Australian
Medical Council Limited

2025 Monitoring Submission to the Specialist Education Accreditation Committee

Royal Australasian College of Surgeons

Contents

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 Sub Committee, considers the monitoring submission and the commentaries on them.
- The Sub Committee 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 202*4 are available on the AMC's website here.

Guidance of 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'

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

1. 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 varies 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

[1] Section 48 Health Practitioner Regulation National Law

following:

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

2. 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 varies 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 2024 submission. If so, it will be included in this section.

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

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

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)

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.

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.

Trainee Committee submission

As part of its accreditation processes, the AMC invites trainees to provide feedback concerning the strengths, and areas for improvement in the processes and programs of accredited education providers, in the interests of quality improvement.

For a number of years, the AMC has invited the Trainee Committee of colleges undergoing an accreditation extension submission to provide its own submission addressing the accreditation standards. In 2025, the AMC will extend this process to invite Trainee Committees to provide comments annually, at the time of the College submitting its monitoring submission to the AMC.

The AMC will invite the College's Trainee Committee to coordinate a submission, addressing the accreditation standards. The College will be copied into all of our correspondence to the Trainee Committee regarding providing this feedback.

The AMC will consider the submission from the Trainee Committee alongside the College's monitoring submission. This process is strictly confidential, and submissions are kept internal to the AMC.

Trainee feedback is one source of information available to the AMC. The AMC would not change the accreditation status of a specialist medical program on the basis of a trainee committee submission alone. The AMC will notify the College if significant concerns or suggestions for improvements were raised in the trainee committee and seek the College's feedback before making any decisions that affect the College's accreditation.

Further Information

Please contact Simon Roche, Policy and Programs Officer, via email at specaccred@amc.org.au if you have any questions about the submission.

Monitoring Submission Template

This submission is due **Monday 2 June 2025**

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*

Accreditation History

Date of last AMC accreditation decision	*2023 via Accreditation Extension*
Periodic submissions since last AMC assessment	*2024*
Next accreditation decision due	*31 October 2027*

To be completed by the College

Officer at College to contact concerning the submission	*Stephanie Clota*
Email	*ceo.racs@surgeons.org*
Phone number	*+61 03 9276 7429*
Submission verification *The information presented to the AMC is complete and represents an accurate response to the relevant requirements, signed by the Chief Executive Officer/executive officer responsible for the program/s*	
Verified by	STEPHANIE CLOTA
Signature	
Date	2nd of June 2025

Summary of 2024 findings

Standard	2024 Findings	No. of Conditions remaining
Overall	**Substantially Met**	**13**
1. The context of education and training	Substantially Met	1
2. The outcomes of specialist training and education	Substantially Met	2
3. The specialist medical training and education framework	Substantially Met	2
4. Teaching and learning methods	Met	0
5. Assessment of learning	Substantially Met	1 (New condition added in 2024)
6. Monitoring and evaluation	Substantially Met	4
7. Issues relating to trainees	Met	0
8. Implementing the training program – delivery of educational resources	Substantially Met	1
9. Assessment of specialist international medical graduates	Substantially Met	2 (New condition added in 2024)

Section A – Reporting against the standards and accreditation conditions

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. Activity against conditions

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

Please address each of these conditions individually.

Condition 1				Due Date: 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 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	
2024 AMC commentary				
The submission provided many lines of evidence that showed far greater interaction and accountability across the College and its bodies such as the Council, the Education Board, Board of Surgical Education and Training, and Specialty Training Boards to enable each of the 13 training programs meet AMC standards and conditions. The approach taken by the College is “strengthening a networked approach with the promise and collaboration from all involved.” Service Level Agreements between the College and each society are at various stages, and arrangements vary, but there are some core elements. Several are up for review at the end of 2024. The status of each SLA and how the Training Committees/Boards are working with the College is outlined. This shows general awareness of the need to work together enable college training to meet standards and the conditions.				

There is evidence clear of progress towards meeting this condition, and greater consistency in many core education and training activities. Before considering it satisfied, the AMC would like to see demonstrated that recent gains in shared processes and accountability are sustained and sustainable.

In the next monitoring submission, the College is asked to please provide an update on the SLAs, as well as the processes being used to strengthen shared accountability for quality education and training.

2025 College response

Overview:

This monitoring response is in two parts:

1. Overall response from the RACS network responsible for the delivery of surgical education and training (SET), which reflects all of RACS and all the STB/Cs and specialty societies within which significant variations are highlighted. The variations are explained contextually and with evidence from one or more STB/C to underpin the variation.
2. Significant variation can be 'in the eye of the beholder' and so many of the contributions from the RACS contributors are also provided, similarly under each standard and condition. All Specialty Training Boards and Committees (STB/Cs) have been engaged in this process—most have submitted written responses, and all were represented at the recent national face-to-face meeting of training managers. Although not all individual contributions have been explicitly documented, they have informed both this submission and RACS' broader continuous improvement initiatives related to SET. This section is intended to illustrate the nuanced, but not necessarily substantially divergent, ways in which each STB/C approaches its role within the framework of SET delivery.

