the accreditation standard.

- For colleges with multiple training programs, please indicate which training programs are covered by each college response. If policy and process vary from program to program, please explain significant variations. AMC conditions and recommendations that apply to multiple training programs should be addressed for each such program.
- If the College believes it will **not be able to address a condition in the timeframe detailed in the accreditation report, please outline the reasons why and indicate when it is likely be addressed or what other arrangements are in place to meet the related standard/s that are currently 'substantially met'**.
- The AMC also set conditions relating to the standards to be addressed in subsequent monitoring submissions. The College is not required to satisfy them until the date shown below but is asked to **report on progress against these, including any challenges in meeting timeframes or alternative options being considered for meeting the relevant standards**.

When assessing the education provider's response against a condition, the AMC reviewer will be looking for the following:

1. What work the education provider has undertaken in the monitoring period to

¹ Section 48 Health Practitioner Regulation National Law

address the condition.

2. Does the information provided satisfy the condition, or otherwise address the standard/s that are substantially met.
3. If the condition is not satisfied and the relevant standard/s have not otherwise been met, what else does the education provider need to do and/ or provide in order to close the condition.

3. Statistics and annual updates

Please provide annual data and/or an annual update under the relevant accreditation standard on:

Standard 1

- The number of appeals heard by the college and the outcome of those appeals, for each of the key assessments/progress decisions
- Costs associated with the College's reconsideration, review and appeals processes
- The College's requirements for Cultural Safety training, and collaboration with other specialist medical colleges around cultural safety activities.
- Any changes to College Governance Chart, Conflict of Interest, and Reconsideration, Review and Appeals

Standard 5

- Each summative assessment activity (e.g. Part 1 and Part 2 exams) and the number and percentage of candidates sitting and passing each time they were held
- Combined summative assessment data showing the number and percentage of Indigenous trainees and Specialist International Medical Graduates sitting and passing each time they were held
- Examination contingency planning

Standard 6

- Evaluations undertaken, the main issues arising from trainee evaluations and supervisor evaluations and the college's response to them
- Evidence of actions stemming from MTS results

Standard 7

- The number of trainees entering each college training program, including basic and advanced training
- The number and gender of trainees undertaking each college training program
- The number of trainees exiting from each program (prior to attaining Fellowship)
- The number of trainees who completed training in each program (attained Fellowship)
- Any changes to the selection into training policy/procedure
- Costs and requirements of training and policies to support trainees in fee distress

Standard 8

- A summary of accreditation activities including sites visited, sites / posts accredited, at risk of losing accreditation or not accredited.
- The College processes to ensure that training sites that are undergoing accreditation are Culturally Safe

Standard 9

- The numbers of applicants and outcomes for Specialist IMG assessment processes for the last 12 months, broken up according to the phases of the specialist international medical graduate assessment process.

The data should reflect both Australian and New Zealand activity for bi-national training programs.

Section B: Reporting on Quality Improvement Recommendations

Quality Improvement Recommendations are included in the AMC Accreditation Report. These are suggestions for the education provider to consider (not conditions on

accreditation), and the AMC is interested in how the College considers these, and what, if any, action occurs as a result.

Updates on Quality Improvement Recommendations are requested **only at the three, six and nine-year mark of a college's accreditation cycle**. This is intended to reduce the reporting requirement for colleges and help focus on activity towards addressing conditions and standards that are substantially met or not met.

This section is therefore OPTIONAL for colleges at different years of their accreditation cycle.

Earlier reporting on Quality Improvement Recommendations is at the College's discretion.

Further Information

Please contact Sarah Keegan, Program Support Officer, via email at accreditation@amc.org.au if you have any questions about the submission.

Guidance on format and submitting to the AMC

The AMC appreciates a focused approach to the information colleges provide in their monitoring submissions. As a guide, a report of no more than approximately of 30-50 pages overall is preferred. Lengthy reports on all the changes in the training programs are not required.

The monitoring submission is a standalone document with a separate, indexed folder of the appendices sent by email to the AMC. We ask that the submission is provided to the AMC using the template provided below. **Please do not submit a separately formatted document.**

Formatting guidelines

- Number appendices according to the relevant standard. For example: Appendix 1.1 and 1.2 are the first two appendices for Standard 1
- Provide an electronic link to the appendices if an appendix and the relevant page/s is referred to in the submission.
- Provide any spreadsheets as 'protected' Excel/Access sheets to improve readability.
- Please ensure that both the submission and the collated appendices are 'searchable' by use of the 'find' function

Please note the College must use the template provided by the AMC. Monitoring Submissions not submitted in the AMC template will not be accepted.

Monitoring Submission Template

This submission is due Monday **10 June 2024**

College Details

Please correct or update these details if necessary:

College Name	Royal Australasian College of Surgeons
Address	250-290 Spring Street, East Melbourne VIC 3002
Date of last AMC accreditation decision	2023 via accreditation extension
Periodic submissions since last AMC assessment	0
Next accreditation decision due	31 October 2024

To be completed by the College:

Officer at College to contact concerning the report	Stephanie Clota
Phone number	+61 03 9276 7429
Email	ceo.racs@surgeons.org

Verify submission

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

Verified by	Stephanie Clota
Signature	
Date	

(Chief Executive Officer/executive officer responsible for the program)

Summary of 2023 Findings

Standard	2023 Findings	No. of Conditions remaining
Overall	Substantially Met	20
1. The context of education and training	Substantially Met	2
2. The outcomes of specialist training and education	Substantially Met	2
3. The specialist medical training and education framework	Substantially Met	5
4. Teaching and learning methods	Substantially Met	1
5. Assessment of learning	Met	0
6. Monitoring and evaluation	Substantially Met	5
7. Issues relating to trainees	Substantially Met	2
8. Implementing the training program – delivery of educational resources	Substantially Met	2
9. Assessment of specialist international medical graduates	Substantially Met	1

Section A: Reporting against the standards and accreditation conditions

Executive Summary

The Royal Australasian College of Surgeons (RACS) appreciates the Australian Medical Council's (AMC) feedback on its last monitoring submission and the accompanying redirection.

The RACS vision is a high-quality, responsive and sustainable surgical education and training system that meets the needs of our two nations and communities, is future-fit, and is recognised for its excellence by health services, regulators and accreditors.

This submission strongly intends to address all the feedback provided and to centre our response on the most critical aspects, namely:

1. Line of sight across all aspects of the surgical education and training (SET) delivery network. This is detailed in the responses and tables compiling specialist societies' contributions.
2. Focus on reporting actions and outcomes, not only on frameworks, policy, position and procedures.
3. Exploring opportunities for innovation through shared participation across RACS, considering significant advancements in the delivery of safe, quality care and training, as evidenced by the work of National Health Practitioners Ombudsmen (NHPO), National Health Workforce Taskforce (NHWT), MBA, MCNZ, AMC and the Independent Review of Overseas Health Practitioner Regulatory (Kruk) Report.
4. The financial and organisational sustainability and capability of RACS as an organisation responsible for the networked delivery of SET in Aotearoa New Zealand and Australia.

Please note that throughout this response, unless otherwise specified, the term 'RACS' is used to describe the entire endeavour that delivers safe, high-quality care and surgical education and training where it is needed most. Thus, unless otherwise specified, 'RACS' refers inclusively to RACS as an organisation, along with all Specialty Societies (Societies) and all Training Committees and Boards (STC/Bs). All societies have actively and fully contributed to this submission.

While the way each society delivers on expected outcomes may differ transparently and defensibly, the outcomes themselves are agreed upon and non-negotiable. RACS has not pursued a level of 'standardisation' that would unfairly discriminate across societies, trainees, health services and the communities they serve. This acknowledges the inherent differences due to contextual, professional and resource variations. Both RACS and the societies understand that the governance required to support whole-of-network alignment is critical to maintaining oversight and best practices in delivering a complex SET program.

The approved (but not yet implemented) Hospital Training Post (HTP) Accreditation Standards Framework ([1.1 Hospital Training Post Accreditation Standards](#)) and the Monitoring and Evaluation (M & E) Framework ([1.2 Monitoring and Evaluation Framework](#)) provide RACS with a transparent process for assessing and reporting on the implementation of AMC standards, demonstrating the relevance, practicality, validity, reliability and impact of these tools.

RACS is increasingly aware that its partnership with health services is essential to fulfilling its vision and meeting AMC standards. Trainees who are well supported and well trained are more likely to succeed in attaining Fellowship of RACS (FRACS) and go on to lead productive careers, delivering safe, high-quality surgical care to those who need it most. The size and complexity of SET has grown exponentially, hence this keen oversight of the surgical units has become more pressing.

RACS acknowledges the challenges facing health services and related government initiatives, such as the implementation of the NHPO recommendations and the expedited pathway for specialist international medical graduates (SIMGs) outlined in the Kruk report. RACS is aware that it has not met Australian Health Practitioner Regulation Agency (Ahpra) benchmarks, despite having adapted

its processes to further reduce application processing times. RACS will continue to contribute and adapt as required. This is discussed further in Standard 9 and the quality improvement (QI) section.

RACS is committed to providing safe, high-quality care and training adaptable to various contexts. Recognising the tension between training and service needs, RACS continues to address this innovatively and respectfully. RACS has developed the HTP Accreditation Framework ([1.1 Hospital Training Post Accreditation Standards](#)) with this respect for workplace needs at the forefront, delivering outcomes-based site accreditation standards to allow sites to meet them flexibly, contextually and adaptively.

RACS is committed to understanding workforce and scope of practice needs across its diverse communities and settings in Aotearoa New Zealand and Australia. RACS also acknowledges the anticipated changes in training post accreditation affecting all medical colleges and is actively engaged in this process. This is addressed in Standard 1 and the QI section.

Standard 1: The context of training and education

Areas covered by this standard: governance of the college; program management; reconsideration, review and appeals processes; educational expertise and exchange; educational resources; interaction with the health sector; continuous renewal.

1 Summary of significant developments

This section gives the AMC information on the continuing evolution of the college's programs. Please provide a summary of significant developments completed or planned relevant to Standard 1.

<p>Has there been any significant developments made against this standard?</p> <p><i>If yes, please describe below.</i></p>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
<p>One of RACS's stated purposes is to ensure safe, high-quality surgical care and training delivered appropriately, accessibly and affordably across Aotearoa New Zealand and Australia. This vision is articulated in the Strategic Plan (1.3 RACS Strategic Plan 2022-2024) and the Business Plan (1.4 Business Plan) and it guides every policy, procedure, evaluation and intervention in delivering SET.</p> <p>While the means of achieving this vision vary by service, specialty and patient need across different locations, the intention and outcomes remain consistent. RACS recognises that surgical care is a team effort, influenced by the roles of other health professionals, facility resources and evolving patient needs.</p> <p>References to the societies emphasise the diversity within SET and how it aligns to meet the expected outcomes set by the AMC, the community and the profession.</p> <p>College governance</p> <p>RACS recognises the ongoing need for practical, clear and agreed-upon governance among all stakeholders to ensure the best outcomes. Addressing governance, and defining authority, responsibility, and accountability, remains a key priority for RACS over the next 3–5 years.</p> <p>In response to recent financial challenges and the evolving landscape of medical colleges, RACS is conducting a governance review (1.5 Constitutional Change Progress Update). This review will allow RACS to align with modern best practice. While the current method of delivering SET has been effective, evolutionary changes will better align RACS with current needs. Specific feedback from AMC/MCNZ, NHPO and societies requires careful</p>		

consideration, alongside the anticipated demands on RACS within the next 3–5 years from the community and from professional, regulatory, government and health services.

In addition, a strategic decision was made to enhance the effectiveness of the networked SET through specialist societies. This review aims to assess, adapt, describe, implement and evaluate its operations and leadership. RACS remains committed to continuous improvement throughout this process including:

Community-centric. RACS has established mechanisms to better understand and respond to the needs and priorities of consumers, patients and communities, recognising the trust placed in their surgical care. RACS has engaged both informally and formally with health services through meetings with each jurisdiction and events like the National Rural Surgeons' Training & Retention Workshop. It is also gathering on-the-ground experiences from surgical specialties and listening to feedback from health services representing their communities.

In early 2024, the RACS CEO and President met with the Australian Commonwealth Government and Te Whatu Ora to discuss community, trainee, and workforce needs. The development of the 10 professional competencies curriculum ([1.6 RACS Professional Skills Curriculum 2023](#)) and curriculum mapping ([1.7 Curriculum Mapping](#)) highlighted the need for surgical and perioperative care to be deeply embedded to meet community needs. Many societies have adapted their governance and advocacy to reflect this community-first approach by including community representatives in key decision-making bodies.

Service-centric. RACS recognises that surgical service needs are diverse and evolve with changes in population, best practice, resources, multidisciplinary teams and technology. The governance relationship between medical colleges and health services is crucial for RACS to effectively recruit, select, train, educate, assess and credential (via FRACS) sufficient practitioners to meet the needs of the community. The HTP Accreditation Standards ([1.1 Hospital Training Post Accreditation Standards](#)) describe this governance very clearly, by clearly outlining the role of RACS and hospitals in the delivery of SET.

Further, in early 2024 the Rural Surgeons' Training & Retention Workshop ([1.8 Rural Surgeons Training & Retention Workshop Action Plan](#)) leveraged this governance arrangement as the foundation for planning activities. The workshop the proposed workplan is discussed in detail in the QI section.

Network-centric. RACS delivers SET through a networked governance model that depends upon the 13 societies delivering SET across 9 different surgical specialties. This model aims to maximise contextual relevance in practice, ensure consistency of outcomes, and minimise inefficiencies and variability. Each society delivers SET tailored to its specific surgical care needs, ensuring high-quality service.

Moving from a devolved and delegated relationship, RACS sees its future role as a bridge within this network, facilitating opportunities to strengthen the network through widespread, practical and efficient innovation. Although surgical competencies have commonalities across specialties, their teaching and practice vary by specific specialty and location.

RACS currently relies on formal service level agreements (SLAs) ([1.9 Sample Partnership Collaboration Agreement Template](#)) that lack the flexibility needed to deliver SET in the networked model. Some SLAs are due for renewal in late 2023–2024, ongoing engagement will aim to ensure mutual and unique needs are better recognised and actioned. Informal assistance has already been provided by societies, as witnessed by the assistance every society has made to this resubmission. Future agreements will formalise this engagement.

RACS holds regular consultations with each society at every level ([1.10 Specialty Society Engagement Schedule](#)) and works together on projects related to SET, including collaborative development of this AMC submission.

RACS has facilitated workshops and meetings ([1.11 RACS and Specialty Society Meetings and Communications Summary](#)) with the societies on critical issues such as HTP accreditation

standards, SIMG alternative pathways, cultural safety training, and supervisor performance development. Each initiative has an agreed action plan, supported by a dedicated project manager to ensure milestones are met and to implement service delivery improvements across the network.

While there is inherent tension in a networked governance approach, the challenge is to harness the model's strengths and to innovate where strategic or business-level differences arise. (This is elaborated upon in the QI section.)

Member-centric. RACS, as a membership-based organisation, encompasses a wide range of views and positions on various aspects of its work. This diversity is a significant strength. Most members who contribute to this work, including as supervisors and trainers, do so on a pro bono basis, saving the community, health services and Trainees considerable costs. And they do so with the most honourable of motives.

Fiduciary-centric. RACS has improved its fiduciary governance in Australia and Aotearoa New Zealand following events in 2022–2023 ([1.12 RACS Financial Report 2023.pdf](#)). An independent financial review provided recommendations to strengthen the financial management and governance ([1.13 June 2024 Governance Structure](#), [1.14 CSET Terms of Reference](#), [1.15 Education Committee Terms of Reference](#)). RACS has developed systems to minimise financial risk, such as requiring comprehensive, risk-assessed business cases for projects of a certain size and scale, improving financial reporting, building financial management capability, and increasing accountability throughout the organisation. As part of this renewal, RACS is pursuing constitutional reform to add additional skills to its board without compromising its core purpose. All board and staff appointments will be guided by an agreed skills matrix.

Governance at RACS involves balancing the needs of the community; of health services, specialties, members and stakeholders; with its financial responsibilities, which are all interconnected. This governance and strategic change is one of the biggest challenges RACS has faced in decades. Despite the complexity, RACS is committed to ensuring each aspect contributes to the College's core mission and governance demands.

To facilitate innovative conversations and collective decision-making, RACS has implemented fortnightly CEO meetings, fortnightly electronic communications with societies, a monthly meeting with society training managers, and a project tracker to ensure full visibility on project status ([1.11 RACS and Specialty Society Meetings and Communications Summary](#)), ([1.16 Training Manager Meeting April 2024](#)), ([1.17 Draft Project Tracker](#)). A schedule of society engagements for 2024 is also provided.

Sustainability of the College

RACS is now on a sound financial footing in Australia and Aotearoa New Zealand and is expecting a small surplus in 2024–2025 ([1.11 RACS Financial Report 2023.pdf](#)). In 2023, the RACS Council took prompt action by developing a recovery plan ([1.5 Constitutional Change Progress Update](#)). A new CEO was appointed with extensive experience in fiduciary governance, financial reporting and financial management systems. Key decision-makers have undergone or are undergoing upskilling in fiduciary matters. The constitution is set for a member vote in 2024 to bring additional fiduciary skills to the governing board. Staff losses did not impact SET functions.

The source of the financial stress is now understood by the Council and the societies. Comprehensive financial analysis has been undertaken to provide that clarity and this has been shared with members, trainees and societies. But the question remains as to whether these costs can be further reduced without harming those whom RACS serves. As an activity, RACS is exploring efficiency improvements such as automation, and a significant reduction of the fixed cost base that is driving unacceptably high overheads.

Prior to 2024, RACS had not increased its fees in line with the cost to deliver SET. At the same time, RACS had invested in several one-off expensive line items. Staff numbers had increased

without any new activity being delivered, and there was a lack of sound financial due diligence and governance at both the council and executive levels. It was very late when the true depth of the overspend relative to revenue was known and actioned.

RACS understands the anguish and impost this unexpected fee increase created, especially for staff and Trainees, and the risk to its reputation as a well-managed organisation. RACS has assured all its participants and stakeholders—internal and external—that this will not happen again. Measures have been implemented to back that assurance. The way RACS engages with its Trainees is reported further in Standard 7 and the role of Trainees on RACS committees is documented ([1.18 RACSTA Committee Introduction Booklet](#)).

RACS communicated the 2024 fee increases against activity-based costing ([1.19 SET Training Fees Breakdown](#)), it provided FAQs on its website ([RACS website for Trainee Fee FAQs](#)) and provided webinars ([1.20 Slides from Trainee Webinar December 2023](#)) having negotiated the changes with many parties including the trainees' representatives.

RACS has published an annual list of its fees since 2022 on its website according to its fee-setting policy ([1.21 RACS website for 2024 fees](#)). RACS, with the societies' support and approval, has included all fees from all societies in one place to further improve transparency, and includes hardship schemes made available from RACS and/or the specialist societies, should Trainees require such assistance ([1.22 Overview of 2024 Training Fees](#)).

Implementation of the NHPO report (Australia only) via the AMC

The NHPO report implementation ([1.23 NHPO Project Update for Colleges](#)) is likely to affect or alter how RACS undertakes several core functions, including HTP accreditation and reconsideration, review and appeals (RRA), and complaints. RACS has developed an action plan ([1.24 NHPO Implementation Plan](#)) to address feedback from the ombudsman. It is reviewing the global NHPO report and collaborating with the Miller Blue Group and NHWT, prior to implementing the new HTP standards and framework ([1.25 RACS Response to NHPO Request for Information 2024](#)).

Implementation of the Independent Review of Overseas Health Practitioner Regulatory Settings (Kruk) Report (Australia only) via the AMC

RACS is contributing to an Ahpra steering committee for this work across all medical colleges and societies, with governance between these pathways being critical to their success. RACS recognises the demand for an expedited pathway for SIMGs to achieve FRACS and to streamline and accelerate a review of its comparability assessment processes. To date, this work has included the introduction of the External Validation of Professional Practice (EVOPP) ([1.26 SIMG EVOPP Policy](#)), a pathway recognised and piloted by RACS in Australia as an appropriate alternative to the Fellowship Exam (FEX). However, the new expedited pathway, as other medical colleges have discovered, brings significant changes to the system, particularly regarding eligibility and resource allocation. This requires careful consideration because it affects all SET.

At this stage, the business case for EVOPP is incomplete, with significant resourcing issues identified during its development ([1.27 EVOPP Discussion Paper](#)), including a shortage of assessors. This work is discussed in Standard 9 and addressed in the QI response.

Reconsidering the governance of RACS

RACS has a long history of leading innovation and producing quality improvements across Australia and Aotearoa New Zealand, earning commendation from the AMC. However, not all efforts have fully impacted Trainees, members, health services and consumers. RACS has sought to understand the enablers and barriers to effective implementation.

The challenge partly arises because RACS has consistently delivered high-quality surgical care and training, making it difficult to compromise the current approach. Given that SET is highly competitive and oversubscribed, the drive for change does not stem from fundamental issues. RACS agrees that comprehensive oversight is crucial for successful training and it works

closely with societies and stakeholders to ensure the safety and wellbeing of patients, Trainees, trainers and workplaces, with a commitment to quality improvement and feedback.

With high stakes for patients and the community, any substantial change requires careful consideration by multiple parties. RACS acknowledges that what worked well in the past may not be as effective in the future. This requires significant consultation, which RACS has proven capable of.

Many societies are leaders in their fields, delivering high-quality SET. Their relationship with RACS and with other societies should involve mutual support and collaboration. This ongoing renewal process is already making a significant impact and is crucial for ensuring that RACS and the societies can continue to provide safe, high-quality surgical care and training where it is most needed. RACSTA supports the need for a governance review, and improved partnership with specialty board/committees with the goal in improvement of training delivery and sustainability.

Hospital Training Post accreditation across all surgical specialties

The HTP accreditation framework is nearly fit-for-purpose and exemplifies ongoing collaboration. This framework will likely receive attention from the Miller Blue group, which is developing a prototype for outcomes-based post-accreditation standards that respect the influence and limitations of medical specialties on Trainee experiences and behaviours at various training sites.

An opportunity to strengthen the SET network approach lies in RACS's facilitation of the HTP framework implementation ([1.1 Hospital Training Post Accreditation Standards](#)) and the proposed accreditation support unit to govern and oversee targeted site accreditation in partnership with societies and health services.

Each society has its own method for assessing HTP, and it is accepted that this process can lead to duplication and inconsistencies. Streamlining HTP accreditation by one specialist society, or by RACS or another specialist medical college could potentially reduce duplication and enhance service robustness without compromising quality. An outcome-based approach, as shared by other medical colleges, could streamline this process: one application, one visit, one report, but different defensible outcomes.

The HTP Standards Framework ([1.1 Hospital Training Post Accreditation Standards](#)) highlights the need for clear, agreed and communicated governance between RACS, each society and the health services accredited to deliver SET. This is increasingly important as the number of specialties and subspecialties grows and health service provision becomes more complex. RACS has signed the Accreditation Communication Protocol and is implementing it across the network while reviewing to ensure compliance and achievement of the intended outcomes. ([1.28 Accreditation Communication Protocol](#)).

Many health services with surgical trainees and non-accredited surgical registrars are now more complex entities from a service and governance perspective, necessitating RACS's adaptation. RACS must recognise what it can and cannot directly action, instead directing via its role as the accreditor of training sites. The HTP standards address critical issues such as the recognition of Aboriginal and Torres Strait Islander and Māori health needs, diversity and inclusion, respect, and bullying and other non-professional behaviours, under specific accountable agreements monitored comprehensively. RACSTA have been involved with the development of the HTP accreditation and look forward to its implementation with a more streamlined process and the embedded consideration and protection of Trainee welfare and cultural safety.

Monitoring and Evaluation across all surgical specialties

The M & E ([1.2 Monitoring and Evaluation Framework](#)) work of RACS is similarly an overarching and comprehensive way of knowing and reporting progress against key outcomes of SET. It is the natural and essential companion to the HTP Standards ([1.1 Hospital Training Post](#)

[Accreditation Standards](#)) as its role is in identification, risk minimisation, mitigation, intervention and remediation for Trainees, training posts and the community. The HTP standards ([1.1 Hospital Training Post Accreditation Standards](#)) set a minimum acceptable behaviour. The M & E framework ([1.2 Monitoring and Evaluation Framework](#)) ensures that a minimum standard is never breached, and that any action against the standards is transparently, rationally and expectedly communicated, and wherever possible that action does not disturb the delivery of safe high-quality care or training delivery at that site.

In 2024, RACS involved the societies more intensively to understand how this work would be of value to each of them and to SET. RACS acknowledges that each specialty has its own ways of monitoring and evaluating the M & E agreed progress and outcomes. The next steps include ensuring that nothing important has been lost in translation as we move to implement those components.

Cultural safety, diversity and inclusion

RACS has a bi-national footprint and has learned much from our Aotearoa New Zealand colleagues in terms of cultural safety ([1.29 Cultural Safety Training Plan for Vocational Medicine in Aotearoa](#)) and cultural safety training (CST) ([1.30 Cultural Safety Report 2024](#)). Throughout the development of this submission, RACS has sought to understand how each society requires and monitors CST for all participants in SET. RACS has developed an action plan around agreed priorities, beginning with mandating an annual CST activity and recognising CST undertaken through other recognised means.

RACS is aware of the very significant progress the MCNZ has made in implementing comprehensive standards around cultural safety ([1.29 Cultural Safety Training Plan for Vocational Medicine in Aotearoa](#)) and understands that mandating cultural awareness or competency training is just a start towards addressing the unfair and unacceptable variation in healthcare and outcomes that Aboriginal and Torres Strait Islander and Māori endure. Over the next 3–5 years, RACS will deliver a comprehensive approach to providing safe, culturally appropriate surgical care, similar to how it ensures safe, clinically appropriate surgical care. This work will be led by our Aboriginal and Torres Strait Islander and Māori elders, cultural advisors, mentors, and leaders across RACS and the societies. RACS has already scoped much of what needs to happen to achieve this ambition.

Rural equity and National Rural Surgeons Training and Retention Workshop (Australia)

RACS's core mission is to promote excellence in surgical education and practice, fostering the highest standards of surgical care and ensuring the wellbeing of patients and the community. RACS has long understood that there are not enough safe, high-quality surgeons trained and working where they are needed most. The workshop provided a snapshot in time of workforce needs. RACS is aware that the 2011 Workforce Projection Report ([1.31 RACS Workforce Projection to 2025](#)) requires continual updating in line with ongoing government and jurisdictional workforce modelling. However, it is easier to understand the problem than it is to find solutions. RACS recognises that this is a multifaceted and complex situation that it both contributes to and can help to resolve in partnership with others. RACS has a comprehensive Rural Equity Strategic Action Plan ([1.32 Rural Health Equity Strategic Action Plan](#)), which it continues to work with societies to implement ([1.33 2024 RHES Progress Report and Indicative Workplan](#)). As part of this, RACS co-convened a multisector workshop with National Rural Health Commissioner (facilitated by Dr Brendan Murphy) to identify the key priorities and action plans. The workshop agreed that rural post accreditation was the primary objective. Subsequently, an action plan to deliver on this was developed for the RACS council and specialist societies. This is explored in depth in the QI section.

Reconsideration, review and appeals process across all surgical specialties

RACS has undertaken a comprehensive external review of RRA requests following feedback from societies, trainees and supervisors seeking transparency in procedural fairness. The

NHPO report provided helpful advice, leading RACS to revise its RRA (merit review) policy and procedures ([1.34 RRA Regulation 2023](#)).

RACS reviewed its fees for appeals and complaints accordingly. As a not-for-profit, RACS recognises that either all members and Trainees share the costs of the RRA process, or appellants make a significant contribution to the rare, individual and often costly steps in the process. A better RRA approach may help appellants be more informed, address concerns earlier, and better understand likely outcomes. RACS has updated the policy to provide a refund where appeals are upheld.

RACS has approved many NHPO recommendations for inclusion in the next iteration of its RRA merit review policy, processes and procedures with endorsement and input provided by specialty training committees/boards in June 2024. Some NHPO recommendations (e.g. a comprehensive complaints policy and procedure) are still being addressed. The existing complaints policy is provided here ([1.35 RACS Advice Support and Complaints Regulation](#)) and on the RACS website ([1.36 RACS Enquiries, Concerns and Complaints Webpage](#)).

RACS is implementing high-priority recommendations from the NHPO and will await the final recommendations later in 2024, ready to respond quickly. One significant change envisaged is an aligned or singular approach to RRA and complaints, making it simpler, more transparent, better risk-managed and fair.

Requests for additional information from the AMC response to the 2023 monitoring submission:

- The College is asked to provide comment around the high proportion of reconsiderations for selection and if the College has noted any themes arising, and if selection processes may need to be reviewed.

Please provide comment below.

AMC feedback on the 2023 monitoring submission noted ‘the high number of requests for reconsideration relating to selection is acceptable, particularly noting that nearly a third (11) resulted in a variation. Other reconsiderations are reported to be very low.’

The RRA process is crucial for maintaining confidence, transparency, accountability and fairness of SET. In 2022, approximately 5% of unsuccessful candidates for selection requested reconsideration, which RACS agrees is not unduly high. As part of a quality improvement activity, RACS will explore other potential explanations for the low number of RRA requests, including ensuring awareness of access to the correct processes.

In 2023, RACS merged the Registration for Selection into SET and Selection to SET regulations into a combined Registration and Selection to SET regulation ([1.37 Registration and Selection to Surgical Education and Training](#)). The goal was to improve clarity and reduce cross-referencing for applicants, as indicated in the previous report.

In response to feedback from several STC/STBs, RACS broadened the scope of the Exceptional Circumstances and Special Consideration policy to include issues relevant to selection. This policy has been approved by the Education Committee, and all STCs/STBs have been given another opportunity to provide feedback. CSET endorsed the policy at the June 7 meeting to allow for implementation ([1.38 Exceptional Circumstances and Special Consideration Policy](#)).

The AMC expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the report.

<p>Has the College made any significant changes affecting the delivery of the program? i.e. changes to training resources such as administrative/technical staff and educational expertise.</p> <p><i>If yes, please describe below the changes and the potential impact on continuing to meet these standards.</i></p>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
<ul style="list-style-type: none"> • RACS has made no changes that would negatively impact the SET program in Australia or Aotearoa New Zealand and has fulfilled its leadership and delivery responsibilities despite staff reductions in 2023. • Staff reductions and financial recovery measures did not materially impact delivery in 2023/2024. Staff full-time equivalents (FTEs) have now returned to 2019 levels. Note that from 2020 to 2023, increased FTEs did not correspond with increased funding or SET functions. • The executive team's current objectives are to reduce turnover and vacancy rates and improve recruitment times. New organisational leadership and filled key educational vacancies are in place for 2024. • RACS staff have clear reporting lines and role clarity. All areas related to education development, delivery and partnerships have been consolidated into a single education portfolio with adequate staffing and supervision. • The society training managers group has been reinstated. Collaborative efforts ensure meetings achieve information-sharing and agreed outcomes. • Further review of the RACS organisational structure is ongoing as part of QI but will not negatively impact SET delivery. • RACS prioritises working across all societies and stakeholders to maintain globally consistent standards (e.g. training post accreditation, non-technical competency assessment, merit and complaints processes, BRIPS, and monitoring and evaluation) while allowing for locally relevant decisions based on health services and specialty needs. • RACS has contracted additional educational expertise for various mapping work in this submission and is in discussions with medical assessment experts as part of a QI activity. 		

2 Activity against conditions

The numbering of conditions matches that used in the AMC Accreditation Report.

Please address each of these conditions individually.

Condition 1	To be met by: 2022
Demonstrate within the College governance structure that accountability is shared by RACS Council, the Education Board, Board of Surgical Education and Training, and Specialty Training	

Boards to enable each of the 13 training programs to meet AMC standards and conditions. Evidence of alignment and robust reporting mechanisms between the College and specialty training boards in developing education and training policies consistently, is needed. (Standard 1.2)

Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	

2023 AMC commentary

Some evidence was provided of greater shared accountability, with signals of greater intent. There has been a realignment and staffing changes in the Education Partnerships portfolio, with it being moved into an Education Development and Delivery portfolio that includes responsibility for the RACS/societies collaboration model.

RACS reports challenges in the devolved training model and has committed to reviewing this governance/support model to identify and address inefficiencies and duplication of effort (see also response under 1 above).

The RACSTA submission notes *‘The interplay between specialty training committees of the College, and the governance structure of the College itself is not always understood. Communication between those committees and the College is not visible to the Trainee membership, resulting in some Trainees feeling they are left in the dark as to why decisions which affect their training are made.’*

As this condition is so fundamental to RACS accreditation, continued monitoring on how the shared accountability between RACS and the societies is working is required, with provision of evidence of how each of the 13 training programs is progressing towards meeting AMC standards and conditions.

2024 College Response

RACS considered various ways of delivering SET in 2023, including complete devolution to specialist societies or a centralised SET. Instead, RACS chose a middle path, strengthening a networked approach with the societies. This approach requires goodwill, compromise and collaboration from all involved.

The mapping of common SET elements across all specialist societies and RACS is now complete and is included in this submission. These elements include outcomes, competencies, curriculum, perioperative care, selection, assessment and SIMG processes, each discussed further under subsequent standards. Engaging with all societies takes time, especially as some are resource-limited, but the effort results in higher-quality information.

There are many commonalities and differences, which should be celebrated for their adaptability to context. As this work progresses, any indefensible or idiosyncratic differences in SET program delivery will be examined. Clear alignment across the network will be transparently shared, with variations explained and justified. Often, an innovation within one specialist society can benefit others.

A workshop with RACS and specialist society presidents will be held on 7 June 2024 to confirm this approach of moving from mapping to better alignment, aiming for a better working agreement towards common outcomes without losing authority, responsibility or accountability.

As part of this review, RACS will be refreshing the SLA ([1.9 Sample Partnership Collaboration Agreement Template](#)) with each specialist society as it comes up for renewal. This will consider shared experiences, changes in service and training demands, government and community expectations, and the conditions needed to strengthen the networked approach between RACS and the societies.

Currently, each of the agreements between RACS and the societies is slightly different, to some degree dependent on the support they require from RACS for SET. Common elements include:

1. The same set of governance principles describing the authority, responsibility and accountability of each party to the agreement.
2. A requirement for both parties to fully engage in compliance with legislative, regulatory and accreditation requirements, including maintaining records for accurate reporting to AMC/MCNZ.
3. Agreement that the society determines its fees transparently and documents the methodology, and that the fees set by each party are shared and communicated transparently to Trainees.
4. Sharing confidential information for AMC/MCNZ accreditation and legislative compliance.
5. Society feedback will be sought and incorporated into policy design.
6. Regular scheduled meetings and reporting will occur.
7. Indemnification of the specialty society for its contribution to SET is predicated on compliance with the partnership agreement.

The SLA ([1.39 Functions, Service Activities and Responsibilities for the Specialty Training Program](#)) specifically delineates for each activity the detail, responsibility and financial accountability, ensuring adherence to AMC/MCNZ standards and delivery of high-quality surgical care and SET. These SLAs are commercial in confidence and cannot be shared without all parties' agreement.

The various entities involved in SET have clearly defined terms of reference describing their governance roles. The RACS council has received independent advice on its structure's suitability within the overall governance framework ([1.13 June 2024 Governance Structure](#)).

Although variable in size and resourcing, thus their reliance on RACS, the societies have become much more crucial and indeed are critical partners in SET. A QI activity will include how societies will engage with RACS at all levels from governance through to SET design and delivery. Constitutional change takes time in membership-based organisations, as other medical colleges can attest. While this progresses, the interdependence between RACS and its partners is being strengthened and evaluated for innovation through delivery of our QI workplan and sequential renegotiation of partnership agreements.

In a 2024 stakeholder consultation, societies provided feedback on current arrangements and proposed constitutional reforms. While the societies were generally satisfied, they sought more flexibility, involvement and relevance in governance. In response to feedback, RACS chose to delay the constitutional vote to address some of the concerns expressed by some societies and stakeholders.

Several societies remain concerned about the balance between large and small societies within RACS. Larger societies question potential cross-subsidisation, while smaller societies seek assurance that their voices are considered as relevant and important in matters affecting them and their Trainees. RACS is hosting a workshop on 7 June 2024 to explore and address these and related issues. The workshop aims to maximise opportunities, while minimising the risks of the collective, with a view to renewing governance before the next round of SLA discussions. Some of the issues are very practical, such as determining who is best placed to collect fees, and all will contribute to setting and implementing an agreed work plan for the next 3–5 years, as outlined in the QI plan and the focus of the 7 June 2024 workshop ([1.40 Workshop Agenda](#)).

RACS acknowledges the due diligence reviews being conducted by AOA, NSA, and NZOA to seek direct accreditation with the AMC/MCNZ and is committed to working collaboratively as we await the outcomes of that process. Throughout the process we are collectively committed to addressing the needs of regulators and stakeholders, meeting standards, and advancing conditions while delivering high-quality SET.