To be more precise and erudite with this submission than the last, those areas within each standard the AMC specifically highlighted in 2024, as well as each condition, have been prioritised. Some of these were areas also discussed at the February meeting following a further RACS written report as requested. This monitoring submission also acknowledges the additional report concerning SIMG processing requested by the AMC in May 2025.

The process for preparing this monitoring submission included comprehensive engagement with the specialist societies – primarily with the responses from every specialist society's training manager and their training board / committee – as well as from many sections of RACS and standing committees. For ease of reading, in the narrative we have used the surgical specialty and country rather than either the names of the specialist societies or their training boards or committees alphabetically. They are, however, the authors of any specified contribution and that is reflected in the content.

Wherever feasible we have, as requested, reported on the whole-of-college status on behalf of RACS and the STB/Cs combined, and this part of the commentary should be read as applying to SET as it is delivered across the network. We have, as requested, referenced where there is significant variation for one or more of the STB/Cs – meaning from each other or from RACS as the hub – and the nature, rationale and intention for that variation.

We have included a lot of the detail provided by the STB/Cs in Part 2, because the AMC were clear they wanted to see the actual impact of SET and changes to SET through various frameworks and policies and there are some contextual differences. The STB/Cs deliver SET and that is where the frameworks and policies are mostly actioned, and where impact for SET participants and the community they serve is most felt. This seemed a good way to reflect both the high-level consistency and

the context-driven diversity that makes up SET in Australia and Aotearoa New Zealand.

In addition to addressing the remaining and new conditions, the stated requirements in the 2024 AMC response and the new ones in this template, we have also added additional information under each standard that the AMC may find useful in its deliberations. This commentary also comes from the broad spectrum that is RACS including the STB/Cs, societies and various committees and recognises important variations and innovations from which the whole continues to benefit.

Many critical issues for RACS and for the AMC corelate with multiple standards, as might be expected when the on-the-ground delivery of the SET meets the more QA needs of the AMC. It is arguable where a theme might sit within the standards. Where there is an obvious alignment with one standard our commentary is therefore found – but where there is not, we have reported earlier rather than later and in comprehensive fashion for each theme.

RACS also appreciates the external environment remains somewhat volatile, uncertain, ambiguous and complex. Adaptation is a continuous process, and this submission reflects a point in time and in a space that is always moving as the core business and mission remain grounded.

Networked Governance, Shared Accountability and Policy Development

RACS has continued to reframe the partnership in surgical training e.g. co-designing training and ways to improve it, information sharing rather than 'reporting' between partners, mutually agreed roles and responsibilities, complementary rather than competitive responsibility allocation, sharing innovative thinking and action, identifying and working on common goals – e.g. ensuring quality, achieving standards, graduates able to meet diverse community needs. On 15 May 2025 the training managers from the specialist societies and those from RACS workshopped the critical areas this submission needed to address as identified by the AMC in its 2024 response and the 2025 provided template. Together they identified and agreed where their impact was 'globally' consistent as well as identifying key variations in one or more of the STB/Cs that others were very keen to learn from and perhaps adapt for their own setting.

Of significant importance is that each of the specialist societies has developed other relationships that impact on their delivery of SET. For instance, the bi-national agreements within a given or related specialty are critical at many levels, from the sharing of site accreditation to the design of curriculum and assessment.

CSET has held several cross-STB/C workshops since the last monitoring submission and the impact is reported throughout this monitoring submission. The aims have been to clarify and agree terminology, principles and specific shared interventions where appropriate, without compromising the integrity of context as set by the service or requirements that are delivered by each specialty. For example, in February 2025 CSET and RACS staff and committee chairs came together to discuss selection requirements focused on reducing bias, and equity strategies focussed on rurality and indigeneity.

A recent workshop held with key RACS managers and the STB/C training managers addressed the most pressing issues relating to the concerns expressed by the AMC in the 2024 response to the RACS submission and subsequently in follow-up meetings, reports and correspondence. The priority topics generated much cross-STB/C sharing, learning and elaborating. There are quarterly workshops with similar focuses planned, as requested by the Training Mangers for more opportunity to discuss such topics.

The topics on this occasion were:

- The schedule that sits with the SLAs and how they are delivered through SET

- The MTS / RACSTA results and the impact of the RACS frameworks
- Community and stakeholder engagement
- Monitoring and evaluation both formal and informal that takes place across the whole of SET and how it is communicated
- SIMG support available and shared from RACS and the STB/Cs

The SLAs are all in a different stage of re-negotiation and the key focus for the SET managers is the way the schedule is implemented, and the outcomes monitored and evaluated.

Attached is the SLA schedule that outlines the proposed governance of SET-related activity and outcomes**,** recognising the STB/Cs are at very different stages of experience and expertise (1.1 Draft RACS Collaboration Agreement Appendix). There is also variation in size, geography and access to resources. These differences are contextual and necessary, and RACS respects this differentiation without relinquishing the need to always demonstrate and hold as consequential the authority as well as the accountability and responsibility of all parties. This governance becomes even more critical to communicate, deliver and adapt as we work together to meet the needs of the profession, the sector and the community. SLAs update with each of the specialist societies and shared accountability (1.2 Society Agreements Tracking April 2025). As previously advised, the SLAs with the specialist societies are negotiated on a rolling timetable, and several were informed by a roadshow undertaken February – April 2025. New SLAs have the roles and responsibilities more clearly delineated. Importantly in this context, the minimum data set (MDS) will be defined and operational by June 2026.

Overall, through discussion with each of the specialist societies there have been strong signs of sustained and sustainable gains in shared processes and accountability including:

- The engagement markers are good with strong attendance and positive feedback from the surgical leader's forum and roadshow meetings. The structure of CSET has been amended to include virtual business meetings and three face to face workshops annually to increase opportunities for collaboration.
- The strong support for RACS board and constitutional revision in October 2024 has created a positive environment for change.
- Removing the previous fiduciary conflict of interest has created a better opportunity for societies/associations to be engaged directly at the Council level. All societies to date have been positive about this opportunity.

There are now standard and clearly defined non-negotiables and negotiables in terms of lines of responsibility for RACS and the Societies:

- Non-negotiables
    - Line of sight, including data, M&E and QA framework
    - Clear and detailed Responsibility/Accountability/Consulted and Informed matrix agreed

    - Flexibility to ensure regulatory compliance can continue to be met (as standards change for example)

- Negotiables

    - Format/structure of the relationship, for example where the responsibility for different activities sits can vary by specialty

There is an ongoing discussion towards a clear and agreed delineation between the need for standardisation and specialty specific contextual variation:

- There is agreement in principle across most of the societies
- There is support so far for the new format of the SLA with a common set of agreement clauses and variation under a RACI style appendix.

Where there is significant variation in the perspectives of RACS partners, it is often based on the capability/capacity/aspirations as an organisation rather than due to the technical specialty requirements.

Progress report on SLA negotiations and outcomes:

- Two iterations of SLA developed shared with all society CEOs.
- Detailed RACI appendix developed in collaboration with GSA, shared with all society CEOs, and Training Managers/STC/Bs for input (1.1 Draft RACS Collaboration Agreement Appendix)
- A third iteration will be required with further specific detail on the M&E, data and QA

Governance structure and accountabilities for SET

- This is well articulated in the terms of reference and the SLAs

Where there might be confusion often relates to the variation between programs. This causes challenges for everyone, as does the regular changeover of office bearers both within the college and specialist societies. Sometimes there is the need for further elaboration as to which entity has the responsibility or accountability for an activity e.g. which entity records compliance with cultural safety training for supervisors, assessors, educators and staff.

Four SLAs are due for renewal by 30 June 2025. All of these specialist societies are supportive of signing extensions to enable more comprehensive negotiation. The renewal through to 31 December 2025 is for the first four on the list. The aim now is for a three-month renewal with a focus on signing a new agreement, rather than continually leaning on more renewals every 6 – 12 months.

Nine SLAs are rolling, with no urgency in terms of time, but the majority of the specialist societies are engaged in renewal process so far (meetings with ANZSCTS and NZAGS are yet to be planned).

The second draft agreement has been circulated for comment, and as suggested by some of the specialist society CEOs, the next CEO monthly meeting is a good forum for discussion about what they would like from the agreement.

The renewal process will continue to take some time, but the next iteration incorporating society feedback should lead to a draft that can be considered by the various boards and councils.

The roadshows with each of the specialist societies and other engagements to date, dating back to last year, turned out to be more of a beginning of engagement in the renewal process, but only in a semi-formal sense.

All training managers now have access to the project tracker mentioned under organisational structure. All Training Managers attend regular meetings with RACS Education Pathways departmental staff. All specialist societies Chief Executive Officers have regular meetings with the RACS Chief Executive Officer across of all SET, mirroring the Training Managers meetings. All STC/B chairs meet in person and online at least six times per year through CSET.

Areas for improvement in 2025 -2026 include clearer communications across the whole of RACS. For example, RACS and Training Managers acknowledge different terms can mean the same thing and language/terminology will be a new area of effort to avoid misunderstanding into the future.

The STB/Cs also wanted to see a distinction between the SLA as signed by the specialist societies and what it meant practically in terms of the delivery of SET across each endeavour, with the thinking that a handbook might be considered to describe how the governance agreed at the Chief Executive Officer level – or Council level – plays out in the delivery of SET. At this level of required detail, the issue of who is responsible is not always apparent e.g. in the implementation of the RACS frameworks with some STB/Cs being more resourced and proactive than others.