Specialty self-assessment for condition 1

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>i. Partnering agreement signed until March 2029.</p> <p>ii. The committee currently reports activities routinely to RACS through various mechanisms including Committee of Surgical Education and Training (CSET) reports and data collection.</p> <p>The committee reports to RACS as outlined through the usual mechanisms and subcommittees.</p> <p>The arrangement between ANZCTS and the cardiothoracic training committee is tight, with the chair of the committee also being on the board of ANZCTS. There are clean and clear reporting lines around Trainees, trainee regulations and other issues between the 2 committees.</p> <p>iii. The cardiothoracic committee is also part of the HTP process that RACS is driving.</p>
Board of Neurosurgery	<p>Governance</p> <p>The first Service Agreement between the RACS and the Neurosurgical Society of Australasia (NSA) for the management of the SET Program in Neurosurgery was entered into during 2004. There have been multiple versions of the Agreement over the period since then, with the expiry date of the current Agreement extended until 31 December 2024, to allow for consultation and negotiation of the terms.</p> <p>In accordance with the Agreement, the SET Board of Neurosurgery was established for the conduct and oversight of the SET Program in Neurosurgery in accordance with Terms of Reference approved by the NSA and the RACS. It is a joint board of the NSA and the RACS. Within the NSA, the SET Board of Neurosurgery reports directly to the NSA Board. Within the RACS, the SET Board of Neurosurgery reports to the Committee of Surgical Education and Training (CSET) and in some instances the RACS Education Committee.</p> <p>All changes to regulations and policies relating to the SET Program in Neurosurgery are first reviewed through the NSA and legal advice is sought and funded by the NSA as required. Following this review, the changes are then submitted to the RACS for consideration by the RACS Education Committee.</p> <p>Reconsiderations, Reviews and Appeals</p> <p>The Neurosurgical Society of Australasia (NSA) and the SET Board of Neurosurgery believe that fundamental principles in ethical decision making include transparency and accountability. All trainees and applicants for selection have the right to question any decisions made which impact upon them, and to have the decisions explained to them in a manner that is easily understood. The availability of the process to have decisions reviewed is</p>

	<p>communicated with each decision notification to create awareness.</p> <p>The SET Board of Neurosurgery also allows applicants who discover that they have made an error in their selection application form to submit a correction, through the Reconsideration process. Errors of this type accounted for 3 of the 12 Reconsideration applications relating to selection during 2023. The remainder of the Reconsiderations primarily relate to applicants subjectively believing that they performed better than the score they were awarded. As the selection process uses structured assessments and scoring processes with multiple assessors and well-defined criteria, objectivity in the decision making is increased.</p> <p>The SET Board of Neurosurgery provides explanations for its Reconsideration decisions within the limitations of the relevant regulations and policies. No selection Reconsiderations have proceeded to Review during 2023. This is reflective of a healthy system where applicants feel comfortable in questioning decisions, and the SET Board of Neurosurgery can appropriately review and justify decisions. The process is also efficient, with most Reconsiderations finalised within two business days.</p>
Committee of Paediatric Surgery	<p>Partnering agreement signed until 31 December 2024.</p> <p>The Committee consistently reports its activities to RACS through multiple channels, including CSET reports and data collection, and also upon request. The collaboration between ANZAPS and the Committee is well-structured, with the Chair of the training committee and the President of ANZAPS serving on both the training committee and the society committee. This ensures transparent reporting lines regarding Trainees, training regulations, and other pertinent issues across both committees.</p>
Board of Urology	<p>The Board of Urology supports the collaboration agreement between USANZ and RACS and the devolved model for delivering the SET Program. This agreement remains in effect until 31 December 2024.</p> <p>The Board of Urology regularly reports its activities to RACS through various channels, including CSET reports and data collection, as well as upon request. The collaboration between USANZ and the Board of Urology is well-organised, with the Chair of the Board of Urology, the President of USANZ, and the RACS Specialty Councillor serving on both the Board of Urology and the USANZ Board of Directors. This arrangement ensures transparent reporting lines concerning all facets of the Training Program and management of SIMGs and other relevant matters.</p>
Board of Vascular Surgery	<p>Condition primarily relates to RACS Reporting</p> <ul style="list-style-type: none"> • Agreement: Initial term: 3 years 1/09/2022 to 31/08/2025. • No significant changes noted specific for vascular surgery. • Society costs associated with training are managed. • Relationship - no change to structure within the ANZSVS. There is an ongoing collaborative relationship with open

	<p>communication, direction and reporting transparency. Collaboration and reporting methods include CSET, regular RACS CEO/Specialty CEO meetings, Training Managers' meetings and the Specialty Elected Council position on training Board.</p> <ul style="list-style-type: none"> • ANZSVS is adopting the RACS TMP program for centralised database, record keeping and reporting.
Australian Board in General Surgery	<p>Partnering agreement signed until end of 31 December 2024.</p> <p>Reviewing of agreement to take place mid-June and to include clear reporting lines to and from ABiGS, GSA, and RACS. ABiGS does currently report activities routinely to RACS through various mechanisms including CSET reports, and data collection.</p> <p>ABiGS has also initiated a meeting with RACS to discuss accreditation outcomes following the NSW-ACT Inspections. This has been well received by RACS. The aim is to meet and collaborate on any issues of concern.</p> <p>ABiGS and RACS have also been working together to discuss the need for further training posts in 2026 due to the lower number of offers being made in that year.</p>
New Zealand Board in General Surgery	<p>Partnering agreement signed until end of 31 December 2024.</p> <p>Changes to the agreement to be sent to RACS late May to clarify reporting and responsibilities. AoNZCiGS currently reports activities routinely to RACS through various mechanisms including CSET reports, and data collection. Any information requested by RACS is provided in a timely fashion if NZAGS collects such data.</p> <p>AoNZCiGS is working with RACS to ascertain who does hold specific pieces of information. Often the information requested is already held by RACS.</p> <p>AoNZCiGS and RACS have also been working together to discuss the need for further training posts in 2026 due to the lower number of offers being made in that year. NZAGS has identified two more.</p>
Board of Otolaryngology Head and Neck Surgery	<p>The Board of OHNS supports the collaborative, devolved model of surgical training.</p> <p>For oversight and accountability, the suggestion that a senior RACS representative can attend Board meetings would be a good conduit for governance purposes.</p>
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	<p>As a training subcommittee, all curriculum is set and administered by the Board of OHNS (BOHNS). Therefore, NZSOHNS response in relation to curriculum conditions align with BOHNS.</p>
Australian Board of Plastic and Reconstructive Surgery	<p>The Australian Board of Plastic and Reconstructive Surgery (ABPRS) supports the collaboration agreement and devolved model of delivering Surgical Education and Training program.</p> <p>We support regular attendance of ABPRS meetings by a senior RACS representative to foster stronger relationships and facilitate</p>

	<p>the socialisation of decisions, concordance with existing policies and mitigation against inherent and indirect risks.</p> <p>We continue to work closely with our counterparts in Aotearoa New Zealand as facilitated through the Plastic and Reconstructive Surgery Oversight Committee Terms of Reference.</p>
<p>New Zealand Board of Plastic and Reconstructive Surgery</p>	<p>The Partnering Agreement between the New Zealand Association of Plastic Surgeons/ Te Kāhui Whakamōhou Kiri (NZAPS) and RACS terminates in December 2024. NZAPS has commenced discussion with RACS to renegotiate the agreement.</p> <p>NZBPRS is an active member of CSET and provides regular reports to RACS as required via annual data reporting, CSET reports and other reports as required. We support the suggestion of regular attendance of senior RACS member at NZBPRS meetings to foster stronger relationships and improve the understanding by RACS of the nuances of the NZBPRS and NZ PRS SET programme.</p> <p>NZBPRS strongly strong supports the devolved model of training but encourages duplicated responsibilities and actions undertaken by STC/Bs to be reviewed and managed centrally to reduce duplication across specialities, especially around Hospital Training Post Accreditation.</p> <p>NZBPRS works closely with the Australian Board of Plastic and Reconstructive Surgery (ABPRS) via the Plastic and Reconstructive Surgery Oversight Committee and through collaboration with our societies to collaborate on shared aspects of the PRS SET programme.</p>
<p>Australian Orthopaedic Association Federal Training Committee</p>	<p>AOAs relationship with RACS is unique in that the AOA Federal Training Committee (FTC) is not a Committee of RACS but of AOA. AOA is a mature and sophisticated specialty, and the AMC has noted in its comments that AOA has continued to rely on the Service Agreement (1.41 RACS AOA Service Agreement) which defines the relationship between RACS and the AOA. The 2020 revision of the Service Agreement includes provision for review and feedback against the AMC Standards for the AOA 21 Training Program. This has not yet been enacted but is eagerly sought by AOA in order to facilitate ongoing quality assurance of the AOA 21 Training Program.</p> <p>AOA through the will of its members is undertaking a formal due diligence on whether it should be directly accredited by the AMC. AOA is liaising closely with RACS, the NZOA and other partners as this process is undertaken. Whilst this exercise may give some cause for concern, openness, transparency and evidence to justify AOA taking such a significant step is viewed as a positive leaning and educational approach. Should this objective be achieved the form of any reshaped relationship with RACS would be explored. There is an intent for AOA and RACS to continue in a relationship, albeit one that is likely quite different from longstanding arrangements.</p> <p>Within its own Governance structure, the AOA has made significant developments in moving towards increasing skills-</p>

	<p>based appointments to the AOA Board and key Committees. AOA now has a non-surgeon appointed to its Board and two external experts on its Audit and Risk Committee. This is in addition to the external and jurisdictional representation already established on the FTC, and consistent trainee representation across the organisation.</p> <p>The Strategic Review of the AOA 21 Training program undertaken across 2022 and 2023 has now concluded. AOA's submission in 2023 included the scope and purpose of the review. In late 2023, the AOA FTC and Board accepted all recommendations from the review team (1.42 AOA 21 Review Report), led by a team of International medical education experts, and have approved a plan for implementation of the recommendations over the next 3-5 years.</p> <p>The implementation plan covers seven areas of focus, including: Accreditation, Curriculum / Delivery, Faculty Development, Research, Assessment, Subspecialty Exposure and "One Source of Truth" (an ongoing process of updating, consolidating, and enhancing program policies, processes, and procedures, as well as the process and platforms by which these are made available), as well as two overarching themes – Communication and Engagement – which are integral to each element of the change process.</p> <p>Preliminary progress against the plan is already well advanced, demonstrating commitment to this strategic priority. AOA Strategic Plan (1.43 AOA Strategic Plan) and activity based costing methodology are also included (1.44 AOA 2023 ABC Methodology).</p> <p>Bryan Ashman, AOA Dean of Education delivered a presentation "Validity Evidence for Programmatic Assessment of Competence in the Australian Orthopaedic Training Program" at the Ottawa 2024: Conference on the Assessment of Competence in Medicine and the Healthcare Professions, in Melbourne in February 2024. This well attended talk provided an excellent opportunity to showcase the AOA 21 Training Program and AOAs aspirations of excellence on the global stage.</p> <p>AOA is not a committee of the college and is not a formal part of the RACS Governance structure. The relationship is fully defined in the service agreement. Having said this, AOA has been an active participant and contributor to RACS and the surgical community under the service agreement in place since 2013. The principles enunciated in that agreement remain contemporary and AOA has delivered fully its obligations within the agreement assisting RACS with meeting the required compliance standards.</p> <p>AOAs self-assessment of this Condition is "Met for AOA".</p>
New Zealand Board of Orthopaedic Surgery	<p>We have a current Collaboration Agreement with RACS entered into in 2023. The SOTB has responsibilities to both the college and NZOA and those responsibilities are clearly outlined in this Agreement. A clear line of sight through to the college and the NZOA exists.</p>

Condition 2		To be met by: 2023		
Provide evidence of effective implementation, monitoring, and evaluation of the:				
<ul style="list-style-type: none"> i. Reconciliation Action Plan ii. Building Respect, Improving Patient Safety (BRIPS) Action Plan iii. Diversity and Inclusion Plan iv. Rural Health Equity Strategic Action Plan (Standard 1.6 and 1.7) 				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
2023 AMC commentary				
<p>It is commendable that the College is continuing with such an extensive program of implementation, monitoring, evaluating and refining these flagship strategies based on feedback and evolving contexts.</p> <p>The Diversity and Inclusion plan is now within the Building Respect Improving Patient Safety Initiative, and there is more emphasis on effecting system-wide approaches. There is a Flexible Approach to Training in Expanded Settings (FATES) Initiative within the rural health strategic action plan.</p> <p>A target of 50% female Trainees by 2027 (RACS centenary) has been proposed by the Women in Surgery Committee.</p> <p>The College's excellent work is recognised by RACSTA in its submission but notes the need for more widespread use of multiyear, multi-region employment contracts and better flexible training options, as these remain barriers.</p> <p>It is acknowledged that the broader cultural changes being guided by these documents will take many years to come to fruition. It is noted that DBSH continues to feature significantly in the MTS survey responses, at a rate similar to previous years. Concerning is that most alleged perpetrators are senior staff in the team or supervisors.</p> <p>It is noted in a stakeholder submission that it is recommended, as a priority, that RACS continues to develop an updated organisational Reconciliation Action Plan (RAP) to drive the changes still needed, including changes in Trainee recruitment, cultural safety and addressing institutional racism.</p> <p>Condition 16 is related to Condition 2, and both require multiple sources of evidence including data, surveys and a range of interviews and site visits, to satisfy the conditions.</p>				
2024 College Response				
Implementation and Progress				
<p>Across the following areas, RACS, in collaboration with societies, has advanced implementation, monitoring, evaluation and refinement through robust data collection and benchmarking:</p> <ul style="list-style-type: none"> • Reconciliation Action Plan: 1.45 RACS Innovate 2023-2025 • Building Respect, Improving Patient Safety (BRIPS) Action Plan: 1.46 2024 BRIPS Work Plan • Diversity and Inclusion Plan: 1.47 BRIPS EAG Report 2022 • Rural Health Equity Strategic Action Plan: Australia (1.32 Rural Health Equity Strategic Action Plan), Aotearoa New Zealand (1.48 AoNZ Regional Rural Health Equity Strategy and Recommendations) 				

The professional competencies RACS mandates include cultural competence and cultural safety ([1.6 RACS Professional Skills Curriculum 2023](#)). Supervisors are required to demonstrate or undertake cultural competency training by the end of the continuing professional development (CPD) year. RACS will accept any option that has been approved by another entity requiring such training (e.g. health services, contractors and employers). A curated list of courses ([1.49 RACS Website Cultural Safety Training](#)) has been provided by the RACS Indigenous Committee and shared via the supervisor hub and PD pages for anyone who has not yet completed a course. Both are reflected in the M & E framework ([1.2 Monitoring and Evaluation Framework](#)) to determine compliance with this requirement.

Cultural Competency

- Cultural Competency: mandated for all supervisors, trainers and assessors in Aboriginal and Torres Strait Islander and Māori culture and health.
- Cultural Safety Training: embedded in the registration and selection to SET policy ([1.37 Registration and Selection to Surgical Education and Training](#)). The HTP Accreditation Standards ([1.1 Hospital Training Post Accreditation Standards](#)) are equally very specific and state: (i) Standard 5.1 The hospital has processes to improve the delivery of healthcare to Aboriginal and Torres Strait Islander and Māori populations, (ii) Standard 5.2 The hospital promotes cultural safety training.
- All RACS staff are required to complete cultural safety training annually.
- Fellows were offered the Groundworks course free of charge in early 2024, with RACS purchasing 250 logins for the initial module. While initial interest was high, some spaces remained unfilled by March. Feedback on the course has been very positive.
- Aotearoa New Zealand staff, the National Committee Chair, and Māori Health Advisory Group members attended the launch of the Cultural Safety Training Framework ([1.29 Cultural Safety Training Plan for Vocational Medicine in Aotearoa](#)) by the MCNZ and Te Ora. This ongoing meeting assists medical colleges in developing cultural safety programs. In 2024, staff received Māori translations of their job titles and learned a Pepeha in Te Reo Māori. Most staff completed an online cultural competency course with Groundworks, which includes Understanding Te Tiriti o Waitangi (Module 1) and a follow-up module in 2024.
- Aotearoa New Zealand staff participated in the Wharewaka Cultural Walking Tour during Māori Language Week, with daily activities to strengthen Te Reo. A similar activity is planned for 2024.

Key Projects and Collaborations

- RACS is participating in the 'A Better Culture' project ([1.50 A Better Culture Project Phase 2 Work Program](#)). The curriculum design working group is chaired by surgeon Associate Professor Rhea Liang.
- RACS helped design and chaired the Network for College Medical Educators (NCME) cultural competency workshop ([1.51 NCME Cultural Competency and Cultural Safety Symposium](#)), attended by 80 colleagues across other the medical colleges in August 2023.
- The second RACS Reconciliation Action Plan (RAP) 2023–2025 (Innovate) has been approved by Reconciliation Australia ([1.45 RACS Innovate Reconciliation Action Plan](#)).

Opportunities and initiatives

- The Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative ([1.52 Aboriginal and Torres-Strait Islander Surgical Trainee Selection Initiative](#)) operates in 8 of 9 STCs/STBs. The expectation is for all to be included by June 2024. The first Trainee selected as part of this initiative started training in 2019.

- The Aboriginal and Torres Strait Islander Health Network was launched to connect Fellows supporting Indigenous health initiatives.
- A list of Aboriginal and Torres Strait Islander suppliers is available for RACS staff to assist with procurement.
- Indigenous health reporting is featured in *Fax Mentis*, *Surgical News* and other RACS publications.
- In 2024, \$100,000 in scholarships to support Aboriginal and Torres Strait Islander medical students and doctors, was funded by RACS, the Foundation for Surgery and by industry ([1.53 RACS Scholarship Overview](#)).
- The Rural Health Equity Strategy facilitates opportunities for Aboriginal and Torres Strait Islander junior doctors to begin SET ([1.33 2024 RHES Progress Report and Indicative Workplan](#)).
- The Johnson & Johnson SET Scholarship covers educational costs for Aboriginal and Torres Strait Islander Trainees.
- The First Nations Australians Surgical Pathway (FNASP) provides a culturally safe space for Trainees, with an Indigenous Trainee Liaison Lead appointed.

Despite minimal increases in the number of Aboriginal and Torres Strait Islander surgeons over the course of the reconciliation journey, these initiatives demonstrate ongoing commitment and progress.

Te Rautaki Māori Health Strategy 2020–2023

Updated at the end of 2023, Te Rautaki Māori Health Strategy ([1.54 Te Rautaki Māori 2024-2026](#)) focuses on Māori health equity and supports activities to improve cultural competency and cultural safety throughout the College. The plan ([1.30 Cultural Safety Report 2024](#)) includes short-, medium- and long-term goals to achieve Pae Ora – Healthy Futures, the New Zealand government's vision for Māori health. The strategy's implementation is led by Dr Ruth Herd (Te Atiawa), the Māori Health Equity Lead, and the secretariat for the Māori Health Advisory Group.

Te Rau Poka – Māori Surgical Academy

One strategic goal, 'Whakatipu,' aims to increase the Māori surgical workforce to 150 fully trained surgeons by 2040, the bicentennial of Te Tiriti o Waitangi. Te Rau Poka recruits potential surgeons from high schools and medical schools, supporting them along the surgical pathway. The Academy is led by Professor Jonathan Koea (Ngāti Tama) with administrative support from Di Waters, a qualified counsellor planning a Tuakana Teina mentoring hui in September 2024.

Partnerships:

- Pūhoro STEMM partners with Te Rau Poka to deliver career expos to secondary school students.
- Johnson & Johnson provides surgical simulators and staffing support.
- Te Oranga Māori Medical Students Association is sponsored by the Academy.

Rangahau/Research

A research project investigating barriers to success will be presented to the Māori Health Advisory Group at the AGM in September. Dr Nasya Thompson, a PGY1 and PhD candidate in Christchurch, leads the research and will attend the hui and Te Oranga events.

Unprofessional behaviour and Trainees reporting bullying and intimidation

RACS shares the AMC's disappointment and concern over the continuing harm of surgical Trainees by senior staff or supervisors, as reported in the MTS results. This issue has persisted

since the 2015 BRIPS report. Merely condemning this behaviour and being transparent about it is not enough. RACS is committed to addressing this issue.

In 2022, the Expert Advisory Group (EAG) conducted a formal external review, resulting in a publicly available report with recommendations ([1.47 BRIPS EAG Report 2022](#)). The BRIPS committee has developed a 2024 action plan ([1.46 2024 BRIPS Work Plan](#)), and the 2023 progress report will be published in July 2024 ([1.55 2024 BRIPS Interim Update](#)).

Each society has also incorporated BRIPS within its programs. RACS recognises its role in supporting supervisors, providing resources, and ensuring supervisor and placement quality through the HTP and M & E frameworks. However, on-the-ground societies can have the most significant impact on service delivery and training culture. In 2024, RACS audited supervisors who had not completed the Introduction to Operating with Respect course, a requirement for all supervisors and trainers. A list of non-compliant supervisors has been shared with specialty societies monthly since 2018. Reports on compliance with the Foundation Skills for Surgical Educators (FSSE) course are also sent monthly.

The HTP Accreditation Standards emphasise zero tolerance for discrimination, bullying and harassment, including sexual harassment, and the call for transparent, timely and effective interventions. These standards promote a culture that addresses discrimination at its core:

- Standard 1.2: Leadership commitment to an inclusive and safe training environment.
- Standard 2.1.1: Policies against discrimination, bullying, harassment and victimisation, with mechanisms for reporting and responding to unprofessional behaviour.
- Standard 3.1.1: Training on unprofessional conduct, including support for speaking up and hospital complaints pathways.
- Standard 4.1.3: A graduated scale of interventions for unprofessional conduct.
- Standard 4.3.2: Privacy policies allowing information sharing with RACS.

By adhering to these standards and actively supporting and monitoring compliance, RACS aims to foster a safer, more respectful training environment.

The HTP standards framework ([1.1 Hospital Training Post Accreditation Standards](#)) outlines specific requirements for approval, monitoring and action by training posts, which will be tied to the M & E framework ([1.2 Monitoring and Evaluation Framework](#)) to be effective.

RACS is reviewing its memoranda of understanding with health services to improve communication and resource sharing to assist in creating a culture of respect and safety.

Diversity and Inclusion Plan

The HTP Accreditation Standards mirror the commitment RACS has to diversity and inclusion at every level:

- Standard 5.3.1: The hospital maintains a relevant policy to promote a healthcare service that is equitable, accessible and responsive to the socially, culturally and linguistically diverse community it serves.
- Standard 12.2.1: Surgical supervisors and trainees, including trainees with disabilities, are afforded the time and resources to discuss necessary feedback on performance, development and progress as required by the relevant specialty-specific regulations.

The RACS Women in Surgery progress report is attached ([1.56 Women in Surgery Progress Report](#)).

Rural Health Equity Strategic (RHES) Action Plan

RACS has been active in driving rural equity through multi-stakeholder workshops, resulting in action plans. The RHES indicative workplan and progress report ([1.33 2024 RHES Progress Report and Indicative Workplan](#)) exemplifies these efforts. The AMC's HTP accreditation recommendations through the Miller Blue NHPO project will also be informative. The National

Rural Surgeons Training and Retention workshop in February 2024 identified strong alignment with 22 actions, mostly for RACS, organised around these key drivers:

1. Flexibility in accreditation, and supervision and support for accreditation – supervision models, post-support accreditation process, safe working hours anomalies, Trainee experience and opportunities, and efficiencies for the post and for accreditors.
2. Opportunities for Trainee selection – focus on meeting community needs and selecting Trainees identifying as Aboriginal or Torres Strait Islander, Māori, and those with rural intent.
3. Leadership role in workforce planning.
4. Regional training hubs with Directors of Clinical Training (DCTs) and administrative support.
5. Collaboration and partnership.

Effective implementation of the workshop outcomes across all surgical specialties will be a primary focus for RHES in 2024.

Additional initiatives:

RACS has secured funding for two FATES-funded projects to support the goals of the RHES committee:

- Rural Accreditation Project: joint initiative with RACMA to support hospitals in rural locations (MM2–7) in applying for training post accreditation.
- Rural Training Models: consortium with RACMA, ANZCA, RACP and RANZCO to develop rural training models ([1.57 FATES STP Summaries](#)).

Stakeholder engagement:

- reconvene the Aotearoa New Zealand Regional and Rural Health Equity Steering Party
- establish Global, Regional/Rural/Remote and Deployable (GRiD) PFET and faculty
- develop rural generalist curriculum in partnership with ACRRM and RACGP.

Stakeholder Engagement Objectives:

- raise the profile of the RACS rural health equity work
- challenge perceptions of rural surgery
- drive conversation on rural health outcomes and inequity
- promote collective responsibility and collaboration for rural health
- support SET to meet the needs of the community.

Stakeholder Engagement Activities:

- RHES presentations and publications in society media outlets
- social media training for rural influencers
- articles in *Surgical News*, *Partyline*, *Cutting Edge* and society publications.

Supporting Rural Surgeons:

- ongoing educational, professional and personal support
- revamped RACS Rural Surgery Section Online Information Hub
- foster a culture of collective responsibility for rural health equity.

Through these initiatives, RACS aims to address rural health inequity, support rural surgeons, and enhance surgical services in rural areas.

Specialist Training Program (STP) Funding

RACS administers STP funding to support training posts in rural and private locations, exceeding its rural targets ([1.57 FATES STP Summaries](#)).

2018 – 2021 ASGS RA classification

Classification	2019		2020		2021	
	Funded	Filled	Funded	Filled	Funded	Filled
RA1	35	35	35	33	23	23
RA2	15	15	18	17	18	17
RA3	8	7	8	7	9	9
RA4	1	1	1	1	1	1
Total # of posts	59	58	62	58	51	50

2022 – 2023 Modified Monash Model

Classification	2022		2023	
	Funded	Filled	Funded	Filled
MM1	23	22	24	24
MM2	18	18	20	19
MM3	10	10	14	14
MM4	1	1	1	1
MM5	2	2	2	2
MM6	1	1	1	1
Total # of posts	55	54	62	61

STP figures for the past few years and are further described ([1.57 FATES STP Summaries](#)).

RACS is meeting with each jurisdiction to understand current and future surgical workforce needs and to establish communication channels to inform the Trainee pipeline regarding its quantity and distribution. In these meetings, RACS is advocating for more widespread use of multiyear, multi-region employment contracts and better flexible training options, as these remain significant barriers. Additionally, RACS has been advocating for the recognition of prior service to enable access to entitlements such as parental leave, and appropriate relocation support. RACSTA has been advocating for some years for these changes alongside greater portability of leave and benefits, and will work closely with RACS to resolve these issues in a timely fashion.

RACS knows that training in rural locations is a key driver of supporting an equitable workforce distribution. The STP program, through salary support and rural support loading (RSL) funds, is critical to supporting RACS to achieve its goals under the RHES Action Plan ([1.32 Rural Health Equity Strategic Action Plan](#)).

RACS has worked hard to increase the number of rural training posts supported under the STP program. This has led to the College exceeding its rural target in 2022 and 2023. RACS forecasts a continuing increase in rural places in 2024 and 2025. Currently, RACS has contracted to provide both salary support and RSL funding to 38.2 rural posts. Under current funding arrangements, RACS is only funded for rural loading up to the target of 27 posts. The College is working with the Australian Department of Health and Aged Care to allow for flexibility in STP funding to support additional rural training posts within the contracted funding envelope.

Expanding supervisor capacity will be a key QI activity, particularly in Aotearoa New Zealand, where some locations lack a Fellow, this absence can be a barrier to accreditation.

Each society has explored the options for more rural SET within their specialty, as outlined in the following table.

Specialty self-assessment for condition 2

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>Reconciliation Action Plan</p> <p>The plan is being formulated and driven by RACS.</p> <p>Building Respect, Improving Patient Safety (BRIPS) Action Plan</p> <p>The Cardiothoracic Training Committee, in collaboration with RACS, continues to advocate for the BRIPS action plan and promptly addresses any issues that may arise. The BRIPS action plan forms the corner stone of our accreditation process.</p> <p>Diversity and Inclusion Plan</p> <p>Cardiothoracic Surgery has implemented the Aboriginal and Torres Strait Island initiative and is proud to have one Aboriginal/Torres Strait Islander Trainee currently on the SET training program.</p> <p>The committee has always been proactive regarding female representation on both the committee and SET selection interview panels.</p> <p>The number of female surgeons in the cardiothoracic specialty is slowly increasing. At least one female interviewer is included on each interview panel at the selection interviews.</p> <p>The committee continues to work closely with its female representatives to increase diversity regarding women in surgery and to have a very close working relationship with female colleagues in this.</p> <p>Last year, for the current selection process (2025 intake), the committee extensively reviewed its selection criteria to remove any significant bias around the length of SET training.</p> <p>The committee also eliminated the need for any unnecessary expensive courses or presentations as part of the SET selection process. It is now better designed to assist candidates with less social and economic support to fulfil the requirements to successfully access training and Cardiothoracic Surgery. The updated selection regulations have removed a significant amount of bias towards women and in particular women with young children. As part of this review, the committee has also included cultural competency courses as eligibility criteria for SET selection and mandated a one-day mandatory intercultural competency course as part of the selection requirements. The committee will continue to review the selection criteria annually and will always look towards removing any unforeseen biases with regards to selection of new Trainees.</p> <p>A 'Women in Cardiothoracic Surgery' group meets twice a year at the ANZSCTS ASM and the April Trainee workshop. The group mentors female SET trainees and supports junior female</p>

	<p>consultants. It provides an educational scholarship to SET Trainees yearly, supporting them on Fellowship travels.</p> <p>The committee and ANZSCTS are regularly looking at ways to encourage Indigenous doctors in the prevocational space to pursue surgical training.</p> <p>Rural Health Equity Strategic Action Plan (Standard 1.6 and 1.7)</p> <p>The RHES action plan is driven by RACS.</p> <p>The cardiothoracic training committee will look at possible ways of encouraging potential and current Trainees to embrace rural health.</p> <p>While not having traditional rural posts, there are several cardiothoracic posts throughout Australia and Aotearoa New Zealand that would be considered semi-rural. The committee looks forward to building on this once the rural health strategy action plan is finalised.</p>
Board of Neurosurgery	<p>Reconciliation Action Plan (Innovate)</p> <p>During 2022 (for the 2023 intake), the SET Board of Neurosurgery introduced what is now known as the Aboriginal and Torres Strait Selection Initiative. The special measures were introduced for the purpose of addressing the low participation of Aboriginal and Torres Strait Islander people in the SET Program in Neurosurgery.</p> <p>The special measures apply preferencing of the top ranked Aboriginal or Torres Strait Islander who has satisfied the eligibility requirements and Minimum Standards for all four selection tools as detailed in the Selection Regulations.</p> <p>Diversity and Inclusion</p> <p>During 2022 (for the 2023 intake), the SET Board of Neurosurgery introduced what is now known as the Diversity and Gender Equity Initiative. The special measures were introduced for the purpose of achieving substantive gender equity and to give effect to the RACS Diversity and Inclusion Plan which sets targets for increased representation of women in SET across all specialties.</p> <p>The special measures are applied after final ranking of suitable applicants and in circumstances where substantive gender equity would otherwise not be met for female applicants based on ranking alone. Applying the special measures, the percentage of successful applicants will be at least equivalent to their percentage of total applicants, provided there are suitable female applicants.</p> <p>Rural Health Equity</p> <p>In 2021 in response to the RACS Rural Equity Plan, the Neurosurgical Society of Australasia (NSA) and the SET Board of Neurosurgery developed a Neurosurgery Rural and Regional Action Plan. The NSA and SET Board of Neurosurgery is actioning that plan and have already made changes to training post accreditation regulations to better accommodate rural and regional posts, changed the Terms of Reference for the SET</p>

	<p>Board of Neurosurgery to include a rural/regional representative and expanded its 'Undersubscribed Home Regions' selection special measures to have 'regional areas' separated out as their own undersubscribed regions to better address workforce shortages.</p> <p>In 2024 and 2025, the NSA working with the SET Board of Neurosurgery is undertaking a "Top End Neurosurgery" Project. The Project has many components including:</p> <ol style="list-style-type: none"> 1. Developing of guidelines for sustainable neurosurgical services 2. Reviewing of the effectiveness of the use of specialist international medical graduates and locum services to build sustainable neurosurgical services. 3. Evaluating and further refining training post accreditation standards for the SET Program in Neurosurgery 4. Evaluating and further refining the SET Program in Neurosurgery selection process to select doctors from areas of workforce shortages
<p>Committee of Paediatric Surgery</p>	<p>Reconciliation Action Plan (Innovate)</p> <p>The Committee and ANZAPS are regularly looking into ways to encourage Indigenous doctors in the prevocational space to pursue surgical training. This plan is formulated and driven by RACS, and we are fully supportive of the plan.</p> <p>Building Respect, Improving Patient Safety (BRIPS) Action Plan</p> <p>The Committee of Paediatric Surgery continues to advocate for the BRIPS action plan, and promptly addresses any issues that may arise, in collaboration with RACS. The BRIPS action plan forms the cornerstone of our accreditation process. The Committee is also heavily involved in the Hospital Training Post (HTP) Standards project.</p> <p>Diversity and Inclusion</p> <p>We maintain a satisfactory representation of female Trainees within our program. We actively encourage female Fellows to assume roles on the committee or within RACS. Our commitment to enhancing gender diversity is evident in our efforts to ensure balanced representation. For instance, we strive to incorporate at least one female interviewer on each selection and referee interview panel.</p> <p>We conduct an annual review of our selection criteria, ensuring they remain inclusive and reflective of our commitment to diversity and fairness. This ongoing process allows us to adapt and refine our criteria, incorporating evolving best practices and feedback from various stakeholders, thus fostering an environment that promotes equal opportunities for all applicants.</p> <p>We are continuously exploring strategies to actively support and promote Indigenous doctors in the pre-SET phase to pursue surgical training.</p> <p>Rural Health Equity</p>

	<p>The Rural Health Equity strategy action plan is driven by RACS. Although Paediatric Surgery does not currently have traditional 'rural' posts, we remain committed to exploring strategies to strengthen our rural presence and engagement. We recently revised our allocation process to acknowledge the substantial educational opportunities provided by regional training centres. It seeks to encourage trainees to prioritise these centres, thereby facilitating their access to valuable experiences and increasing the likelihood for trainees to return to these regional centres as consultants.</p>
Board of Urology	<p>Diversity and Inclusion</p> <p>Surgical Women in Australia and New Zealand Urology (SWANZU) Committee</p> <p>The Surgical Women in Australia and New Zealand Urology (SWANZU) committee serves as an advisory committee focused on gender equity in urology, aiming to promote women's participation.</p> <p>SWANZU's main goal is to remove barriers hindering women's full participation in urology, complementing existing initiatives like flexible training. It advocates for measurable, sustainable changes in women's status within USANZ, focusing on identifying and eliminating gender discrimination, including the training program.</p> <p>SWANZU identifies and promotes women for representative roles on committees, including training committees. It advocates for gender equity in USANZ's services to the RACS and the Board of Urology in the SET Program.</p> <p>SWANZU includes a trainee representative, ensuring female trainees' perspectives and concerns are addressed.</p> <p>Diversity and Inclusion Sub-Committee</p> <p>USANZ is committed to fostering diversity, equity, and inclusion. The Diversity & Inclusion Sub-Committee provides expert advice on diversity-related matters and aims to ensure equitable access and participation in USANZ activities. The Committee consults with the Board of Urology to ensure the SET Program in Urology promotes diversity and equality.</p> <p>Presenters at Meetings</p> <p>USANZ has also incorporated a Panel Pledge into the <i>USANZ Diversity and Inclusion Framework and Action Plan</i> to increase the visibility and contribution of women in public and professional forums.</p> <p>USANZ tracks and reports gender split of panellists/speakers at all USANZ events (including Trainee Week). In 2023, the gender split of faculty at Trainee Week was 65% male, 35% female.</p> <p>Flexible Training Working Party</p> <p>Based on anecdotal feedback, the Board of Urology recognised that formal support for trainees returning from extended periods of leave, or when undertaking flexible training was lacking. Additionally, there was limited understanding amongst Training</p>

	<p>Supervisors of the challenges faced by these trainees. The Board established a working party, which sought to gather information regarding challenges and perspectives. The working party has subsequently proposed several recommendations including:</p> <ul style="list-style-type: none"> • Provision of clear information and support regarding flexible work arrangements, including the application process and expectations. • Establishment of a structured return-to-work program for trainees on interruption, utilising a transition period for reintegration. • Maintenance of closer oversight for those in flexible positions, to provide adequate support. • Encouragement of culture change within hospitals and the urology community to foster greater acceptance of flexible training. • Conduct ongoing evaluation of interventions and provide feedback to trainees regarding outcomes and Board interventions. <p>The Board recognises that implementation of the proposed recommendations can contribute significantly to creating a supportive environment conducive to the professional development of trainees and is essential in fostering a more inclusive and adaptable training environment.</p> <p>Rural Health Equity</p> <p>The Board of Urology awarded points for rural/regional origin, rural clinical school experience and rural/regional prevocational clinical rotations in 2023 for the 2024 selection intake. Points were awarded to applicants who have undertaken prevocational clinical rotations in areas classified as MMM 2-7 or in approved regional locations in Aotearoa New Zealand. A regional area in Aotearoa New Zealand is defined as outside the main urban areas of Auckland, Wellington (includes Upper and Lower Hutt, Porirua, and Kapiti), Christchurch, Hamilton, Tauranga, and Dunedin.</p> <p>Concerted efforts are made to ensure urologists from MM2+ areas participate on interview panels.</p> <p>There are 6 Training Posts in MM2 centres (VIC, TAS, WA, QLD) and 3 Training Posts in MM3 centres (NSW). There are also 5 training posts in New Zealand that are outside the main urban centres. Allocations to these posts are all 12-month rotations which allows trainees to experience life and training in a non-metropolitan centre.</p> <p>USANZ does not currently collect data on rural members or urban urologists who undertake outreach work and suggests that RACS develops the tracking and reporting tools necessary to capture this data. This would ensure data relating to RACS members who are not members of USANZ is captured. There may also need to be consideration of how to capture data relating to vocationally registered surgeons in New Zealand working in rural/regional centres who are not RACS Fellows.</p> <p>The Board of Urology do not set diversity selection targets</p>
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<p>Board of Vascular Surgery</p>	<p>BRIPS Action Plan</p> <p>Vascular Surgery continues to advocate for safe working environments for trainees and is working in collaboration with the college and hospitals to address issues identified.</p> <p>Rural Health Equity</p> <p>Selection criteria is reviewed annually. CV Scoring guidelines include points awarded for rural or regional residency, training, or employment. Rural or remote is defined as clinical placement in the ASGS-RA 2-5 region or NZ UAC medium urban accessibility or less. Points are awarded for cultural engagement in Māori and/or Aboriginal or Torres Strait Islander communities as well as participation in Māori and/or Aboriginal or Torres Strait Islander organisations for periods greater than 12 months.</p> <p>Diversity and Inclusion Vascular has adopted the Aboriginal or Torres Strait Islander initiative in the selection regulations. While the initiative is in place the number of applicants remain low.</p> <p>Addressing a shortage of vascular surgeons in Aotearoa New Zealand, a similar initiative is being introduced in 2025 (2026 intake) to ensure that at least one New Zealand trainee can be successful in applying for Vascular Surgical training (if minimum standards are met). In addition, selection tools will be updated to include both written and verbal referee reporting.</p> <p>As a small specialty Vascular acknowledges selection is limited to the number of posts available and the number applying for selection and remains committed to identifying and progressing opportunities wherever possible to ensure training is not exclusionary.</p>
<p>Australian Board in General Surgery</p>	<p>Reconciliation Action Plan</p> <p>The Australian Board in General Surgery (ABiGS) has implemented the Aboriginal and Torres Strait Islander initiative into selection since the policies inception. The ABiGS has also ensured the needs of Aboriginal and Torres Strait Islander and Māori have been included in the curriculum through the Cultural Competency and Cultural Safety competency domain as well as ensuring cultural safety throughout the curriculum.</p> <p>In 2024 ABiGS also included that all trainees who commence in 2025 onwards complete the RACS Cultural Competency Modules 1 and 2 prior to commencing Training.</p> <p>Building Respect</p> <p>The ABiGS continues to monitor culture in general surgery accredited posts and has taken action to ensure that issues are addressed. The ABiGS has a process by which trainees can provide confidential feedback at the end of each term. The ABiGS also ensures that trainees feel comfortable to speak and report on issues at the inspections. This is managed by including a Trainee Representative on the inspection team who meets with the trainees without Fellows present. ABiGS has fully participated in</p>

the plan and double checks that trainers and supervisors have undertaken the required courses.

Diversity and Inclusion Plan

General Surgery is at the forefront of gender equality. The ratio of male and female trainees currently in training is 56.79% Male, 42.99% Female, 0.22% Not Specified/Other. Offers for selection made to female applicants has increased from 29.41% in 2016 to 45.61% in 2023.

Research undertaken by E Ip, M Carrarini, I Incoll and D Nestel demonstrates no bias towards female applicants overall in selection.

Ip, E.C., Carrarini, M., Nestel, D. and Incoll, I.W. (2023), Gender associations with selection into Australian General Surgical Training: 2016–2022. ANZ Journal of Surgery, 93: 2350-2356. <https://doi.org/10.1111/ans.18584>

General Surgery has been progressive in its ability to support Trainees who request flexible training. Flexible Training is defined in the Regulations in two ways:

- When the Trainee is undertaking clinical training in an accredited post in a less than full time capacity
- When the Trainee has been able to only complete a portion of their training rotation

Several stand-alone flexible training posts exist in General Surgery; however, trainees are also able to job share with either another trainee or an unaccredited registrar. It is important to also remember that the ability to provide flexible training options is heavily dependent on the accredited training hospital being able to provide the opportunity. In 2016 the number of requests for flexible training was 7 and in 2023 the number of requests was 22. All requests were approved. This is reflection of ABiGS committed to ensuring trainees who desire and require different working arrangements can complete their training.

Rural Health Equity

GSA are mapping their workforce and have indicated they are happy to share their data with RACS. The ABiGS has provided in principle support for rural training hub model and collaboration with RACS to expand this within the context of surgical training. They sought support from RACS to increase accredited training posts with a joint action approach commenced across both rural and metro.

Australian Board in General Surgery – like others – sought to understand from the jurisdictions what their workforce requirements are (both now and into the future) so the SET, including post accreditations, could be planned accordingly to meet community needs with no loss of safe high-quality care or training.

General Surgery has been at the forefront of this standard. General Surgery included points for rural experience in Selection since 2019 and in 2024 Rurality was separated from the CV points and candidates able to obtain points based on not only rural

	<p>experience but rural origin and rural education. Rurality is based on the Monash Modified System and includes areas and hospitals classified as MM2-7.</p>
<p>New Zealand Board in General Surgery</p>	<p>The AoNZCiGS review selection criteria every year to ensure that they are not exclusionary. Any applicant who kaupapa to Māori get an extra point in the selection process.</p> <p>NZAGS has a Rural Representative on the Executive Committee, and he is the rep on the RACS Rural Working Group.</p> <p>NZAGS has a focus on workforce planning. Training more surgeons requires increased Government spending including having jobs for those surgeons graduating.</p>
<p>Board of Otolaryngology Head and Neck Surgery</p>	<p>Reconciliation Action Plan</p> <p>The Board of OHNS was the first training Board to implement the Aboriginal and Torres Strait Islander selection initiative in 2017 for the 2018 Intake.</p> <p>One Torres Strait Islander applicant was appointed in 2024 applying this initiative.</p> <p>A number of OHNS surgeons are mentoring Aboriginal and Torres Strait Islander medical students and junior doctors to pursue surgical careers, whether in the OHNS specialty or other surgical specialties.</p> <p>Building Respect, Improving Patient Safety (BRIPS) Action Plan</p> <p>The Board of OHNS monitors completion of compulsory training by Surgical Supervisors which forms part of the BRIPS Plan.</p> <p>The Board supports the BRIPS plan and considers it in all decision-making processes.</p> <p>Diversity and Inclusion</p> <p>The Board conducts an annual review of selection criteria to ensure they remain inclusive and reflect diversity and fairness, to the extent permitted by law.</p> <p>The Board of OHNS implemented a Gender Equity selection initiative in 2021.</p> <p>Gender diversity of trainees is monitored and gender diversity of interview panels, referee interviews and selection tool applications is planned for gender balance.</p> <p>The special measure was implemented for the purpose of achieving substantive gender equity.</p> <p>Gender diversity is reported to the Board at each November meeting.</p> <p>Rural Health Equity</p> <p>The Board has actively sought and approved additional training posts in regional areas.</p>

	<p>An adapted Regional Accreditation criterion for hospital posts was approved by the Board in 2020.</p> <p>A Rural Origin initiative was implemented by the Board to support doctors from regional areas applying to training.</p> <p>Additional CV scoring is available where an applicant has a demonstrated long-term commitment to a rural / regional area.</p>
<p>New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee</p>	<p>NZOHNS are developing possible clinical network models of training across sites. This has involved:</p> <ul style="list-style-type: none"> • Understanding where the jobs will be (workforce planning) and the link to training. • Recognising a limited ability to increase training while maintaining the standard. • NZOHNS has agreed to share their workforce survey results with RACS. <p>Diversity and Inclusion</p> <p>NZOHNS have implemented a number of strategies within selection to increase diversity and inclusion, initiatives include interview training for the committee in bias reduction; consultation with Māori otolaryngology surgeons to incorporate assessment of cultural competency within interviews of referees, and applicant interviews. They also incorporated non-TEAC members in referee interview panels to reflect rural workforce and cultural diversification.</p>
<p>Australian Board of Plastic and Reconstructive Surgery</p>	<p>Reconciliation Action Plan (Innovate)</p> <p>The Australian PRS training board – as a board of RACS CSET – has an Indigenous selection pathway, though no candidates yet.</p> <p>Diversity and Inclusion</p> <p>The ASPS offer associate membership for SIMGs on the RACS pathway, invite them to conference and education events (including webinars) and the trial FEX.</p> <p>Unprofessional Behaviour and Trainees Reporting Bullying</p> <p>The Australian PRS Board seeks confirmation from HTPs on their experience and outcomes with complaints from trainees at their quinquennial accreditation reviews.</p> <p>Generally, Australian Hospital Training Posts (HTPs) are provided with aggregated reports from a 24-month period on the performance of each HTP from the perspective of trainees. The dissemination of reports is delayed by at least 18 months to mitigate against retribution towards trainees from unit members.</p> <p>In 2023 in WA, a groundswell of anonymous complaints from trainees resulted in two visits to Perth by the Australian PRS Board and senior RACS representatives. Out of cycle inspections are planned for 2024.</p>

	<p>Rural Health Equity</p> <p>The ASPS supported the Darwin surgical unit and its surgeons, and specifically a SIMG towards FRACS who a supervisor now in Darwin. They have published a guide to establishing a regional or rural PRS service and implemented a ‘selecting for rural’ initiative.</p> <p>ASPS recognised the need to upskill others. They have an appetite for:</p> <ul style="list-style-type: none"> • Rural generalists to have a scope of practice in skin cancer and burns management. • Developing the curriculum based on clinical and community need.
<p>New Zealand Board of Plastic and Reconstructive Surgery</p>	<p>Diversity and inclusion</p> <p>Through the CV scoring for SET selection, NZBPRS allocates points for the ability to provide evidence of Te Ao Māori. The Regulations including CV scoring are reviewed annually and consideration is given to supporting and engaging RACS policies.</p> <p>The Board has already reached the RACS target of 50% women trainees by 2027.</p> <p>The Board has also engaged a Māori advisor who participates in the SET selection process including interview day.</p> <p>Regional Health Equity</p> <p>NZAPS and NZBPRS supports the concept of regional health equity and delivery of PRS services in regional locations in Aotearoa New Zealand.</p> <p>NZBPRS and NZAPS are restricted in regional service delivery as currently Te Whatu Ora have domiciled PRS surgeons in metropolitan areas only. NZAPS continuously advocates for a hub and node service delivery model which would enable PRS surgeons to be in secondary/regional hospitals. Until this occurs PRS SET training is limited to tertiary level hospitals. Trainee exposure to regional service delivery is undertaken when they participate in outreach clinics with their surgical trainer. On completion of training, there are currently limited PRS consultant appointments in regional locations and NZBPRS encourages RACS to advocate with Te Whatu Ora to place more PRS consultants in regional hospitals. As part of their workforce planning and workforce development strategy.</p> <p>SET Selection CV scoring for regionality – This is currently difficult for NZBPRS to apply as non-accredited registrars on the pathway to PRS SET apply for placement and experience in PRS units prior to SET application. As mentioned above these units are currently only located in tertiary level hospitals and are not in regional locations</p>
<p>Australian Orthopaedic Association Federal Training Committee</p>	<p>Reconciliation Action Plan (Innovate)</p> <p>For 2023 and 2024 actionable focus areas for AOA are to:</p> <ol style="list-style-type: none"> 1. Deepen involvement with the Australian Indigenous Doctors’ Association (AIDA) and other similar organisations

	<p>to engage and foster more interest and access for Aboriginal and Torres Strait Islander medical students and doctors into orthopaedics.</p> <ol style="list-style-type: none"> 2. Identify and report to the AOA Board one best practice standard in diversity, equity, and inclusion per annum to progress/implement. 3. Develop a Reconciliation Action Plan (RAP) program and framework for AOA and its members to be inclusive and contribute to national reconciliation. <p>Subsequently, the AOA Federal Training Council (FTC) undertook the RACS Cultural Competence & Cultural Safety training for STCs. AOA made mandatory the completion for trainees of the RACS Intercultural Competency for Medical Specialists and Aboriginal and Torres Strait Islander Health and Cultural Safety Curriculum courses have been formalised in AOA policy.</p> <p>AOA also made mandatory the completion of cultural competence and cultural safety training for consultants involved in training and this is currently being implemented in relevant Position Descriptions and incorporated in director of training (DoT) and trainee supervisor (TS) training materials.</p> <p>Diversity and Inclusion</p> <p>AOA has implemented a specific, core strategic pillar – Culture, Diversity, Equity, and Inclusion within the 2022 – 2026 AOA Strategic Plan. Within this core strategic pillar, AOA will aim to cultivate belonging within the orthopaedic community through diverse and inclusive representation in AOA leadership roles and work with relevant organisations to promote orthopaedic surgery as a career to under-represented groups. AOA looks to be world recognised in Diversity, Equity, and Inclusion (DEI) leadership and best practice. Our aim is also to encourage flexibility, work-life balance and well-being within the orthopaedic community and create a culture of psychological safety in orthopaedic training and practice. AOA will look to raise awareness and promote AOA staff and member cultural competency and facilitate ethical decision making and professional conduct through the ongoing practice of AOA's ethical principles.</p> <p>AOA Rural and Remote ASM Bursary Program</p> <p>AOA in 2023 launched a AOA Rural and Remote ASM Bursary Program to provide opportunity for rural and remote emerging and practicing orthopaedic surgeons to participate in AOA's flagship annual scientific meeting. The bursary is offered as a way of engaging with new and current rural and remote members and recognises the accessibility issues faced by these members. An eligibility and application and selection process provided governance around the program.</p> <p>In 2023 one bursary was made available for participating state/territories which included VIC, ACT, QLD, WA and SA/NT and for an associate member and or fellow, and fellow – for NSW only.</p>
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The Rural and Remote ASM bursary includes full costs of the ASM conference registration, including social functions (cocktail party and gala dinner), accommodation at a premium CBD hotel for the conference duration and return flights (if applicable).