RACS is working with the specialist societies through the roadshows on shared goals and priorities, the most important being the relationship with SET.

Variation: Networked Governance and Orthopaedics

In 2024 a tri-partite working group was formed across AOA, NZOA and RACS to investigate four potential models for improved engagement going forward - ultimately seeking to identify the best way for all three organisations to work collaboratively together in delivering orthopaedic surgery training and reducing costs for Trainees.

Shared Policy Review and Development

All policies and processes, including those relevant to SET and SIMG assessment are being reviewed this year. This is to ensure policies and processes are more easily accessed and responsiveness to feedback will be achieved by June 2026. This work, as it applies to SET, is being undertaken by CSET.

RACS is also developing a QA framework for SIMG assessment, and the policy audit/review aspect is discussed in Standard 9. This framework will be extended to SET as the policies are renewed.

With the assistance of the STB/Cs, the SET policy environment is being designed in a principles-based manner. Many of the STB/Cs have highly advanced policies and

robust procedures as well, and the key issue is how the governance and communication is subsequently agreed and delivered consequentially. The authority at each stage is assessed against the willingness and ability to action the concomitant accountability and responsibility. Not all polices are equal in their impact and risk and this aspect is also being taken into consideration in the SET policy review.

Example: Policy Review Urology

In 2024, the Board of Urology undertook a complete rewrite of the SET Urology Training Regulations. The main goal was to make the Regulations clearer, more practical, and aligned with current standards in medical education.

To do this, the Board benchmarked regulations from other medical and surgical specialties and referred to definitions and guidelines from key healthcare regulators such as the AMA and AHPRA. This helped ensure the updated Regulations reflected modern terminology and best practices.

Key improvements included:

- Clear definitions of key terms in an easy-to-read table
- Logical structure with headings, subheadings, and numbering
- Simplified wording and removal of confusing or unnecessary content
- Grouping of background information into a definitions section for better clarity

The RACS Education Committee Executive were supportive of the updated regulations, and thought they were considered orderly, clearer, and simpler than before. They commended the Board on such an approach.

Reconsideration, Review and Appeals

Those policies and processes concerning RRA are prioritised in the policy review. Concerning RRA, RACS undertook an external review through KPMG and is reviewing the advice as it awaits further direction from the NHPO before establishing an implementation plan. As discussed with the AMC in February, while some immediate changes have been made, RACS favours a single pivot – should that be required – to the RRA policies rather than a piecemeal approach that may confuse more than clarify Trainee and SIMG options.

Attached are the procedure details of the processes to be undertaken by an Original Decision Maker and RACS in implementing the three phases as per the Reconsideration, Review, and Appeal (RRA) regulation (1.3 Reconsideration, Review and Appeal Regulation). The scope of this procedural document applies only to decisions of RACS with due consideration to agreements with specialty societies.

Attached is the new Reconsideration, Review and Appeal Procedure (REG-2053) (1.4 Reconsideration, Review and Appeal Procedure)

These are also available for candidates, Trainees and SIMGs on the following pages of the RACS website:

https://www.surgeons.org/Trainees/the-set-program

https://www.surgeons.org/about-racs/policies

Attached is the Complaints Management Internal Audit led by KPMG (1.5 KPMG Complaints Management Internal Audit).

Attached is the Conflicts of Interest Regulation (1.6 Conflict of Interest Regulation).

Attached is Registration and Selection to Surgical Education and Training REG-2017 (1.7 Registration and Selection to Surgical Education and Training Regulation).

The same RRA applies to candidates as well as to Trainees and is outlined in the registration / selection policy. This is replicated for each of the STB/Cs. It is publicly available to all candidates and Trainees. Some STB/Cs such as AOA have RRA policies that are specifically related to selection. The AOA Selection Regulations are available on their website here: AOA Selection Regulations.pdf

Areas for improvement in 2025 - 2026 include clearer communications across the whole of RACS. A communication and escalation protocol between RACS and the STB/Cs will be developed to promote early resolution of issues and increase the efficiency and effectiveness of training outcomes. This also applies when Ahpra received complaints and actions them without the STB/Cs being formally aware. The training site may be aware of an investigation, and not necessarily the STB/C or RACS. A more joined-up process could see complaints managed more efficiently and effectively. This is under consideration as RACS is now aware of its obligations to Trainees and SET staff under The WHS legislation and looks forward to engaging with health services and AMC/Miller Blue as we progress the framework for managing complaints.

Terminology Across the Network

Some communication is easily rectified when a misunderstanding is based on terminology. RACS and training managers acknowledge different terms can mean the same thing and language / terminology will be a new area of effort to avoid misunderstanding into the future. RACS is working with the specialist societies through their roadshows on more individual missteps and how to address them better together in the future.