In 2024 this program will again run with QLD increasing to two bursaries and WA also allowing those consultants that participate in Fly In, Fly Out (FIFO) services to be eligible.

AOA Orthopaedic Women’s’ Link (OWL) ASM Bursary Program

AOA in 2023 launched a AOA OWL AMS Bursary Program to encourage and facilitate attendance at AOA’s flagship scientific meeting among female orthopaedic surgeons. The program, provided to existing AOA OWL members, aims to achieve new and greater female member attendance at the annual ASM. It recognises gender-equity issues faced by emerging OWL trainees and early-career OWL fellows.

Five OWL bursaries were provided and included registration the ASM, open to two AOA fellows and three AOA trainees. An eligibility and application and selection process provided governance around the program.

In 2024, the NSW branch opened up State Branch OWL Bursaries to extend the concept to the 2024 state branch meeting. Further bursaries for the 2024 Annual ASM will again be made available, two for current OWL trainees, two for current OWL Fellows. An extension of the program will see two ASM bursaries available to female medical students and two for female doctors in training. This sees eight in total bursaries under the OWL ASM Bursary Program for 2024.

AOA ASM – AIDA Bursary Program

To further support indigenous workforce and health AOA will provide AIDA with two bursaries for the 2024 Annual ASM. These bursaries will be available for AIDA members.

We provide two bursaries for AIDA members to attend our Emerging Leaders Forum commencing June 2024. This will run annually across the country herein.

Selection Initiatives

In 2024 the AOA has strengthened its approach to Selection Initiatives with specific initiatives targeted to female applicants, to applicants of indigenous origin and applicants with a rural background. These initiatives seek to promote diversity within the training program and address the workforce needs of rural communities. Please refer to section 6.3 of the *Regulations for Selection to the AOA 21 Training Program in Orthopaedic Surgery for 2025*.

AOAs self-assessment of this Condition is “Complete and ongoing for AOA”.

	The AOA Regional Orthopaedic Surgery Strategy Plan (1.58 AOA Regional Orthopaedic Surgery Strategic Plan) and AOA Diversity Strategic Plan (1.43 AOA Strategic Plan) are attached.
New Zealand Board of Orthopaedic Surgery	<p>Rural Health Equity</p> <p>Regarding workforce, NZOA have:</p> <ul style="list-style-type: none"> • Worked closely with the Ministry of Health New Zealand around workforce planning. There is currently a shortage of surgeons in Aotearoa New Zealand. • The NZOA has a detailed profile of their workforce. • The NZOA has collegial support for career planning with trainees. <p>Selection and training strategies in place to address workforce and community need. Training events are spread around the country including small centres.</p> <p>A large majority of trainees spend at least 1-2 years in a non-urban centre.</p> <ul style="list-style-type: none"> • Have a specific small centre representative on the NZOA Council and the NZOA Education Committee <p>Diversity</p> <p>Regarding workforce, NZOA have:</p> <p>Approved NZOA's Diversity Equity and Inclusion Plan is on the NZOA website. We have selection initiatives in place for Māori, Pasifika, and female applicants.</p> <p>We include tikanga Māori into our training events and selection and have cultural safety training at the SET 0 training weekend. The development of a cultural safety module which will include a broad range of literature on Māori health in NZ as it relates to orthopaedics is currently under development.</p> <p>OWR</p> <p>We support the colleges requirement of OWR to be completed in person for surgical supervisors.</p>

3 Statistics and annual updates

Please provide data in the tables below showing:

- the number of reconsiderations, reviews and appeals that were heard **in 2023**, the subject of the reconsideration, review or appeal (e.g. selection, assessment, training time, SIMG assessment) and the outcome (number upheld, number dismissed).
- the outcomes of its processes for evaluating the reconsideration, reviews and appeals to identify system issues.

Please do not alter the table.

Requests for Reconsideration in 2023 (per program)

Subject of Reconsideration	Number of reconsiderations	Outcome	
		Upheld	Varied
Australian Board of Plastic and Reconstructive Surgery			
Dismissal	1	1	
Trainee progression	1	1	
Selection – CV scoring	3	3	
Selection – Referee reporting	1		1
New Zealand Board of Plastic and Reconstructive Surgery			
Dismissal	1	1	
Australian Board in General Surgery			
Disaccreditation decision	1		0
Review of unsatisfactory rotation for Term 2 – 2022	2	Both rejected by RACS	
Review of CV application	3	All rejected by RACS	
Dismissal	1	1	
New Zealand Association of General Surgeons			
Selection – Interview	1		
Board of Neurosurgery			
Selection – CV scoring	2	2	
Selection – CV scoring (applicant correcting an error)	3		3
Selection – Reference report	5	5	
Selection – Interview	2	2	
Training – Suspension from training	1	1	
Training post accreditation decision	1	1	
Australian Orthopaedic Association			
Selection results	43 – Grounds not established for remaining applications	20	10 – Results varied based on decision to scale SJT score, not because of reconsideration

			applicati ons
Board of Vascular Surgery			
Selection – CV scoring	2	2	
Board of Urology			
Application for interruption from training	1		1
Board of Otolaryngology Head and Neck Surgery			
Selection	3	3	
Board of Cardiothoracic Surgery			
Selection – CV scoring	9	9	
Specialist International Medical Graduates			
Comparability	26 (2 not accepted)	15	9
Examinations			
Review of marks / calculations	12	12	

Requests for Review in 2023 (per program)			
Subject of Review	Number of reviews	Outcome	
		Upheld	Varied
Australian Board of Plastic and Reconstructive Surgery			
Summative assessments of Terms 1 and 2 of 2022	2 – RACS CEO escalated to an appeal which was upheld		
Selection – CV scoring	2	Both rejected by RACS	
Australian Board in General Surgery			
Review of CV application	2	Both rejected by RACS	
Board of Neurosurgery			
Suspension from training	1	Applicati on rejected by RACS as ineligible for RRA	
Australian Orthopaedic Association			

Selection results	3 – Grounds not established	0	0
Board of Vascular Surgery			
Selection – CV scoring	1	1 Matter progressed to appeal.	
Board of Otolaryngology Head and Neck Surgery			
Selection	2	2	
Committee of Paediatric Surgery			
Dismissal	1	1	

Requests for Appeal in 2023 (per program)

Subject of Appeal	Number of appeals	Outcome	
		Upheld	Varied
Australian Board of Plastic and Reconstructive Surgery			
Summative assessments of Terms 1 and 2 of 2022	2	2	
Board of Vascular Surgery			
Selection – CV scoring	1		1

- Please confirm the costs associated with the College's reconsideration, review and appeals processes **for 2024**, and describe how the College ensures that these costs are transparent and communicated to Trainees. Please also include in the comment how the College ensures costs are not prohibitive for Trainees and if the College has any processes to ensure duty of care for Trainees' health and wellbeing currently.

Please include a link to where this information is provided on the College's website.

College response

The proportion of unsuccessful candidates seeking a reconsideration (5%), largely due to being unsatisfied with not being selected, doesn't seem like an excessive number, but the proportion in other medical specialties is unclear.

Requests for reconsideration are considered by the original decision-maker. In terms of selection, this would be the chair/training board. RACS will provide advice, but all decisions are made by the STC/Bs. RACS directly manages the reviews and appeals as per the SLAs, and reconsideration for examinations and SIMGs.

RACS will be reporting a substantial increase for selection reconsiderations in 2023, with the AOA data almost doubling the previously reported number. There will also be SIMG and examination data previously unprovided.

RACS has considered the themes and drivers for requests for reconsideration for selection. Some of the key drivers include the competitiveness of the program and the narrow margin in points

between successful and unsuccessful candidates. Limits on selection attempts by specialty, and that reconsideration is at no cost to the applicant, also drive an uptake in reconsiderations.

RACS continues not to charge for reconsiderations and reviews. While this may generate more reconsiderations than if applicants of the process incurred a fee, it is believed to be important not to place barriers before applicants if they have valid grounds for reconsideration or review as outlined in the policy.

At the appeal stage, RACS charges the appellant a fee of A\$9,995.00. This is a modest contribution to the substantial costs of a heard appeal, which is in the range of A\$30,000 borne by the organisation (RACS). The appeal fees are provided on the website as part of a broader summary of fees and includes fees for previous years for context. The policy is currently being updated to provide for a refund of the appeal fee if the applicant is successful in their appeal.

[College fees | RACS \(surgeons.org\)](#)

Changes to cost associated with reconsideration, reviews and appeals for 2023	Rationale for changes
Changes to fees made <input type="checkbox"/> No changes made <input checked="" type="checkbox"/>	

- Please describe:
 - if there are any changes to the College’s requirements for cultural safety training for its senior leadership team, staff and college committee members **in 2024** (i.e. training is mandated, training not required, how long is the course, how often must it be undertaken), and describe if the College is considering any changes to its requirements around Cultural Safety training in the next 12 months.

If the College is bi-national, please describe Cultural Safety training requirements for both Australia and New Zealand.

 - how the College is collaborating with other specialist medical colleges around activities around cultural safety.

College response
<p>There has been no change to cultural training for staff; all staff are required to complete annual training. College committee members that are surgeons are required to complete one CPD activity in Cultural Competence and Cultural Safety training per annum as part of their CPD requirements. Details on the RACS-led NCME workshop dedicated to Cultural Competence and Cultural Safety are discussed in the submission. (1.51 NCME Cultural Competency and Cultural Safety Symposium)</p>

- If the College has made any changes to the following documents **for 2024** please describe the changes in the table below and attach or provide a website link to the updated documentation to this submission.

Policy / Procedure	Description of changes
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College Governance Chart Revised document attached <input checked="" type="checkbox"/> No changes made <input type="checkbox"/>	Please see 1.13 June 2024 Governance Structure
Conflict of Interest Revised document attached <input checked="" type="checkbox"/> No changes made <input type="checkbox"/>	The existing Conflict of Interest Regulation has been updated with sections addressing 'confidentiality' and 'failure to comply' to strengthen compliance with current mandatory accreditation requirements.
Reconsideration, Review and Appeals Revised document attached <input checked="" type="checkbox"/> No changes made <input checked="" type="checkbox"/>	Draft policy for consultation is attached. As previously described, RACS is implementing the high priority recommendations at the request of Miller Blue group and will await advice from them before actioning the items they requested put on hold.

Standard 2: The outcomes of specialist training and education

Areas covered by this standard: educational purpose of the educational provider; and program and graduate outcomes

1 Summary of significant developments

This section gives the AMC information on the continuing evolution of the college's programs. Please provide a summary of significant developments completed or planned relevant to Standard 2.

Has there been any significant developments made against this standard? <i>If yes, please describe below.</i>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
RACS now has an aligned competency document mapped for each specialty across the different curricula (1.7 Curriculum Mapping). This improves comparability, transparency, reporting and monitoring of continuous progress, early intervention where there are setbacks, and public communication about graduate outcomes.		

The AMC also expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the report.

Has the College made any significant changes affecting the delivery of the program? i.e. changes to statement of graduate outcomes for training programs. <i>If yes, please describe below the changes and the potential impact on continuing to meet these standards.</i>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
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RACS has worked with the societies in Paediatric Surgery and Cardiothoracic Surgery to develop new competency-based curricula. Both curricula are now ready to go out for consultation to other societies and broader stakeholder groups for feedback prior to finalisation. These have been included in the curriculum mapping ([1.7 Curriculum Mapping](#)) across all specialist societies.

2 Activity against conditions

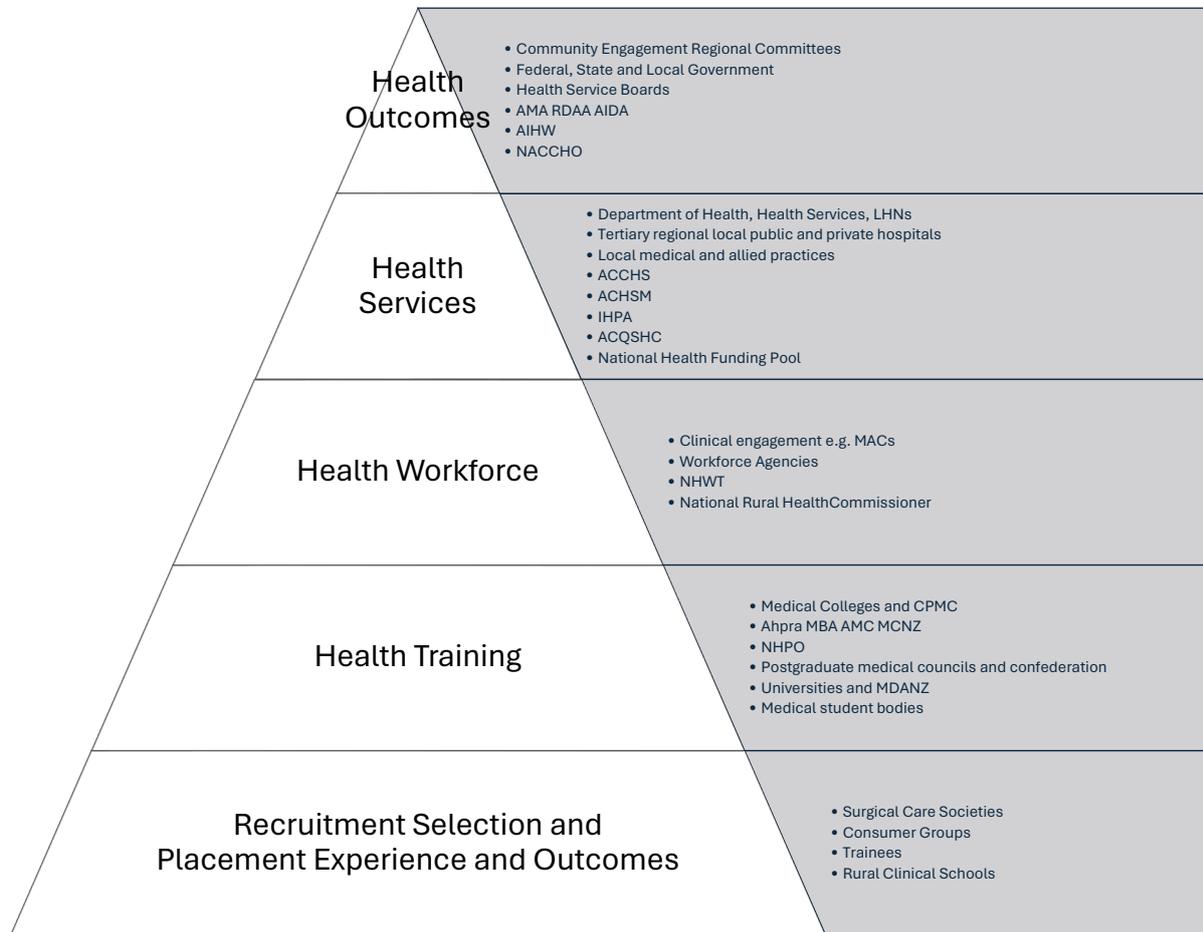
The numbering of conditions matches that used in the AMC Accreditation Report.

Please address each of these conditions individually.

Condition 3		To be met by: 2023		
Broaden consultation with consumer, community, surgical and non-surgical medical, nursing, and allied health stakeholders about the goals and objectives of surgical training, including a broad approach to external representation across the College. (Standard 2.1)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
2023 AMC commentary				
<p>This condition relates to broad consultation on the goals and objectives of surgical training.</p> <p>As mentioned in the 2022 submission, and confirmed in the document itself, the PCS curriculum was developed by college-related bodies and experts and did not appear to involve outside stakeholders.</p> <p>Examples were given:</p> <ol style="list-style-type: none"> 1. A stakeholder matrix developed for the M and E framework to which the framework will be sent for feedback which contains a wider range of non-surgical stakeholders. 2. Development of standards for Hospital Training Process (HTP) accreditation. <p>While these are commendable engagements, the College might consider whether sending a document out for review/ feedback is sufficient or are other forms of consultation needed in some settings.</p>				
2024 College Response				
<p>The 2015 AMC Standards Review led to an increased emphasis on community engagement, and RACS has developed a comprehensive stakeholder engagement plan for key deliverables (2.1 Stakeholder Engagement Framework) including the HTP Standards (1.1 Hospital Training Post Accreditation Standards) and the M & E Plan (1.2 Monitoring and Evaluation Framework). This is reflected in the Strategic Plan (1.3 Strategic Plan), the Business Plan (1.4 Business Plan), and the Rural Equity Plans for Australia (1.32 Rural Health Equity Strategic Action Plan) and New Zealand (1.48 AoNZ Regional Rural Health Equity Strategy and Recommendations), as well as the dedicated plans to contribute to better Aboriginal and Torres Strait Islander and Māori health services and outcomes (2.2 IHC Report to Council 2024).</p> <p>The RACS Stakeholder Engagement Plan (2.1 Stakeholder Engagement Framework) underpins the network approach to the delivery of SET. This relationship-based approach ensures direct line-of-sight with each society responsible for delivering SET. This framework aligns health outcomes with the key stakeholders involved in the recruitment, selection, training and assessment of future surgeons. Currently, there is a framework tailored for Australia (2.1</p>				

[Stakeholder Engagement Framework](#)) and a similar framework being developed in collaboration with our Aotearoa New Zealand stakeholders.

This document is dynamic and evolves based on regular feedback. The CEOs provide quarterly reports to the RACS and society presidents, ensuring continuous adaptation and alignment with stakeholder input.



At each level, practical examples demonstrate stakeholder engagement in SET. All societies have websites offering essential information and direct contact options. While some websites are more comprehensive, a small number rely on a redirect to the RACS website for some aspects of SET.

Community Needs

The process of HTP accreditation allows RACS to closely engage with communities, ensuring safe, high-quality care through training. Implementation of the HTP Accreditation Standards ([1.1 Hospital Training Post Accreditation Standards](#)) will enhance communication and partnership with health services to address workforce challenges through SET. The revised HTP standards emphasise:

- Standard 5.1.2: Hospitals must collect, monitor and measure local population data to enhance cultural awareness and reduce healthcare disparities, particularly for Aboriginal and/or Torres Strait Islander and Māori populations.
- Standard 5.3.1: Hospitals must maintain policies promoting equitable, accessible and responsive healthcare services for diverse communities.

RACS is committed to leadership to address workforce and community needs, including diversity and rural equity across SET. This is further outlined in the QI plan, and will be discussed with societies at the 7 June 2024 workshop.

Workforce Needs

RACS Fellows, supervisors, trainers and assessors work across diverse health services, bringing practical workforce insights into SET and RACS governance ([2.3 Councillor Declarations](#)). RACS is involved in designing and delivering surgical services in underserved areas. Future directions include contributing to rural generalist, non-medical rural and remote staff education and providing virtual surgical supervision to ensure high-quality, accessible and affordable care for remote communities.

RACS is leading two FATES projects ([1.57 FATES STP Summaries](#)) specifically aimed at developing workforce data-sharing agreements, identifying barriers to rural training and accreditation, and developing innovative models to improve access to address community need. RACS is also developing a proposal for a FATES 4 funding application around workforce, community need and engagement.

Advocacy

Most societies advocate for maintaining high surgical training standards and call for RACS to seek funding and support for sustainable training in resource-limited posts. As advocacy is undertaken across the network, mapping outcomes and activities to ensure a consistent message while recognising each society's unique situation will be a key feature of the next RACS work plan.

RACS actively engages with Trainees to ensure it is responsive to emergent needs. In addition to RACSTA ([2.4 RACSTA Terms of Reference](#)), RACS is establishing a supervisor reference group ([2.5 Supervisor Reference Group Terms of Reference.pdf](#)).

RACS is investigating community engagement perspectives. While there are currently two community representatives on the council ([2.6 Engagement of Community Members and Expert Advisors on RACS Committees and Boards Regulation](#)), other structures, such as a community reference group, to be known as the RACSCRG, are being explored ([2.7 Community Reference Group Terms of Reference](#)).

Key advocacy actions:

- More focus on practical advocacy goals of cross-jurisdictional leave entitlements, bi-directional relocation support, recognition of prior service and three-year contracts for trainees.
- RACS leadership has met with the Australian Commonwealth Government and the NZ Ministry of Health and Te Whatu Ora and scheduled meetings with health service representatives across other jurisdictions to advance advocacy efforts.
- RACS Censor in Chief (CiC), President, society representatives and CEO met with Trainee representatives in April 2024, identifying key advocacy issues such as governance, training impacts, fees, leave portability and workforce planning.

These efforts aim to improve surgical training, address community needs and ensure equitable, high-quality healthcare delivery across Aotearoa New Zealand and Australia.

Specialty self-assessment for condition 3

Training Committee/Board	Response
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<p>Cardiothoracic Surgery Training Committee</p>	<p>The Committee is currently rewriting its curriculum in consultation with RACS.</p> <p>The Committee envisages finalising the first draft curriculum by mid-June.</p> <p>The final draft curriculum will be circulated to a broad range of stakeholders, and the public for input and review.</p> <p>It looks forward to imbedding this properly into the Cardiothoracic training programme.</p>
<p>Board of Neurosurgery</p>	<p>The Neurosurgical Society of Australasia (NSA) and the SET Board of Neurosurgery have been conducting a review of the curriculum for the SET Program in Neurosurgery.</p> <p>On 24 March 2024 a consultation draft was released on the NSA's public facing website inviting feedback. The feedback period runs for two months.</p> <p>Targeted consultation emails were also sent to all trainees in the SET Program in Neurosurgery, Surgical Supervisors, members of the NSA, representatives from other surgical specialties and training committees, the AMC, the MCNZ, health department representatives and other surgical and medical colleges. Submissions from the public are also invited.</p>
<p>Committee of Paediatric Surgery</p>	<p>Curriculum</p> <p>The Committee of Paediatric Surgery is currently rewriting its curriculum in consultation with the RACS Education Design and Development team. We anticipate that this work will be completed by June. Following its completion, the curriculum will be disseminated to a diverse range of stakeholders and the public for comprehensive input and review, ensuring its effectiveness and relevance.</p> <p>Governance</p> <p>The Committee of Paediatric Surgery has a community advisor who is a full member and represents the wider community, bringing non-medical perspectives to assist the Committee in the performance of its duties.</p> <p>While no regular projects have necessitated the need for a broad consultation, it is acknowledged that, when necessary, broader consultation will be actively pursued to ensure comprehensive understanding and consideration.</p>
<p>Board of Urology</p>	<p>Curriculum</p> <p>Broad input was sought from relevant parties during the recent urology specialty curriculum redevelopment, this document defining the objectives of urology training and governing the outcomes of it. This included other specialist medical societies (such as radiation oncology, anaesthetics, emergency medicine, and obstetrics and gynaecology), Australian and New Zealand Urological Nurses Association, as well as community-based organisations such as the Prostate Cancer Foundation of Australia.</p>

	<p>The process of periodic review of the curriculum will incorporate further input from these relevant parties, and any others as appropriate.</p> <p>Governance</p> <p>For nearly a decade, the Board of Urology has collaborated closely with an experienced medical education consultant. Their extensive expertise in governance and regulation, curriculum development, and training program development has been extremely beneficial in ensuring the SET Program aligns with contemporary medical educational standards, providing a robust educational environment for trainees. The Board has benefited from their experience and insight, leading to significant improvements in program governance and quality, enhanced communication with stakeholders, and the development of comprehensive documentation supporting all facets of the training program.</p> <p>The Board of Urology is also in the process of recruiting an external representative with the skills, knowledge, and perspectives to complement existing Board members.. This individual will provide valuable input to the Board's functioning, enhancing its effectiveness and ensuring a diverse range of insights and expertise are considered in decision-making processes.</p>
Board of Vascular Surgery	<p>Curriculum</p> <p>Vascular Surgery has published the redeveloped Curriculum for broader feedback from stakeholders in 2021. Aligning with the curriculum, a revised competency-based training program is currently in development. This will include a strong emphasis on supporting less than full time training pathways. Further input from external parties including specialist societies, health departments and/or consulting experts is being undertaken.</p> <p>Governance</p> <p>Vascular surgery has community representation on their board. The selection interview process also involves the participation of the community representative.</p>
Australian Board in General Surgery	<p>Curriculum</p> <p>When the General Surgery curriculum was redeveloped, a range of stakeholders were contacted for input and review. This included Australian and Aotearoa New Zealand Trainees in the Surgical Education and Training Program as of May 2021 as well as related organisations that in turn are responsive and responsible for trainees and the community they serve. These included the Australasian College for Emergency Medicine, Australian and New Zealand Endocrine Surgeons, Australian and New Zealand Gastric & Oesophageal Surgery Association, Australian and New Zealand Hepatic, Pancreatic & Biliary Association, Australian and New Zealand Metabolic and Obesity Surgery Society, Australian and New Zealand Supervisors as at May 2021, Australian College of Perioperative Nurses, Australian College of Rural and Remote Medicine, Australian Indigenous</p>

	<p>Doctors' Association, Australian Medical Council, Australian Orthopaedic Association Federal Training Committee, Australian Patients Association, Breast Surgeons of Australia and New Zealand, Colorectal Surgical Society of Australia and New Zealand, General Surgeons Australia, Medical Council of New Zealand, New Zealand Association of General Surgeons, New Zealand Orthopaedic Association Specialty Orthopaedic Training Board, Perioperative Nurses College of NZ Nurses Organisation, RACS, Australian Board of Plastics and Reconstructive Surgery, RACS, Board of Cardiothoracic, RACS, Board of Neurosurgery, RACS, Board of Otolaryngology - Head and Neck, RACS, Committee of Paediatric Surgery, RACS, Board of Urology, RACS, Board of Vascular Surgery, RACS, New Zealand Board of Plastics and Reconstructive Surgery, Royal Australasian College of Physicians, Royal Australasian College of Surgeons (RACS), Royal Australian College of General Practitioners, Royal New Zealand College of General Practitioners, and Te Ora (Māori Medical Practitioners).</p> <p>Advocacy</p> <p>GSA have a very significant advocacy role, as do most of the larger and better resourced societies, to support both their profession and the communities they serve.</p> <p>Community and External Stakeholders and Representatives</p> <p>For the Inspection, ABiGS has always requested Jurisdictional Representatives to be part of the inspection teams. The response from Health Departments has been varied over the years, however in 2024 the ABiGS is working with Justine Harris at NSW Health to include JRs on the inspection teams.</p> <p>An external representative is also a voting member of ABiGS and acts as the community representative.</p> <p>Selection</p> <p>In 2024, ABiGS determined to include referee reports from nurses, allied health, clerical staff, junior doctors and ED/ICU/HDU practitioners in recognition that trainees and surgeons work with a wide variety of professions. It was therefore deemed that the opinion of these professions was important and needed to be included in the selection process.</p>
New Zealand Board in General Surgery	<p>Selection</p> <p>As part of the 2023 selection process, NZAGS received a wide range of reference reports from allied health professionals and non-surgical SMOs for selection applicants.</p>
Board of Otolaryngology Head and Neck Surgery	<p>Governance</p> <p>The Board of OHNS has a consumer representative who has been on the Board for six years.</p>
New Zealand Otolaryngology Head and	<p>Understanding Workforce Needs</p> <p>To greater understand workforce needs, NZSOHNS are looking to advocate for more funding for unaccredited positions.</p>

Neck Surgery Training Subcommittee	
Australian Board of Plastic and Reconstructive Surgery	<p>Governance</p> <p>The Australian Board of Plastic and Reconstructive Surgery regularly involves community, non-surgical medical, nursing, and allied health stakeholders in process design pertaining to SET trainees. All Board meetings and all selection decisions includes the Board's community representative. Their community representative contributes valuable and broad perspectives from nurses and medical doctors to the community at large. While no regular projects have necessitated the need for a broad consultation, where major changes are in train or in planning, the Board has consulted broadly. For example:</p> <ul style="list-style-type: none"> • In 2018/2019 with the publication of the P&RS Curriculum (including the RACSTA, RACS Indigenous Health Committee, RACS International Medical Graduate Committee, and the Australasian Foundation For Plastic Surgery Limited, Australian and New Zealand Society of Craniomaxillofacial Surgeons, Australasian Society of Aesthetic Plastic Surgeons, The Australian Hand Surgery Society, Australian and New Zealand Burn Association, The Australian and New Zealand College of Anaesthetists, Australasian Cleft Lip & Palate Association Inc) • Since 2021: as a contributor to the development of RACS IT system called the Training Management Platform (TMP). • Currently: regulation of the cosmetic surgery industry (AHPRA, Medical Board) and its impact on the training environment. • 2022-2023: Darwin Workforce Project. Working with Top End Health representatives to build a sustainable plastic surgery service. Leading to an application from Royal Darwin Hospital for accreditation assessment in 2024.
New Zealand Board of Plastic and Reconstructive Surgery	<p>Governance</p> <p>NZBPRS appointed a new Community Advisor as of 1 May 2023 who is a full and active member of the Board. The Community Advisor also participates in the SET Selection interview day as an independent observer.</p> <p>Reference reports are obtained from nurses as part of the SET selection process.</p> <p>NZAPS recently hosted a National PRS Service meeting to discuss with key stakeholders in the health sectors the challenges and opportunities facing the delivery of PRS services across Aotearoa New Zealand. A key component of this is the delivery of SET training.</p>
Australian Orthopaedic Association Federal Training Committee	<p>Recommendations from the Strategic Review of AOA 21 include proactively confirming and communicating to the AOA community that the overall goal of AOA training is a graduate with the competencies to provide excellent patient care as a general orthopaedic surgeon anywhere in Australia. This links to ensuring that all trainees have adequate exposure to all subspecialty areas of orthopaedic surgery and developing an expanded national</p>

	<p>professional skills syllabus that prepares AOA graduates for working independently in any practice environment.</p> <p>The recommendations of this focus area are mostly scheduled for development in 2025. One notable variation to this is the review of competencies relating to Cultural Competence and Cultural Safety, discussed under Condition 4, scheduled for action in 2024.</p> <p>Stakeholder Engagement</p> <p>AOA consulted widely in the development of the AOA 21 Training Program. Since our last report AOA has:</p> <ul style="list-style-type: none"> • Conducted an external stakeholder consultation on AOA 21 with non-surgical health professionals and health care administrators. The responses to this consultation are currently being reviewed and are due to be reported to the FTC in June. • Consultation with Consumer and community representatives is in progress. • Been an active participant in the development of RACS M&E Framework <p>Governance</p> <p>AOA continues to include:</p> <ul style="list-style-type: none"> • a Jurisdictional Representative, and External Representative on the Federal Training Committee • a Jurisdictional Representative on our Accreditation Committee • non-surgeon representatives on all Selection Interview panels. <p>MSK Patient Advocacy Coalition</p> <p>The AOA has stewarded and lead the formation of the MSK Patient Advocacy Coalition comprising Consumer Health Forum, Australian Patients Australia, Arthritis Australia, Pain Australia and MSK Australia. The MSKPAC advocates for patient community representing over 7m Australians seeking improved equitable access to healthcare. Representations have been made to all Ministers of Health and the Coalition recently met with the Federal Minister of Health to seek changes to health system to better reflect the patient experience. Patient advocacy is a key competency AOA is working alongside these patient groups. Members of the groups are being invited to support MRFF grant submissions seeking to improve patient healthcare through dedicated research and also to participate in key committee discussions.</p>
New Zealand Board of Orthopaedic Surgery	<p>Governance</p> <p>The NZOA has representation from Māori, LIONZ and consumers on the NZOA Council, the Specialty Orthopaedic Training Board (SOTB) and Māori and LIONZ representatives on the Education Committee. These representatives regularly liaise with the membership of LIONZ and Nga Rata Koiwi (NRK) on training and all orthopaedic matters. LIONZ and NRK are represented at selection and all training events.</p>

	<p>During the selection process the SOTB collect 'additional workplace assessments' from senior nursing staff and other allied health professionals.</p> <p>The NZOA attend and collaborate with a range of allied health stakeholders. Via NZOA Council and SOTB we consult with Ministry of Health, ACC, STONZ, consumer, LIONZ, Māori health organisation and Private Hospital groups about training matters.</p>
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Condition 4 To be met by: **2022**

Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available, reflecting community needs and mapped to the ten RACS competencies. (Standard 2.2 and 2.3)

	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	

2023 AMC commentary

The College is to be commended on the quality, clarity, and evidence basis behind the recently published [RACS Professional Skills Curriculum | RACS \(surgeons.org\)](#). Production was a shared development across the College.

Graduate outcomes are clearly specified for eight of the ten competencies in the RACS Professional Skills Curriculum (PSC). The two other areas of Medical expertise and technical expertise are regarded as specialty specific. Suggested teaching and learning activities are provided. Thus, it provides an excellent framework for the 'non-technical' skills expected of Trainees and Fellows.

In this document it states that 'safe, high-standard surgical practice necessitates Fellows of RACS to be competent across all 10 RACS competencies'.

This submission states that 'program and graduate outcomes are defined for each of the Specialty Training Programs'.

Templated curriculum maps were provided for 5 of the 13 programs: AOA, Au GS, OHN, Plastic and Reconstructive Surgery, USANZ. The format was variable.

The only maps that showed a clear link to RACS were AOA and USANZ, which had one tab for each of the 10 RACS competencies.

Also of note:

- The AOA map is not yet reflected in the foundation competencies on the AOA website, which do not specifically mention cultural competence or cultural safety.
- The AU GS and OHN show the curriculum map but do not show how the competency lists map to the RACS 10 competencies.
- The PRS training documents show graduate outcomes and mapping, but not how they link to the RACS competencies. Commendably, cultural competence and safety are included in the PRS graduate outcomes, and cultural safety is covered in EPAs 1, 4 and 6.
- USANZ has learning outcomes that include cultural safety and competence, and both are included in two EPAs. Cultural safety is covered in a neurogenic bladder EPA.

To meet this condition requires a simple and clear map of how the publicly available, highest-level competencies or graduate outcomes for each program clearly map to the RACS competencies.

2024 College Response

With the full support of the specialist societies, the curriculum of each specialty has been mapped to the 10 competencies ([1.6 RACS Professional Skills Curriculum 2023](#)) expected. These had already been developed by most specialist societies and are now tabulated collectively ([1.7 Curriculum Mapping](#)). Both the HTP Standards ([1.1 Hospital Training Post Accreditation Standards](#)) and the M & E Framework ([1.2 Monitoring and Evaluation Framework](#)) are underpinned by this mapping. Each specialty describes how each competency is developed and assessed.