Underpinning the Improved Governance Across RACS

The STBs and STCs that make up CSET form part of the operational governance of RACS. They report to CSET, which is a committee of Council, and their TOR's and regulations are approved by RACS. The exception is AOA, whose training board operates under the authority of the AOA Board, with its powers and role defined by the service agreement between RACS and AOA. NZOA and NSA training boards report jointly to RACS and their respective society governing bodies. The STC/B training managers are employed by the specialist societies in a truly matrixed management model. The training managers also attend CSET.

The new RACS organisational structure and the constitution both sought to strengthen the relationships across the SET and SIMG endeavours, recognising such mechanisms facilitate rather than determine the success of those relationships.

Attached is an organisational structure (1.8 Governance Structure May 2025) that identifies where and how the STB/Cs and specialist societies and RACS as the hub of the network interact. It includes committees that members of the specialist societies are involved and also the more formal structures and functions that incorporate the views of the diverse in a RACS-wide manner.

An external review was undertaken to better align structure with strategic goals and ensure that critical member and operating activities are prioritised and resourced effectively. The corporate strategy has Council approval and sets a high-level future-focused map for the college as a whole. Progress against the plan is assisted by a project tracker. This should ultimately reduce workload pressures and position us strongly for the future. The new structure has been optimised for:

1. Member and stakeholder value creation by collating skills and know-how into logical groupings
2. Operational efficiencies by better organising the way we work and what we focus on to reduce complexity while maximising knowledge sharing and the cross-pollination of ideas and innovation
3. Financial sustainability and efficiency.

The structure is therefore designed with the same intentions as the constitution, as regards the AMC requirements. Specifically for SET, it has been implemented to improve the cross-departmental and specialist society collaboration, communication and decision-making. The impact of the changes is being monitored closely, looking for greater effectiveness and efficiency, less duplication and fewer gaps in service delivery.

A new Executive Leadership Team structure came into effect in September 2024 following an extensive analysis seeking the best fit-for-purpose and led by the Chief Executive Officer who joined RACS in February 2024. The new Executive Leadership Team engage with training and assessment and receive regular reports in order to do so. A Senior Leadership Team meeting was held in early May to align executive effort against the needs and priorities of the whole college.

FTE levels in the Education portfolio have remained stable, time to hire has been reduced significantly across RACS and a new Executive General Manager for Education Pathways (EGM) has now been appointed. An interim appointment ensured continuity of leadership through the recruitment process. Further evaluation of SET- and SIMG-related activity has been planned with an SIMG assessment outcomes audit in progress.

RACS has achieved financial stability and did not increase its member or Trainee fees in 2024 (not even by the CPI increase) but continues to closely monitor the new austerity to ensure training, education and assessment are not impacted adversely. RACS is reviewing all its products and services and is looking to reduce its skills course fees in 2026 as a result of an ongoing operational efficiency review and feedback from the STB/Cs, participants and educators.

Some STB/Cs have also restructured and reformed their leadership and training regulations with a view to improving the experience for Trainees, Trainers and Assessors in their SET.

RACS New Constitution

Attached is the new constitution and the status of its implementation, which began in October 2024 (1.9 RACS Constitution). With specific reference to training and assessment, the place of both is highlighted in the new governance structure and decision-making mechanisms. RACS has kept the specialist societies well-informed

through this process and is seeking to strengthen the connection with societies at all levels of RACS – including Council, Professional Standards, SET, advocacy and through CEO and management.

Adoption of a new constitution had similar objectives. The objectives the AMC required RACS to address are recognised in the new constitution.

- Line of sight across the networked SET
- Report impact and outcomes of changes to the SET program
- Facilitate innovation across the networked SET
- Ensure financial stability

RACS has strengthened its governance processes with a new transition board working towards the establishment of a skills-based board. The governance working group is building a governance system for the future that enables better alignment of strategic and operational priorities, thus improving the delivery and impact of surgical training, education and assessment and enhancing the position of CSET in that endeavour.

Governance review update is attached (1.10 Governance Reform Update).

Condition 21

Condition 21 NEW				**Due Date: 2025**
Demonstrate systematic processes for monitoring and evaluation across all specialties of the Reconciliation Action Plan, the Building Respect, Improving Patient Safety (BRIPS) action plan, the diversity and inclusion plan, and the Rural Health Equity Strategic Action Plan (Standard 6.1 and 6.2).				
Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
2024 AMC commentary				
Condition 2 was assessed as satisfied. Provide evidence of effective implementation, monitoring and evaluation of the: i. Reconciliation Action Plan ii. Building Respect, Improving Patient Safety (BRIPS) Action Plan				

iii. Diversity and Inclusion Plan
iv. Rural Health Equity Strategic Action Plan (Standard 1.6 and 1.7)

The College are commended for continuing with such an extensive and evidence-based program of implementation, monitoring, evaluating and refining these flagship strategies.
There have been recent updates to most strategies, and a Managing Bias Working Party was established in 2023. The second RACS Reconciliation Action Plan (RAP) 2023–2025 (Innovate) has been approved by Reconciliation Australia.

A detailed and reflective response was provided, showing renewed focus on many fronts and further integration of these plans into policy and operations across the College.

The Training Committees/Board self-assessments show in some detail how they are implementing elements of the policies e.g. in governance, selection, diversity and inclusion, accreditation, rural health equity, flexible training.

A further stimulus to enhancing cultural safety, all Training Committee/Boards are progressing with implementation of formal curricula towards meeting RACS Competency 10 in cultural competence and cultural safety (see Condition 8).

The approaches being taken vary. For example, in selection, not all Training Committees/Boards have a dedicated Indigenous applicant pathway. Instead, some award points for cultural engagement in Māori and / or Aboriginal and Torres Strait Islander and/or Aboriginal or Torres Strait Islander communities as well as participation in Māori and / or Aboriginal and Torres Strait Islander organisations for periods greater than 12 months. This could apply to non-Indigenous applicants.

A final challenge is how the outcomes of implementation appear in the M & E framework, and how it is reported to stakeholders.

There is evidence suggesting there is still much more work to do, and momentum must not be lost for:

- Ongoing underrepresentation of Māori and/or Aboriginal or Torres Strait Islander Trainees
- Feedback from Trainees on workload, poor work life balance, and concerningly high rates of bullying/ discrimination and harassment from senior medical staff.

While this condition is satisfied, a new condition has been added to the College's accreditation, focused on the monitoring and evaluation of the outcomes from these initiatives.

College Response

We ask that subsequent commentary on other standards in this monitoring submission be read in the light of this condition 21 response.

This condition reaches into many other standards and conditions. Most critical in monitoring and evaluating the impact of the frameworks is the relationship to the MTS and other Trainee surveys led by RACS and the STB/Cs because these demonstrate the impact most deliberately.

RACS and the STB/Cs appreciated the AMC recognition of their cross-college work to develop and implement the frameworks that underpin some of the most critical aspects of SET and relate directly to the strategic plans of RACS and the specialist societies, namely:

- Our approach to SET that is responsive to and culturally safe for the needs Aboriginal and Torres Strait Islander and Māori people and attractive for them to train towards a career in surgery
- Our commitment to rural communities and making rural training attractive for those seeking a career in surgery as well as upskilling others to provide necessary services capably and safely
- Our determination, with our partners the health services, to ensure SET provides a safe as well as quality training experience for all Trainees
- Our commitment to diversity and inclusion across many facets and as witnessed for example in the increasing numbers of women in SET while not dismissing there is still a lot to do in this space that is impacted by so many aspects of the SET experience.

The implementation of each of these frameworks is necessarily complex, having some common and unique aspects within each, and respectful of all other parties to their success. This is because the frameworks are overarching for SET and are implemented according to specific elements at every level of RACS and the STB/Cs as described in the relevant framework and have their most significant impact at the training site.

While this condition asks specifically about the systematic processes in place for evaluating the impact in implementing each framework, this might apply narrowly to Standard 6 and importantly to all the Standards. Reporting the actual impact is equally if not more important as it informs whether the frameworks need adjusting, supplementing, extending, strengthening or focusing. Each framework needs to be monitored against its specific and comprehensive KPIs, which are for the most part unique to that framework if sharing a common intention with other frameworks. The data collection, analysis, reporting and even audience can be quite different. RACS has done this work of mapping each framework, for Australia and Aotearoa New Zealand, and identifying progress on each. This is not yet ready for publication as the committees responsible for each of the frameworks and STB/Cs have not yet been consulted to verify the analysis. This is a QI / QA process for 2025 -2027.

Therefore, the ways the impact can be measured, reported and evaluated currently and for each framework are multiple.

From a reporting point of view, addressing this condition involves other key aspects of this monitoring submission, namely:

- M&E development and ability to generate reports related to one or more frameworks to be shared within the sector and publicly (see commentary Standard 6)
- Trainee feedback on their training, supervision, site, and experience with RACS and the STB/Cs as collected by the MTS and RACSTA surveys but also from surveys issued by each of the STB/Cs, informal feedback, and more closely target feedback by topic or cohort can be compared with MTS / RACSTA results. Trainee survey feedback is one monitoring source that arguably addresses all or most of the frameworks in terms of their impact (described here and related to Standard 7)

- Responses by each of RACS and the STB/Cs to the MTS results longitudinally and cross-sectionally with Trainees of other medical colleges (1.11 MTS 2024 Hospital Based Medical Specialties)
- Commitment to safe quality accessible and appropriate surgical care for Aboriginal and Torres Strait Islander and Māori people (Standard 3)
- Competency-based training and assessment that includes cultural competency training for SET Trainees, Supervisors and Assessors (Standards 3 and 8)
- Context as well as systemic short and long-term strategies to attract more Aboriginal and Torres Strait Islander and Māori into SET (described here and related to Standards 3 and 7)

Within this complexity, there will be significant overlap as we describe how the frameworks have been implemented and evaluated for impact in 2025.