With the full support of the specialist societies, RACS mapped the graduate outcomes of each specialty ([1.7 Curriculum Mapping](#)). These had already been developed by most specialist societies. Graduate outcomes are co-branded and available to the public for each specialty on the RACS website and on each specialty website:

The Australian & New Zealand Society of Cardiac & Thoracic Surgeons:

<https://www.surgeons.org/Trainees/surgical-specialties/cardiothoracic-surgery/program>

General Surgery Australia: <https://www.generalsurgeons.com.au/education-and-training/gset>

New Zealand Association of General Surgeons: <https://www.nzags.co.nz/education-training/curriculum/>

The Australian Society of Otolaryngology Head and Neck Surgery:

<https://asohns.org.au/Training-and-Education/SET-Program/Surgical-Training-in-OHNS-Graduate-Outcomes>

Neurosurgical Society of Australasia:

https://www.nsa.org.au/Public/Public/SET_Program/Curriculum.aspx

Australian Orthopaedic Association: <https://aoa.org.au/docs/default-source/aoa-21-resources/aoa-curriculum-framework-2017.pdf?sfvrsn=2>

Australian and New Zealand Association of Paediatric Surgeons:

<https://www.surgeons.org/Trainees/surgical-specialties/paediatric-surgery/program/Regulations-for-Fellowship>

Australian Society of Plastic Surgeons: <https://plasticsurgery.org.au/about-asps/becoming-a-specialist-plastic-surgeon/graduate-outcomes-statement/>

New Zealand Association of Plastic Surgeons: <https://plasticsurgery.org.nz/education-and-training/surgical-education-and-training-set-programme/>

Urological Society of Australia and New Zealand: https://usanz.org.au/publicassets/b1346318-60c1-ed11-911c-0050568796d8/GraduateOutcomesSET_ProgramUrology_202303.pdf

Australian and New Zealand Society for Vascular Surgery: <https://anzsvs.org.au/education-training/set-curriculum/>

Specialty self-assessment for condition 4

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>The Committee is currently rewriting its curriculum in consultation with RACS. The first draft will be complete by mid-June 2024.</p> <p>The draft will be circulated to a broad range of stakeholders and the public for input and review.</p> <p>The curriculum will then be embedded fully into the Cardiothoracic SET.</p>

Board of Neurosurgery	<p>The graduate outcomes for the SET Program in Neurosurgery are clearly stated and mapped against the 10 RACS competencies in the Statement of Competence which is available on the public facing NSA website with unrestricted access.</p> <p>The Neurosurgical Society of Australasia (NSA) and the SET Board of Neurosurgery have released a consultation draft of the new curriculum, which also has the graduate outcomes mapped against the 10 RACS competencies (see section 2 Graduate Outcomes). This draft is available on the NSA's public facing website with unrestricted access.</p>
Committee of Paediatric Surgery	<p>As part of the curriculum rewrite, the graduate outcomes have been identified and aligned with the 10 PSC competencies. In addition, the RACS Professional Skills Curriculum is integrated into the new curriculum structure, ensuring a cohesive and comprehensive educational experience.</p>
Board of Urology	<p>A graduate outcomes document based on the SET Urology Curriculum and aligned to the RACS competencies is publicly available on the USANZ website. The document reflects community consultation mentioned in Condition 3 and is intended for health consumers, prospective applicants, and international doctors interested in seeking SIMG Assessment.</p> <p>Program and graduate outcomes can be viewed at: Graduate Outcomes - Urology</p>
Board of Vascular Surgery	<p>Vascular contributed to and adopted the finalised RACS Professional Skills Curriculum. The curriculum is mapped back to the ten college competencies with graduate outcomes identified on a public facing document, while more detailed learning outcomes are included in the trainee version (restricted access). In-training assessments map back to competencies. Several new work-based assessments were introduced in 2024, after a process of codesign with relevant stakeholders and trainees. Program and graduate outcomes can be viewed at: https://anzsvs.org.au/education-training/set-curriculum/</p>
Australian Board in General Surgery	<p>The General Surgery Curriculum (GSET), which is publicly available here https://www.generalsurgeons.com.au/education-and-training/gset, clearly stipulates the Graduate outcomes, which are the final milestones in GSET5. In terms of the 10th Competency, General Surgery was awaiting finalisation of the RACS Professionalism Curriculum. The 10th competency has now been finalised and the milestones are currently being added to the GSET Curriculum.</p> <p>GSA program and graduate outcomes can be viewed at: https://www.generalsurgeons.com.au/education-and-training/gset</p> <p>The General Surgery Curriculum utilises the 10 RACS competency domains. The General Surgery curriculum was developed prior to the RACS Professionalism Curriculum; however, we believe that the areas in the RACS Curriculum are fully covered in the General Surgery Curriculum. ABIGS has reviewed the mapping of the GS Curriculum to the RACS general curriculum and is satisfied that all areas in the RACS curriculum are fully covered in the General Surgery Curriculum.</p>

<p>New Zealand Board in General Surgery</p>	<p>AoNZCiGS worked with GSA to map all competencies and provided the work to RACS.</p> <p>The curriculum clearly stipulates the Graduate outcomes, which are the final milestones in GSET5.</p> <p>In terms of the 10th Competency, General Surgery was awaiting finalisation of the RACS Professionalism Curriculum. The 10th competency has now been finalised and the milestones are currently being added to the GSET Curriculum.</p>
<p>Board of Otolaryngology Head and Neck Surgery</p>	<p>OHNS has outlined graduate outcomes and mapping of the competency-based curriculum.</p> <p>The Professional Standards Curriculum was released after the OHNS curriculum was developed. The OHNS curriculum has been mapped against the PSC. There is one aspect of the PSC which is yet to be factored into the curriculum by the Board of OHNS.</p>
<p>New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee</p>	<p>As a training subcommittee, all curriculum is set and administered by the Board of OHNS (BOHNS). Therefore, NZSOHNS response in relation to curriculum conditions align with BOHNS.</p>
<p>Australian Board of Plastic and Reconstructive Surgery</p>	<p>A bi-national review committee is currently undertaking a review of the PRS syllabus, assessment strategy and public facing documents (PRS Graduate Outcomes) with respect to the AMC's accreditation conditions and standards. The review should conclude in 2024 with a community consultation period in early 2025 and formal adoption/ratification of the revised 2019 Curriculum by Mid-2025.</p> <p>Draft revisions (April 2024) were shared with RACS and include:</p> <ul style="list-style-type: none"> • PRS Graduate Outcomes Statement: now mapped statements to all 10 College competencies. • Cultural Safety and Cultural Competence has a standalone chapter in the Curriculum document. • RACS Professional Skills Curriculum is completely mapped to the PRS Curriculum <p>Consultation will include Australian and Aotearoa New Zealand memberships of RACS PRS community and wider socialisation with interested parties, such as the Australian Indigenous Doctors' Association (AIDA) and relevant groups in Aotearoa New Zealand through the relationship with the NZ PRS Board.</p>
<p>New Zealand Board of Plastic and Reconstructive Surgery</p>	<p>The PRS Curriculum and Graduate Outcomes document are bi-national documents developed and implemented by the NZBPRS and ABPRS. A bi-national review of the Curriculum and Graduate Outcomes document is currently underway with the later to include mapping to the RACS Competencies. It is anticipated the documents will be ratified in early 2025. The review has been led by ASPS and draft documents shared with RACS.</p> <p>Specialty SET program and graduate outcomes can be viewed at: Surgical Education and Training (SET) Programme - New Zealand Association of Plastic Surgeons (plasticsurgery.org.nz)</p>

<p>Australian Orthopaedic Association Federal Training Committee</p>	<p>The AOA has contributed fully to the mapping of its curriculum to the 10 competencies.</p> <p>Cultural Competence and Cultural Safety is currently mapped to a sub-component of the Advocacy section of the AOA 21 Foundation Competencies, labelled as “Cultural Awareness and Sensitivity”, alongside Advocacy for Individual Patients and for the Community, as illustrated in the table below.</p> <table border="1" data-bbox="451 510 1417 1406"> <thead> <tr> <th colspan="2" data-bbox="451 510 1417 611"> SECTION 1 – FOUNDATION COMPETENCIES <i>Competencies that, together with medical and surgical expertise, are the foundation for quality patient care.</i> </th> </tr> </thead> <tbody> <tr> <td data-bbox="451 611 815 775"> 1.1 Communication </td> <td data-bbox="815 611 1417 775"> Establishing relationships with patients and their families* Eliciting relevant information Sharing information with patients and their families Sharing information with colleagues and others </td> </tr> <tr> <td data-bbox="451 775 815 887"> 1.2 Teamwork and Conflict Management </td> <td data-bbox="815 775 1417 887"> Working with others Handover Conflict management </td> </tr> <tr> <td data-bbox="451 887 815 999"> 1.3 Professionalism </td> <td data-bbox="815 887 1417 999"> Professional and ethical behaviour Commitment to Orthopaedic Surgery as a Profession Health and sustainable practice </td> </tr> <tr> <td data-bbox="451 999 815 1133"> 1.4 Leadership and Organisational Skills </td> <td data-bbox="815 999 1417 1133"> Leadership Organisational practice (including practice management) Cost and allocation of healthcare </td> </tr> <tr> <td data-bbox="451 1133 815 1245"> 1.5 Advocacy </td> <td data-bbox="815 1133 1417 1245"> Advocacy for individual patients Advocacy for the community <u>Cultural awareness and sensitivity</u> </td> </tr> <tr> <td data-bbox="451 1245 815 1406"> 1.6 Education and Research </td> <td data-bbox="815 1245 1417 1406"> Ongoing learning (CPD and integration of evidence) Teaching Critical evaluation of literature Research, development and dissemination of new knowledge </td> </tr> </tbody> </table> <p>An action within the AOA 21 Review Implementation Plan includes a detailed review of the current competency statements in the AOA 21 Curriculum against the newer RACS 10th Competency statements. This work is scheduled for 2024 and will consider an alignment with newer terminology and overall positioning within the Curriculum.</p> <p>AOAs self-assessment of this Condition is “Met for AOA”</p>	SECTION 1 – FOUNDATION COMPETENCIES <i>Competencies that, together with medical and surgical expertise, are the foundation for quality patient care.</i>		1.1 Communication	Establishing relationships with patients and their families* Eliciting relevant information Sharing information with patients and their families Sharing information with colleagues and others	1.2 Teamwork and Conflict Management	Working with others Handover Conflict management	1.3 Professionalism	Professional and ethical behaviour Commitment to Orthopaedic Surgery as a Profession Health and sustainable practice	1.4 Leadership and Organisational Skills	Leadership Organisational practice (including practice management) Cost and allocation of healthcare	1.5 Advocacy	Advocacy for individual patients Advocacy for the community <u>Cultural awareness and sensitivity</u>	1.6 Education and Research	Ongoing learning (CPD and integration of evidence) Teaching Critical evaluation of literature Research, development and dissemination of new knowledge
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<p>New Zealand Board of Orthopaedic Surgery</p>	<p>The NZOA Curriculum has been mapped with the help of RACS. The curriculum and graduate outcomes are not publicly available.</p>														

Standard 3: The specialist medical training and education framework

Areas covered by this standard: curriculum framework; curriculum content; continuum of training, education, and practice; curriculum structure.

1 Summary of significant developments

This section gives the AMC information on the continuing evolution of the college's programs. Please provide a summary of significant developments completed or planned relevant to Standard 3.

<p>Has there been any significant developments made against this standard? <i>If yes, please describe below.</i></p>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
<p>RACS and the societies collaborated to develop the Guide to assessing the Professional Skills Curriculum (3.1 Guide to Assessing the Professional Skills Curriculum) and this has been approved, shared and uploaded to the RACS website.</p> <p>The Cardiothoracic Surgery (1.7a Cardiothoracic Surgery Curriculum Map) and Paediatric Surgery (1.7b Paediatric Surgery Curriculum Map) new competency-based curricula have been drafted and are ready for the next phase of stakeholder engagement.</p> <p>As outlined in Standard 2, curriculum maps for each specialty (1.7 Curriculum Mapping) have been completed outlining the continuum of training, learning opportunities and assessment.</p>		

<p>Requests for additional information from the AMC response to the 2023 monitoring submission:</p> <ul style="list-style-type: none"> • Could the college please comment on the implications for reporting and analysis, considering that not all specialties will utilise the College Trainee Management Platform (TMP)? • Given the heterogeneity in the mapping process, what strategies can be implemented to facilitate a clearer demonstration of how the curricula align with both RACS outcomes and AMC standards. <p><i>Please provide comment below.</i></p>

<p>Training Management Platform (TMP)</p> <p>While some of the specialist societies use the RACS TMP (3.2 TMP Phase 0 Assessment-2023), all specialist societies have data information systems for collecting training data for their training committee or board, designed around the unique needs of each specialty training program. RACS and the specialist societies have an agreed data reporting template that is completed prior to each CSET meeting. This ensures information sharing and that RACS has a clear line of sight and can use data for activities such as providing AMC statistics. A quality improvement activity will be the development of an agreed upon bi-directional data specification and reporting schedule. This can involve sending and receiving data, enabling both parties to share information and updates reciprocally. Ensuring continuous and updated communication and information sharing will improve the Trainee experience and may create efficiencies. For example, this approach could streamline the admission to Fellowship process.</p> <p>In 2023, RACS paused further development of the TMP to assess future requirements (3.3 TMP Assessment: Baseline Features Mapping), as most specialist societies have their own</p>

systems. A way of capturing data from different databases is under consideration, requiring a data dictionary and agreement on a minimum dataset (3.4 [TMP Update part 1](#)). In 2024, RACS confirmed the continued provision of, support for, and improvement of the user experience of the TMP.

A user acceptability study has been undertaken and recommendations made for platform enhancement. Each recommendation is currently being considered for inclusion in the digital services workstream. Where the recommendation requires outside expertise, a business case will be developed to ensure that the enhancements are fit for purpose (functionally and financially).

TMP Phase 0 Assessment – 23 November 2023 ([3.2 TMP Phase 0 Assessment- 2023](#)) provides the background, approach and user experience. RACS has also listed TMP features and bugs after assessment ([3.5 TMP list of Features and Bugs After Assessment](#)).

RACS adopted the agile methodology for the TMP project, featuring iterative releases. Each release encompasses features and user stories, all meticulously tracked via Azure DevOps. This serves as an authoritative platform for managing development, testing, user acceptance testing (UAT), production releases and bug triaging.

A collaborative TMP Reference Group comprising specialist Society Board Chairs and, Trainer / Trainee Board Representatives was established to contribute to the design and user acceptance testing phases. All test cases are not yet systematically documented and stored within Azure DevOps.

In November 2023, a thorough assessment of TMP was conducted in collaboration with the reference group, focusing on user experience and feature prioritisation. This evaluation resulted in a prioritised list of defects and enhancements, categorised into the following features: must have, should have, could have, not required.

RACS has already addressed several defects and user experience issues, and will continue throughout 2024 to focus on the remaining user experience improvements, defect resolutions and essential features, prioritised by the Reference Group.

Work is planned to be undertaken in Q2 and Q3 2024 to consolidate data from disparate systems and migrate it to a centralised platform (Dynamics 365). A business case has been developed and approved, and a project will be run to migrate the data from iMIS to Dynamics 365 and build SET-related data management and reporting capability within the Dynamics 365 platform.

As part of the TMP project, the current SET-related data for 3 of the 13 specialty Societies and Training Boards—the Australian Society of Plastic Surgeons (ASPS), the Board of Cardiothoracic Surgery, and the Committee of Paediatric Surgery—were moved over to Dynamics 365. SET-related data for the remaining 10 societies, as well as historic data for the abovementioned 3 specialties, remain in iMIS to date. These data are currently managed by the RACS SET team through several manual processes.

As part of the project, Dynamics 365 will be established as the database for the new reporting functionality developed using Power BI. Power BI reports and dashboards will read data from Dynamics 365 and produce reports required by the College for various reporting purposes, including AMC accreditation. This will address RACS staff's requirements for reporting purposes and facilitate the delivery of the M & E Framework that RACS has developed in response to the current AMC condition.

The proposed project is considered a high-priority project that must be undertaken to address the risk of data fragmentation and manual processing of data for reporting purposes. RACS intends to decommission iMIS and consolidate all data and technical applications to the one platform (Dynamics 365).

Curricula mapping

RACS has completed standardised mapping of each specialty curricula into an agreed template ([1.7 Curriculum Mapping](#)). All societies have confirmed the mapping for their specialty. This mapping clearly demonstrates how the curricula align RACS outcomes and AMC standards.

The AMC also expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the report.

<p>Has the College made any significant changes affecting the delivery of the program? i.e. changes to the curriculum framework.</p> <p><i>If yes, please describe below the changes and the potential impact on continuing to meet these standards.</i></p>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
<p>As documented above, the Paediatric Surgery and Cardiothoracic Surgery new competency-based curricula have been drafted and are ready for the next phase of stakeholder engagement.</p>		

2 Activity against conditions

The numbering of conditions matches that used in the AMC Accreditation Report.

Please address each of these conditions individually.

Condition 5				To be met by: 2023
Enhance and demonstrate how non-technical competencies are or will be aligned across all surgical specialties including a consideration of the broader patient context. (Standard 3.2)				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
2023 AMC commentary				
<p>As per the response to Conditions 1 and 4, Curriculum maps were provided from AOA, Au GS, OHN, Plastic and Reconstructive surgery, and USANZ. The presentation and content varied, as did the degree to which the non-technical competencies mapped to the RACS competencies,</p> <p>In the College response to Condition 10 it is stated that the New Zealand Board of Orthopaedic Surgery, the Board of Cardiothoracic Surgery, the Board of Vascular Surgery, and the Committee of Paediatric Surgery have confirmed they will implement the PSC. Other STC/Bs are mapping their curricula to the RACS PSC.</p> <p>To address this Condition clear mapping for all specialties is required.</p>				

The RACS PCS mentions the broader patient context under several competencies, so as long as the programs map to the relevant ones in the PCS, this part of the condition will be met.

2024 College Response

To address the requirement for clear mapping of non-technical competencies across SET, RACS has undertaken a comprehensive mapping exercise. This ensures alignment with the RACS professional skills curriculum (PSC) and demonstrates consideration of the broader patient context as required by Standard 3.2.

Mapping of non-technical competencies:

- **Curriculum maps:** For each society, non-technical competencies within their curricula have been mapped to the RACS PSC competencies. Graduate outcomes are clearly defined in terms of both technical and non-technical competencies. The high-level curriculum map ([1.7 Curriculum Mapping](#)) shows how these competencies are integrated and highlights the inclusion of broader patient context considerations.
- **Website transparency:** Each society's public website section includes information on most SET aspects and provides a contact point for questions or feedback. While the full curriculum is not typically available online, stakeholders can access essential details and request further information as needed.

Broader patient context:

- This is emphasised in several RACS PSC competencies, including those related to cultural awareness, health literacy, socioeconomic status, geography and overall health status. These elements have been highlighted in the mapping exercise, ensuring that they are reflected in the curricula of all SET.
- Network-wide efforts—RACS has undertaken significant work to embed the broader patient context within the network and through each society. This effort ensures that the needs of diverse populations are adequately addressed, promoting an inclusive approach to surgical training and patient care.

By thoroughly mapping non-technical competencies and emphasising the broader patient context, RACS ensures that all societies meet the required standards. This ongoing commitment to alignment and transparency supports the consistent delivery of high-quality SET and patient care across diverse settings.

Specialty self-assessment for condition 5

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>All the required competencies will be incorporated into the new Cardiothoracic curriculum including the RACS Professionalism Curriculum.</p> <p>Please also refer to previous standard. It is envisaged that the milestones will be accessed through EPAs as well as through in training assessments. Once the curriculum is complete the Cardiothoracic Training Program will be a competency-based program.</p>
Board of Neurosurgery	<p>The Curriculum for the SET Program in Neurosurgery has been mapped to the RACS Curriculum and thoroughly covers all the competencies.</p>

Committee of Paediatric Surgery	The competencies have been aligned in the curriculum redesign.
Board of Urology	<p>The SET Urology Curriculum provides a detailed overview of the necessary non-technical competencies and is strongly aligned with the Professional Skills Curriculum (PSC) developed by RACS. This ensures consistency in the teaching of non-technical skills across various specialties.</p> <p>Further review will consider integration of aspects of the PSC, reflecting but not reproducing its content whilst also ensuring ongoing alignment with best practices in non-technical skill training.</p> <p>Given the close alignment of the SET Urology Curriculum with the PSC, the Board of Urology anticipates utilising educational resources developed for the PSC.</p>
Board of Vascular Surgery	Vascular has adopted the PSC. Curriculum mapping complete, work in progress to update regulations to reflect a competency-based program.
Australian Board in General Surgery	The General Surgery Curriculum has been mapped to the RACS Curriculum and thoroughly covers all the competencies.
New Zealand Board in General Surgery	The General Surgery Curriculum has been mapped to the RACS Curriculum and thoroughly covers all the competencies.
Board of Otolaryngology Head and Neck Surgery	The Board of OHNS has mapped the curriculum which addresses non-technical competencies. The OHNS curriculum has been mapped against the Professional Skills Curriculum.
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	As a training subcommittee, all curriculum is set and administered by the Board of OHNS (BOHNS). Therefore, NZSOHNS response in relation to curriculum conditions align with BOHNS.
Australian Board of Plastic and Reconstructive Surgery	<p>A revision of the PRS curriculum is currently under way (2024), as was planned and previously communicated to RACS and the AMC. Progress to May 2024 includes:</p> <ul style="list-style-type: none"> • The incorporation of all RACS core competencies (includes a separate chapter 'Cultural Competency and Cultural Safety'); • The mapping of RACS Professional Skills Curriculum is done, where gaps were identified they are corrected; • Peri-operative care is moved to its own new section; • Curriculum map will be updated at the conclusion of the PRS curriculum review to align with the aforementioned changes; • Graduate outcomes statement is updated as a revised draft to align with 10 RACS competencies. <p>All revisions will go through stakeholder consultation before the end of 2024. A final PRS curriculum is expected to be completed and adopted by May 2025.</p>

New Zealand Board of Plastic and Reconstructive Surgery	As previously mentioned, a review of the curriculum is currently being undertaken by the ABPRS and NZPRS and will include clearer mapping of the PRS curriculum to this AMC condition. The review should conclude in 2024 and be implemented in 2025.
Australian Orthopaedic Association Federal Training Committee	<p>Please refer to standard 2 above regarding recommendations of the Strategic Review of AOA 21.</p> <p>The Review found that the AOA 21 curriculum framework is valued and appreciated for a number of its strengths, including:</p> <ul style="list-style-type: none"> • providing a structured guide (pathway for learning and development) for trainers and trainees • emphasising the importance of a broad skill set for generalist practice in any setting • placing a greater focus on foundational competencies/professional skills <p>The Review has not recommended any major structural changes to the curriculum or training program format. Feedback on the Transition to Practice (TTP) Stage of Training, was positive, especially from trainees who reported feeling better prepared for consultant practice at the conclusion of training. However, some elements of TTP required greater clarity and a number of the guideline documents have undergone a refresh to address this.</p> <p>An introduction to CPD has been an element of TTP since its inception and in 2023 the format of the TTP CPD requirements were adapted to confirm with the new CPD Registration Standard along with the broader AOA CPD Program.</p> <p>AOAs Foundation Competencies map to the RACS Professional Skills Curriculum as detailed in the completed mapping template.</p>
New Zealand Board of Orthopaedic Surgery	We are going to have the professional skills curriculum embedded into our competency based curriculum.

Condition 6		To be met by: 2023		
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)				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
2023 AMC commentary				
Under Health Advocacy in the RACS PCS there is an appropriate behavioural marker, as well as associated Stage 1 and 2, and Stage 3 Graduate Outcomes. The marker is:				

Demonstrates a commitment to the sustainability of the healthcare system. Gives due consideration to the financial and environmental effects relating to healthcare sustainability. Does not undertake investigations or procedures that are shown to have minimal or marginal improvement possibilities for patients.

To satisfy this condition, evidence of how each program is reflecting this material in their outcomes and curricula elements is required.

2024 College Response

Understanding the community's needs and expectations for safe, high-quality care is the core mission of RACS. It informs all aspects of professional skills and a comprehensive understanding of perioperative care. RACS has expanded and aligned the curricula across SET to reflect the contribution that Trainees make to the healthcare system's efficiency and sustainability.

Meeting the surgical care needs of the communities and settings RACS serves requires a comprehensive understanding of the health services that provide these and how they adapt in a timely fashion to scientific and academic advances, and changes in demographics, resources, health literacy, morbidity and community expectations. RACS acquires this understanding from its jurisdictional and national stakeholders globally and its accredited health services locally.

Curriculum mapping and integration:

- **Curriculum maps:** RACS has mapped each society's curriculum to the RACS PSC, ensuring the inclusion of non-technical competencies. The comprehensive curriculum map ([1.7 Curriculum Mapping](#)) demonstrates how each program incorporates the required elements.
- **Broader patient context:** The curricula emphasise the broader patient context, including cultural awareness, health literacy, socioeconomic status, geography and health status. These aspects are critical for understanding community needs and ensuring equitable healthcare delivery.

Health advocacy and system sustainability:

- Under health advocacy in the RACS PSC, key behavioural markers include:
 - demonstrating a commitment to healthcare system sustainability
 - considering the financial and environmental impacts of healthcare
 - avoiding procedures with minimal patient benefit.
- Each program reflects these markers within their graduate outcomes and curricula elements, ensuring Trainees are equipped to advocate for and contribute to a sustainable healthcare system.

Continued improvement and evidence: The RACS partnership with health services will be an enabler for continuous improvement. RACS will continue to gather evidence to demonstrate how each program reflects these requirements in their outcomes and curricula elements. The curriculum mapping exercise and ongoing reviews will ensure alignment with the broader goals of healthcare system sustainability and efficiency.

By incorporating these elements into the training programs, RACS ensures that Trainees are prepared to contribute to a high-quality, cost-effective and equitable healthcare system.

Specialty self-assessment for condition 6

Training Committee/Board	Response
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Cardiothoracic Surgery Training Committee	<p>All the required competencies will be incorporated into the new Cardiothoracic curriculum including the RACS Professionalism Curriculum.</p> <p>Please also refer to previous standard.</p> <p>It is envisaged that the milestones will be accessed through EPAs as well as through in training assessments.</p> <p>Once the curriculum is complete the Cardiothoracic Training Program will be a competency-based program.</p>
Board of Neurosurgery	<p>The graduate outcomes for the SET Program in Neurosurgery are clearly stated and mapped against the 10 RACS competencies in the Statement of Competence. This is available on the public facing NSA website with unrestricted access. This includes relevant outcomes in the health advocacy, judgement and clinical decision-making, and leadership and management sections.</p>
Committee of Paediatric Surgery	<p>The Professional Skills Curriculum has been integrated into the new curriculum structure.</p>
Board of Urology	<p>The SET Urology Curriculum emphasises trainees' role in healthcare system efficiency and effectiveness.</p> <p>The Health Advocacy competency expects trainees to advocate for healthcare improvements through an understand of healthcare system structures and points of influence as well as the efficient use of resources. Feedback mechanisms include Observed Patient Consultation and Multisource Feedback, evaluating efficient service delivery and broader healthcare advocacy.</p> <p>The Leadership and Management competency focuses on:</p> <ul style="list-style-type: none"> • Principles of safe, effective, and efficient urologic care. • Developing and implementing strategies for clinical practice improvement. • Identifying opportunities for quality improvement. <p>The Research Requirements have been updated whereby an audit of clinical practice is required by all trainees during the training program. This is a vital skill in ensuring effective and efficient healthcare delivery continues to be delivered.</p>
Board of Vascular Surgery	<p>The graduate outcomes for the SET program are stated and mapped against the ten RACS competencies.</p> <p>Within the vascular curriculum, there is specific emphasis on health economic evaluation of vascular devices, avoidance of 'futile' or non-beneficial surgery, and professional relationships with industry.</p> <p>The annual vascular skills week provides direct teaching/activities related to professional skills, preparation for practice, addressing implicit bias and teamwork.</p>
Australian Board in General Surgery	<p>The General Surgery Curriculum incorporates these areas. Examples include competencies and milestones relating to:</p> <ul style="list-style-type: none"> • Waiting lists • Prioritisation • System factors that may impact access to healthcare. • Factors that may impact on access to healthcare. • Factors include, but not limited to:

	<ul style="list-style-type: none"> ○ Distance ○ Socioeconomic status ○ Disability ○ Cultural background ○ English as a second language ○ Literacy ○ Personal safety such as domestic violence ○ Wellness ○ Environmental ○ Financial
New Zealand Board in General Surgery	<p>The General Surgery Curriculum incorporates these areas. Examples include competencies and milestones relating to:</p> <ul style="list-style-type: none"> ● Waiting lists ● Prioritisation ● System factors that may impact access to healthcare. ● Factors that may impact on access to healthcare. ● Factors include, but not limited to: <ul style="list-style-type: none"> ○ Distance ○ Socioeconomic status ○ Disability ○ Cultural background ○ English as a second language ○ Literacy ○ Personal safety such as domestic violence ○ Wellness ○ Environmental ○ Financial
Board of Otolaryngology Head and Neck Surgery	<p>The Board of OHNS curriculum includes a section within the “Universal Professional Skills” module on ‘Health advocacy’. The wording could be updated to RACS wording if required, but currently includes “Consider costs and benefits of different investigations and management strategies” which is comparable to the marker requirement.</p>
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	<p>The Board of OHNS curriculum includes a section within the “Universal Professional Skills” module on ‘Health advocacy’. The wording could be updated to RACS wording if required, but currently includes “Consider costs and benefits of different investigations and management strategies” which is comparable to the marker requirement.</p>
Australian Board of Plastic and Reconstructive Surgery	<p>A bi-national review committee is currently undertaking a review of the PRS syllabus, assessment strategy and public facing documents (PRS Graduate Outcomes) with respect to the AMC’s accreditation conditions and standards. The review should conclude in 2024 with a community consultation period in early 2025 and formal adoption/ratification of the revised 2019 Curriculum by Mid-2025.</p> <p>Draft revisions (April 2024) were shared with RACS and include:</p> <ul style="list-style-type: none"> ● PRS Graduate Outcomes Statement: now mapped statements to all 10 College competencies.

	<ul style="list-style-type: none"> • Cultural Safety and Cultural Competence has a standalone chapter in the Curriculum document. • RACS Professional Skills Curriculum is completely mapped to the PRS Curriculum. These are non-technical competencies, which are referred to as Essential Surgical Competencies. <p>Consultation will include Australian and Aotearoa New Zealand memberships of RACS PRS community and wider socialisation with interested parties, such as the Australian Indigenous Doctors' Association (AIDA) and relevant groups in Aotearoa New Zealand through the relationship with the NZ PRS Board.</p>
New Zealand Board of Plastic and Reconstructive Surgery	<p>Refer to the response provided by the Australian Board of Plastic and Reconstructive Surgery who are the project lead in the curriculum review project.</p> <p>As previously mentioned, a review of the curriculum is currently being undertaken by the ABPRS and NZPRS and will include clearer mapping of the PRS curriculum to this AMC condition. The review should conclude in 2024 and be implemented in 2025.</p>
Australian Orthopaedic Association Federal Training Committee	<p>The AOA reported that the AOA 21 Training Program covers this requirement as evidenced by the Curriculum Mapping. Further:</p> <ul style="list-style-type: none"> • The Transition to Practice stage of training has been refined in an iterative way as each cohort progresses through the TTP Learning Modules. Feedback from trainees and Fellows continues to suggest these modules are invaluable in preparing trainees for consultant practice. • An outcome of the AOA 21 Review is to continue to refine both material for TTP and Professional Skills. <p>AOAs self-assessment of this Condition is "Met for AOA".</p>
New Zealand Board of Orthopaedic Surgery	<p>The NZOA will be adopting the Professional Skills Curriculum, and it will run alongside the NZOA curriculum.</p>

Condition 7		To be met by: 2023		
Document the management of perioperative medical conditions and complications in the curricula of all specialty training programs. (Standard 3.2.3, 3.2.4 and 3.2.6)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding		X		
2023 AMC commentary				
There was not enough material provided in the submission to assess progress against this condition.				
2024 College Response				

RACS and the societies recognise that perioperative care encompasses all aspects of patient management around the surgical procedure ([3.6 Improving Perioperative Care Before, During and After Surgery](#)). As such, it is integral to the curriculum of all SET programs. Each society has integrated perioperative care into its curriculum, clearly outlining the competencies, experience and performance required of Trainees. RACS has developed a summary of the perioperative learning outcomes, learning opportunities and assessments relevant to perioperative care ([3.7 Summary of Perioperative Care](#)). The overarching curriculum map ([1.7 Curriculum Mapping](#)) and specialty-specific maps demonstrate that elements are included. Each society delineates specific activities and expected outcomes around each dimension, for example the General Surgery SEAM perioperative module ([3.8 General Surgery Peri-Operative Care Map](#)).

The RACS CCrISP (Care of the Critically Ill Surgical Patient) course provides Trainees with essential skills in managing perioperative medical conditions and complications to ensure high standards of patient care.

RACS also understands the pivotal role of a whole-of-system approach to perioperative care, and the primary roles of the health services as accredited by ACQSHC, other medical colleges (most significantly ANZCA), and the other health professionals involved in perioperative care. RACS collaborates with other medical colleges, particularly ANZCA, and health services accredited by ACQSHC to enhance perioperative care. This includes involvement in cross-College projects and the development of the ANZCA perioperative curriculum ([3.9 The Perioperative Care Framework](#), [3.10 ANZCA Perioperative Medicine Curriculum](#)).

Representatives have been involved in projects and committees and the cross-College development of the ANZCA course.

ANZCA is reviewing the co-developed perioperative curriculum ([3.10 ANZCA Perioperative Medicine Curriculum](#)). The RACS representative is the deputy chair of the Vascular Surgery Training Board, Professor Sarah Aitken, FRACS (ANZSVS).

Perioperative care is clearly embedded in the curriculum across all SET programs, with many societies providing dedicated learning resources; however, RACS recommends establishing a working group ([3.11 Terms of Reference for Perioperative Working Group](#)). This working group would review the summary document and identify strategies for addressing any gaps, facilitate sharing of resources across specialties and further enhance perioperative care teaching and learning opportunities to ensure that RACS trainees understand and can respond to the broader perioperative care required for patients. RACS has developed a discussion paper for consideration by societies at the 7 June 2024 workshop. The paper contains a proposal for RACS to establish a dedicated Perioperative Working Group, which will take a broader perspective that includes the full patient journey and not just the surgical procedure.

Specialty self-assessment for condition 7

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>All the required competencies will be incorporated into the new Cardiothoracic curriculum including peri-operative medical conditions and complications.</p> <p>Please also refer to previous standard.</p> <p>It is envisaged that the milestones will be accessed through EPAs as well as through in training assessments.</p> <p>Once the curriculum is complete the Cardiothoracic Training Program will be a competency-based program.</p>

Board of Neurosurgery	<p>The current curriculum for the SET Program in Neurosurgery has a dedicated module titled Perioperative Care, with learning outcomes, which is available on the public facing NSA website with unrestricted access.</p> <p>The Neurosurgical Society of Australasia (NSA) and the SET Board of Neurosurgery have also released a consultation draft of the new curriculum. This is available on the public facing NSA website with unrestricted access. In the Core Principles Module (section 5) there is a dedicated section with learning outcomes in the following areas:</p> <ul style="list-style-type: none"> • Assessment and management • Pre-operative care • Intra-operative care • Peri-operative care • Post-operative care <p>The learning outcomes have not been specifically stated in each individual specialty practice curriculum module in the new curriculum, to prevent repetition throughout, however they are applicable to all modules, and this is stated in the curriculum. In some instances, specialty practice curriculum modules provide selected examples of how the Core Principle learning outcomes apply to that specific area of practice.</p>
Committee of Paediatric Surgery	The curriculum rewrite addresses this objective.
Board of Urology	<p>SET Urology Trainees are expected to acquire thorough knowledge and specific skills in the perioperative care of urology patients. The Foundation Knowledge and Skills section of the SET Urology Curriculum includes a comprehensive overview of the requirements for perioperative care. This is divided into Medical Expertise knowledge (Pre-operative, Perioperative and Post Operative) and Clinical Decision Making.</p> <p>According to the Teaching and Learning Blueprint, knowledge of perioperative care is acquired through the mandatory EMST, ASSET and CCrISP course, tutorials and online modules and self-directed learning. Clinical skills for perioperative care are also acquired through the mandatory courses as well as during clinical rotations, formative feedback tools and self-directed learning.</p>
Board of Vascular Surgery	<p>Perioperative medical is included as a vascular competency in section 2 of the curriculum and has been enhanced since last review.</p> <p>Perioperative Medicine is included in the trainee tutorial program mandatory for trainees to attend.</p> <p>Peri-operative medicine is a key component in the currently under development competency-based program.</p>
Australian Board in General Surgery	<p>AMC recorded this as met for General Surgery in the template provided to ABiGS by RACS.</p> <p>SEAM module entitled Peri-Operative Care is mandatory for all Trainees.</p>

New Zealand Board in General Surgery	<p>AMC recorded this as met for General Surgery in the template provided to AoNZCiGS by RACS.</p> <p>SEAM module entitled Peri-Operative Care is mandatory for all Trainees.</p>
Board of Otolaryngology Head and Neck Surgery	<p>This condition is MET by the Board of OHNS. Peri-operative management is incorporated in the curriculum in the "Patient Management" Module, pages 161 – 171.</p>
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	<p>This condition is MET by the Board of OHNS. Peri-operative management is incorporated in the curriculum in the "Patient Management" Module, pages 161 – 171.</p>
Australian Board of Plastic and Reconstructive Surgery	<p>Peri-operative care exists in the 2019 PRS Curriculum.</p> <p>Part of the current bi-national review of the PRS syllabus is the creation of a standalone specific section on peri-operative care under the PRS surgical principles section of the curriculum.</p> <p>RACS was provided with a copy of the relevant section of the draft revision (April 2024) of the PRS Curriculum for verification. The review is expected to be completed in 2024, followed by a brief community consultation period before adopting in mid-2025.</p>
New Zealand Board of Plastic and Reconstructive Surgery	<p>Peri-operative care exists in the 2019 PRS Curriculum.</p> <p>Part of the current bi-national review of the PRS syllabus is the creation of a standalone specific section on peri-operative care under the PRS surgical principles section of the curriculum.</p> <p>RACS was provided with a copy of the relevant section of the draft revision (April 2024) of the PRS Curriculum for verification. The review is expected to be completed in 2024, followed by a brief community consultation period before adopting in mid-2025.</p>
Australian Orthopaedic Association Federal Training Committee	<p>The AOA has covered perioperative care in the AOA 21 Training Program as evidenced by the Curriculum Mapping. We have noted this condition as "Met" for AOA based on previous report feedback.</p>
New Zealand Board of Orthopaedic Surgery	<p>This is covered in the curriculum.</p>

Condition 8		To be met by: 2023		
Include the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori, along with cultural competence training, in the curricula of all specialty training programs. (Standard 3.2.10)				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
2023 AMC commentary				
<p>Cultural competence and cultural safety are a separate competency in the RACS PCS. This is described as:</p> <p style="padding-left: 40px;">Demonstrates a willingness to embrace diversity among all patients, families, carers and the healthcare team and respects the values, beliefs and traditions of individual cultural backgrounds that are different to their own. Promotes self-reflection, acknowledges their own biases, prejudices and stereotypes, and works to mitigate their effects. Promotes a safe and inclusive healthcare environment and works to eliminate health inequities.</p> <p>There are three behavioural markers with associated Stage 1 and 2 Learning Outcomes and Stage 3 Graduate Outcomes.</p> <p>The RACSTA submission states that <i>“the introduction of Cultural Competence and Safety as a 10th competency has been a positive step in driving education in this oft-underdeveloped domain. RACS has made steps to develop online modules which will allow Trainees to satisfy this competence and direct further learning by individual Trainees. Two modules are currently available, with a further two in development. The roll-out of these modules to all Trainees is an ongoing process and RACSTA is supportive of this process.”</i></p> <p>The curricular material provided shows how some programs are incorporating this competency:</p> <ul style="list-style-type: none"> • USANZ: map has a cultural competence/safety tab and lists associated competencies. The teaching-and-learning blueprint indicates cultural competence and safety are covered in tutorials and online modules, clinical rotations and formative feedback tools. Assessment blueprint includes cultural safety and competence in the EPAs on prostate cancer and stone disease, and cultural safety is included in the neurogenic bladder EPA. • AOA: map has a cultural competence/safety tab and lists competencies. No specific related learning or assessment activities listed yet. • ABPRS: cultural competence and safety are included in the public list of competencies. In the curriculum map cultural safety appears under health advocacy and is part of EPA1, EPA4 and EPA6. <p>RACS has developed several e-learning modules for use in Australia and AONZ. It will be important to see how knowledge gained is put into practice and assessed by the programs.</p> <p>Module completion data give but no denominator to determine percentage.</p> <p>To satisfy the condition, evidence that outcomes and curricular activities are embedded as core in each program is required. A clarification of the responsibility for educating trainees in cultural competence and cultural safety and assuring achievement would be helpful.</p>				
2024 College Response				
<p>RACS is committed to embedding the specific health needs of Aboriginal and Torres Strait Islanders and Māori, as well as cultural competence training, within the curricula of all specialty training programs.</p> <p>The RACS Indigenous Health Committee plays a crucial role in ensuring the integration of Indigenous health needs and cultural competence training into all specialty training programs,</p>				

as mandated by Standard 3.2.10. The committee provides guidance on curriculum development, ensuring that learning objectives and assessments address the unique health challenges faced by Aboriginal and Torres Strait Islanders and Māori. It supports the creation and continuous improvement of e-learning modules on cultural competence and safety, advocates for mandatory training for all Trainees and supervisors, and facilitates specialised workshops to enhance cultural awareness and competency. By engaging with Indigenous communities and key stakeholders, the committee ensures that the training programs are relevant and responsive to the needs of Indigenous populations. Additionally, the committee monitors and evaluates the effectiveness of these initiatives, providing regular reports and developing educational resources to support culturally appropriate care. Through these efforts, the RACS Indigenous Health Committee helps promote health equity and improve healthcare outcomes for Indigenous populations.

Cultural Competence and Safety:

- Cultural competence and cultural safety are defined as key competencies within the RACS PSC elements ([1.6 RACS Professional Skills Curriculum 2023](#)). Trainees must demonstrate these competencies through various learning objectives, activities and assessments. This includes understanding and respecting the values, beliefs and traditions of diverse cultural backgrounds and promoting a safe, inclusive healthcare environment.
- RACS has developed several e-learning modules on cultural competence and safety, accessible to Trainees in both Australia and Aotearoa New Zealand. Completion data for these modules are monitored to ensure widespread uptake.

Each curriculum describes the necessary learning objectives, activities and assessment that Trainees must complete satisfactorily in each specialty to meet this competency.

The HTP Accreditation Standards ([1.1 Hospital Training Post Accreditation Standards](#)) ensure that these curricula are implemented on the ground every day. For instance: 5.3.2 The induction to the surgical unit, includes orientation to relevant cultural safety training and policies on delivering culturally appropriate care, including cultural safety and competency training for patient care, and hospital processes to improve the delivery of Aboriginal and Torres Strait Islander and Māori healthcare. Mandatory Treaty of Waitangi training for Trainees and surgeons in Aotearoa New Zealand is included if not previously completed.

STCs/STBs have provided detailed responses confirming the incorporation of cultural competence and safety into their curricula. This includes specific learning outcomes, dedicated training sessions and the integration of these competencies into overall assessments.

By embedding cultural competence and safety into all SET programs, RACS ensures that Trainees are prepared to meet the diverse health needs of Aboriginal and Torres Strait Islander and Māori populations, promoting health equity and improving healthcare outcomes.

Specialty self-assessment for condition 8

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	All the required competencies will be incorporated into the new Cardiothoracic curriculum including the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori, along with cultural competence training. Please also refer to previous standard. It is envisaged that the milestones will be accessed through EPAs as well as through in training assessments.