Results of the MTS (2019 - 2024) and RACSTA (2016 – 2021) Surveys

Arguably the MTS provides the monitoring of Trainee sentiment across many issues, none more important than the impact of the RACS frameworks.

If the frameworks were delivering on their intention, the most critical shift would be seen in the experience of the RACS Trainees and the behaviour of the RACS Fellows responsible for delivering SET in the training setting. While teasing out variables, and understanding the impact of each, is complex work, recognising RACS and the STB/Cs have incomplete authority to act, the responsibility and accountability is well understood. The advice given to all colleges in this regard by Minter Ellison later in 2024 underscores this responsibility and accountability.

We have included the multiple ways RACS and the STB/Cs also collect Trainee feedback as it is central to the frameworks as well as to how they are implementing – and quality assuring their impact – and allows correlating their findings with those of the MTS.

Not all STB/Cs report the same findings as the MTS.

The RACS Trainee feedback survey has just been analysed across all participating STB/Cs (1.12 RACSTA Training Evaluation Survey 2016-2021). The results mirror those of the MTS but to a lesser extent. This survey has not yet been discussed at CSET or compared with those of the non-participating STB/Cs who have each undertaken their own Trainee survey since the last AMC monitoring submission. The reports will be tabled at the relevant committees over the coming quarter and action plans developed.

Trainees are overall more critical of their training experience than the national average and yet are more likely to complete their program, think they will do so more successfully than other Trainees, and are less likely to leave the program.

RACS Trainees report lower satisfaction on most survey questions.

RACS Trainees report a negative variance of > 5% lower than the national average.

Some of these issues of dissatisfaction are more critical than others.

Some responses show a satisfaction < 30%

To better understand the impact of the hospital environment in which many medical Trainees are employed, RACS compared the MTS results with those of other hospital-based training programs (1.11 MTS 2024 Hospital Based Medical Specialties). In some ways this is a reasonable comparator. Those areas where RACS does >10% better or >10% worse were tabulated for 2024. This provided valuable insight into where RACS might exert its greatest effort at redressing the topics of greatest concern.

Areas that are most obvious in comparison with other medical specialties include:

- Bullying, harassment and discrimination
- Access to flexible training
- Workload
- Supervisor expectations of Trainees
- Relocation
- Cultural safety training and interest in a career working with Aboriginal and Torres Strait Islander people
- Orientation and various workplace-based education activities
- College support and financial considerations

Attached is the MTS longitudinal and the cross-medical Trainees comparison for RACS (1.13 Medical Training Survey Master Data 2019-24). There are action plans for each of the key areas in the process of being negotiated with the STB/Cs.

Attached is the RACSTA results for comparison (1.12 RACSTA Training Evaluation Survey 2016-2021). Some STB/Cs have commented that the RACSTA survey is more comprehensive and actionable than the MTS in some areas. The MTS seemed to create survey fatigue in 2021, but this is an option to be reconsidered by CSET and the STB/Cs.

Attached is the table describing how STB/Cs have approached the 2024 MTS results so far (1.14 Draft Medical Training Survey Report 2024 and 1.15 MTS 2024 and RACSTA Survey Feedback From Specialties).

Attached is the 2023 RACS Annual Surgical Education and Training Program Monitoring Report (1.16 Monitoring Report 2023). This provides quantitative data that supports the impact of many of the frameworks. Some STB/Cs have suggested a single end-of-term assessment for all specialties that would feed into action against each framework and the MTS results. Some have found a trend where Trainees are speaking up more than was perhaps the case, but this trend needs to be corroborated across STB/Cs.

Known Impact to date of Each Framework

Reconciliation Action Plan

Attached is an update on the RAP (1.17 Reconciliation Action Plan Tracking 2023 - 2025).

As part of RACS' evolving commitment to reconciliation, the 2023–2025 RAP focuses on:

- Strengthening cultural safety training and embedding cultural humility across the organisation
- Increasing Aboriginal and Torres Strait Islander representation across all surgical specialties and leadership roles
- Supporting and retaining Indigenous Trainees through every stage of training, Fellowship, and employment
- Partnering with Aboriginal Community Controlled Health Organisations (ACCHOs) to co-design programs and outreach
- Co-developing equity measures, data systems, and feedback loops that are community-led and strengths-base

Attached is a report on the experience of Aboriginal and Torres Strait Islander Trainees in SET and a more detailed analysis (1.18 Towards Culturally Safe and Effective Training Pathways for Aboriginal and Torres Strait Islander Medical Specialist Trainees).

Building Respect, Improving Patient Safety (BRIPS) Action Plan

Attached is a review of the bullying, discrimination and harassment action with reference to the MTS, RACSTA and other Trainee surveys (1.19 MTS and RACSTA Longitudinal Survey Data Summary March 2025)

Attached is a report on the culture shock theme describing both the generic Trainee experience and the additional challenges for rural, female and Aboriginal and Torres Strait Islander Trainees (1.20 Draft Summary of Surgical Trainee and Registrar FATES2 Interview Data).