	Once the curriculum is complete the Cardiothoracic Training Program will be a competency-based program.
Board of Neurosurgery	<p>The graduate outcomes for the SET Program in Neurosurgery are clearly stated and mapped against the 10 RACS competencies in the Statement of Competence. This is available on the public facing NSA website with unrestricted access.</p> <p>Cultural Competence and Cultural Safety is a dedicated section which includes an outcome specific to understanding the special status of Aboriginal and Torres Strait Islander peoples in Australia, and Māori in Aotearoa New Zealand as Indigenous people as part of patient care.</p>
Committee of Paediatric Surgery	This is covered in the curriculum rewrite.
Board of Urology	<p>Within the Cultural Competence Cultural Safety section of the SET Urology Curriculum, there is a dedicated section relating to the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori people, and cultural competence training is embedded in this.</p> <p>Additionally, trainees in Aotearoa NZ attend a dedicated session at the USANZ Aotearoa New Zealand Section meeting devoted to Māori health, research, and education, designed with Māori input.</p> <p>This Urology curriculum addresses cultural competency training and aligns with the RACS PSC. Whilst Urology does not specifically use the Professional Skills Curriculum, there is a dedicated section within the Urology curriculum dedicated to the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori people, and cultural competence training is embedded in this.</p>
Board of Vascular Surgery	<p>Vascular Surgery aligns with the RACS PSC. Graduate outcomes are mapped against the ten competencies.</p> <p>CV points are awarded for completion of the RACS online cultural competency modules. Currently, modules 1 and 2 are recommended prior to selection and module 3 during training. All modules must be completed prior to graduating from training.</p> <p>Vascular Surgery is currently reviewing their Hospital Accreditation regulations which will include a requirement for Hospitals to demonstrate cultural competency training and mechanisms to support cultural safety.</p> <p>The vascular curriculum/tutorial objectives include care of Aboriginal and Torres Strait Islander people and Māori people.</p>
Australian Board in General Surgery	<p>General Surgery was awaiting finalisation of the RACS Professionalism Curriculum. The 10th competency has now been finalised and the milestones are currently being added to the GSET Curriculum.</p> <p>Several competencies and milestones already include cultural safety. Examples include but not limited to the following:</p>

	<ul style="list-style-type: none"> • Communicates with respect and uses culturally appropriate language. • Applies cultural awareness to everyday healthcare delivery. • Demonstrates the importance of family, carer, community, and cultural background in communication. <p>As of 2024 all Trainees that commence on the Training Program in 2025 will be required to complete the RACS Cultural Competency and Safety online modules.</p>
<p>New Zealand Board in General Surgery</p>	<p>AoNZCiGS awards CV points for entry into training for those applicants who kaupapa to Māori.</p> <p>All training supervisors must complete the RACS Cultural Competency course.</p> <p>The General Surgery curriculum addresses cultural competency training and aligns with the RACS PSC. The 10th competency has been finalised and the milestones are currently being added to the GSET Curriculum.</p> <p>Several competencies and milestones already include cultural safety, examples include but not limited to the following:</p> <ul style="list-style-type: none"> • Communicates with respect and uses culturally appropriate language. • Applies cultural awareness to everyday healthcare delivery. • Demonstrates the importance of family, carer, community, and cultural background in communication.
<p>Board of Otolaryngology Head and Neck Surgery</p>	<p>The curriculum has both specific sections as well as integrated approaches to cultural competencies.</p> <p>The Board of OHNS is committed to ensuring the training program addresses the specific health needs of Aboriginal and Torres Strait Islanders and Māori people.</p> <p>Professor Kelvin Kong is Deputy Examiner in OHNS and collaborated with the Board of OHNS to ensure the curriculum addressed specific needs.</p>
<p>New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee</p>	<p>The NZSOHNS Training Subcommittee awards double CV points for Kaupapa Māori research; research primarily focused on rural medicine and rural kaupapa Māori research.</p>
<p>Australian Board of Plastic and Reconstructive Surgery</p>	<p>The Plastic and Reconstructive Surgery Board has reviewed the Professional Skills Curriculum through the bi-national Curriculum review committee vehicle and closed all document gaps between the two documents. A review in the way competence is taught and assessed in relation to the indigenous population's needs will be undertaken in 2024 as part of the holistic assessment strategy review. The existing P&RS Curriculum already covers indigenous health needs in terms of non-technical competencies Health Advocacy, Communication and Teamwork and Leadership. For example:</p> <ul style="list-style-type: none"> • "Display respect towards people from other cultures and care... without prejudice"

	<ul style="list-style-type: none"> • "Demonstrate a knowledge of the history and culture of the Indigenous populations of Australia and New Zealand and how this may impact on health outcomes." • "Explain the health inequalities and inequities experienced by Indigenous populations." • "Incorporate knowledge about medical conditions known to be more prevalent in Indigenous populations, when formulating a diagnosis and developing a management plan." and so on. <p>These examples and previously missing assessment standards have been escalated to a chapter dedicated to the 10th competency, as per the responses to Conditions 4, 6 and 7.</p>
New Zealand Board of Plastic and Reconstructive Surgery	<p>The NZBPRS is a partner in the bi-national review of the PRS curriculum review referred to by the ABPRS above.</p> <p>NZAPS has asked RACS for guidance on approved cultural competency and cultural safety training courses/modules applicable for Aotearoa New Zealand which are considered acceptable by RACS to meet this criterion.</p> <p>NZ PRS SET trainees include a presentation on cultural competency and cultural safety at their annual SET conference.</p>
Australian Orthopaedic Association Federal Training Committee	<p>The AOA 21 Curriculum has been mapped to the 10th Competency as outlined at Condition 4.</p> <p>The AOA Federal Training Committee recently completed the RACS Cultural Safety and Cultural Competency training workshop. The Federal Training Committee previously mandated completion of the RACS online modules for trainees. Given a fairly low uptake of the modules by trainees, the FTC recently updated the training program requirements to explicitly include the mandatory requirement for completion. This has since been communicated to trainees.</p> <p>The Federal Training Committee had previously recommended completion of Cultural Safety and Cultural Competency training as useful CPD for surgeons involved in training. This has recently been approved as a mandatory eligibility requirement for Directors of Training and Trainee Supervisors. This change will shortly be reflected in PDs for these roles and a supporting online module is in development. This module will explain the requirement and facilitate uploading of evidence of completion of training in this area. This in turn will facilitate effective reporting on compliance with this requirement.</p>
New Zealand Board of Orthopaedic Surgery	<p>The NZOA will be using the Professional Skills Curriculum.</p> <p>The NZOA have a Māori cultural adviser who attends selection, training events along with attending the NZOA ASM.</p> <p>The NZOA supports compulsory cultural safety training for supervisors and trainers.</p>

Condition 9		To be met by: 2023		
In conjunction with the Specialty Training Boards, develop a standard definition across all training programs of 'competency-based training' and how 'time in training' and number of procedures required complement specific observations of satisfactory performance in determining 'competency'. (Standard 3.4.2)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
2023 AMC commentary				
<p>This condition originated in 2017 and reflects RACS's intention that training be 'competency-based', yet there did not seem to be a shared view of the implications of this pedagogy nor reflection in program documents. A 2016 review showed that workplace-based assessment in SET was not being used appropriately, with the relationship between work and end-of-term assessment poorly understood. A particular concern of the accreditation team in 2017 was feedback that competent Trainees could be held back from progressing for minor time- or number of procedure-based breaches.</p> <p>Considerable work has been done by RACS and the STBs to develop an extensive and informative report, which produced 3 evidence- and experience-based recommendations for the definition, which are principle-based. A set of principles is identified in Figure 4 of this submission. These are currently under consideration and the result will be of great interest.</p> <p>Given prior concern, the College could consider whether mitigation of unnecessary delay in training is encapsulated adequately in the principles and recommendations.</p>				
2024 College Response				
<p>RACS has made significant progress in developing and implementing a standard definition of 'competency-based training' across all SET programs. The definition of competency-based medical education (CBME) has been agreed upon by all societies (3.12 Approved Definition of CBME). This standard definition ensures consistency across SET.</p> <p>Some STCs/STBs have implemented competency-based programs, while others have adopted a hybrid approach that combines time-based and competency-informed curricula. One challenge in this context is balancing the time spent in training and logged procedures with competency-based assessments. While time-based elements provide a structured learning timeline, competency-based assessments focus on the actual skills and performance demonstrated by the Trainee.</p> <p>RACS recognises the importance of mitigating unnecessary training delays. Timely admission to Fellowship is crucial for Trainees and health services. Trainees often secure consultant positions based on expected Fellowship completion, impacting relocation and life changes. As part of the QI plan, RACS and the societies will review the Fellowship admission process to ensure Trainees progress without undue hindrance while meeting all competency requirements.</p> <p>The development of a standard definition and the integration of competency-based assessments across specialties ensure that Trainees are well-prepared for independent practice. Continuous monitoring and adjustments will address any remaining challenges, ensuring a balanced and effective training program.</p>				

Specialty self-assessment for condition 9

Training Committee/Board	Response

Cardiothoracic Surgery Training Committee	CSET Endorsed the competency-based definition in October 2023 and the Committee has adopted this.
Board of Neurosurgery	<p>Time in training</p> <p>As stated in the Training Program Regulations and the curriculum, the SET Program in Neurosurgery is structured on a three-level sequential curriculum to facilitate the cumulative acquisition of the experience, knowledge, skills, and attributes aligned with the overall objective of the SET Program.</p> <p>The optimal time required to achieve the SET Program in Neurosurgery graduate outcomes is five years. While five years is the optimal training time, the SET Program in Neurosurgery has a flexible structure which allows trainees to progress at different rates according to their ability to achieve the training requirements and graduate outcomes. The SET Program in Neurosurgery also allows for flexible training and possible interruption, to accommodate individual circumstances as detailed in the Training Program Regulations.</p> <p>As such, the SET Program in Neurosurgery can be completed in a minimum of five years full-time equivalent but can also extend to a maximum of nine calendar years from commencement of training, subject to satisfactory progression through the levels in the timeframes outlined in the Training Program Regulations. The maximum training times do not include periods of approved interruption from the SET Program in Neurosurgery for parental responsibilities, carer responsibilities or health reasons.</p> <p>This flexibility is evident in the spread of trainees in the SET Program in Neurosurgery which include trainees beyond the optimal five years.</p> <p>Number of procedures</p> <p>Trainees must maintain an operative experience log of all procedures that they participate in as part of the SET Program in Neurosurgery during active Clinical Terms. This information is assessed against minimum case requirements to determine suitability of the experience to meet the standards in the SET Program.</p> <p>During 2019 a comprehensive logbook analysis was undertaken by the NSA to help inform the curriculum review for the SET Program in Neurosurgery. Based on the analysis, trainees perform an average of 1,496 cases during the SET Program in Neurosurgery (759 as primary surgeon). In Basic Training, the average is 262 cases per year. In Intermediate Training the average is 308 cases per year and in Advanced Training the average performed is 309 cases per year. This then informed the training requirements, as they relate to case requirements which are outlined in the Training Program Regulations.</p>

Committee of Paediatric Surgery	Paediatric Surgery is a competency-based training program.						
Board of Urology	<p>Work was undertaken by RACS to demonstrate compliance with this condition. The Board of Urology was consulted and provided feedback to RACS.</p> <p>In 2024, the SET Urology Training Program transitioned to a more competency-based program providing greater clarity regarding the expectations of trainees at the various stages. It also includes more targeted workplace-based assessments to assist in assessing competence.</p> <p>The new program comprises 3 stages of training: Basic, Intermediate and Advanced and enables trainees to learn at their own pace (to a point) with progression based on minimum time and competence. The program comprises sequential learning and assessment with defined points to reflect on progress. Whilst the first stage is relatively short, this is to re-assess suitability. All high stakes decisions (such as progression) will be made by Regional Training Committees and ratified by the Board of the Urology.</p> <p>Trainees will be required to complete 10 Entrustable Professional Activities (EPAs). These are discrete tasks or responsibilities that supervisors entrust a trainee with unsupervised once they have reached competence. Each EPA requires multiple competencies (abilities) and multiple episodes and types of assessment to confirm 'entrustment'. The EPAs that have been identified to cover the breadth of the curriculum are as follows:</p> <table border="1" data-bbox="555 1216 1423 1563"> <tr> <td data-bbox="561 1225 836 1350">Must be completed in Basic</td> <td colspan="2" data-bbox="842 1225 1417 1350">Any 3 EPAs completed during Intermediate Remaining 4 EPAs completed in Advanced</td> </tr> <tr> <td data-bbox="561 1359 836 1554"> <ul style="list-style-type: none"> • Renal Colic • Acute Scrotum • Acute Urinary Retention </td> <td data-bbox="842 1359 1075 1554"> <ul style="list-style-type: none"> • Definitive Stone • Localised Prostate Cancer • Renal Mass </td> <td data-bbox="1082 1359 1410 1554"> <ul style="list-style-type: none"> • Lower Urinary Tract Symptoms • Haematuria • Neurogenic Bladder • Muscle Invasive Bladder Cancer </td> </tr> </table> <p>The revised training program was launched in 2024 as follows:</p> <ul style="list-style-type: none"> • Trainees who commenced in 2024 are undertaking the revised training program • Trainees who completed SET1 or SET2 in 2023 have transitioned into the revised program • Trainees who completed SET3 or SET4 in 2023 have remained in the current training program 	Must be completed in Basic	Any 3 EPAs completed during Intermediate Remaining 4 EPAs completed in Advanced		<ul style="list-style-type: none"> • Renal Colic • Acute Scrotum • Acute Urinary Retention 	<ul style="list-style-type: none"> • Definitive Stone • Localised Prostate Cancer • Renal Mass 	<ul style="list-style-type: none"> • Lower Urinary Tract Symptoms • Haematuria • Neurogenic Bladder • Muscle Invasive Bladder Cancer
Must be completed in Basic	Any 3 EPAs completed during Intermediate Remaining 4 EPAs completed in Advanced						
<ul style="list-style-type: none"> • Renal Colic • Acute Scrotum • Acute Urinary Retention 	<ul style="list-style-type: none"> • Definitive Stone • Localised Prostate Cancer • Renal Mass 	<ul style="list-style-type: none"> • Lower Urinary Tract Symptoms • Haematuria • Neurogenic Bladder • Muscle Invasive Bladder Cancer 					
Board of Vascular Surgery	An updated curriculum incorporates elements of competency-based training. A time limitation on training will remain but trainees						

	<p>will have the flexibility to accelerate their personal progress. A review of the training regulations is currently under way to incorporate regular and appropriate use of WBAs.</p> <p>Definitions align with RACS principles.</p> <p>In a move towards competency training, Vascular surgery has implemented, work-based assessments replacing the mini-CEX and DOPS in 2024 allowing for greater support and encouragement of trainees' performance. The SET Training Regulations for Vascular Surgery are currently under development with the intention to move to a competency-based training program that aligns to the updated curriculum. Implementation is expected by 2027.</p> <p>Having noted reduced numbers in Aotearoa New Zealand surgical applicants, Vascular Surgery has developed an initiative to ensure trainees are selected for Aotearoa New Zealand. This initiative will be implemented for the 2025 selection process.</p>
Australian Board in General Surgery	<p>The ABiGS contributed feedback to the RACS definition.</p> <p>GSET is a competency-based training program whilst also be cognisant of the time-based considerations.</p>
New Zealand Board in General Surgery	<p>AoNZCiGS contributed feedback to the RACS definition.</p> <p>GSET is a competency-based training program but one that is also cognisant of the time-based consideration.</p>
Board of Otolaryngology Head and Neck Surgery	<p>The Board of OHNS was an early adopter of competency-based training.</p> <p>Based on AMC commentary, it is understood that RACS will consider whether mitigation of unnecessary delay in training is encapsulated adequately in the principles and recommendations.</p>
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	<p>As a training subcommittee, all curriculum is set and administered by the Board of OHNS (BOHNS). Therefore, NZSOHNS response in relation to curriculum conditions align with BOHNS.</p>
Australian Board of Plastic and Reconstructive Surgery	<p>The ABPRS has:</p> <ul style="list-style-type: none"> • Contributed to the standard definition document developed by RACS to define Competency Based Medical Education. • Intrinsically linked work-place based assessments (WBAs) to entrustable professional activity (EPA) assessments. Further publishing a guide to both the number of assessments to be completed, the stage of training linkage to Early SET milestones, assessment of subspecialty training and the appropriateness of clinical scenarios to the kinds of WBAs and EPAs being assessed.
New Zealand Board of Plastic and Reconstructive Surgery	<p>The NZ PRS SET program has not adopted competency-based training, nor does it have prescribed minimum number of procedures required as a component of training. The Board</p>

	supported the standard definition of competency based medical education developed by RACS and approved by CSET.
Australian Orthopaedic Association Federal Training Committee	<p>The AOA have:</p> <ul style="list-style-type: none"> • Contributed to the development of the standard definition document developed by RACS. • A project that is currently underway as an implementation action of the AOA 21 Review to facilitate provision of more guidance to trainees and AOA Directors of Training regarding an appropriate range of procedural experience for Level 1 procedures (those procedures that every trainee graduating from the AOA 21 training program will be able to competently perform on their first day of independent practice) in the curriculum.
New Zealand Board of Orthopaedic Surgery	<p>The NZOA is developing a competency-based training program in line with the AOA 21.</p> <p>We are working on a hybrid competency -based and time in training model as we feel that will work best for us.</p>

Standard 4: Teaching and learning approach and methods

Areas covered by this standard: teaching and learning approach; teaching and learning methods.

1 Summary of significant developments

This section gives the AMC information on the continuing evolution of the college's programs. Please provide a summary of significant developments completed or planned relevant to Standard 4.

Has there been any significant developments made against this standard? <i>If yes, please describe below.</i>	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No change

The AMC also expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the report.

Has the College made any significant changes affecting the delivery of the program? i.e. changes to teaching and learning approaches <i>If yes, please describe below the changes and the potential impact on continuing to meet these standards.</i>	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No change

2 Activity against conditions

The numbering of conditions matches that used in the AMC Accreditation Report.

Please address each of these conditions individually.

Condition 10		To be met by: 2023		
For all specialty training programs develop curriculum maps to show the alignment of learning activities and compulsory requirements with the outcomes at each stage of training and with the graduate outcomes. This could be undertaken in conjunction with the curricular reviews that are currently planned or underway. (Standard 4.1.1)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
2023 AMC commentary				
Like the comments earlier (Standard 3), the AOA Federal Training Committee, the Board of Urology, the Australian Board of Plastic & Reconstructive Surgery, the Australian Board in General Surgery and the Board of Otolaryngology Head and Neck Surgery have completed their mapping. Mapping is underway for the remaining STC/Bs.				

It is notable that the New Zealand Board of Orthopaedic Surgery, the Board of Cardiothoracic Surgery, the Board of Vascular Surgery, and the Committee of Paediatric Surgery have confirmed they will implement the PSC. Other STC/Bs are mapping their curricula to the RACS PSC.

To close this condition needs a satisfactory map for each of the 13 programs.

2024 College Response

RACS has developed curriculum maps for each specialty training program and the entire SET endeavour. All societies have confirmed the accuracy of these mappings. This mapping process clearly demonstrates how the curricula elements of graduate outcomes, learning opportunities and assessment align with the RACS 10 competencies ([1.7 Curriculum Mapping](#)).

Societies actively review their technical curricula to ensure they are up to date in an ever-changing environment, recognising innovations, evolving community expectations and the role of the healthcare system.

Specialty self-assessment for condition 10

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	This will be covered as per above and as part of the curriculum review and mapping to the RACS Professional Skills Curriculum. We will also actively work with RACS on the monitoring and evaluation project which is driven by RACS.
Board of Neurosurgery	The NSA and SET Board of Neurosurgery have been conducting a review of the curriculum for the SET Program in Neurosurgery. The new curriculum articulates graduate outcomes in the RACS competency areas, which include eight professional competencies and two technical competencies (see section 2 on Graduate Outcomes). The new curriculum includes a map of the graduate outcomes against the learning and assessment tools.
Committee of Paediatric Surgery	This is covered as part of the curriculum rewrite.
Board of Urology	As outlined in the AMC Commentary of 2023, the Board of Urology has completed the mapping exercise.
Board of Vascular Surgery	In the move to competency-based training, a review of the SET program is under way. Stages of training will be determined as early-, mid- and late SET and will integrate learning and graduate outcomes at each stage. Outcomes are mapped back to the ten competencies. Workplace-based assessment tools will be applied to determine progression and it is anticipated the revised program will be implemented in 2027.
Australian Board in General Surgery	AMC report General Surgery curriculum map is complete.

	The mapping was undertaken through an MS Access database which is searchable and can be exported to Excel for the public to search. The map includes the following elements mapped to each competency, sub-competency, and milestones - link to syllabus, learning opportunities, assessments (including the specific EPAs, PBAS, SEAM modules), and keywords.
New Zealand Board in General Surgery	AoNZCiGS have completed curriculum mapping in conjunction with ABiGS.
Board of Otolaryngology Head and Neck Surgery	The OHNS curriculum has been mapped.
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	As a training subcommittee, all curriculum is set and administered by the Board of OHNS (BOHNS). Therefore, NZSOHNS response in relation to curriculum conditions align with BOHNS.
Australian Board of Plastic and Reconstructive Surgery	Mapping already completed. As per response to self-assessment for condition 4, the bi-national curriculum review committee is currently holistically reviewing the PRS syllabus and assessment strategy (publication aiming for Mid-2025).
New Zealand Board of Plastic and Reconstructive Surgery	The NZBPRS completed the curriculum mapping at the end of 2023 and provide this to RACS.
Australian Orthopaedic Association Federal Training Committee	<p>The Recommendations of the Strategic Review of AOA 21 include a purposeful review of many of the mandatory training program requirements of the AOA 21 Training Program. Training Program requirements currently include completion of a number of courses and exams at significant expense to the trainees. The FTC has agreed to review each of these training program requirements to ensure they remain fit for purpose.</p> <p>The FTC also supported a recommendation for all Bone School sessions to be supervised by a consultant. It is anticipated that this will not only ensure a more standardised delivery of Bone School across the country but also amplify the educational impact for trainees leading and attending these sessions, by combining registrar leadership with consultant supervision.</p> <p>The FTC is also actively striving to support the work and professional development of directors of training and trainee supervisors in order to better equip them for their training roles. This is an area of immediate priority for which work is progressing at pace. A comprehensive online Guide for Directors of Training (DoTs) is at an advanced stage of development. This resource will comprise 12 self-paced modules, of which nine focus on the responsibilities outlined in AOA's position description for DoTs. The first tranche of six modules is due for imminent release and will be followed by a further six in approximately June 2024. This will be followed by a similar set of modules for Trainee Supervisors.</p>

	<p>The AOA has completed RACS' AMC Curriculum Mapping Template. A project is currently underway as an implementation action of the AOA 21 Review to review and update the Expectations of Performance document which details expectations for each stage of training.</p> <p>AOAs self-assessment of this Condition is "Met for AOA"</p>
New Zealand Board of Orthopaedic Surgery	The NZOA Curriculum has been mapped. The Curriculum is aligned with the AOA21.

Standard 5: Assessment of learning

Areas covered by this standard: assessment approach; assessment methods; performance feedback; assessment quality.

1 Summary of significant developments

This section gives the AMC information on the continuing evolution of the college's programs. Please provide a summary of significant developments completed or planned relevant to Standard 5.

<p>Has there been any significant developments made against this standard?</p> <p><i>If yes, please describe below.</i></p>	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No change
<p>RACS has mapped the assessment processes (5.1 Assessment Mapping) for each specialty training program to better understand the overall similarities and differences, as well as to provide a clearer overall description publicly. These data are available on each society's website but not collectively across all societies. The mapping has been provided to societies to promote transparency, information sharing and continuous quality improvement in assessment practices across SET.</p> <p>FEX exam</p> <p>Assessment quality</p> <p>RACS is committed to ensuring Trainees have opportunities to provide feedback to quality improve our assessments. RACS has recently updated the FEX evaluation survey to ask candidates how their workplace-based assessments helped them prepare for the exam. Responses will be reviewed and shared with societies after the FEX in September.</p> <p>RACS has a quality assurance process involving independent observers (Fellows, supervisors, medical educators and senior college management) who monitor FEX oral vivas to ensure examiners adhere to protocols and to identify potential improvements to processes or examiner training. The most recent FEX Observer Report (September 2023) is attached (5.2 FEX Observer Report). A mandatory e-learning module for all independent observers, developed in late 2023, ensures a standard approach to this important role, with 100% compliance required. Completion of this training is reported to the Court of Examiners before each exam.</p> <p>New examiners complete four e-learning modules and attend a 2-hour webinar. Examiners undergo refresher training at three and six years, with compliance reviewed annually. Non-compliant examiners are contacted by a senior examiner. To date, RACS has achieved 100% compliance, as examiners must complete training to be eligible.</p>		

In November 2022, RACS engaged Professor Lambert Schuwirth to present on 'best practices in assessment' to senior examiners. Two priority areas were identified: blueprinting and marking rubrics. By November 2023, senior examiners received feedback on their blueprints, most of which were mapped against competencies and question levels. A marking rubric template was discussed, and it was agreed that sharing of rubrics between each specialty would be undertaken to help achieve best practice. Sharing with RACS has occurred; sharing across specialties will occur after the May examination. The principal educator will provide feedback at that time.

Specialties have shared examples of marking rubrics, agreeing that each specialty would clearly articulate what scores of 4, 3, 2 and 1 represent for examiners to follow. Four of the nine marking rubrics, although in slightly different formats, have all clearly articulated the meaning of each mark as agreed. This represents a significant improvement in sharing across the network.

Blueprints are developed by senior examiners. Components of the exam are then developed and mapped to the blueprint and the RACS PSC competencies. We have provided samples of the FEX marking rubric ([5.3 Sample FEX marking Rubric](#)) and a deidentified FEX blueprint ([5.4 Sample De-identified FEX Blueprint](#)).

RACS collects feedback from candidates after each Fellowship examination and reports it at the annual Executive Court of Examiners Workshop. This feedback is filtered by specialty and shared with examiners at annual specialty exam writing workshops, providing candidates a direct voice to address specialty-specific issues ([5.5 May Fellowship Exam Candidate Feedback](#), [5.6 September Fellowship Examination Candidate Feedback](#)).

Assessment approach

RACS has approved the uncoupling of the written and oral viva components of the FEX, to be implemented in 2025. Candidates who fail both written examinations will not proceed to the oral examinations. A successful pilot of the uncoupling occurred in May 2024 to ensure seamless implementation from 2025. Trainees have been notified via the RACS website and other communications (<https://www.surgeons.org/Examinations/Fellowship-Examination> – see 'Fellowship Examination in 2025 – Written Examination as a pre-requisite to the Clinical/Viva Examinations' subheading).

In response to Trainee feedback and RACSTA, RACS has updated the website to provide greater awareness of the support options for failing candidates. Additional supports will be in place for the September FEX and will be communicated to Trainees. RACSTA feel strongly about the need for improved Fellowship Examination support, and it will be discussed with RACS at the upcoming June meeting in order to guide tangible solutions.

For Vascular Surgery, the clinical examination (CE) is currently an early training requirement for completion by SET 2. Vascular Surgery is considering aligning with other specialties by making the CE a prerequisite for selection, with a transition period to ensure applicant numbers are not impacted.

In moving towards competency-based training, Vascular Surgery has implemented work-based assessments to replace the mini-CEX and DOPS in 2024, allowing for greater support and encouragement of Trainee performance.

Australian Orthopaedic Association

Assessment is a key area of focus for the Recommendations of the Strategic Review of AOA 21. Whilst the Review recommended maintaining the current WBA requirements for module sign-off, performance appraisals and reviews there was a call to refine WBA and feedback processes, in acknowledgment of the assessment burden created by the AOA 21 assessment strategy. Prof Ashman, AOA's Dean of Education has been leading a small

working group in a review of workplace-based assessment processes with this in mind. A proposal is in development and will be considered by the FTC in coming months.

The Review highlighted the importance of communicating the purpose and value of the WBA Assessment Framework to trainers and trainees and this will be an ongoing process. It is anticipated that an enhanced understanding of the purpose and value of tools used to maintain oversight of progression and competence, may improve 'buy in' and reduce 'gaming' and regional variation. Specific consideration is being given to provision of more explicit guidance to trainees and AOA Directors of Training regarding an appropriate range of procedural experience for Level 1 procedures (those procedures that every trainee graduating from the AOA 21 training program will be able to competently perform on their first day of independent practice) in the curriculum.

<p>Has the College postponed or changed the format or methods of any examinations and work-based assessment since the last monitoring submission?</p> <p><i>If yes, please describe below:</i></p> <ul style="list-style-type: none"> • <i>plans and policies for organising the logistics and resources for these examinations</i> • <i>any impacts to trainees' progression through training program</i> 	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<p>RACS will be moving to a 2-day format for the Fellowship examination in 2025. There will be no other change to the format of the individual examination components. Trainees have been notified of this on the website and via other direct communications.</p>		

The AMC also expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the report.

<p>Has the College made any significant changes affecting the delivery of the program? i.e. changes to assessment methods.</p> <p><i>If yes, please describe below the changes and the potential impact on continuing to meet the standards.</i></p>	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No change
<p>In moving towards competency-based training, work is in progress to update the SET training regulations for Vascular Surgery to align with the updated curriculum. These updated regulations are anticipated for implementation in 2027.</p>		

2 Activity against conditions

The numbering of conditions matches that used in the AMC Accreditation Report.

Please address each of these conditions individually.

Nil Conditions Remain.

3 Statistics and annual updates

- Please provide data **for 2023** in the table showing each summative assessment activity (e.g. Part 1 and Part 2 exams) and the number and percentage of trainees who passed at their first, second, third and subsequent attempts.

Assessment Activity	1 st attempt			2 nd attempt			3 rd and subsequent attempt			Total		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Generic Surgical Science Examination (GSSE)	576	399	69.3%	116	52	44.8%	140	44	31.43%	830	495	59.60%
Clinical Examination (CE)	291	200	68.7%	70	46	65.7%	27	20	74.07%	388	266	68.60%
Cardiothoracic Surgical Sciences and Principles Examination Part 1	6	5	83.3%	1	1	100.0%	0	0		7	6	85.70%
Cardiothoracic Surgical Sciences and Principles Examination Part 2	9	8	88.9%	1	1	100.0%	0	0		10	9	90.00%
Orthopaedic Principles & Basic Science Examination	65	65	100.0%				1	1	100.00%	66	66	100.00%
Otolaryngology, Head and Neck Surgery Surgical Science Examination	20	18	90.0%	4	3	75.0%	0	0		24	21	87.50%
Paediatric Anatomy and Embryology Examination	8	8	100.0%	2	2	100.0%	2	2		12	12	100.00%
Paediatric Pathophysiology Examination	3	3	100.0%				0	0		3	3	100.00%
Plastic and Reconstructive Surgical Science & Principles Examination	33	21	63.6%	11	11	100.0%	0	0		44	32	72.70%
Urology Surgical Sciences Examination	20	17	85.0%	3	3	100.0%	0	0		23	20	87.00%
Vascular Surgical Sciences Examination	12	11	91.7%				0	0		12	11	91.70%
Cardiothoracic Fellowship Examination	9	4	44.4%	7	4	57.1%	5	3	60.00%	21	11	52.40%
General Surgery Fellowship Examination	115	83	72.2%	31	19	61.3%	26	13	50.00%	172	115	66.90%
Neurosurgery Fellowship Examination	9	8	88.9%				0	0		9	8	88.90%
Orthopaedic Fellowship Examination	78	62	79.5%	13	9	69.2%	5	3	60.00%	96	74	77.10%

Otolaryngology Fellowship Examination	20	17	85.0%	2	2	100.0%	4	2	50.00%	26	21	80.80%
Paediatric Fellowship Examination	4	2	50.0%	3	1	33.3%	4	2	50.00%	11	5	45.50%
Plastics Fellowship Examination	18	13	72.2%	8	5	62.5%	4	2	50.00%	30	20	66.70%
Urology Fellowship Examination	21	19	90.5%	3	1	33.3%	3	2	66.67%	27	22	81.50%
Vascular Fellowship Examination	9	7	77.8%	1	1	100.0%	4	2	50.00%	14	10	71.40%
TOTAL	1326	970	73.2%	276	161	58.3%	225	96	42.67%	1825	1227	67.20%

- In the table below, please provide combined summative assessment data **for 2023** showing the number and percentage of the cohort who passed at their first, second, third and subsequent attempts.

Cohort	1 st attempt			2 nd attempt			3 rd and subsequent attempt			Total		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Aboriginal and/or Torres Strait Islander trainees	8	5	62.5%	1	1	100.0%	1	0	0.00%	10	6	60.00%
Māori trainees*	23	17	73.9%	6	3	50.0%	4	2	50.00%	33	22	66.70%
Pasifika trainees*	14	12	85.7%				1	1	100.00%	15	13	86.70%
Specialist International Medical Graduates	15	9	60.0%	8	2	25.0%	13	6	46.15%	36	17	47.20%

*One candidate reported both Māori and Pasifika ethnicity, they are counted in both groups.

Note: Ethnicity data are voluntarily self-reported, thus incomplete.

- Please provide details on the College’s examination contingency plans for **2024** and how these are communicated to trainees.

College response
<p>As with any large-scale assessment process, not all potential situations can be predicted. However, RACS has standard contingency measures in place, which are updated in response to new emergent situations such as COVID-19. These measures include:</p> <ul style="list-style-type: none"> • Backup computer hardware and digital services personnel are on site during the days of the examination. Testing of this contingency measure occurs prior to the examination. • An executive of the Court of Examiners serves as the key control point for each day of the examination and is responsible for decisions regarding pausing examinations, extending time, etc., depending on the situation. All staff and senior examiners are informed of the contact person at the pre-examination briefing and court meeting. A backup executive is also allocated in the unlikely event the designated person becomes unavailable. • RACS successfully conducted all examinations during COVID-19; these plans would be reimplemented should a similar situation arise. • Established communication protocols and up to date information and contact lists. Examination candidates would receive information via the RACS website, pre-examination webinar and direct communication, depending on the situation. • A post-examination debrief highlights lessons learned and identifies any necessary process or communication changes in responding to contingencies.

Standard 6: Monitoring and evaluation

Areas covered by this standard: program monitoring; evaluation; feedback, reporting and action.

1 Summary of significant developments

This section gives the AMC information on the continuing evolution of the college’s programs. Please provide a summary of significant developments completed or planned relevant to Standard 6.

<p>Has there been any significant developments made against this standard? <i>If yes, please describe below.</i></p>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
<p>RACS has made significant progress in developing the M & E Framework, which has been a work-in-progress reported in previous AMC submissions. While all specialist societies have independently monitored and evaluated their SET programs, RACS acknowledges that consistent, timely and robust reporting across SET is currently inadequate. Moving forward, RACS and the societies are committed to implementing a unified M & E Framework. This framework will standardise reporting processes while allowing for differentiation in approach, ensuring timely and comprehensive evaluations across all STCs/STBs. This will provide RACS with line of sight that the standards are being met for all SET programs.</p>		

Since the last AMC submission, the Education Committee has approved the M & E Framework ([1.2 Monitoring and Evaluation Framework](#)) and its implementation plan, with support from all societies following extensive internal and external consultation. The implementation plan was approved by CSET in June 2024 ([6.1 M and E Implementation Plan](#)).

RACS expects to have the minimum dataset agreed upon and to advance to the evaluation aspects of the framework. A draft monitoring prototype, including the minimum dataset required for monitoring, has been prepared for consultation ([6.2 Draft M and E Prototype](#)). Additionally, a project tracker is in place to manage this and other work ([1.17 Draft Project Tracker](#)).

The process has been conducted methodically and responsibly, considering the sensitivity of the information collected and the challenges of de-identification for smaller societies. RACS is currently exploring a feasible IT solution to support the implementation of the M & E Framework and the reporting.

The AMC also expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the report.

<p>Has the College made any significant changes affecting the delivery of the program? i.e. changes to processes for monitoring and evaluation of curriculum content, teaching and learning activities, assessment, and program outcomes.</p> <p><i>If yes, please describe below the changes and the potential impact on continuing to meet these standards.</i></p>	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No change

2 Activity against conditions

The numbering of conditions matches that used in the AMC Accreditation Report.

Condition 11				To be met by: 2023
Develop an overarching framework for monitoring and evaluation, which includes all training and educational processes as well as program and graduate outcomes. (Standard 6.1, 6.2 and 6.3)				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
2023 AMC commentary				
The College continues with the large and complex task of development of a Monitoring and Evaluation framework. The College has noted it has now approved the Monitoring and Evaluation framework as of 22 September 2023.				
2024 College Response				
RACS has developed and approved its overarching M & E Framework (1.2 Monitoring and Evaluation Framework) and the implementation plan for its monitoring and reporting obligations (6.1 M and E Implementation Plan). Progress is well advanced towards a prototype				

for an agreed minimum dataset for all societies to share SET-relevant information, which will be in place by 2025. Until then, monitoring is conducted via requests to each society and information sharing via the CEOs and/or STBs/STCs training managers group (further detailed in the QI section). The societies have already contributed significantly to this work.

Condition 12		To be met by: 2022		
Establish methods to seek confidential feedback from individual supervisors of training, across the surgical specialties, to contribute to the monitoring and development of the training program. (Standard 6.1.2)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
2023 AMC commentary				
This is an element of the Monitoring and Evaluation framework. Further details are needed as what feedback comes back to the program and what to RACS, and how it is used.				
2024 College Response				
<p>Each of the societies collect feedback from their supervisors formally and informally, but to date this is not seamlessly collated across societies within a single overarching framework. Advantages of the overview would be that smaller specialist societies would be less exposed in failing to de-identify feedback, but absent a watertight information sharing agreement embedded in each SLA, the risk of identification in sharing the information is ironically greater for the smaller specialist societies. Even if RACS were to conduct its own surveys, de-identification remains an issue with smaller specialties and training sites.</p> <p>Another way of collecting supervisor feedback can be via the working agreement (under HTP accreditation) that RACS has with the health service facilities (6.3 Information Sharing Protocol). De-identification can remain an issue in some settings. This option is being explored in the current round of talks by the RACS CEO and president with each jurisdiction.</p> <p>Draft terms of reference for a RACS Reference Group (2.5 Supervisor Reference Group Terms of Reference), mirroring the RACSTA committee (2.4 RACSTA Terms of Reference) where appropriate, are under consideration. This will require engagement with each of the specialist societies and, of course, the supervisors, assessors, mentors and clinical educators it would represent across RACS. That RACSSRG could—as does RACSTA—provide de-identified feedback on global issues affecting many supervisors, and—with permission—could advocate for individual or small groups of supervisors willing to be identified. It would link with other supervisor-related groups internal and external to RACS (including the RACSTA committee and RACSCRG) to ensure its environmental scanning on issues was current, accurate and actionable.</p> <p>RACS has begun mapping how each STC/B incorporates Trainee and supervisor feedback in the development of the training programs (6.4 Mapping of Trainee and Supervisor Evaluations).</p> <p>Additionally, the jurisdictions and health services collect feedback from supervisors. The M & E Framework will provide a more robust way of collecting information from each of them. The HTP Accreditation Standards require: Standard 14.4.1 The hospital has clear policy and procedure for surgical supervisors to raise and have concerns addressed in a timely and effective manner.</p> <p>With the RACS protocol for information sharing (6.3 Information Sharing Protocol), non-urgent de-identified supervisor feedback can be collated via the M & E Framework (1.2 Monitoring and</p>				

[Evaluation Framework](#)). Urgent feedback is to be actioned in a more timely manner as per the HTP Accreditation Standards ([1.1 Hospital Training Post Accreditation Standards](#)).

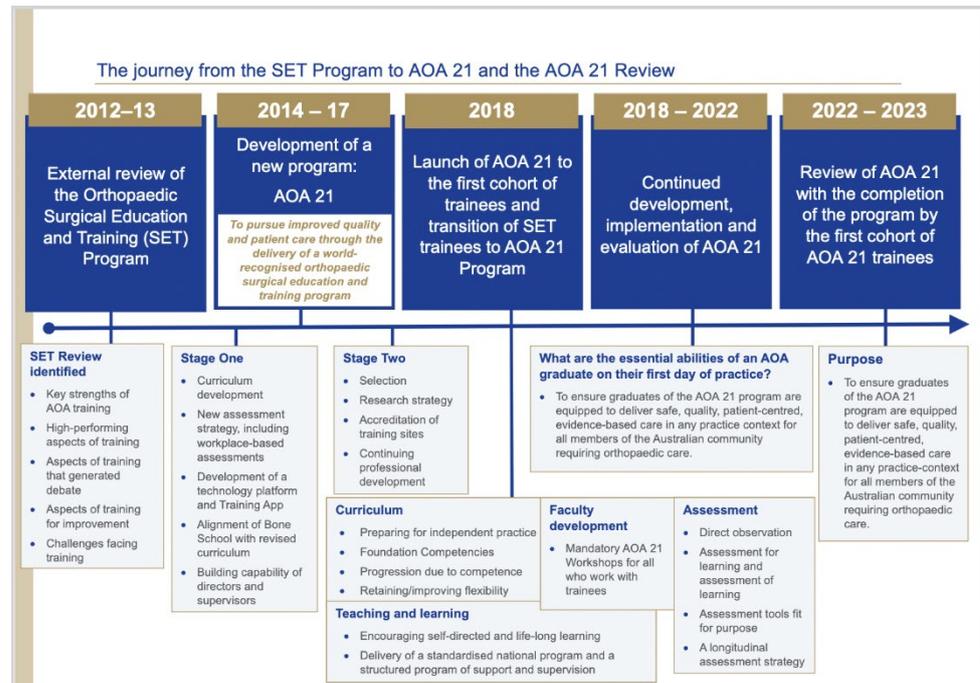
Specialty self-assessment for condition 12

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>The Committee currently use the Training Management Program (TMP) which has been developed with input from Cardiothoracics, Plastics and Paediatrics. It can seek and collate confidential feedback which can then be used to report on training units' performance against the standards of accreditation. Cardiothoracics plans to use this feature once the curriculum rewrite is complete.</p> <p>Cardiothoracics also plans to utilise the RACS M & E Framework through TMP once the curriculum rewrite is completed.</p> <p>The committee currently obtains confidential feedback at accreditation inspections, and they find this to be an extremely valuable tool.</p>
Board of Neurosurgery	<p>The SET Board of Neurosurgery conducts surgical supervisor workshops but does not undertake confidential surveys completed by surgical supervisors. Surgical supervisors are consulted with changes to the SET Program in Neurosurgery, including targeted requests for feedback on the new curriculum. Some of the changes to the SET Program in Neurosurgery have resulted from the surgical supervisor workshops. The next workshop is scheduled for August 2024.</p>
Committee of Paediatric Surgery	<p>The Monitoring and Evaluation framework is formulated and driven by RACS, and we are fully supportive of the plan.</p>
Board of Urology	<p>Multi-faceted Approach for Supervisor Feedback:</p> <ul style="list-style-type: none"> • Discussions at Regional Training Committee meetings. • Focused webinars, presentations at Section meetings and USANZ ASM • Feedback in these forums has not been confidential but provided opportunities for supervisors to convey their feedback. <p>Sub-Committees:</p> <ul style="list-style-type: none"> • Comprises USANZ members. • Provide valuable insights and views at regular meetings. <p>Working Parties:</p> <ul style="list-style-type: none"> • Established to address specific aspects of the training program • Crucial role in providing feedback and suggestions for ongoing improvements. <p>Surveys for Targeted Feedback:</p> <ul style="list-style-type: none"> • Concise and targeted surveys developed for specific program elements. • Has allowed supervisors to confidentially provide input. • Assisted the Board in developing meaningful program improvements.

	<ul style="list-style-type: none"> Copies of distributed surveys have been provided to RACS.
Board of Vascular Surgery	<p>Surgical supervisor meetings are conducted annually with supervisors where feedback on the training program is sought.</p> <p>Vascular Surgery is agreeable in administering the RACS Supervisor self-assessment survey as a method of confidential feedback. Vascular surgery will take direction from the college on these or other peer review surveys.</p>
Australian Board in General Surgery	<p>The GSET Evaluation Strategy undertakes questionnaires of Supervisors, Trainers, and Trainees. The results are de-identified, but the outcomes of the evaluation are publicly available.</p> <p>Trainees are also surveyed at the end of term to obtain their anonymous feedback on training posts, supervisors, and trainers.</p>
New Zealand Board in General Surgery	<p>AoNZCiGS is awaiting the framework template from RACS. Any information requested by RACS is provided.</p>
Board of Otolaryngology Head and Neck Surgery	<p>This will form part of RACS M&E framework.</p>
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	<p>Response from NZSOHNS aligns with BOHNS as the administrator of the OHNS SET program.</p>
Australian Board of Plastic and Reconstructive Surgery	<p>The ABPRS has:</p> <ul style="list-style-type: none"> Methods for seeking feedback from Supervisors of training and hospitals, including leveraging the use of technology – ABPRS were an early adopter of the RACS Training Management Platform (TMP) Current limitations to acting swiftly on “urgent” feedback due to a halt in development of the TMP – an emergent issue from 2022-23 RACS financial anguish. Through ASPS, completed the RACS M & E Mapping template for sources of data and information.
New Zealand Board of Plastic and Reconstructive Surgery	<p>The NZBPRS has contributed to this project which has been led by RACS. As a small specialty, with only 5 training units, 7 supervisors of training and with all supervisors holding a dual role as Board members, the issue of confidentiality is difficult to manage. NZBPRS therefore looks to RACS to lead this condition.</p>
Australian Orthopaedic Association Federal Training Committee	<p>The Final Report of the Strategic Review of AOA 21 presented an overview of the extensive review of the AOA 21 Training Program undertaken by an international team, from 2022 to mid-2023. It mapped the transition of the program from a time-based to a competency-based training approach, outlined the methodology used for the 2022/23 review, encapsulated key findings, and provided actionable recommendations</p>

which will guide AOAs journey over the coming years as we work in partnership to refine and shape the trajectory of our program.

Transformative changes to the AOA training program were initiated with the development of AOA 21. As the first cohort graduated in 2022, it was believed to be the right time for a comprehensive review, in line with our unwavering commitment to continuous improvement. The alignment of the Review with the first cohort of AOA 21 Trainees completing the program allowed for a “full picture” snapshot of their journey through training to consultant practice.



AOA is committed to excellence and the FTC and Board fully embraced the Recommendations of the Review Team to enhance our training program’s design and delivery in alignment with our overarching vision – “To be global leaders in the advancement of orthopaedic surgery through training and education; culture, diversity and inclusion; clinical practice and research; and advocacy and engagement”.

Our Review Team included four international medical-education experts, as well as the current and former dean of Education, the current and former chair of the Federal Training Committee and the Accreditation Committee chair, as well as the CEO and Education and Training staff of AOA. A summary of the plan to implement the recommendations of the review is outlined at Standard 1.

The AOA has:

- Well established processes for seeking feedback from Directors of Training via targeted annual surveys, Regional Training Committee Meetings and Accreditation Reviews
 - Actively contributed to the broader RACS Surgical Supervisors Project
- AOAs self-assessment of this Condition is “Met for AOA”.

New Zealand Board of

The NZOA has an established process for feedback from supervisors via the NZOA Education Committee to the SOTB.

Orthopaedic Surgery	
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Condition 13 To be met by: **2022**

Develop and implement completely confidential and safe processes for obtaining and acting on regular, systematic feedback from trainees on the quality of supervision, training, and clinical experience. (Standard 6.1.3 and 8.1.3)

Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	

2023 AMC commentary

At the attachment level, Trainees report they ‘continue to be concerned about recrimination if they provide negative feedback or criticise the specialty training committees or the College itself. Anonymous reporting structures are in place, but in smaller specialties, the complainant can often be easily identified, simply by naming a time and training post location’.

There is more Trainee engagement in the RACSTA survey, which provides some high-level feedback on overall training experience, but which is not specific enough to meet this condition.

A pilot is underway for a Trainee survey via the TMP. This looks promising, but is yet to be fully and safely implemented, which is what is needed to meet this condition.

2024 College Response

At June CSET, the Committee endorsed the proposed Trainee Feedback process with a defined minimum dataset of:

- blank copy of evaluation tools used for trainees
- number of Trainees evaluated and response rate
- deidentified results of Trainee feedback tool
- recommendations and action plan as a result of the evaluation

Chairs of each STC/B were nominated whether they wished for RACS to implement the Trainee feedback process or if they wished to use their own process, with information sharing between RACS and STC/Bs according to the minimum dataset.

Board of Otolaryngology Head and Neck Surgery, Australian Orthopaedic Association Federal Training Committee and Board of Neurosurgery have elected to develop their own processes for eliciting Trainee feedback. All other STC/Bs have opted for RACS to collect this data on their behalf.

RACS has previously reported the Trainee survey that has been developed to elicit this feedback ([6.5 Trainee Survey](#)). This survey tool is based on the Supervisor Framework, which outlines the competencies required by RACS Supervisors. The first Trainee feedback process will occur in November 2024 with reporting in February 2025.

The RACSTA survey now has a disclaimer regarding confidentiality of data and has removed some demographic data to hopefully increase response rates.

The societies have from the ground up matters that concern Trainees, including:

- funding from medical defence organisations when Trainee disputes arise
- whether relocation disruption can be minimised
- limited accreditable posts, restricting selection and admission to SET
- workplace laws, safe working hours
- wellbeing

- portability of leave entitlements
- flexible training.

Regarding the need to raise fees, RACS held a webinar 7 December 2023, attended by about 45 Trainees. Trainee leaders voiced their appreciation at being communicated with regarding the decision to raise the fees. In March and April 2024, RACS held webinars for Trainees and RACSTA regarding AMC accreditation. These webinars aimed to gather feedback about SET and reassure participants that RACS and the societies were working together to ensure compliance with the standards, ensuring that training would not be impacted.

The MTS and RACSTA surveys in Australia ([6.6 Draft MTS Survey Analysis](#)) and Aotearoa New Zealand ([6.7 2023 RACSTA AoNZ Survey](#)) provide actionable de-identified feedback that is relatively stable over the past 5 years and consistent across SET cohorts.

RACS includes Trainee representatives at every level of its governance. These representatives can provide de-identified feedback from Trainees as individuals, as specialty Trainees, as health service employees or more globally, depending on the issue.

The RACSTA terms of reference ([2.4 RACSTA Terms of Reference](#)) and the RACSTA Committee Introduction Booklet ([1.18 RACSTA Committee Introduction Booklet](#)) detail the committees on which Trainees are represented.

RACS may also seek feedback from Ahpra, MBA, NZMC, TWO, HDC and MDOs concerning trends in complaints or concerns about SET related matters.

Societies include Trainees and new Fellows in their governance, allowing representatives to report de-identified concerns held by Trainees. The societies hold specific sessions on wellbeing, use direct emails for keeping Trainees informed, and work with Trainees with flexible individual variations in their training programs.

Feedback can be de-identified in some larger health services and passed to RACS as per the HTP Accreditation Standards ([1.1 Hospital Training Post Accreditation Standards](#)). The RACS information sharing protocol ([6.3 Information Sharing Protocol](#)) assists with this two-way communication. The standard requires that Trainees must have clear pathways to express their views on working hours, conditions and organisational culture, and must have processes to encourage Trainees to speak up.

Standard 4.2.2 The hospital systematically tracks and monitors de-identified reported complaints as a surgical unit and institutional level as a performance measure.

The HTP Accreditation Standards ([1.1 Hospital Training Post Accreditation Standards](#)) require as part of supervisor performance management:

Standard 14.3.2 Feedback is sought from trainees in a de-identified manner as part of the process.

RACS is considering using social media for outreach in a less intimidating way, without replacing more reliable and effective methods.

As with several conditions relating to feedback concerning Trainees, non-surgical parties, supervisors and consumers, issues of data privacy emerge. RACS has an overarching policy ensuring data security ([6.8 Information Security Policy](#)). As with supervisor feedback, the issue affects smaller training posts and societies more often but applies to the whole SET endeavour. This issue of feedback privacy versus actionable transparency will become more pressing as HTP monitoring and the M & E MDS evolves, and the demands of government and regulators become more precise. The 7 June 2024 workshop and the subsequent work plan will provide an opportunity to find the best way through this issue, which is faced by all medical colleges and others.

RACS has completed a mapping exercise documenting how each STC/STB incorporates Trainee and supervisor feedback in the development of training programs ([6.4 Mapping of Trainee and Supervisor Feedback](#)).

Specialty self-assessment for condition 13

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>The Committee currently use the Training Management Program (TMP) which has been developed with input from Cardiothoracics, Plastics and Paediatrics. It can seek and collate confidential feedback which can then be used to report on training units' performance against the standards of accreditation. Cardiothoracics plans to use this feature once the curriculum rewrite is complete.</p> <p>Cardiothoracics also plans to utilise the RACS M&E Framework through TMP once the curriculum rewrite is completed.</p> <p>The committee currently obtains confidential feedback at accreditation inspections, and they find this to be an extremely valuable tool.</p>
Board of Neurosurgery	<p>Confidential trainee evaluations are collected twice yearly as part of the SET Program in Neurosurgery at the end of the second and fourth clinical terms. This has been ongoing for more than ten years. An example of the survey can be viewed here: https://www.surveymonkey.com/r/DRH53F7</p> <p>This information is used in a constructive way by the SET Board of Neurosurgery, with de-identified consolidated reports presented to the SET Board of Neurosurgery every six months. This information has been used to modify training post accreditation regulations and to identify trends for generic notifications to training posts.</p> <p>The individual reports are used in a confidential manner as part of the hospital training post accreditation process. There is also a process in place to manage issues of concern that are raised in confidence by trainees, which includes reporting bullying and harassment allegations to the RACS through its complaints process.</p>
Committee of Paediatric Surgery	<p>Annually, the committee meets with Trainees to gather feedback regarding the quality of supervision, training, and clinical experience. Trainees are provided the option to confidentially share their insights with the committee or request specific actions be taken based on their feedback. As a small training program, obtaining confidential feedback poses unique challenges due to our limited numbers. In recognition of this, we prioritise providing Trainees with the freedom to share information in a manner they are comfortable with. In addition, we are dedicated to working closely with RACS to develop and implement supplementary mechanisms that facilitate the collection of confidential feedback.</p> <p>The committee fosters transparent communication with Trainees, regularly engaging them in one-on-one discussions with the Chair when required. Additionally, the Chair hosts an annual informal session with</p>

	all Trainees at our Registrar Annual Training Seminar, enhancing opportunities for regular contact and providing a platform for expressing feedback and addressing significant concerns in an impartial and supportive atmosphere.																																			
Board of Urology	<p>Urology Trainee Forum:</p> <ul style="list-style-type: none"> • Comprised of Trainee Representatives from each region. • Provides comprehensive feedback exchange and discussion with the Board. <p>Trainee Representative on the Board:</p> <ul style="list-style-type: none"> • Represents trainee perspectives at every meeting. • Provides insights and feedback. • Member of the Training Post Accreditation Subcommittee. • Offers feedback and recommendations for post improvements and accreditation. <p>Confidential Post Assessment Process:</p> <ul style="list-style-type: none"> • Post Assessment Form - completed by incumbent trainees to identify strengths and weaknesses of training posts. Allows trainees to highlight concerns. Confidential and anonymous. • Regional Trainee Representatives - reviews post assessment reports and convenes meetings with trainees to discuss posts. Meets with the Chair, Training Post Accreditation Subcommittee to discuss outcomes and concerns. Assists Board in identifying posts requiring out-of-cycle inspections. • Information Collation - collated over a 3-year period and reviewed by the Chair, Board of Urology, and Chair, Training Post Accreditation Committee. De-identified results provided to inspectors during post assessments. Ensures trainee identities remain confidential, encouraging honest appraisals. <p>Trainee Surveys:</p> <ul style="list-style-type: none"> • Concise and targeted surveys developed to gather insights on specific program elements. • Allows confidential input from trainees and SET applicants. • Aids in developing meaningful program improvements. <p>Summary of Surveys below:</p> <table border="1" data-bbox="472 1442 1426 2024"> <thead> <tr> <th>Survey Topic</th> <th>Target Group</th> <th>Frequency</th> <th>Response Rate</th> <th>Confidential</th> </tr> </thead> <tbody> <tr> <td>Post Assessment</td> <td>Trainees</td> <td>Annual</td> <td>100%</td> <td>Y</td> </tr> <tr> <td>Challenges returning to training after interruption</td> <td>Trainees</td> <td>One off</td> <td>80%</td> <td>Y</td> </tr> <tr> <td>Variations to Training</td> <td>Trainees</td> <td>One-off</td> <td>70%</td> <td></td> </tr> <tr> <td>Selection Process</td> <td>Applicants interviewed</td> <td>Annual</td> <td>50%</td> <td>Y</td> </tr> <tr> <td>Feedback Tools & EPAs</td> <td>Basic Trainees</td> <td>One off</td> <td>50%</td> <td>Y</td> </tr> <tr> <td>Start of Clinical Rotation</td> <td>Trainees</td> <td>One off</td> <td>60%</td> <td>Y</td> </tr> </tbody> </table>	Survey Topic	Target Group	Frequency	Response Rate	Confidential	Post Assessment	Trainees	Annual	100%	Y	Challenges returning to training after interruption	Trainees	One off	80%	Y	Variations to Training	Trainees	One-off	70%		Selection Process	Applicants interviewed	Annual	50%	Y	Feedback Tools & EPAs	Basic Trainees	One off	50%	Y	Start of Clinical Rotation	Trainees	One off	60%	Y
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	Research Requirements	Trainees and Supervisors	One off	50%	
	New Curriculum	Trainees, Trainers, and Supervisors	One off	10%	Y
	Induction Course	Basic Trainees	Annual	50%	Y
Board of Vascular Surgery	<p>Confidential trainee evaluations are collected as part of the SET program.</p> <p>Vascular surgery conducts annual trainee interviews and has a process in place to manage issues of concern raised in confidence by trainees, which includes but is not limited to allegations of bullying and harassment and are addressed through the college through the complaints process.</p> <p>Individual reports are also collected in confidence as part of the hospital training post accreditation.</p>				
Australian Board in General Surgery	<p>General Surgery undertakes this through the end of term trainee feedback. This is a process that has been in existence for 10+ years and is outlined in the Hospital Accreditation and Trainee Feedback Regulations. Effective changes in response to trainee have been made following anonymous trainee feedback.</p> <p>ABiGS and its Regional Training Committees also include a Trainee Representative who are voting members and contribute to the decisions made.</p> <p>Trainee Representatives are also included in the inspection teams. Trainees are met with for each inspection to obtain their feedback on training posts.</p>				
New Zealand Board in General Surgery	<p>AoNZCiGS holds an induction day for all trainees to demonstrate what is required of them. The first training day after starting on the training program, AoNZCiGS holds interviews with each trainee to ensure they have the support they need.</p> <p>A trainee representative sits on AoNZCiGS and TSC. Trainee reps are also included on hospital training post accreditation visit teams.</p> <p>Feedback from trainees is sought through regular feedback anonymously.</p>				
Board of Otolaryngology Head and Neck Surgery	<p>Trainees are requested to complete an end of term survey every six months. The results from these surveys are reviewed across each hospital post to identify potential issues.</p>				
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	<p>The NZ Training Subcommittee does not undertake confidential surveys. However, TEAC and the SET trainees meet annually at the Registrar hui and confidentially discuss topics regarding SET performance, progress, surgical supervisors and hospital training posts.</p> <p>The meetings are minuted and distributed to TEAC.</p>				

<p>Australian Board of Plastic and Reconstructive Surgery</p>	<p>The ABPRS has:</p> <ul style="list-style-type: none"> • Methods for seeking feedback from trainees including leveraging the use of technology – ABPRS were an early adopter of the RACS Training Management Platform (TMP) • Current limitations to acting swiftly on “urgent” feedback due to a halt in development of the TMP – an emergent issue from 2022-23 RACS financial anguish. • Together with RACS representatives initiated targeted meetings in 2023 with Western Australia surgeons and trainees about behavioural and cultural concerns. These meetings were acted on following receipt of a critical number of anonymous complaints via the RACS Complaints mechanism. The engagement process has been subject of much criticism, from surgeons, yet no individual trainee has been identified by RACS or the Board. Currently an inspection by interstate inspectors is being planned to effect meaningful change.
<p>New Zealand Board of Plastic and Reconstructive Surgery</p>	<p>The NZBPRS has contributed to this project which has been led by RACS. As a small specialty, the issue of trainee confidentiality is difficult to manage. NZBPRS therefore looks to RACS to lead this condition.</p>
<p>Australian Orthopaedic Association Federal Training Committee</p>	<p>AOA has well established and effective processes for obtaining confidential feedback from trainees which has demonstrated the ability to effect meaningful change.</p> <p>AOA has an active Registrars Association with a representative executive committee, which is a standing committee of the AOA Board.</p> <p>As noted elsewhere, trainees have representation across all levels of the AOA governance including holding a voting position on the AOA Board, Federal Training Committee, Regional Training Committees and Accreditation Committee.</p> <p>AOAs self-assessment of this Condition is “Met for AOA”.</p>
<p>New Zealand Board of Orthopaedic Surgery</p>	<p>An annual survey is sent to all trainees in January of each year, this seeks feedback on all aspects of training.</p> <p>The Chair of the Education Committee meets with each trainee on an annual basis for a confidential meeting.</p> <p>The Trainee Representative is a member of the SOTB and reports to the SOTB on any matters that trainees bring to them.</p>

Condition 14		To be met by: 2022		
Develop formal consultation methods and regularly collect feedback on the surgical training program from non-surgical health professionals, healthcare administrators and consumer and community representatives. (Standard 6.2.3)				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
2023 AMC commentary				

This is an element of the M and E framework. Further details are needed.

2024 College Response

The HTP Accreditation Standards ([1.1 Hospital Training Post Accreditation Standards](#)) also have several data sharing requirements that reflect the importance of non-surgical input into the SET. These underpin more formal global feedback on the SET program and include:

Standard 4.3 The hospital has a commitment to sharing complaints information with RACS to improve patient safety and the standard of education and training.

Standard 12.2.2 Trainees are facilitated to obtain multisource feedback.

Standard 20.2.2 The surgical unit has regular multidisciplinary meetings and pathology meetings.

This will also be addressed as part of the implementation of the M & E processes once established.

Specialty self-assessment for condition 14

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>The Committee currently use the Training Management Program (TMP) which has been developed with input from Cardiothoracics, Plastics and Paediatrics. It can seek and collate confidential feedback which can then be used to report on training units' performance against the standards of accreditation. Cardiothoracics plans to use this feature once the curriculum rewrite is complete.</p> <p>Cardiothoracics also plans to utilise the RACS M & E Framework through TMP once the curriculum rewrite is completed.</p> <p>The committee currently obtains confidential feedback at accreditation inspections, and they find this to be an extremely valuable tool.</p>
Board of Neurosurgery	<p>The Neurosurgical Society of Australasia (NSA) and the SET Board of Neurosurgery released a consultation draft of the new curriculum. This draft was available on the NSA's public facing website inviting feedback from the public and contact was also made directly with external stakeholders to invite feedback. There was no restriction on who could provide feedback.</p>
Committee of Paediatric Surgery	<p>These conditions are undertaken through RACS.</p>
Board of Urology	<p>This will be implemented as part of the RACS M & E Framework. When the curriculum is due for review, external stakeholders will also be consulted.</p>

Board of Vascular Surgery	Consultation with external stakeholders will be implemented as part of the RACS M & E Framework.
Australian Board in General Surgery	The Board sought from various non-surgical health professionals, healthcare administrators and consumer and community representatives when the Curriculum was redeveloped and will once again obtain feedback from these stakeholders when the Curriculum is reviewed.
New Zealand Board in General Surgery	Various non-surgical health professionals, healthcare administrators and consumer and community representatives were consulted when the Curriculum was redeveloped and we will consult again when the Curriculum is reviewed.
Board of Otolaryngology Head and Neck Surgery	There is scope for liaison with external stakeholders to address this condition as part of RACS M & E framework.
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	The SET hui each year gets confidential feedback on set hospital placements and the training program in general from registrars during our confidential interviews.
Australian Board of Plastic and Reconstructive Surgery	<p>Standard 12.2.2 - Trainees are required to conducted multisource (360) feedback from co-worker (surgeons, allied health, administrators, nurses) in 4 of 14 EPAs, of which 2 are conducted early in training.</p> <p>Standard 20.2.2 – Assessed through existing HTP Accreditation processes.</p> <p>Confidential survey data are collected each 6 months from trainees in relation to their most recent term. Questions include markers aligned to the Hospital Training Post accreditation criteria. Aggregated data of 18 to 24 months is reported to hospitals after the elapsing of at least 24 months since the data were collected. Data are provided (de-identified) to Hospital Inspection Teams at 5-year accreditation re-assessments.</p> <p>Two surveys were designed and partly developed in the TMP for a) Supervisor feedback and evaluation and b) hospital management. The halt in the TMP's development in 2023 resulted in the incomplete process. We are confident that once development resumes, these surveys will be implemented as they use the same technology as the existing 360 reviews.</p>
New Zealand Board of Plastic and Reconstructive Surgery	<p>NZBPRS obtains feedback from administrators and non-medical staff during hospital training post accreditation inspections. Full inspection reports are provided to the unit Operations Managers, Clinical Directors, and hospital executives.</p> <p>Input and comment on the program from the NZBPRS Community Advisor is encouraged.</p> <p>NZBPRS collects referee reports from nurses as part of the SET selection process.</p>

<p>Australian Orthopaedic Association Federal Training Committee</p>	<p>Details of AOAs non-surgical stakeholder consultation has been covered under Condition 3.</p> <p>AOAs Training Post Accreditation process also utilises feedback from non-surgical health professionals and healthcare administrators.</p> <p>Trainees in the Transition to Practice stage of training are required to complete either a multi-source feedback or patient experience survey to facilitate direct feedback on their performance.</p> <p>Selection Interview Panels include a non-surgeon on each panel except the panel focusing on Medical and Surgical Expertise (4/5 stations).</p> <p>AOA continues to include non-surgical representatives on many of its committees as noted under Condition 3.</p>
<p>New Zealand Board of Orthopaedic Surgery</p>	<p>The NZOA Cultural Adviser and Consumer Adviser sit in the Training Board, as well as attending as an interviewer on the SET Selection. Both are non-surgical and provide advice. NZOA Council has regularly met with Te Whatu Ora. NRK has external links and representation on our Board and Council.</p>

Condition 15		To be met by: 2023		
<p>Report the results of monitoring and evaluation through governance and administrative structures, and to external stakeholders. It will be important to ensure that results are made available to all those who provided feedback. (Standard 6.3)</p>				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
2023 AMC commentary				
<p>This is an element of the M and E framework. The stakeholder matrix identifies key external stakeholders to be informed of findings and associated actions.</p>				
<p>2024 College Response</p> <p>The minimum dataset (MDS) for evaluation is not yet finalised; the MDS for monitoring is currently undergoing stakeholder refinement. Once the MDS is operational, reports can be run on the priority aspects of the M & E Framework (1.2 Monitoring and Evaluation Framework). The M & E Framework itself will remain a living document that can be adapted to report on emerging trends and issues as well as on long-standing aspects of SET, requiring the input of the specialist societies each time it is adapted to address an additional or different issue/question.</p> <p>Additional reports may be requested by and shared appropriately through the CSET and Education Committee to the RACS Council with recommendations for action. The reports will be instrumental in ensuring the data are comprehensive and high-quality as they will drive innovation and necessary interventions at all levels within the SET program. The reports will be made available on the RACS website with links to the specialist society websites as appropriate (further discussed in the QI section).</p>				

Specialty self-assessment for condition 15

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>The Committee currently uses the Training Management Program (TMP) which has been developed with input from Cardiothoracics, Plastics and Paediatrics. It can seek and collate confidential feedback which can then be used to report on training units' performance against the standards of accreditation. Cardiothoracics plans to use this feature once the curriculum rewrite is complete.</p> <p>Cardiothoracics also plans to utilise the RACS M & E Framework through TMP once the curriculum rewrite is completed.</p> <p>The committee currently obtains confidential feedback at accreditation inspections, and they find this to be an extremely valuable tool.</p>
Board of Neurosurgery	This will be implemented as part of the RACS monitoring and evaluation framework as it relates to Surgical Supervisors.
Committee of Paediatric Surgery	<p>The Committee currently uses the Training Management Program (TMP) which has been developed. It can seek and collate confidential feedback which can then be used to report on training units' performance against the standards of accreditation. Paediatrics plans to use this feature once the curriculum rewrite is complete.</p> <p>Paediatrics also plans to utilise the RACS M & E Framework through TMP once the curriculum rewrite is completed.</p> <p>The committee currently obtains confidential feedback at accreditation inspections, and they find this to be an extremely valuable tool.</p>
Board of Urology	This will be implemented as part of the RACS M & E Framework.
Board of Vascular Surgery	Vascular surgery contributed to the M & E Framework and has adopted the RACS TMP for data collection and reporting. Implementation will be led by RACS.
Australian Board in General Surgery	The Evaluation results are de-identified, but the outcomes of the evaluation are publicly available. A report is also sent to each hospital supervisor providing information for their specific hospital. A summary report of updates and changes is then sent to trainees, supervisor, and trainers.
New Zealand Board in General Surgery	Any evaluation results are de-identified, but outcomes will be made publicly available. A report is sent to each hospital supervisor providing information for their specific hospital. A summary report of updates and changes is sent to trainees, supervisor, and trainers.
Board of Otolaryngology Head and Neck Surgery	This will be implemented as part of RACS M&E Framework.

New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	NZSOHNS has in place an Ear, Nose, Throat (ENT) training platform which contains all documentation pertaining to the surgical training program.
Australian Board of Plastic and Reconstructive Surgery	<p>The ABPS has contributed to the RACS M & E matrix on data and information sources as well as key stakeholders. Implementation of M & E will follow the lead of RACS in relation to M & E.</p> <p>The ABPRS collects information from nurses and allied health professions during the selection of trainees and separately from hospital executives during the Hospital Training Post (HTP) accreditation process. Hospital executives receive feedback as a matter of course during HTP accreditation while reporting on selection has been limited to SET supervisors due to the highly competitive nature of selection.</p>
New Zealand Board of Plastic and Reconstructive Surgery	This will be implemented as part of the RACS M & E Framework.
Australian Orthopaedic Association Federal Training Committee	The first report from AOA's non-surgical stakeholder consultation is due to be considered by the FTC in June 2024. A formal report will be published and distributed following finalisation of the consultation.
New Zealand Board of Orthopaedic Surgery	Currently we do not do this, but we will be involved in the Monitoring and Evaluation Framework.

3 Statistics and annual updates

Please provide data **for 2023** in the table below showing:

- A summary of evaluations undertaken
- The main issues arising from evaluations and the college's response to them, including how the College reports back to stakeholders.

Please include the College response to the issues arising from the results of the 2022 Medical Training Survey (MTS). In 2022, the AMC noted data is still showing patterns of bullying, discrimination and harassment in the workplace reported by trainees.

Evaluation activity	Issues arising	College response to issues
Medical Training Survey	bullying, discrimination, and harassment in the workplace	RACS has prepared a comprehensive analysis of the 2023 MTS results, including a longitudinal analysis of data from the MTS survey over the past 5 years (6.6 Draft MTS Survey Analysis). The Censor in Chief has written to relevant College committees and to

		<p>the societies sharing the analysis and asking each committee to respond with their answers to consultation questions:</p> <ul style="list-style-type: none"> • What is your committee/board doing or thinking about doing, given the MTS and RACSTA Evaluation Survey results? • What does your committee/board think RACS should be doing or thinking about doing as a collective, in response to these results? • What does your committee/board want RACS to be doing or thinking about doing, to assist your committee and/or the collective? <p>Committees included in this consultation were:</p> <ul style="list-style-type: none"> • STCs/STBs • Court of Examiners • Prevocational and Skills Education Committee • SIMG Committee • RACSTA • Building Respect, Improving Patient Safety Operational Group <p>The results of this consultation will be considered by the Education Committee and form the basis of an agreed action plan to address the results of the MTS survey.</p>
<p>Strategic Review of AOA21</p>	<p>Multi-faceted</p>	<p>Recommendations developed and accepted</p>

		Implementation Plan approved and commenced Details provided above
AOA non-surgical stakeholder consultation	Findings pending	

- The AMC has previously signalled to colleges that it will look at how the results of the MTS can be used in accreditation and monitoring processes. In this section the AMC is asking the College to comment on how it has used or plans to use the results.

Can the College please provide evidence on actions taken based on MTS results, including:

- Developments and changes made by the College as a result of the MTS
- Future directions and planning based on the results

	College response
Developments and changes made by the College as a result of the MTS?	RACS has analysed the MTS and drafted a report that has been circulated to all specialties for their input in our collective action plan. The action plan will be discussed at CSET and endorsed at EC.
How is the College reflecting on its performance in the MTS?	RACS is currently reflecting on these results in several forums including Council, EC, CSET, BRIPS committee and RACSTA. An action plan is under development and will clearly assign actions responsibilities and outcomes.
What are the future directions and planning of the College based on MTS results?	As above. RACS will share the plan when it is complete.

Standard 7: Issues relating to trainees

Areas covered by this standard: admission policy and selection; trainee participation in education provider governance; communication with trainees; trainee wellbeing; resolution of training problems and disputes.

1 Summary of significant developments

This section gives the AMC information on the continuing evolution of the college's programs. Please provide a summary of significant developments completed or planned relevant to Standard 7.

Has there been any significant developments made against this standard? <i>If yes, please describe below.</i>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
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In 2023, the College merged the Registration for Selection into SET and the Selection to SET regulations into a combined Registration and Selection into SET regulation ([1.37 Registration and Selection to Surgical Education and Training](#)). Trainees are also provided with a Trainee Agreement ([7.1 SET Trainee Agreement](#)).

The goal was to improve clarity and reduce the amount of cross-referencing required by applicants, as indicated in the previous report. The College has also published on its website a guide for all SET enquiries, including a list of appropriate contacts, so Trainees know who to contact for each aspect of training ([7.2 SET Enquiries Contacts](#)).

In response to requests and feedback from several STCs/STBs the College broadened the scope of the Exceptional Circumstances and Special Consideration policy to include issues relevant to selection. This policy is currently in place, and CSET will consider further feedback on both the policy and opportunities for future alignment with selection regulations ([1.38 Exceptional Circumstances and Special Consideration Policy](#)).

A workshop will be held on 7 June 2024 with all specialties to discuss selection.

Situational judgement tests (SJTs) have been implemented by three specialties as part of their selection, with RACS facilitating the process. Recommendation from the Indigenous Health Committee ([2.2 IHC Report to Council 2024](#)) and the Managing Bias working group is to cease SJTs due to the potential for bias, the recommendations are currently being considered by the STC/Bs as most recommendations relate to SET. RACS is committed to being responsive to contemporary research in relation to selection and RACS has reviewed the use of SJTs and decided to cease use of the selection tool for 2025 selection processes. this has been communicated to all specialist societies.

An example from one of the specialist societies exemplifies the SET commitment to transparency and engagement when changes are made to the program. During 2023, Trainee communication about changes to the Urology training program was increased, with specific sessions delivered at Trainee Week in 2023 and at the USANZ ASM in February 2023. Correspondence to all stakeholders became more frequent during 2023 to advise of the launch of the revised program in 2024 and the impact upon training pathways. Trainees who had variations in training and did not conform to standard SET levels were contacted directly and requirements of their individual program from 2024 discussed. Trainees were informed that the revised training program would be an opportunity to receive more direct supervision and feedback and that the board has adhered to the principle that no Trainee would be disadvantaged by the change.

The Urology board held a series of meetings and webinars in 2023 for training supervisors and trainers to provide an overview of the changes, as well as the phased introduction of new workplace-based feedback tools and arrangements for Trainees who would be transitioning. SET1 and SET2 Trainees were encouraged to undertake components of the new program in preparation for their transition in 2024. A streamlined and shortened In-Training Assessment Form was also introduced, which included more meaningful items for providing feedback.

Vascular Surgery will be adopting both written and verbal references as a selection tool from 2025.

For the 2024 Selection process (2025 Intake), AOA has introduced more structure around Selection Initiatives to promote diversity within the training program and address the workforce needs of rural communities. This more structured approach seeks to attract Aboriginal and Torres Strait Islander, Rural and Female applicants to Orthopaedic Surgery, consistent with the aims of our Diversity and Inclusion strategy. It is designed to provide these applicants with the best opportunity to be assessed for the training program throughout the Selection process by facilitating access to each Selection tool. Further

details can be found under section 6.3 of the *Regulations for Selection to the AOA 21 Training Program in Orthopaedic Surgery for 2025*.

The AMC also expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the report.

<p>Has the College made any significant changes affecting the delivery of the program? i.e. changes to trainee selection procedures or the college's role in selection.</p> <p><i>If yes, please describe below the changes and the potential impact on continuing to meet these standards.</i></p>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
<p>As above.</p>		

2 Activity against conditions

The numbering of conditions matches that used in the AMC Accreditation Report.

Please address each of these conditions individually.

Condition 16				To be met by: 2022
<p>Promote, monitor, and evaluate the Diversity and Inclusion Plan through the College and Specialty Training Boards to ensure there are no structural impediments to a diversity of applicants applying for, and selected into all specialty training programs. (Standard 7.1 and 6.1 and 6.2)</p>				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
2023 AMC commentary				
<p>Commendably, the College's 2023 response reflects renewed commitment to make Trainee cohorts and College bodies even more diverse, and to monitor progress. The College is aware of the need to sustain this during the governance review.</p> <p>To meet Condition 2 and Condition 16 will require multiple sources of evidence including data, surveys, and a range of interviews and site visits.</p>				
<p>College Response</p> <p>The M & E Framework (1.2 Monitoring and Evaluation Framework) describes a specific MDS for the monitoring and evaluation of all SET selection processes with clear reference to diversity and inclusion. This is lag data.</p>				

Lead data are examined through the selection criteria and processes of each specialty, as well as by merit (appeals), requests and complaints by specialty and applicant demographics. Every year each specialty society submits its selection regulations ([7.3 Summary of Selection Regulations](#)) for approval by the RACS Education Committee. Where concerns are raised, legal advice is sought. Each review also tries to obtain a degree of alignment across the specialist societies. In 2024, RACS has undertaken mapping of the specialty societies selection processes ([7.4 Summary of Selection Tools and Requirements](#)).

Conditions driving diversity and inclusion are RACS policies, position papers and frameworks, underpinned by community expectations, health service demands and AMC requirements. These have set acceptable and aspirational KPIs and timelines for the RACS Trainee cohort to better reflect population demographics across indigeneity, ethnicity, gender, rural intention and socioeconomic status, without diminishing the delivery of safe, high-quality surgical care and training where it can be delivered and is needed most.

Selection is a critical but not singular variable in achieving diversity and inclusion within SET and must be understood in the whole journey for each Trainee in SET. Not all diversity will be declared. Thus diversity and inclusion policies and procedures are relevant for the whole endeavour and aligned at every level.

Candidates are selected into the SET program in line with the RACS Diversity and Inclusion plan and associated RACS policies and STB/STC regulations for selection into surgical training.

- number of applications to SET
- number of Trainees entering SET
- number of Trainees completing training
- standardised generic selection processes
- published, objective, transparent selection processes

Specialty self-assessment for condition 16

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	<p>This condition is undertaken through RACS.</p> <p>The committee remains committed to all RACS policies relating to this standard. We also remain committed to the Aboriginal and Torres Strait Islander initiative. We remain committed to supporting similar semi-rural posts but do not have a particularly major rural component to our practise by the nature of the services we provide. We remain committed to improving the communication between the committee and our trainees with regards to their wellbeing and encouraging them to escalate their concerns.</p> <p>The committee has become far more proactive in engaging with the trainees via the chair who is able to assist with disputes / concerns around training and general trainee wellbeing.</p> <p>The new chair hosts an informal session with all trainees at our two conference events per year and two trainee weekends per year - all of which promote regular contact and the ability for feedback any significant concerns in an impartial and supportive environment.</p>
Board of Neurosurgery	During 2022 (for the 2023 selection intake) the SET Board of Neurosurgery introduced what is now known as the Diversity and

	<p>Gender Equity Initiative, as part of the Selection Regulations. This initiative is now in its third year of operation.</p> <p>The special measures were introduced for the purpose of gender equity between men and women to give effect to the RACS Diversity and Inclusion Plan, which sets targets for increased representation of women in SET across all specialties. The special measures are applied after final ranking of suitable applicants and in circumstances where substantive gender equity would otherwise not be met for female applicants based on ranking alone. Applying the special measures, the percentage of successful applicants will be at least equivalent to their percentage of total applicants, provided there are suitable female applicants.</p> <p>Statistics for selection of applicants are shown on the NSA's public facing website.</p>
Committee of Paediatric Surgery	These conditions are undertaken through RACS.
Board of Urology	<ul style="list-style-type: none"> • The Selection Regulations include the Aboriginal and Torres Strait Islander Selection Initiative • The ratio of male and female trainees currently in training is changing. • The number of female applicants has increased from 12.8% in 2021 to 34.4% in 2023. • Offers made to female applicants has increased from 6.3% in 2021 to 33.3% in 2023 • Refer also to information provided in Condition 2 <p>The Board of Urology does not otherwise set diversity-driven selection targets</p>
Board of Vascular Surgery	<p>See Condition 2: Selection conducted with initiatives applied to ensure equity in compliance with the RACS strategic plan.</p> <p>Vascular surgery has adopted selection initiatives but no targets yet. Being one of the smaller specialties, Vascular surgery's focus is to attract a more diverse group of applicants without diluting the quality of trainee selected.</p> <p>Over the past three years, an average of 40 applications (30% female) were received for approximately 10 positions each year. Of these, 2 female trainees (20%) were successfully selected each year. Of the 50 trainees currently in the program, 10 (20%) are female. Vascular surgery also noted a 25% drop in applications in 2024 for the 2025 intake and will continue to monitor this.</p> <p>One applicant was successfully appointed through the Aboriginal and Torres Strait Islander initiative in 2021.</p> <p>Vascular surgery has noted low numbers of applicants from Aotearoa New Zealand and is adopting an initiative for 2025 selection (2026 intake) to ensure a minimum of one applicant from Aotearoa New Zealand is selected.</p>

	In addition, selection tools will be updated to include both written and verbal referee reporting.
Australian Board in General Surgery	<p>ABiGS has responded to diversity and inclusion plan. Below are examples:</p> <ul style="list-style-type: none"> • General Surgery has implemented Aboriginal and Torres Strait Islander initiative. • Ratio of male and female trainees currently in training is currently 56.79% Male, 42.99% Female, .22% Not Specified/Other • Offers made to female applicants has increased from 29.41% in 2016 to 45.61% in 2023. • Research undertaken by E Ip, M Carrarini, I Incoll and D Nestel demonstrates no bias towards female applicants overall in selection. <ul style="list-style-type: none"> ○ Ip, E.C., Carrarini, M., Nestel, D. and Incoll, I.W. (2023), Gender associations with selection into Australian General Surgical Training: 2016–2022. ANZ Journal of Surgery, 93: 2350-2356. https://doi.org/10.1111/ans.18584 <p>7.5 General Surgery Gender Associations Publication</p> <ul style="list-style-type: none"> • Increased rural points in 2024 <p>The Australian Board in General Surgery (ABiGS) aims to reach the targets set by RACS. General Surgery (Australia) is performing well in terms of gender diversity in selection. In 2023, 45.61% of offers were made to female candidates. This is an increase of 16.2% from 2016, where 29.41% of offers were made to female candidates.</p> <p>Ratio of male and female trainees currently in training is currently 56.79% Male, 42.99% Female, 0.22% Not Specified/Other</p>
New Zealand Board in General Surgery	<p>AoNZCiGS has proactively introduced Selection Initiatives to promote equity in Selection including additional CV points for those who kaupapa to Māori, as well as additional points for rural experience. The gender split for selection applicants and current trainees is almost exactly 50/50.</p>
Board of Otolaryngology Head and Neck Surgery	<p>The OHNS Selection Regulations include:</p> <ul style="list-style-type: none"> • Gender Selection initiative • Aboriginal and Torres Strait Islander initiative • Rural origin point <p>One Torres Strait Islander and one Māori trainee appointed in Australia in 2024.</p> <p>These initiatives will take time to take effect, starting from medical students.</p>
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	<p>In accordance with the 2024 OHNS-NZ SET selection regulations 3.1 Diversity & Gender Equity and 3.1.1, the NZ Training Subcommittee has introduced special measures for substantive gender equality for the purpose of gender equity between men and women to give effect to the RACS Diversity and Inclusion</p>

	<p>plan, which sets targets for increased representation of women in SET across all specialties. Special measures will only be applied after the final ranking of suitable applicants.</p>
<p>Australian Board of Plastic and Reconstructive Surgery</p>	<p>The ABPRS report that:</p> <ul style="list-style-type: none"> • It has proactively introduced Selection Initiatives to promote equity in Selection: Rural Selection, Aboriginal and Torres Strait Islander Selection Initiative • Selection applicants have become homogenous and stream early into PRS units. To mitigate against early career streaming ABPRS introduced attempt limits (2020) and balanced points for PRS and non-PRS surgical experience (2024-2026).
<p>New Zealand Board of Plastic and Reconstructive Surgery</p>	<p>NZBPRS undertakes an annual review of their SET selection process to ensure there are no barriers to selection. Points are currently allocated to applicants that provide evidence of Te Ao Māori.</p> <p>50% of the current NZ PRS trainees are females.</p> <p>NZBPRS encourages and supports RACS promotion of surgery to Māori doctors and Māori secondary school students through their education campaigns in Aotearoa New Zealand.</p>
<p>Australian Orthopaedic Association Federal Training Committee</p>	<p>In recognition of the increasing demand for training places, the FTC has removed the limit on the number of attempts that can be made for Selection. A counselling session after a third unsuccessful attempt will be maintained. Members have been encouraged to provide continuous and frank feedback to their unaccredited registrars.</p> <p>AOA has a Diversity & Inclusion Strategic Plan. Progress against the Plan is closely monitored through AOA Governance Structures and is reported in each AMC submission.</p> <p>FTC has proactively introduced Selection Initiatives to promote equity in Selection.</p> <p>Further information is included at Condition 2.</p> <p>AOAs self-assessment of this Condition is “Complete and ongoing for AOA”.</p>
<p>New Zealand Board of Orthopaedic Surgery</p>	<p>The NZOA has a published Diversity, Equity, and Inclusion Plan. We regularly review the selection statistics, specifically focusing on diversity and inclusion.</p> <p>NZOA Diversity Equity and Inclusion Plan 2024 has targets for diversity includes Aspirational Trainee Targets: 50% female; 17% Māori; 8% Pacific Islander.</p>

Condition 17	To be met by: 2022
<p>Increase transparency in setting and reviewing fees for training, assessments and training courses by the College and all specialty training boards, while also seeking to contain the costs</p>	

of training for trainees and specialist international medical graduates. (Standard 7.3.2 and 10.4.1)

	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	

2023 AMC commentary

This is an ongoing issue which is likely exacerbated by RACS's financial situation. In the RACSTA survey, trainees expressed concern re: the rising fees for training and courses. Societies mentioned need for more transparency in how fees are set, costs are allocated, and revenues associated with activities; as well as reducing unnecessary duplication of activity.

The material provided did not show how the fees and course costs are determined but mentioned the principle of cost recovery.

For example, the website indicates:

Not all training related fees will need to increase. Only training activities that are not recovering costs will incur fee increases above CPI. The fee increase will be 25% above current amounts. The final percentage figure has yet to be confirmed. We will add a final figure to this page as soon as possible. RACS Fellows have also been notified of an increase in subscription fees in the order of 25% which will minimise a disproportionate rise in Fees for Trainees.

RACS reports it will communicate the outcomes of a fees review to all Trainees and prospective Trainees as a matter of transparency, with a summary of the breakdown contributing to the costs.

Progress is being made, but the financial situation and fees increases are confounding progress towards meeting this condition.

2024 College Response

RACS acknowledges and has responded to the need for increased transparency in setting and reviewing fees for training, assessments and training courses, both as an entity and across the STCs/STBs ([1.20 Slides from Trainee Webinar December 2023](#), [1.21 RACS Website for 2024 fees](#)). In 2023, it became evident that RACS did not fully understand its cost base. This has contributed to the current financial challenges. Like many medical colleges, RACS must revisit its cost structures to mitigate the impact on Trainees and members.

Short-term solutions involve fee increases. Long-term measures include enhancing productivity and commercial activities to raise revenue and improve efficiency, as recommended by the external review RACS commissioned. Over the next 3–5 years, RACS will carefully evaluate its value proposition to ensure it meets the needs of Trainees, members, health services, government and the community. This evaluation will guide RACS in investing resources where they can have maximum impact.

In setting the fees for 2024, RACS has implemented activity-based costing ([1.19 SET Training Fees Breakdown](#)). Operating on a calendar year basis (January to December), RACS undertakes a comprehensive budgeting process from August to October each year ([1.22 Overview of 2024 Training Fees](#)). The budget is developed in consultation with internal stakeholders, including the executive, managers and staff, and aligns with the College's activities, strategic plan and economic conditions.

The budget aims to ensure the sustainable use of funds and efficient resource allocation within the organisation. It supports the ongoing provision and refinement of core College services, education, training activities, new initiatives and necessary capital expenditures. Expenditure required to deliver services and activities is reviewed and analysed to ensure cost-effectiveness and value, with fees modelled on a cost-recovery basis. SET fees are determined by each society and most are collected by RACS on their behalf.

The budget is reviewed by the College’s Finance Audit and Risk Committee before being recommended to the RACS council for approval. To increase transparency regarding fees, RACS held a webinar in December 2023 (all Trainees invited) where activity-based costing was presented ([1.20 Slides from Trainee Webinar December 2023](#)) and Trainees were given the opportunity to ask questions.

RACS also supports financial hardship cases through initiatives such as the Anwar and Myrtha Girgis SIMG Grant (value A\$6300), which assists migrant, refugee and asylum-seeker doctors in gaining the professional development required to practice surgery in Australia or Aotearoa New Zealand ([7.6 Anwar and Myrtha Girgis SIMG Grant](#)). The Censor in Chief reviews all requests for Trainee instalments per the relevant policy ([7.7 Financial Hardship Provisions](#)). A table of requests for personalised payment plans shows that 100% of requests have been approved ([7.8 SET Financial Hardship Requests](#)).

RACS remains committed to minimising fee increases and ensuring transparency to address the concerns of Trainees and stakeholders as it continues to refine its financial practices.

Specialty self-assessment for condition 17

Training Committee / Board	Response
Cardiothoracic Surgery Training Committee	<p>This condition is undertaken through RACS.</p> <p>All fees relating to the Cardiothoracic SET are published on the RACS website. Fees were developed through an activity-based costing that RACS undertook.</p>
Board of Neurosurgery	<p>The fee increases determined by the NSA relating to trainees are documented below. The percentage shows the change from the 2023 to the 2024 training year.</p> <ul style="list-style-type: none"> • Training Fee (NSA component) 6% CPI increase • Neurosurgery Anatomy Examination – 0% increase • Selection Application Fee – 1% increase • Training Seminars – 0% increase <p>The NSA retains long term activity-based costings for all activities and is therefore able to set fees with a high degree of accuracy. Training fees were increased by CPI (6%) for 2024. Selection fees did not increase by a material amount (1%). Training seminar fees did not increase at all, as they are subsidised by the NSA through sponsorship.</p> <p>The NSA Board sets the fees in August each year for the following year as part of its budgeting processes (it runs on a financial year ending 30 June). The aim of the NSA is to run the SET Program in Neurosurgery at a marginal profit annually and this has occurred in all of years the NSA has been managing the SET Program in Neurosurgery.</p>
Committee of Paediatric Surgery	<p>Fees are determined by RACS. We advocate for greater transparency in the process of setting and reviewing training fees, which includes providing a comprehensive breakdown outlining the factors contributing to the costs.</p>
Board of Urology	<ul style="list-style-type: none"> • USANZ Trainee Membership – mandated for all trainees • Induction Course – mandated for Basic trainees. Registration fee supplemented by sponsorship

- Trainee Week - mandated for Basic and Intermediate trainees. Registration fee supplemented by sponsorship
- USANZ ASM – mandated for Basic and Intermediate trainees. Discounted fee for SET trainees
- USANZ Section Meetings - mandated for Basic and Intermediate trainees. Discounted fee for SET trainees
- Specialty Specific Training Fee – mandated for all trainees. Fees listed on RACS website.
- SSE (Urol) – mandated for all trainees to complete. Fees listed on RACS website

Information on the fees for events is accessible via the Events page on the USANZ website when the events are promoted.

The USANZ Board resolved that the Specialty Training Fee is set on a cost recovery basis where the cost of the training activities is fully recovered. Detailed costings of the program are used to determine the Specialty Training Fee. Trainees are informed of fee changes as a matter of process. Sponsorship for certain initiatives and meetings contribute significantly to subsidising registration fees.

While USANZ does not have a formal hardship policy, the organisation is committed to supporting trainees and understands the financial challenges that can arise during the training program. Trainees experiencing financial hardship are encouraged to reach out to USANZ to discuss their circumstances. Should a trainee seek special consideration, USANZ would explore all avenues to help ensure that financial barriers do not impede professional development and participation in essential training activities. No applications received in 2023.

Board of Vascular Surgery

The Society component of fees was increased by an average of 5% as detailed below.

Fee Type	2024 Fees		2023 Fees	
	Ex-GST	Inc-GST	Ex-GST	Inc-GST
Vascular Surgery Administration Fee (Australian trainees)	\$ 553.50		\$ 525.00	
Vascular Surgery Administration Fee (New Zealand trainees)	\$ 635.65	\$ 731.00	\$ 603.00	\$ 693.45
Specialty Specific Fee - Vascular Surgery (Australian trainees)	\$ 3,838.00		\$ 3,641.00	
Specialty Specific Fee - Vascular Surgery (New Zealand trainees)	\$ 4,727.83	\$ 5,437.00	\$ 4,485.00	\$ 5,157.75

Specialty Specific Training and Admin fees were increased by an average of 5%.

Trainee membership of the Society is included in the Specialty Specific fee. Apart from RACS Courses, Vascular mandates an annual Skills Training course conducted by Vascular surgery. The cost of the course and accommodation is

	<p>included in the Specialty Specific fee (i.e. funded by Vascular), trainees are required to cover their travel arrangements (variable cost) for attending the course.</p> <p>Attendance at a Vascular ASM or RACS ASC for the fulfillment of a research requirement i.e. poster presentation would incur the cost of a registration fee. This is one of several options available under the research requirement and is recommended. Registration fees are published.</p> <p>Vascular ASM Registration Fee AUD \$760.00 (2024)</p> <p>Published on the ANZSVS website (ANZSVS Conference 2024)</p> <p>No policy currently – Vascular has been guided by RACS principles. Fees are generally calculated on activity-based costing. The ANZSVS makes every effort to contain costs wherever possible to keep the specialty specific fees low. During the COVID-19 period, the specialty specific fees were reduced and following this, they were kept the same. 2023 was the first increase in fees in three years and the increase was based on CPI factors.</p> <p>Vascular will consider developing a hardship policy in the future, although no applications for financial hardship consideration were received in 2023.</p>
<p>Australian Board in General Surgery</p>	<p>GSA can account for the training fee as well as the selection fee and both fees are set using activity-based costing.</p> <p>The Specialty Specific Training fee and SIMG fee are available on the GSA website https://www.generalsurgeons.com.au/education-and-training/fees</p> <p>All course and event fees are set using a combination of historical financial data and predicted activity-based costing. Fees are reviewed annually as part of the Board of Directors budget setting procedures.</p>
<p>New Zealand Board in General Surgery</p>	<p>NZAGS runs a separate training profit and loss, and activity costs all activities. RACS should do the same with \$NZ shown separately as training funds from NZ come through DHB's and should only be spent on NZ training.</p>
<p>Board of Otolaryngology Head and Neck Surgery</p>	<p>Specialty specific training fees are set annually to recover costs and are outlined to trainees.</p> <p>In 2023 and 2024, the increased cost of the training management platform was not passed on in full to trainees, instead absorbed as a cost to ASOHNS.</p> <p>OHNS SET Training Fee is \$3,920 (Australia)</p> <p>In addition, course fees apply for skills courses mandated during training:</p> <ul style="list-style-type: none"> - Temporal bone course - Head and neck course - Functional endoscopic sinus surgery (FESS) course <p>These courses are run by various universities / course venues or may be held as a pre annual scientific meeting with fees varying between \$1,000 to \$2,500 for advanced courses.</p> <p>https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf?rev=1adacae787f84968a007d7e8f1498f64</p>

	<p>The SET fee is based on activity-based costing. There is no hardship policy and no applications for hardship.</p>	
<p>New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee</p>	<p>Specialty specific fees for ORL HNS 2024 is \$4477 FESS course (2 required per trainee within training, one or both of which can be this one): \$1800 Temporal bone course – Auckland (two temporal bone courses required during training): \$1800 Head and neck dissection course (one required during training): approx. \$1800 Annual reg training week (compulsory - annually): \$750 This information is not provided publicly. Each course’s fees are set by the university for course related costs and the course organisers with an aim of breaking even. Course directors receive no income. Specialty specific fees have remained constant for many years until 2023. At this point they were adjusted based on training-related costs as provided to the Society (NZSOHNS) by its treasurer, increasing by 10%.</p>	
<p>Australian Board of Plastic and Reconstructive Surgery</p>	<p>The ASPS has:</p> <ul style="list-style-type: none"> • Undertaken activity-based costing in 2013 to set fees. The Society training fee has been kept steady with no increases since 2018. • Annually communicated with trainees the method used for fee setting. 	
<p>New Zealand Board of Plastic and Reconstructive Surgery</p>	<p>NZAPS undertakes an annual review of the SET budget and approves the SET fees for the forthcoming year based on this review. The budget is based on an activity-based cost recovery model. The result of the review and the approved SET fees for the coming year is communicated to the trainees. Fees have not increased for several years. One of the considerations made by the NZAPS when fee setting is the cost of training and their cognizance that in New Zealand this expense is covered by Te Whatu Ora.</p> <p>NZAPS SET fees are \$2000pa excl GST Emergency Management of Burns course – mandated course ASPS (America) EdNet (e learning) modules – note the fees for this is paid by NZAPS via the Specialty Specific SET fees Mandated SET Conferences, 2 per year (1 x Australasian and 1 x NZ). Conference fees apply and NZAPS subsidises the NZ conference. The fees are not publicly listed on the NZAPS website, but the specialty specific fee is listed on RACS website. Training fees and training related costs paid by NZ trainees are reimbursed by their employer, therefore financial hardship for trainees is not relevant for NZ. There have been no applications received by NZAPS for financial hardship. In the unlikely case of any applications for hardship, NZAPS would refer the trainee to the RACS policy. NZAPS supports RACS discussion with Te Whatu Ora to collect the fees directly from Te Whatu Ora.</p>	
<p>Australian Orthopaedic Association Federal Training Committee</p>	<p>Education and Training Fees</p>	<p>2024</p>
	<p>S.E.T. Fee – AOA</p>	<p>\$7,626</p>
	<p>S.E.T. Fee – RACS</p>	<p>\$4,900</p>
	<p>S.E.T. Fee – Research (AOA)</p>	<p>\$3,813</p>
	<p>S.E.T Fee – Research (RACS)</p>	<p>\$2,450</p>

	National Trial Fellowship Exam (NTFE)	TBC
	Selection Application Fee	TBC
	International Medical Graduates (IMG) per semester (6 months)	TBC
	<p>The AOA undertook activity-based costing (ABC) in 2013 this ABC was refreshed in 2023 for the introduction of AOA 21. A report on the methodology utilised is attached (1.44 AOA 2023 ABC Methodology).</p> <p>AOA consulted with the Australian Orthopaedic Registrars Association (AORA) with the regard to the fee increase necessitated by the refreshed ABC and how best to communicate this to trainees. AOA is also working in collaboration with AORA regarding minimizing the effects of fee increases on trainees.</p> <p>AOA has always been fully transparent on the activity-based costs associated with training and welcomes review and discussion. It is important that this is reciprocated by RACS and this level of transparency is welcomed.</p> <p>AOAs self-assessment of this Condition is “Complete and ongoing for AOA”.</p>	
New Zealand Board of Orthopaedic Surgery	<p>Training fees are calculated on activity-based costings.</p> <p>All courses are RACS, the training weekends, mock and pre-exam are cost recovery and trainees claim back the fees from their hospital. Current charge is \$1,050 based upon budgeted TIMS / Protrack costs for 2023/2024. As course costs are activity based in cost it is not possible to publish these too far in advance of the course.</p>	

Links to specialty-specific SET fees

Training Committee / Board	Response
Cardiothoracic Surgery Training Committee	https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
Board of Neurosurgery	https://www.nsa.org.au/Public/Public/SET_Program/Registration-and-Fees.aspx https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
Committee of Paediatric Surgery	https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
Board of Urology	https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
Board of Vascular Surgery	https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf

Australian Board in General Surgery	https://www.generalsurgeons.com.au/education-and-training/fees https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
New Zealand Board in General Surgery	https://www.nzags.co.nz/general-surgical-training-fees/ https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
Board of Otolaryngology Head and Neck Surgery	https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
Australian Board of Plastic and Reconstructive Surgery	https://plasticsurgery.org.au/about-asps/becoming-a-specialist-plastic-surgeon/selection-for-training/ https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
New Zealand Board of Plastic and Reconstructive Surgery	https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/2024-set-training-fees.pdf
Australian Orthopaedic Association Federal Training Committee	https://aoa.org.au/aoa-about/governance-and-committees/aoa-fees
New Zealand Board of Orthopaedic Surgery	

3 Statistics and annual updates

Please provide data in the tables below showing:

- The number of trainees, including Aboriginal and Torres Strait Islander, Māori and Pasifika trainees entering the training program, including basic and advanced training **in 2024**, and the number of applicants from these cohorts who applied and were unsuccessful.

- The number and gender of trainees undertaking each college training program **in 2024**.
- The number of trainees, including Aboriginal and Torres Strait Islander, Māori and Pasifika trainees who exited the training program **in 2023** (does not include those trainees who withdrew to take an extended leave of absence).
- The number of trainees, including Aboriginal and Torres Strait Islander, Māori, and Pasifika trainees who completed training (attained Fellowship) in each program **in 2023**.
- The number of Fellows of the College in **2024**.

Number of Trainees entering training program in 2024											
Training program	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total	No. of applicants who applied to training program and were unsuccessful
Australian Board of Plastic and Reconstructive Surgery	Combined with NSW	4	7	Combined with SA	0	Combined with VIC	4	5	n/a	20	30
New Zealand Board of Plastic and Reconstructive Surgery	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1	1	7
New Zealand Orthopaedic Association	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	19	19	
General Surgery Australia	Combined with NSW	20	52	Combined with SA	4	Combined with VIC	30	6	n/a	109	7 (number of applicants who were eligible) 3 (applicants deemed ineligible due to not meeting minimum criteria)

												121 (applicants deemed ineligible due to not meeting minimum criteria to progress to interview)
New Zealand Association of General Surgeons	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	16	16	
Board of Neurosurgery	1	2	1	1	1	0	1	1	0	8		
Australian Orthopaedic Association	Combined with NSW	6	20	Combined with SA	5	Combined with VIC	13	7	N/A	51		214
Board of Vascular Surgery	0	2	3	0	1	1	2	0	2	11		
Board of Urology	3	23	32	0	5	1	24	6	17	111	24	
Board of Otolaryngology Head and Neck Surgery	0	6	2	0	1	0	5	2	n/a	16		
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	3	3		
Board of Cardiothoracic Surgery	0	0	3	0	1	0	2	0	0	6		
Committee of Paediatric Surgery	0	0	1	0	1	0	1	0	1	4		
Aboriginal and/or Torres Strait Islander Trainees										2	6	

Māori Trainees	5	9
Pasifika Trainees	7	18

Number and gender of Trainees undertaking each training program in 2024					
Training program	Male	Female	Non-binary	Not stated	Total
Australian Board of Plastic and Reconstructive Surgery	64	37	-	-	101
New Zealand Board of Plastic and Reconstructive Surgery	10	13	-	-	23
New Zealand Orthopaedic Association*	23	51	-	-	74
Australian Board in General Surgery	263	191	-	1	455
New Zealand Association of General Surgeons	40	37	-	-	75
Board of Neurosurgery	44	15	-	-	59
Australian Orthopaedic Association	195	50	-	-	245
Board of Vascular Surgery	40	9	-	-	49
Board of Urology	83	28	-	-	111
Board of Otolaryngology Head and Neck Surgery	56	27	-	-	83
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	1	2	-	-	3
Board of Cardiothoracic Surgery	25	11	-	-	36
Committee of Paediatric Surgery	10	14	-	-	24

*Note: 2 female Trainees had interruption time of 3 months to make up, and have since completed, which are additional to the numbers above. One Trainee has 6 months interruption to make up starting back in July 2024 and is counted in the 23.

Trainees exiting from program in 2023 (prior to attaining Fellowship)		
Training Program	Number	Reason for exiting
Australian Board of Plastic and Reconstructive Surgery	1	Dismissed

New Zealand Board of Plastic and Reconstructive Surgery	1	Dismissed
New Zealand Orthopaedic Association	0	
General Surgery Australia	8	5 withdrew voluntarily, 3 dismissed for performance or time
New Zealand Association of General Surgeons	0	
Board of Neurosurgery	0	
Australian Orthopaedic Association	0	
Board of Vascular Surgery	0	
Board of Urology	0	
Board of Otolaryngology Head and Neck Surgery	0	n/a
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	0	
Board of Cardiothoracic Surgery	0	
Committee of Paediatric Surgery	1	Resigned or withdrew (voluntary)
Aboriginal and/or Torres Strait Islander Trainees	0	
Māori Trainees	0	
Pasifika Trainees	0	

Number of Trainees completing training program in 2023 (attained Fellowship)										
Training program	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Cardiothoracic Surgery	0	0	2	0	0	0	2	0	0	6, includes 2 overseas
General Surgery	4	20	29	0	7	2	28	11	18	122, includes 3 overseas

Neurosurgery	0	3	0	0	0	0	0	2	0	7, includes 2 overseas
Orthopaedic Surgery	1	11	16	1	1	0	12	3	15*	69, includes 9 overseas
Otolaryngology Head and Neck Surgery	0	3	6	0	1	0	3	2	6	23, includes 2 overseas
Paediatric Surgery	0	0	1	0	0	0	2	0	1	5
Plastic and Reconstructive Surgery	0	2	3	0	4	0	3	2	1	17, includes 2 overseas
Urology	0	4	5	0	0	0	4	0	3	21, includes 5 overseas
Vascular Surgery	0	3	0	0	1	0	2	0	0	6
Aboriginal and/or Torres Strait Islander Trainees										0
Māori Trainees										0
Pasifika Trainees										0

*Note: 2 Trainees had additional time to complete from interruptions in 2022 and so completed in 2023 additional to these 15.

	Number of Fellows in 2024		
	Australia	New Zealand	Other
New Fellows	206	35	25
Total Fellows	7,169	1,108	8,750

	Number of Fellows in 2024			
	Australia	New Zealand	Overseas	Other
Active & Retired Fellows	7,169	1,108	473	8,750
Active Fellows Only	5,954	895	336	7,185

- Can the College please comment in the table below:
 - how it ensures that costs and requirements associated with its specialist medical program/s (e.g. examinations, pre-examination workshops, college membership) are transparent and communicated to trainees. Please also include in the comment how the College ensures its

costs associated with training and education meet the outcomes of the National Registration and Accreditation Scheme², and are not prohibitive for potential trainees.

- if the College has made any changes to its policies to support trainees in fee distress. Please include links to where this information is available on the College’s website.
- if there have been any changes to fees for this year, please comment on the rationale for the change, and how changes were communicated to trainees.

College response	
<p>The College recognises the importance of transparency in fee-setting and all training costs are publicly available on the RACS website (Training Fees RACS (surgeons.org)). As discussed above, training fees for 2024 were established via rigorous activity-based costing (1.19 SET Training Fees Breakdown). These have been widely consulted on and communicated to Trainees, SIMGs and prospective Trainees via emails and webinars and made available on the RACS website.</p> <p>Trainees wishing to apply for special consideration are required to write to the RACS Censor-in-Chief (CollegeCIC@surgeons.org) for review and assessment of support. Should support be provided, the request is then forwarded to the RACS treasurer for approval. This information is available to all Trainees via the RACS website (Training Fees RACS (surgeons.org)).</p>	
Has there been any changes to the policies to support trainees in fee distress for 2024?	Comment
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Changes to College fees made for 2024	Rationale for changes
Changes to fees made <input checked="" type="checkbox"/> No changes made <input type="checkbox"/>	Activity based costing has been used to establish the 2024 fees in line with RACS’s need to be financially sustainable.

- If the College has made any changes to the following documents **for 2024**, can the changes be described in the table below and the updated documentation attached to this submission.

Policy / Procedure	Description of changes
Selection in to training	The Vascular Surgery selection regulations are updated annually. Updates for 2025 selection (2026 intake) are in progress for approval by October 2024.

Please note: do not fill in the above table and provide documentation if the College has previously supplied the current documentation to the AMC and **did not** make any changes to the above documentation for 2024.

² A guiding principle of the National Law requires that fees that are to be paid under the scheme be reasonable, having regard to the efficient and effective operation of the scheme. Section 4 Health Practitioner Regulation National Law.

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

Areas covered by this standard: supervisory and educational roles and training sites and posts

1 Summary of significant developments

This section gives the AMC information on the continuing evolution of the college's programs. Please provide a summary of significant developments completed or planned relevant to Standard 8.

<p>Has there been any significant developments made against this standard affecting the delivery of the program? i.e. changes to arrangements for monitoring the quality of clinical training.</p> <p><i>If yes, please describe below.</i></p>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
<p>RACS is responding to the NHPO recommendations being implemented as part of an AMC project led by the Miller Blue Consulting Group. RACS is participating in both the working group of the consultation as well as implementing the high priority recommendations (1.25 RACS Response to NHPO Request for Information 2024). RACS is committed to progressing all the recommendations and will defer new processes until NHPO Miller Blue project outcomes are determined. In line with our collaboration with the Specialty societies, we requested and were granted approval for an additional representative from the societies on the working group. This representative will work with the RACS representative to ensure all specialties are kept informed of key progress.</p> <p>The RACS NHPO Implementation Action Plan (1.24 NHPO Implementation Plan) rigorously addresses the ombudsman's recommendations for all actions flagged for consideration and to proceed to implementation. The plan refines accreditation standards, enhances transparency around training posts and streamlines appeal processes. Initiatives include revising accreditation policies to be more explicit about outcomes, improving the accessibility of training post information, and updating the appeals policies to ensure clarity in processes and fee structures. These efforts, set to be completed by specified deadlines on or before September 2024, underscore RACS's commitment to upholding high standards in accreditation and ensuring procedural transparency and efficiency.</p>		

The AMC also expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the report.

<p>Has the College made any significant changes affecting the delivery of the program?</p> <p><i>If yes, please describe below the changes and the potential impact on continuing to meet these standards.</i></p>	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No change

2 Activity against conditions

The numbering of conditions matches that used in the AMC Accreditation Report.

Please address each of these conditions individually.

Condition 18		To be met by: 2022		
Mandate cultural safety training for all supervisors, clinical trainers, and assessors. (Standard 8.1.3, 8.1.5 and 8.2.2)				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
2023 AMC commentary				
<p>The College is gradually aligning educational activities including CPD towards the Cultural Competency and Cultural Safety competency in the PCS.</p> <p>RACS's plan to identify appropriate resources to mandate for training, as well as to mandate 3 hours annually of CPD seem appropriate.</p> <p>This needs to be reflected across all specialties including AOA and NZOA who run their own CPD.</p> <p>Once training is mandated, this condition can be satisfied.</p>				
2024 College Response				
<p>With support from every society, RACS has mandated cultural competency and cultural safety competency training for all SET supervisors, clinical trainers and assessors (8.1 Mandated Cultural Competency and Cultural Safety Training). For supervisors, the need to be culturally competent is referenced in the supervisor framework competencies (8.2 Supervisor Framework). A list of curated resources has been provided by RACS and appears on the website. All documents, policies, frameworks and procedures have been amended to reflect this mandating of CST, and the requirement has been shared directly with all supervisors, clinical trainers and assessors.</p> <p>RACS recognises that cultural competency and cultural safety require life-long skills development and continuous practice in different settings and for different supervisors, clinical trainers and assessors. For instance, some will identify as Aboriginal or Torres Strait Islander or Māori, for whom a global mandate rather than an individual conversation would be quite inappropriate. Equally, the variability across Australian and Aotearoa New Zealand communities requires not only attention to care aspects of any cultural competency course but bespoke attention to local needs and requirements.</p> <p>To this end, the HTP accreditation standards (1.1 Hospital Training Post Accreditation Standards) state that for SET post(s) to be accredited:</p> <p>5.2.1 The hospital provides educational activities relating to the cultural competence and Indigenous health that is developed with the input of Aboriginal and Torres Strait Islander and / or Māori people.</p> <p>5.2.2 The hospital ensures all RACS surgeons and trainees are given time to complete cultural safety training and other educational activities that promote and enhance cultural competence.</p> <p>From 1 July 2024, all new supervisors, clinical trainers and assessors contributing to any aspect of SET must demonstrate they have completed cultural competency and cultural safety competency training.</p> <p>From 1 January 2025, all existing supervisors, clinical trainers and assessors contributing to any aspect of SET must have demonstrated they have completed cultural competency and cultural safety competency training as part of their RACS CPD requirements.</p>				

RACS has proactively communicated this mandate and is assisting new and existing supervisors, clinical trainers and assessors to demonstrate that they have already completed cultural competency and cultural safety competency training. RACS will accept recognition of prior learning in this case, as most will have undertaken significant training via their health service. RACS has developed a curated list of suitable resources (available on the RACS [website](#)) to meet this requirement, in addition to its online modules approved by the RACS Indigenous Health Committee to the RACS council for those who have not yet undertaken cultural competency and cultural safety training.

Compliance will be monitored annually, as it is with other BRIPS mandatory requirements, and reported to each specialty for follow-up. Non-compliance will be addressed proactively, with the intention of assisting supervisors, trainers and assessors to undertake cultural competency and cultural safety competency training rather than exiting them from their SET roles. Exiting a supervisor, trainer or assessor would remain a possible, if undesirable, outcome.

Specialty self-assessment for condition 18

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	This condition is driven through RACS.
Board of Neurosurgery	The SET Board of Neurosurgery has mandated training for all Supervisors and Surgical Trainers. The RACS CPD Program has made it a requirement to complete one cultural competence and safety activity under its CPD program annually. As such, compliance with this requirement for SET purposes is determined using a compliance report provided by RACS.
Committee of Paediatric Surgery	This condition is undertaken for paediatric surgery through RACS.
Board of Urology	Urology will mandate CST once the curated resources are released by RACS.
Board of Vascular Surgery	Vascular surgery will comply with RACS requirement to mandate cultural safety training for all Supervisors, clinical trainers, and assessors, and will embed into the training regulations currently under review.
Australian Board in General Surgery	The ABiGS is supportive of this mandate and is awaiting resources and guidance from RACS on suitable courses. ABiGS will include the reporting of this requirement in the inspection reports as well as assist RACS in following up supervisors and trainers who have not complied.
New Zealand Board in General Surgery	The NZAGS had earlier mandated completion of cultural competence and cultural safety training for all consultants involved in training. And all staff.
Board of Otolaryngology Head and Neck Surgery	Consultants and trainees have hospital cultural training requirements – discuss / consider how to manage recording of these to remove any duplication.

New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	Response aligns with BOHNS.
Australian Board of Plastic and Reconstructive Surgery	<p>The ABPRS has previously mandated, through its regular <i>Accreditation of Training Post</i> process, that sites delivery cultural competence and cultural safety training.</p> <p>The ABPRS has not mandated that supervisors or trainers are required to undergo cultural training, however RACS has mandated it via the CPD program. Plastic surgeons must comply with CPD requirements.</p>
New Zealand Board of Plastic and Reconstructive Surgery	<p>NZAPS has asked RACS for guidance on approved cultural competency and cultural safety training courses/modules applicable for Aotearoa New Zealand which are considered acceptable by RACS to meet this condition.</p> <p>NZAPS welcomes the news that RACS will accept recognition of prior learning for this condition as most PRS trainers and trainees will have undertaken training through their health service and acknowledges most hospitals provide employees with training in this area.</p>
Australian Orthopaedic Association Federal Training Committee	<p>As part of the Strategic Review of AOA 21, Recommendations relating to Accreditation of Training Sites are due to be actioned in 2024. AOA is awaiting further outcomes of the NHPO working group to ensure any developments in this area are aligned with regulatory requirements and jurisdictional needs.</p> <p>The AOA has mandated completion of cultural competence and cultural safety training for all consultants involved in training.</p> <p>The requirement to undertake a CPD activity each year relating to Culturally Safe Practice has also been agreed, incorporated into AOA CPD policy and will shortly be communicated to members.</p> <p>AOAs self-assessment of this Condition is "Complete and ongoing for AOA".</p>
New Zealand Board of Orthopaedic Surgery	<p>We support the college requirement for mandated cultural competence and cultural safety training.</p> <p>The NZOA intends to embed cultural safety in CPD through our Professional Development Plan.</p>

Condition 19	To be met by: 2023			
In conjunction with the Specialty Training Boards, finalise the supervision standards and the process for reviewing supervisor performance and implement across all specialty training programs. (Standard 8.1)				
	Unsatisfactory	Not progressing	Progressing	Satisfied

Finding			X	
2023 AMC commentary				
<p>The 2022 review noted that standards were now available and that to satisfy this condition, a process for reviewing individual supervisor performance across all specialty training programs is required.</p> <p>A supervisor self-assessment survey has been piloted, as has a TMP based trainee feedback pilot. The supervisor survey is designed to assist self-reflection on the role as a RACS Supervisor.</p> <p>There was not enough evidence provided to see the extent of the implementation across all programs and the process by which the data is synthesised and acted upon.</p>				
2024 College Response				
<p>In 2023, RACS piloted supervisor self-assessments and Trainee feedback assessments, based on the competencies clearly articulated in the supervisor framework. There has been strong support for reviewing supervisor performance, and all STCs/STBs have agreed to share questions asked in both supervisor and Trainee surveys, so a whole-of-SET perspective can be collated and actioned as agreed—individually or collectively, depending on the survey results.</p> <p>RACS has considered more systematic surveys, such as client focused evaluation plan (CFEP) surveys, to better gauge the performance of SET supervisors. For example, RACS has developed a pilot multi-source feedback tool with CFEP survey. This pilot is complete, and the project evaluation is underway (8.3 MSF Evaluation). RACS also acquires significant collective lag data from Trainees via surveys such as the MTS and RACSTA survey.</p> <p>Each STC/STB is currently considering how to best achieve the goal of ensuring safe, high-quality training through the performance of supervisors. Chairs of each STC/B nominated whether they wished for RACS to implement the Supervisor evaluation process for them or if they wished to use their own process, with information sharing between RACS and STC/Bs according to the minimum dataset:</p> <ul style="list-style-type: none"> • Blank copy of evaluation tools used for supervisors • Number of supervisors evaluated and response rate • Deidentified results of Supervisor Self-Assessment for each question asked • Recommendations and action plan as a result of the evaluation <p>The Board of Otolaryngology Head and Neck Surgery, Australian Orthopaedic Association Federal Training Committee and Board of Neurosurgery have elected to develop their own processes for completing Supervisor evaluation. All other STC/Bs have opted for RACS to collect this data on their behalf. RACS has developed a draft Supervisor Self-Evaluation tool (8.4 Supervisor Self-Evaluation Tool) which will be implemented in November 2024 with reporting in February 2025.</p> <p>On-the-ground assessment of supervisors is greatly enhanced by the feedback RACS can acquire from the health services. The HTP standards (1.1 Hospital Training Post Accreditation Standards) are very clear about the requirement to assess both RACS and specialty-specific supervisor performance. For instance:</p> <p>12.1.2 The appointed surgical supervisor implements their role and responsibilities in line with the RACS standards for supervision and relevant specialty regulations.</p> <p>13.1.1 There is a clearly articulated process for selecting a surgical supervisor.</p> <p>13.2.2. The surgical supervisor satisfies the generic requirements, including the mandatory training, in the RACS Surgical Supervisor Policy and satisfies the relevant specialty regulations.</p>				

13.2.3 The hospital has a process to monitor the surgical supervisor's performance and advise the STB in a timely manner of any issues regarding the surgical supervisor that may impact on the eligibility, performance and suitability for the role after appointment.

14.2 The hospital and surgical unit ensures that the surgical supervisor has the time to attend necessary RACS induction courses, professional development, STB activities and any further activities or events associated with the role.

14.3 All surgical staff complete performance appraisals

14.3.1 Performance development processes are completed according to the frequency required by the employing hospital to a maximum of three years.

14.3.2 Feedback is sought from Trainees in a de-identified manner as part of the process.

14.3.3 The hospital's appraisal mechanism assesses technical and non-technical professional skills and includes an appraisal of the surgical supervisors against their role.

14.3.4 The hospital has an appropriate documented process to address concerns identified through the performance development process.

To date, RACS has not required health facilities and training posts to report on these standards or to notify RACS of any variations or violations of these standards. This is being addressed in the current meetings with each jurisdiction to determine how this reporting should be undertaken and who is responsible for resolving any issues arising from the reports (further discussed in the QI section).

Supervisors have access to a hub and to podcasts to support their professional development, including:

Coffee Break Conversations with Surgical Supervisors podcast

Episode name	Publish date	Downloads
What makes a great surgical supervisor?	11 Aug 2023	137
Judgement and clinical decision making with Dr Rebecca Garland	30 Nov 2023	94
Health Advocacy - Part 1	20 Sep 2023	86
Health Advocacy - Part 2	18 Oct 2023	42

Supervisor Support Hub analytics from 7 August 2023–15 May 2024

Specific URL viewed	Number of Views
/Fellows/for-educators-trainers/supervisor-support-hub	75
/Fellows/for-educators-trainers/supervisor-support-hub-old/Policies-and-procedures	69
/Fellows/for-educators-trainers/supervisor-support-hub/Resources-to-assist-supervisors	57
/en/Fellows/for-educators-trainers/supervisor-support-hub-old/Policies-and-procedures	46
/Fellows/for-educators-trainers/supervisor-support-hub-old	39
/Fellows/for-educators-trainers/supervisor-support-hub-old/Supervisor-Framework	32
/Fellows/for-educators-trainers/supervisor-support-hub/Policies-and-procedures	22
/Fellows/for-educators-trainers/supervisor-support-hub-old/Resources-to-assist-supervisors	16

/Fellows/for-educators-trainers/supervisor-support-hub-old/Contacts	12
/Fellows/for-educators-trainers/supervisor-support-hub-old/Academy-of-Surgical-Educators	8
/en/Fellows/for-educators-trainers/supervisor-support-hub-old/Resources-to-assist-supervisors	6
/Fellows/for-educators-trainers/supervisor-support-hub/	2
Total number of views	384

Specialty self-assessment for condition 19

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	This condition is driven through RACS.
Board of Neurosurgery	The SET Board of Neurosurgery reviews the confidential evaluations submitted by trainees in the SET Program in Neurosurgery. This evaluation includes feedback on supervisor performance and informs training post accreditations. Where serious issues arise, they are managed on a case-by-case basis in collaboration with the trainee so as not to breach confidence. All allegations of bullying and harassment are forwarded, with the consent of the trainee, to the RACS complaints department for processing.
Committee of Paediatric Surgery	This initiative is led by RACS, and we support this process. We are eager to be more involved in its development and implementation to better assist both Supervisors and Trainees.
Board of Urology	The Board of Urology has participated with RACS in the development of supervision standards and the proposed process for reviewing supervisor performance.
Board of Vascular Surgery	The responsibility for appointing and managing supervisors reside with the Board. Confidential evaluations submitted by trainees are managed in collaboration with the college, the hospital, to inform accreditation of posts, and the trainee, where appropriate, to ensure confidentiality.
Australian Board in General Surgery	ABiGS has contributed to the RACS Surgical Supervisors Project. As part of GSET Evaluation reports are also provided to Supervisors with data relating to work-based assessments as they relate to the hospital, unit, and trainers.
New Zealand Board in General Surgery	AoNZCiGS has responsibility for supervisor appointment, training, and performance. AoNZCiGS has undertaken, in principle, to work towards aligning processes with RACS in this regard.

Board of Otolaryngology Head and Neck Surgery	The specialty is sufficiently small and Surgical Supervisors work in collaboration with a Regional Training Chair to deliver training. When a RACS process for review has been designed, the Board of OHNS will implement.
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	Response aligns with BOHNS.
Australian Board of Plastic and Reconstructive Surgery	The ABPRS has: <ul style="list-style-type: none"> Contributed to the RACS Surgical Supervisors Project, including three PRS surgeons in the pilot project, report awaited. Responsibility to appoint and train supervisors. Undertakes, in principle, to work towards aligning processes with RACS in this regard.
New Zealand Board of Plastic and Reconstructive Surgery	NZBPRS has worked with RACS on this project and as a small specialty looks forward to RACS leading this project. As a small specialty the NZPRS Supervisors of Training have dual roles as members of the NZBPRS.
Australian Orthopaedic Association Federal Training Committee	The AOA has contributed to the RACS Surgical Supervisors Project. Under the Service Agreement AOA has responsibility for supervisor appointment, training, and performance. AOA has undertaken, in principle, to work towards aligning processes with RACS in this regard. An update and copies of piloted surveys are awaited.
New Zealand Board of Orthopaedic Surgery	The NZOA has contributed to the RACS Surgical Supervisors Project. We support this project.

3 Statistics and annual updates

- Please provide data in the tables below showing a summary of accreditation activities in **2023** including sites visited, sites/posts accredited, at risk of losing accreditation, and not accredited.

Site Accreditation Activities			
	Australia	New Zealand	Total
Total number of sites	515	83	598
Number of sites/posts visited	247	46	293
Number accredited – new sites	16	10	26
Number accredited – reaccredited sites	161	35	196
Number not accredited – new sites	4	0	4

Number not accredited – reaccredited sites <i>If there are sites not reaccredited, please provide reasons why in the box below</i>	5	1	6
See Table			
Number at risk of losing accreditation <i>If there are sites at risk of losing accreditation, please provide reasons why in the box below</i>	7	1	8
See Table			
Training Committee/Board	Response		
Cardiothoracic Surgery Training Committee	Number: Risk:		
Board of Neurosurgery	<p>Number: No sites were disaccredited in 2023. One Training Network converted to a single Training Site, reducing its posts from three to two (by choice). One new training site applied and was not accredited.</p> <p>Risk: During 2023, four training units were identified with deficiencies resulting in reduced validity periods of one year with reassessment during 2024, and a fifth training unit was given a reduced validity period of three years with reassessment during 2026.</p>		
Committee of Paediatric Surgery	<p>Number: One</p> <p>Risk: None</p>		
Board of Urology	<p>Number: One Victorian hospital disaccredited from commencement of 2024. The hospital had 4 posts and the Board determined that there was insufficient major operative exposure for 4 trainees so disaccredited one post. The remaining 3 posts are accredited.</p> <p>One New Zealand training post was reviewed in 2023 and disaccredited immediately (May 2023) due to lack of trainee operative exposure which did not meet the minimum criteria. The trainee was offered the opportunity to relocate to continue training but elected to remain in the post in an unaccredited capacity and interrupted training for the remainder of 2023.</p> <p>Risk: None</p>		
Board of Vascular Surgery	<p>Number: None</p> <p>Risk: Currently, no training posts require monitoring.</p>		

	In 2024, accreditation in progress includes 10 hospitals undergoing accreditation assessment in 2024. (One new accreditation and nine standard re-accreditation inspections)
Australian Board in General Surgery	Number: No sites were disaccredited in General Surgery in 2023. Risk: Cannot provide this information as we have not conducted the inspections in 2024. There are 171 posts across 55 hospitals that are being inspected in 2024.
New Zealand Board in General Surgery	Number: None Risk: None
Board of Otolaryngology Head and Neck Surgery	Number: One site lost accreditation due to the departure of surgical supervisor, who was a previous SIMG who returned overseas leaving insufficient supervision for the trainee at the post. Risk:
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	Number: One Risk: There are no centres which are planned or threatened with dis-accreditation in 2025.
Australian Board of Plastic and Reconstructive Surgery	Number: One site in NSW not accredited for failing to adhere to conditions placed on previous accreditation. At the point when a new accreditation application form was produced by the site, the hospital failed to meet more than one of the 8 standards for accreditation. Risk: One site in NSW at risk for lack of appropriate level of requisite consultants (supervisors and trainers). Out of cycle inspection planned for 2024. One site in NSW at risk for lack of provision of adequate case mix and case volume combined with inadequate trainee rosters and planned educational activities. Annual follow up reporting has been insufficient or refused to be submitted. Out of cycle inspection planned for 2024.
New Zealand Board of Plastic and Reconstructive Surgery	Number: One post with concerns over appropriate supervision of trainees. Risk: Two posts with follow-up review to be undertaken in July 2024 relating to concerns over appropriate supervision of trainees.
Australian Orthopaedic Association Federal Training Committee	Number: Two training posts had accreditation withdrawn in 2023 Risk: Significant impact in staff changes meant inability to meet AOA standards relating to supervision and operative exposure
New Zealand Board of Orthopaedic Surgery	Number: None Risk: None

- Please provide a brief outline in the table below on college processes to ensure that training sites that are undergoing accreditation are Culturally Safe.

f

College response	
As discussed elsewhere in this report, the HTP standards mandate that sites undergoing accreditation must be culturally safe. More specialty specific comments are made in the table.	
Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	
Board of Neurosurgery	The SET Board of Neurosurgery approved new training post accreditation regulations in 2023 which will be introduced when the new RACS HTP process is implemented. The revised regulations include a section on Cultural Competency and Safety.
Committee of Paediatric Surgery	The inspection team gather information (such as policy and procedures) and conduct interviews with key stakeholders around expected behaviours when dealing with Trainees, workplace culture, actions taken around complaints and request examples and outcomes. All visiting inspection teams are required to comment on the Hospitals ability to Build and maintain a Culture of Respect for patients and staff (standard 1).
Board of Urology	The Board of Urology is awaiting the implementation of the RACS HTP process and will update the Training Post Accreditation Standards at that time. The update will include specific criteria to ensure training post are culturally safe.
Board of Vascular Surgery	Vascular Surgery reviewed and updated the HTP Accreditation regulations (pending approval by EC) to include the requirement for hospitals to provide evidence of cultural safety policy and training.
Australian Board in General Surgery	ABiGS follows the Accreditation Standards are per RACS. Issues with DBSH are reported as per the Regulations and legal guidelines noting that neither ABiGS nor RACS has the investigative authority. However, issues are raised with the hospital and it has been the practice of the ABiGS to work with the hospital to review the issues, request the hospital undertake an investigation, and request that the hospital reports back to the ABiGS on how the issues are addressed to ensure that the work place is safe.
New Zealand Board in General Surgery	The NZAGS had earlier mandated completion of cultural competence and cultural safety training for all consultants involved in training. And all staff.
Board of Otolaryngology Head and Neck Surgery	The Board will apply RACS approved training post accreditation regulations when the new RACS HTP process is implemented.

	The revised regulations include a section on Cultural Competency and Safety.								
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	Response aligns with Board of Otolaryngology Head and Neck Surgery (BOHNS).								
Australian Board of Plastic and Reconstructive Surgery	<p>The Australian Board of Plastic and Reconstructive Surgery has developed a draft training post accreditation regulations (2024) for consideration in July 2024. The regulation references the current assessment form which include the following cultural safety standard:</p> <table border="1"> <thead> <tr> <th>Accreditation Criteria</th> <th>Factors Assessed / Minimum Requirements</th> </tr> </thead> <tbody> <tr> <td>1. The hospital culture is of respect and professionalism</td> <td> <p>Expressed standards about building respect and ensuring patient safety.</p> <ul style="list-style-type: none"> • ... • Hospital has policies and procedures, including training for all staff, that promotes a culture and environment of respect. </td> </tr> <tr> <td>...</td> <td></td> </tr> <tr> <td>4. Indigenous cultural competence</td> <td> <ul style="list-style-type: none"> • Sites can demonstrate a commitment to Aboriginal and Torres Strait Islander cultural competence through formalised policies. • Unit staff are trained on discussion of Aboriginal and Torres Strait Islander cultural competence with their peers and trainees. • Monitoring of interactions with indigenous populations and processes to evaluate local or network programmes. </td> </tr> </tbody> </table> <p>By February 2023 the Board had developed a “Part B” Training Post Accreditation regulation. The implementation of this regulation has halted while the Miller Blue Group reviews accreditation. It will introduced when the new RACS HTP process is implemented. The revised regulations will reference the assessment form which will include a section on Cultural Competency and Safety.</p>	Accreditation Criteria	Factors Assessed / Minimum Requirements	1. The hospital culture is of respect and professionalism	<p>Expressed standards about building respect and ensuring patient safety.</p> <ul style="list-style-type: none"> • ... • Hospital has policies and procedures, including training for all staff, that promotes a culture and environment of respect. 	...		4. Indigenous cultural competence	<ul style="list-style-type: none"> • Sites can demonstrate a commitment to Aboriginal and Torres Strait Islander cultural competence through formalised policies. • Unit staff are trained on discussion of Aboriginal and Torres Strait Islander cultural competence with their peers and trainees. • Monitoring of interactions with indigenous populations and processes to evaluate local or network programmes.
Accreditation Criteria	Factors Assessed / Minimum Requirements								
1. The hospital culture is of respect and professionalism	<p>Expressed standards about building respect and ensuring patient safety.</p> <ul style="list-style-type: none"> • ... • Hospital has policies and procedures, including training for all staff, that promotes a culture and environment of respect. 								
...									
4. Indigenous cultural competence	<ul style="list-style-type: none"> • Sites can demonstrate a commitment to Aboriginal and Torres Strait Islander cultural competence through formalised policies. • Unit staff are trained on discussion of Aboriginal and Torres Strait Islander cultural competence with their peers and trainees. • Monitoring of interactions with indigenous populations and processes to evaluate local or network programmes. 								
New Zealand Board of Plastic and Reconstructive Surgery	NZBPRS currently applies the RACS Hospital Accreditation standards. A review of 3 training hospitals will be undertaken later in 2024 and will be including provision of a culturally safe environment.								
Australian Orthopaedic Association Federal Training Committee	<p>AOA Accreditation Standards incorporate provision of a culturally safe environment as follows:</p> <p>Standard 2: Trainees’ wellbeing, health and safety is prioritised.</p> <p>The training environment prioritises trainee wellbeing, health and safety, and minimises the effects of fatigue and workload.</p> <p>2.1 Trainees work in an environment that promotes respect for one another and professionalism of all employees. The hospital can demonstrate:</p>								

	<ul style="list-style-type: none"> the mechanisms in place to manage complaints in relation to bullying, harassment or discrimination should the situation arise. a commitment to cultural competence, including Aboriginal and Torres Strait Islander, Māori, and all other cultures.
New Zealand Board of Orthopaedic Surgery	This is one of the components of our accreditation documentation. The inspectors discuss with the hospital management, staff and current trainees cultural safety in the hospital, this is reported on in the report to the Board.

Standard 9: Assessment of specialist international medical graduates

Areas covered by this standard: assessment framework; assessment methods; assessment decision; communication with specialist international medical graduate applicants.

1 Summary of significant developments

This section gives the AMC information on the continuing evolution of the college's programs. Please provide a summary of significant developments completed or planned relevant to Standard 9.

<p>Has there been any significant developments made against this standard?</p> <p><i>If yes, please describe below.</i></p>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No change
<p>SIMG assessment is a high-stakes decision for the SIMGs; for RACS; for regulatory authorities such as the AMC, MBA and MCNZ; for government; and for the community. FRACS authorises doctors to provide surgical care anywhere in Australia and Aotearoa New Zealand across a diverse array of patient and variably resourced health services for any given scope of practice. Each SIMG, in any program or location, needs to know what skills they need to develop and the scope of practice they are working towards, based on context and community need (vocation and location). They also need to know the expectations required of them and that they will have the support needed to meet them.</p> <p>RACS has undertaken a review of its SIMG application process and identified a significant number of pain points and risks that need to be addressed (9.1 SIMG Application Process).</p> <p>The process (very simplified) is:</p> <ul style="list-style-type: none"> application reviewed and any missing documents requested progress to document-based review proceed to interview following review outcome arrange interview notify SIMG of outcome. <p>RACS is committed to improving its SIMG assessment process to meet Ahpra benchmarks. RACS will develop and implement strategies to ensure that it meets these performance measures for both the document-based reviews and the interviews (i.e. overall outcome measures). RACS is currently reviewing its SIMG assessment policy; however, changes in assessment processes, including the review and revision of assessor training and ensuring that assessors are assessing in accordance with AMC and MBA regulations, will take 3–6 months to align procedures with policy.</p> <p>RACS has also begun to address issues in application processing times, with a dedicated review and quality improvement process implemented in January 2024. RACS has undertaken a review of its SIMG application process and the SIMG assessment team</p>		

structure. Current process and team management has been under review and improvement over the past 6 months. KPIs have been established for SIMG application processing to ensure that applications are allocated in a timely manner and there is resourcing and support to ensure that the coordinators can deal with the applications efficiently and in accordance with the performance indicators that have been set. RACS has a strategy in place to increase the number of assessors, which is being discussed at the SIMG meeting on 30 May 2024.

In 2024, as part of improving the SIMG applicant experience, RACS has:

- implemented regular touch points with each SIMG, to ensure they are updated on the progress of their application
- addressed SIMG management, working towards 1- or 2-day timeline responses to requests/communications after initial SIMG contact
- edited all RACS materials and resources that SIMGs utilise to ensure they are accessible and align to Ahpra material to reduce process confusion
- designed a self-assessment tool for SIMGs to complete before applying to ensure eligibility requirements can be met and to improve process efficiency
- committed to undertake regular pipeline reviews to ensure no bottlenecks or unnecessary delays arise.

In March 2023, RACS had a 10-month backlog in Australia; as of May 2024 there is a 2-week backlog (recognising the backlog start date refers to the application being allocated to a RACS specialist assessment coordinator to ready the documents for the assessors). RACS intends to continue work in improving this process and to reduce the waiting time post-submission of applications to 2–4 weeks by early 2025.

RACS aims to ensure that it is meeting the needs of SIMGs in terms of overall experience, as well as seeking to see how it can implement systems that provide efficient, effective and sustainable application management to meet the needs of the organisation. The College commenced a project in February 2024 looking into application software to determine effective long-term management of applications, as well as improving overall SIMG experience. Process mapping has been done and a business case has been developed for approval in May 2024 ([9.2 Outline Business Case SIMG Application Process](#)). The project is in the preliminary stages of investigating application software to determine whether it will meet RACS's needs. This project does not delay RACS in continuing to implement process improvements in terms of SIMG assessments.

There are 3 parts that require consideration in terms of quality assessment of SIMGs: (i) the information provided; (ii) the policies, processes and procedures that need to be in place to ensure that the assessments are fair, transparent, equitable and accountable to the regulatory authorities; and (iii) the SIMG pathways that must address the needs not only of each SIMG but also the patients and communities they serve. RACS has commenced a comprehensive review of its SIMG assessment process from application to FRACS and its Fellowship pathways, from the perspective of the information and support provided for SIMGs and the overall SIMG experience. The preliminary outcomes of this review process are presented here, acknowledging that the work is ongoing and forms a major part of RACS quality improvement plans for 2024 onwards.

As part of its ongoing quality improvement, RACS has undertaken review of its guides, regulations and policies and of the website to ensure that the information provided for SIMGs is readily accessible, current and consistent with the policies and processes of the AMC, MBA and MCNZ. RACS also wishes to continue to work closely with the MBA and

MCNZ to ensure that its SIMG pathways continue to deliver skilled surgeons where they are most needed.

RACS has undertaken preliminary mapping terms of the SIMG assessment processes across the College and the societies ([9.3 2023 SIMG Assessment Data](#)). The specialist societies have also progressed their work in terms of assessment of SIMGs, as outlined in this report.

Assessment for eligibility for RACS Fellowship for New Zealand SIMG surgeons is a separate process once vocational registration has been attained. In Aotearoa New Zealand, similar processes are utilised by RACS for SIMG assessment progression to FRACS as in Australia, including the Fellowship examination. In Aotearoa New Zealand, the Fellow is not required to practice an approved surgical scope of practice. MCNZ has reported that it is expecting ministerial and government action with regards to SIMG processes, and RACS intends to work closely with MCNZ in this work. RACS Aotearoa New Zealand reports that it is now 70% on time with all advice for 2024. This will continue to improve as the new process is implemented. MCNZ has provided positive feedback to RACS about the complete and rapid turnaround of advice timeframes ([9.4 International Medical Graduates Report to MCNZ](#)).

The most pressing issue relates to the SIMG assessment process conducted by RACS, specifically the comparability of experience. RACS takes this matter seriously and is committed to ensuring that its assessments align with MBA and AMC standards. It is essential that there is consistent alignment across RACS, supported by evidence-based practices, on how to assess comparability of experience. Currently, this alignment is being reviewed to ensure full compliance with the standards, policies and procedures of regulatory authorities such as the MBA, MCNZ and AMC. Further information on this review process is outlined in the QI section.

RACS is committed to working closely with the AMC, MBA and MCNZ to ensure that its SIMG assessment processes are working efficiently and effectively to meet the needs of SIMGs and their communities. This includes implementing key performance measures for each step of its SIMG assessment processes and monitoring progress against these timelines, looking for efficiencies where possible. Further information about the steps RACS is taking in terms of the quality improvement of its SIMG assessment process is in the QI section of this report.

The AMC also expects accredited providers to report on matters that may affect the accreditation status of the programs, such as a change to capacity to meet the accreditation standards, or any change that may meet the definition of a major change to the program. If relevant, please report on such matters in this section of the report.

<p>Has the College made any significant changes affecting the delivery of the program? i.e. changes to processes for assessing overseas-trained specialists.</p> <p><i>If yes, please describe below the changes and the potential impact on continuing to meet these standards.</i></p>	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No change

2 Activity against conditions

The numbering of conditions matches that used in the AMC Accreditation Report.

Please address each of these conditions individually.

Condition 20		To be met by: 2023			
Develop and implement alternative external assessment processes such as workplace-based assessments to replace the Fellowship Examination for selected specialist international medical graduates. (Standard 10.2.1)					
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied	
			X		
2023 AMC commentary					
There is continued development of EVOPP as an alternative to the FEX for selected IMGs, but this is not yet fully implemented, but seems urgent. More information is required to be able to close this condition.					
2024 College Response					
<p>The external validation of professional performance (EVOPP) has undergone piloting (1.27 EVOPP Discussion Paper) for several years now but has not become mainstream business for RACS as the resources needed for this approach are extensive and the business case to support widespread availability is not developed. The SIMG committee assessed these pilots at first, but the committee was disbanded and no further pilots have been evaluated since it was reformed in February 2024.</p> <p>RACS has finalised an EVOPP policy (1.26 SIMG EVOPP Policy) and implemented assessor training for EVOPP, with 9 pilots completed in 5 specialties in 4 jurisdictions, and candidates from a range of countries of origin.</p>					
<p style="text-align: center;">EVOPP Pilot Process</p> <pre> graph TD A["Two fellows from specialty with minimal prior knowledge of the SIMG or potential conflict of interest"] --> B["Well trained and supported"] B --> C["Observe in: • Theatre • Consulting • Ward round"] C --> D["Gather feedback from multiple sources • Interview Supervisor • Interview Peers • Interview Junior Doctors • Interview Nursing and ancillary staff"] D --> E["Case based discussion"] </pre>					
Six of the 9 candidates were regarded as ready for independent practice.					
<u>EVOPP pilot results</u>					
PILOT	SPECIALTY	STATE	COUNTRY of ORIGIN	DATE	INDEPENDENT PRACTICE?
1	ORTHO	QLD	UK	Oct-18	YES
2	UROLOGY	QLD	UK	Nov-18	YES

3	UROLOGY	VIC	UK	Feb-19	YES
4	GENERAL	VIC	INDIA	Jan-20	NO
5	VASCULAR	WA	EUROPE	Jul-22	YES
6	GENERAL	NSW	UK	Nov-22	YES
7	GENERAL	NSW	EUROPE	Nov-22	NO
8	VASCULAR	QLD	SRI LANKA	Jul-23	NO
9	CARDIO	VIC	INDIA	Aug-23	YES

EVOPP assessors agreed that it was possible to assess all RACS competencies. EVOPP 1–8 assessors were comfortable in being able to answer the question ‘Is this surgeon ready for independent practice’. EVOPP 9 assessors expressed their concern that while they felt the SIMG was ready for independent practice in the setting in which they were being observed (large tertiary setting), they were uncertain as to how this would translate to performance in a smaller centre.

EVOPP 5–8 assessors were asked to separately rate specific competencies that had been mapped for each activity. This enabled a map of competencies to be developed for each assessor, then combined. Examples of the competency maps are shown below, with the addition of a traffic-light overlay.

This candidate’s performance has been rated as satisfactory in all areas. All competencies have been assessed multiple times, with a total of 110 assessment points. In reality the number is higher, as the case-based discussion with variations was rated only once, when it could have been rated 20 times.

	EVOPP2	PILOT7										TOTALS
COMPETENCY		MEDICAL EXPERTISE	TECHNICAL EXPERTISE	JUDGEMENT	PROFESSIONALISM	HEALTH ADVOCACY	COMMUNICATION	COLLABORATION	LEADERSHIP	SCHOLARSHIP	CULTURAL SAFETY	
ASSESSOR 1	ACCEPTABLE	0	2	4	5	4	2	5	5	3	5	35
	CONCERNS	2	2	2	0	0	0	0	0	0	0	6
												41
ASSESSOR 2	ACCEPTABLE	2	3	4	7	7	4	7	4	3	7	48
	CONCERNS	2	0	3	0	0	0	0	2	0	0	7
												55
COMBINED	ACCEPTABLE	2	5	8	12	11	6	12	9	6	12	83
	CONCERNS	4	2	5	0	0	0	0	2	0	0	13
												96

The assessors have indicated concerns in the areas of medical expertise, technical expertise, judgement and decision-making, and management and leadership. There is reasonable but not complete concordance between the assessors, remembering that each assessor obtains a slightly different view of the candidate due to which element of the EVOPP is undertaken. There are no concerns regarding the other competencies.

EVOPP8		PILOT 8										TOTALS
COMPETENCY		MEDICAL EXPERTISE	TECHNICAL EXPERTISE	JUDGEMENT	PROFESSIONALISM	HEALTH ADVOCACY	COMMUNICATION	COLLABORATION	LEADERSHIP	SCHOLARSHIP	CULTURAL SAFETY	
ASSESSOR 1	ACCEPTABLE	2	3	4	6	5	4	7	6	3	6	46
	CONCERNS	1	1	3								5
												51
ASSESSOR 2	ACCEPTABLE	3	5	7	7	6	4	8	7	3	6	56
	CONCERNS											0
												56
COMBINED	ACCEPTABLE	3	8	11	13	11	8	15	13	6	12	100
	CONCERNS	1	1	3	0	0	0	0	0	0	0	105

Assessor 1 raised concerns in the competencies of medical expertise, technical expertise, and judgement and decision-making. Assessor 2 did not raise any concerns. However, in their final report both assessors agreed there were concerns in these areas. This candidate was judged as not ready for independent practice. During feedback, strategies to improve performance in these areas was provided.

The maps confirm that the rating for each competency was based on multiple observations. A 2-point scale was used for assessment. Performance was rated either as acceptable or there were concerns. The threshold for recording concerns was low. This rating scale contrasts with the more common 4- or 5-point scales as used in SET. It is easier for assessors to indicate if they have concerns, than to rate performance as borderline or satisfactory.

There are currently 28 EVOPP assessors, covering all specialties.

The piloting of EVOPP has been hampered by difficulties in distinguishing those SIMGs suitable for an alternative assessment such as EVOPP, rather than the FEX – in other words, identifying selected SIMGs with a sound assessment evidence base on which to make that distinction. EVOPP is also resource heavy, like many alternative pathways for SIMGs, and thus relatively expensive. For instance, the clinical assessment elements and time spent for SIMGs on EVOPP includes:

- 3 monthly meetings with clinical assessors for performance review
- completion of the RACS Morbidity Audit and Logbook Tool (MALT)
- 6 monthly multisource feedback (eMSF)
- 3 monthly direct observation of procedural skills (DOPS)
- 3 monthly mini-clinical examination (Mini-CEX) assessments.

Sponsorship from health services and others could assist once the cohort for EVOPP is clearly determined.

RACS is aware of the ACCC issues surrounding recognition of the scope of practice and selection of SIMGs into FRACS over more than two decades, when significant differences remain in comparability rates across different specialties and across Aotearoa New Zealand and Australia. The advantage of being a bi-national medical college is that RACS has extensive experience in terms of assessment of SIMGs in two different regulatory systems, which in turn helps inform Australian and New Zealand processes in terms of assessment of scope of practice and surgical specialist comparability. This in turn helps inform both countries' regulatory authorities in terms of next steps forward. RACS intends to work closely to assist AMC, MCNZ and MBA in this important work.

RACS will undertake a formal evaluation of EVOPP as part of its QI to ensure that it can affordably and accessibly deliver good performance in terms of its psychometric measures, with a focus on reliability (sampling), validity (authenticity and integration of competencies) and educational impact, as well as addressing issues such as feasibility and how the assessment method addresses context-dependent compromises.

Specialty self-assessment for condition 20

Training Committee/Board	Response
Cardiothoracic Surgery Training Committee	This condition is undertaken through RACS.
Board of Neurosurgery	<p>The SET Board of Neurosurgery and NSA cannot comment on the management of Specialist International Medical Graduates as it receives no funding from RACS to perform tasks in this area and there is no Agreement in place between the RACS and the Neurosurgical Society of Australasia (NSA) to that effect. These are functions coordinated by RACS.</p> <p>Independently, the NSA is currently undertaking a review of overseas specialist qualifications in neurosurgery in comparison to the SET Program in Neurosurgery. The purpose of the review is to determine the comparability of specialist international medical graduates to Australian or New Zealand neurosurgeons. The outcome of the review will be published by the NSA during 2024.</p>
Committee of Paediatric Surgery	The Committee of Paediatric Surgery has a Specialist International Medical Graduate Representative on the Committee of Paediatric Surgery and is keen to agree to a strategy and pathway for SIMGs to achieve FRACS.
Board of Urology	<p>RACS is undertaking work to demonstrate compliance with Conditions 20. The SIMG Representative on the Board of Urology is a member of the RACS SIMG Committee and has been actively involved.</p> <p>Additional commentary</p> <p>USANZ personnel are in regular contact with Urology SIMGs and invite them to all available Fellowship Examination preparation activities, including:</p> <ul style="list-style-type: none"> USANZ Trainee Week Practice Examination Sessions Regional Training Activities (e.g. Skills Labs, Hospital Teaching Sessions) <p>SIMGs are also encouraged to liaise with SET Trainees for examination preparation purposes and to join study groups.</p>
Board of Vascular Surgery	While most of the work is done by the college, Vascular Surgery has a member responsible for SIMGs on its Board and is committed to working in collaboration with the college in managing SIMGs following initial assessment.
Australian Board in General Surgery	The Australian Board of General Surgery continues to manage SIMGs following initial clinical assessment and works closely with RACS. Whilst the EVOPP program is driven by RACS, General Surgery has also participated in the pilot EVOPP program.

New Zealand Board in General Surgery	The NZ Board of General Surgery noted most of this work is being done by RACS and have advised RACS that the MCNZ is looking at piloting EVOPP with government funding.
Board of Otolaryngology Head and Neck Surgery	<p>Several current / past members of the OHNS Board have completed EVOPP training and supports this model for SIMG assessment in place of the Fellowship examination in appropriate cases.</p> <p>ASOHNS acknowledges that there has been a significant reduction in the timeframe for SIMG assessment by the SIMG team at RACS.</p>
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	NZOHNS plan to pilot the EVOPP with government funding.
Australian Board of Plastic and Reconstructive Surgery	The ABPRS notes that most of this work is being done by RACS. EVOPP has not been trialled/piloted by ABPRS.
New Zealand Board of Plastic and Reconstructive Surgery	<p>The NZBPRS has limited direct involvement in this activity.</p> <p>The SIMG process in Aotearoa New Zealand is carried out by the RACS Aotearoa New Zealand SIMG committee on behalf of MCNZ, but the MCNZ makes the final decision regarding vocational registration. NZBPRS has nominated PRS representatives on the RACS Aotearoa New Zealand SIMG committee.</p> <p>RACS Aotearoa New Zealand SIMG committee is involved, along with Australia, in streamlining the process for applicants.</p> <p>NZAPS would support a pathway to Fellowship for SIMGs who have undergone the stringent assessment process and been approved as vocational registered as PRS surgeons in Aotearoa New Zealand.</p>
Australian Orthopaedic Association Federal Training Committee	<p>The AOA Board, Federal Training Committee, Rural / Regional Committee and SIMG Assessment Committee have jointly been giving strategic consideration to better supporting SIMGs under assessment. In very practical ways the AOA SIMG Assessment Committee has implemented several measures to support SIMGs including establishment of a mentoring program, Fellowship Examination preparation support and readiness assessments, and a recommendation that any SIMGs on a pathway to Fellowship via examination be required to attend bone school alongside AOA trainees. To make bone school more accessible, the fee has been reduced. SIMGs who pay the bone school fee are invited to attend local bone school sessions (which in turn facilitates joining local study groups) practice exams and the national trial fellowship exam as well as having access to all online training resources on AOAs Learning Management System. The AOA have potential EVOPP assessors nominated, most of whom are awaiting provision of training by RACS.</p>

New Zealand Board of Orthopaedic Surgery	The NZOA is involved in the accreditation of SIMGs through involvement of the NZOA Censor who is a member of our NZOA Education Committee and SOTB with assessment and monitoring as well as independent VPAs.
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3 Statistics and annual updates

Please provide data showing:

- the numbers of applicants and outcomes for Specialist IMG assessment processes **for 2023**, broken up according to the phases of the specialist international medical graduate assessment process (e.g. paper-based assessment, interview, supervision, examination). If a bi-national college, please provide separate figures for New Zealand and Australia. Please provide separate area of need and Specialist IMG figures.

Australian processes

New Applicants undertaking SIMG Assessment	
*Number of new applicants in 2023:	Number
	75

Assessment of SIMGs	
Phase of IMG Assessment	Number
Interim assessment	57
Interim assessment outcome: <ul style="list-style-type: none"> not comparable partially comparable substantially comparable 	not comparable: 22
	partially comparable: 23
	substantially comparable: 12
**Ongoing assessment	108
	Cardiothoracic Surgery: 16
	General Surgery: 30
	Neurosurgery: 4
	Orthopaedic Surgery: 20
	Otolaryngology, Head and Neck Surgery: 13
	Paediatric Surgery: 3
	Plastic and Reconstructive Surgery: 12
	Urology: 6
Vascular Surgery: 4	
***Final assessment	Recommended for specialist recognition (full scope): 23

	Recommended for specialist recognition (limited scope) – specify limited scope: 2
	Not recommended for specialist recognition: 7
****Total:	32

Notes:

* Applications ‘received in 2023’ or ‘received and assessed in 2023’ or ‘received from 2021 and assessed in 2023’ (Metric 1 Ahpra reporting) is **136**.

** Total number of SIMGs on the specialist pathway, by specialty (status: accepted recommendation, under supervision, completed supervision pending admission) as of 31 December 2023, who have not yet been issued a Report 2.

*** Outcome of final assessment in 2023 (as recorded in Report 2). Final assessment completed as per MBA Report 2.

**** Metrics are not aligned to provide a total as multiple SIMGs are included across figures. This figure is the total number of SIMGs who received an outcome of final assessment.

New Zealand processes

Advice provided to the MCNZ on the equivalence of SIMG qualifications, training and experience in 2023.

Preliminary (paper-based) advice		
Outcome	Vocational scope 1	Vocational scope 2
Equivalent	0	
As satisfactory as	5	
Neither equivalent to, nor as satisfactory as	3	
Unable to make a recommendation	3	
Total	11	

Interview advice		
Outcome	Vocational scope 1	Vocational scope 2
Equivalent	3	
As satisfactory as	20	
Neither equivalent to, nor as satisfactory as	4	
Total	27	

Section B: Reporting on Quality Improvement Recommendations

The College's accreditation report contains Quality Improvement Recommendations. These are suggestions for the education provider to consider (not conditions on accreditation), and the AMC is interested in how the College considers these, and what, if any, action occurs as a result.

The College is in **YEAR 7** of its accreditation cycle, this section is OPTIONAL, and a response is not required.

Quality Improvement Recommendation	Has the College undertaken any activities against this recommendation? <i>If yes, please describe below</i>	If no activities have occurred, will the College be considering this recommendation in the future? <i>If yes, please indicate below when the College is likely to consider the recommendation</i> <i>If no, please comment below on why the College has decided not to adopt the recommendation</i>
Standard 1: The context of training and education		
Nil Remain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard 2: The outcomes of specialist training and education		
Nil Remain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard 3: The specialist medical training and education framework		
Nil Remain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard 4: Teaching and learning approach and methods		
DD Consider mechanisms to support better access to training identified as lacking in parts of Australia and New Zealand (Standard 4.2.1)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard 5: Assessment of learning		

Nil Remain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard 6: Monitoring and evaluation		
Nil Remain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard 7: Issues relating to trainees		
Nil Remain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard 8: Implementing the program – delivery of education and accreditation of training sites		
Nil Remain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard 9: Assessment of specialist international medical graduates		
FF The College and specialty training boards are strongly encouraged to consider: <ul style="list-style-type: none"> i. Ways to improve timelines and transparency in communicating assessment decisions to SIMGs. ii. If expectations of SIMG candidates in the assessment of comparability in both Australia and New Zealand were reasonable. (Standard 10.3 and 10.4) 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>RACS is aware that there are several areas where it has been unable to make the progress intended since its last accreditation report. A major focus for RACS has been the need to strengthen its foundation in terms of governance, stakeholder relationships, and monitoring and evaluation, to provide assurance that it can and will deliver on key areas in terms of SET, assessment and SIMG pathways. These form the basis of this QI plan, from which a work plan has been designed for endorsement by the specialist societies and RACS council approval. Business cases will be developed for each activity.</p>	
Standard 1	
Governance innovation opportunities	<p>While RACS acknowledges the importance of the relationships it has with the specialist societies, its Trainees and Fellows, and its training site partner organisations, it now realises that if innovation opportunities are to be found, these relationships need to be leveraged to address pain points through the sharing of</p>

	<p>differing viewpoints and recognising differing skills sets. The 7 June 2024 workshop will provide the forum to commence a dialogue, recognising that this conversation must be more inclusive of the viewpoints of all stakeholders, including jurisdictions, to make progress.</p>
<p>SLAs with specialist societies</p>	<p>The work of rebuilding the relationships (authority, responsibility and accountability) with the specialist societies has begun and will continue to be a key priority to be managed through 2024–2025. This includes prioritising and sequencing the questions to be addressed in conversations with each training partner.</p> <p>Decisions around how to action these focus areas collaboratively are informing the process for renewed agreements as they fall due. The intention of these renewals is not wholesale change but to identify and better meet the needs of each party and those they serve over the next 3–5 years.</p> <p>Where the agreements differ only in syntax, the changes can be made to simplify and streamline expectations. Where one agreement offers a more precise or useful approach on a certain matter, this will be offered to other societies. Bespoke clauses—either short-term or permanent—will be negotiated and delineated.</p> <p>Where there is room for improvement—most notably around the flexibility and adaptability of the agreements to respond to changes in the SET environment or community, government, regulators, health services, other medical or health organisations and advocates—these will be sought from the societies as well as from RACS and its various advisory and governance bodies. These agreements are intended to become more flexible and adaptive to the changing context. Only excellent governance sitting beneath these documents can deliver that outcome, hence the RACS focus on governance at every level over the next 5 years.</p> <p>The common appendix A (who does what) is being developed as information for Trainees on who to contact for what purpose. RACS will be consulting with the specialty societies to implement this through Trainee communiques and website publication.</p> <p>Relationships with the specialist societies is a priority in 2024–2025. While the process of preparing this submission has shown where there have been gaps in</p>

	<p>understanding how each has approached their SET contribution, the diversity in process toward common outcomes has become even more apparent.</p> <p>The 7 June 2024 workshop with the specialist societies will start a program of renewal and reform across several key areas where alignment (not only mapping) makes good sense. This will commence with:</p> <ol style="list-style-type: none"> 1. responses to various reviews on behalf of RACS 2. cultural safety training provided by each of the specialist societies 3. SIMG comparability assessment processes and outcomes 4. HTP monitoring of jurisdictional and health services against HTP and early intervention when issues are possible or flagged 5. complaints management and governance across RACS 6. fee-sharing and key program milestones shared across RACS.
Organisational structure	<p>Further review of the RACS organisational structure is ongoing, with a view to remodelling following the financial review and likely constitutional changes. This will not impact negatively on the networked delivery of SET. A full review of the governance of education has commenced and will be implemented in 2024.</p> <p>RACS will explore efficiency reductions in fixed costs and direct costs through automation.</p>
Reconsideration, review and appeals process	<p>The impact of a revised reconsideration, review and appeals policy and process may also emerge from the NHPO implementation phase. RACS has reviewed its RRA and made some changes, but these have not yet reached the more comprehensive outcomes recommended by the NHPO.</p> <p>As a QI activity, RACS will explore if there are any other explanations for the low numbers of RRAs, including fearless access to the correct processes.</p>
Educational/technical expertise	<p>RACS recognises that many of the innovations it intended to implement for SET, particularly in terms of training management, Fellowship assessment and SIMG assessment, require educational/technical expertise.</p> <p>RACS will be in discussion with medical assessment experts. This is a dedicated QI activity and discussed in Standard 7 and 9.</p>

Interaction with the health sector	<p>RACS is committed to ensuring community needs are understood and integrated throughout RACS programs and is establishing a community reference group (terms of reference provided).</p> <p>RACS is aware that the implementation of its many frameworks depends on sound governance with the jurisdictions, the health services and the community. RACS cannot be on the ground in the setting where decisions are made and behaviours condoned, be they aligned or conflicting with the stated requirements under each framework. The HTP standards business case will address governance—the authority, responsibility and accountability of each party—and will determine ways to monitor, evaluate and action the proper implementation of the HTP standards behind which sit the AMC standards and the following action plans and frameworks:</p> <ul style="list-style-type: none"> • BRIPS and diversity and inclusion • Aboriginal and Torres Strait Islander and Māori health and cultural safety • Rural equity • Gender equity • Aboriginal and Torres Strait Islander and Māori reconciliation
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Standard 4

Ensuring policies and processes are accessible, available and responsive to ongoing feedback	<p>A major QI focus for RACS from 2024 through to end of 2025 will be to ensure that the College deeply understands the job to be done in terms of training from the community perspective—in this case, the Trainees current and future, the supervisors and assessors delivering SET, and the employing health services responsible for supporting SET delivery. This work includes review of all RACS and specialist society policies and processes to ensure they are in alignment, and are accessible, available and user-friendly. RACS recognises that strengthening the mechanisms by which all users can provide timely and actionable feedback on these policies and processes, will make sure that the needs and voices of key stakeholders are being listened to and appropriate action is being taken. RACS will implement quality measures to ensure all website links to the specialist societies are fully supported, and all fees—both overt and covert—will be added to this single source of truth for the public.</p>
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	A website renewal project will commence in 2024.2, so RACS and the specialist societies can more seamlessly provide information about fees, policies, processes and who-to-contact-for-what directories. This work will be assisted by the new working relationship between the specialist societies and the Trainees, supervisors, assessors, mentors and clinical educators across RACS.
Perioperative terms of reference	RACS has developed the terms of reference for a Perioperative Working Group, which will take a broader perspective that includes the full patient journey, not only what happens when surgery is planned. This working group will review the summary document mapping current specialty curricula and identify strategies for addressing any gaps, facilitate sharing of resources across specialties and further enhance perioperative care teaching and learning opportunities to ensure that RACS trainees understand and can respond to the broader perioperative care required for patients.
Standard 6	
Sharing of data	<p>RACS will develop an agreed upon bi-directional data specification and reporting schedule. This can involve sending and receiving data, enabling both parties to share information and updates reciprocally.</p> <p>Part of the challenge in transparently and conveniently packaging and presenting data and information, stems from the different timetables the specialist societies have in their activity schedules (e.g. fee setting). This will be addressed in negotiations with the specialist societies in 2024.2</p>
Monitoring and evaluation framework	<p>RACS has developed and had approved its overarching M & E Framework and the plan for implementation of the monitoring aspects of the framework. Work is well advanced towards a prototype for an agreed minimum dataset for all societies to share SET-relevant information; however, this will not be in place until 2025. (The reasons this will take time are documented above.)</p> <p>The MDS for evaluation is not yet finalised, and the MDS for monitoring is undergoing stakeholder refinement at present. Once the MDS is operational, reports can be run on the priority aspects of the M & E Framework. The M & E itself will remain a living document that can be adapted to report on emerging trends and issues, as well as on long-standing aspects of SET, requiring the input</p>

	<p>of the specialist societies each time it is adapted to address an additional or different issue or question.</p> <p>Additional reports may be requested by and shared appropriately through the CSET and Education Board to the RACS council, with recommendations for action. The reports will be instrumental in ensuring data are comprehensive and high-quality, as they will drive innovation and necessary interventions at all levels of the SET program. The reports will be made available on the RACS website, with links to the specialist society websites as appropriate.</p>
<p>Standard 7</p>	
<p>Selection</p>	<p>A quality assurance study will be undertaken to better understand if the variability in selection processes leads to consistent outcomes, and where this might not be the case, discussions with each of the specialist societies affected will take place as the SLAs are renegotiated. RACS will also interrogate selection outcomes along several variables over the past 3–5 years as a QI activity and share the results with the specialist societies.</p> <p>The recent national workforce reports suggest there has been improvement in the gender gap but not in the rural or Aboriginal and Torres Strait Islander gaps. These gaps are being progressed as a QI activity in 2024.</p>
<p>Fees</p>	<p>As RACS is a bi-national College, synergies are created by combining the respective resources of both countries. This arrangement drives economies of scale, which leverages resources to drive efficiencies in activities and relationships to achieve desired outcomes. Nevertheless, as part of the work undertaken on activity-based costing, a program of work exists to review direct and indirect costs across all the activities of the College over 2024 and possibly into 2025. The review will include all activities delivered and run in Aotearoa New Zealand. Undertaking this work together with the appropriate apportionment of overhead costs (Finance, HR, Governance, IT, marketing, insurance, accreditation costs etc.) will enable enhanced reporting, including the ability to provide an accurate profit & loss statement for the Aotearoa New Zealand operations.</p> <p>The activity-based costing will also provide greater clarity on the true cost (direct and indirect) to deliver the Aotearoa New Zealand operations, and likewise to clearly account for cashflows generated from those operations. As a bi-national</p>

	<p>entity, the cost to deliver services provided across both countries needs to be accounted for accurately, including for Fellowship engagement services (member engagement, member queries, debtor invoicing, debtor management etc.) use of the library, accreditation, staff to deliver training, and various marketing activities to name a few.</p> <p>Post-completion of the activity-based costing, RACS will be able to separate the cost of training programs in Australia and Aotearoa New Zealand over 2024/2025.</p> <p>RACS acknowledges fees are set by all specialist societies and RACS on an activity-based cost basis, but this does not address either price elasticity or inelasticity and as such does not address the value proposition for its members, for Trainees and the community. For instance, Aotearoa New Zealand Trainees commonly have their training fees reimbursed by their employer. This is part of a larger project that will commence in 2025.</p>
<p>Standard 8</p>	
<p>Supervisor feedback</p>	<p>Another way of collecting supervisor feedback can be via the working agreement (under HTP accreditation) that RACS has with health service facilities. De-identification can remain an issue in some settings. This option is being negotiated in the current round of talks by the RACS CEO and president with each jurisdiction.</p> <p>The establishment of a reference group equivalent to the RACSTA committee is under consideration and would require engagement with each of the specialist societies and the supervisors. That group could—as does RACSTA—provide de-identified feedback on global issues affecting many supervisors, and—with permission—could advocate for individual or small groups of supervisors willing to be identified.</p> <p>The lack of sufficient safe, high-quality supervisors in some locations and specialties in both Aotearoa New Zealand and Australia is a major barrier and threat to a more distributed, community-centric approach to site accreditation. All options are on the table—especially following the rural training summit early in 2024—to redress this shortfall.</p>

Supervisor assessment and HTP reporting and actioning	To date, RACS has not required health facilities and training posts to report on these standards or to notify RACS of any variations or violations of these standards. This is being addressed in the current meetings with each jurisdiction to determine how this reporting should be undertaken and who is responsible for resolving any issues arising from the reports.
Standard 9	
SIMG assessment process	<p>RACS intends to undertake a comprehensive review of its SIMG assessment process in its entirety, in terms of assessment processes, pathways and information provided for SIMGs.</p> <p>RACS commits to revise its policies and processes in relation to SIMG assessment to ensure that it is compliant with the standards and regulatory requirements. This work will commence beginning 2024.2 and be completed within the following 6 months, including revision of assessments, assessor training and revised published policies and processes.</p> <p>The issue of variability, in terms of comparability of experience, also needs to be addressed, with formal analysis of the assessments undertaken with the societies and led by an external assessment expert. This work will commence in parallel with the revision of the SIMG policies and processes for completion in 2025.1, as it is dependent on adoption of revised compliant policies and new processes in terms of assessment of comparability.</p>
EVOPP	RACS intends to host a meeting with all the societies at the governance and service level to address the foreseen and unforeseen barriers and enablers for EVOPP implementation. It is likely that these aspects—many of which are addressed in the Kruk report—will be the subject of further discussion across the whole medical college sector. RACS is keen to progress quickly on this critical matter, with its societies to inform the Kruk implementation process later in 2024-5. The 7 June 2024 workshop will be the first forum for discussing the concerns, as well as the best practice options, that the societies may have progressed or may have deliberated upon at that workshop.