Attached is the RACS Code of Conduct that all Fellows commit to, including sections related to SET and SIMGs (1.21 Code of Conduct). This code is called upon when breaches arise.

RACS has worked extensively in building a BRIPS Plan and evaluating its impact over the years. Like all the frameworks RACS acknowledges its authority, capability, accountability and responsibility in situations that are complex and highly interactive. It would seem from the MTS longitudinal results that RACS Trainees experience bullying, discrimination and harassment from their Supervisors more than other medical Trainees, and for several years were more willing to report it than some other medical specialties. This suggests growing awareness of the issues surrounding bullying, discrimination and harassment but not necessarily the change in behaviour – expressly across generations of surgeons – that RACS had intended with its BRIPS plan. Training Managers check Supervisor compliance with BRIPS and related training and obligations, but these do not extend to the less formal role of trainers in the health care setting. The degree to which SET Trainees distinguish between a Supervisor and other senior Fellows is unclear and is being investigated by RACS.

Diversity and Inclusion Plan

Diversity in the Training Program

There are resources for flexible training, which is also aimed at increasing diversity by making SET more flexible (https://www.surgeons.org/Trainees/the-set-program/flexible-training) and thereby address some of the excessive workload-related issues.

Activities of the Women in Surgery Group:

- Developing the Women in Surgery Strategic plan (PDF 263.71KB).
- Advocating for flexible training and assisting in the development of resources and toolkits to support Trainees and hospitals.
- Assisting in the development of some of the College's key policies and related documents. It has been fundamental in establishing guidelines on issues such as discrimination and harassment, and safe working hours, and plans to continue this work with a mentoring scheme
- Developing draft guidelines to provide a supportive framework for pregnancy and parenthood throughout the surgical careers of Trainees, Fellows, and SIMGs. The specialty societies are currently being consulted, with feedback due in July 2025. Draft guidelines are attached (1.22 Draft Pregnancy Policy).

RACS also has these policies:

Breastfeeding (PDF 191.4KB)

Disability Inclusiveness (PDF 198.04KB)

Equal Opportunity and Acceptable Workplace Behaviour (PDF 109KB)

Gender Equality (PDF 202.04KB)

Returning to Work after a Period of Leave (PDF 163.4KB)
Trainee Registration and Variation (PDF 98.7KB) (Regulation)

Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative (PDF 30.25KB)

Religious Observance (PDF 26.12KB)

Diversity in Selection

In addition to agreed Aboriginal and Torres Strait Islander, Māori and Pasifika recruitment and selection initiatives, CSET at its selection workshop worked on the Selection Bias Mitigation Framework. All STB/Cs have adopted a range of ways of doing so including interviewer selection, interviewer training, questions assessment, phone or other non-visual references, non-surgical references, and post- selection analysis of the results. Across all STB/Cs there is a significant improvement in diversity although some would like to see much more diversity than currently exists.

Attached is the summary of the Selection Workshop held in February 2025 with the chairs of the STB/Cs that brings significant consistency across all STB/Cs (1.23 Report and Outcome on CSET Selection Workshop February 2025). Written agreement to the overall strategy and the new policies is sought from all STB/Cs to be implemented. There is a further discussion set down at CSET for 8 June 2025.

Attached with the summary is Report on the Outcomes including data on various relevant indices (1.23 Report and Outcome on CSET Selection Workshop February 2025).

Attached is the Aboriginal and Torres Strait Islander Surgical Trainee Initiative that all STB/Cs implement (1.24 Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative).

The draft framework has been sent to STB/Cs earlier this year as part of phase 2 of this project. This consultation process together with feedback from this workshop will result in an improved bias mitigation framework for further consultation in phase 3 with input from the Women in Surgery Committee (WiS), the Indigenous Health Committee (IHC), RACSTA, the Rural Health Equity Committee, and with community representatives before submission for endorsement and implementation.

Selection Bias Mitigation Framework and Design Process

During the CSET workshop in February 2025, draft principles were agreed for a selection bias mitigation framework and design process, as outlined in 1.23 Report and Outcome on CSET Selection Workshop February 2025. These will be confirmed at a future CSET workshop.

Scholarships and grants continue to target applicants from diverse backgrounds including Aboriginal and Torres Strait Islander and Māori people (1.25 Scholarships and Grants on Offer 2026).

Variation: Limited Selection Attempts for Cardiothoracic Surgery

Attached are the selection regulations for cardiothoracic surgery (1.26 Cardiothoracic Selection Regulations 2025). The number of selection attempts permitted has been limited to 3 from 2026 but the count towards the maximum only commences with applications made from 2026. The Cardiothoracic Training Committee introduced the 3-strike rule to prevent repeat unsuccessful applicants from applying year after year, thereby saving their time and money.

It also encourages applicants to consider alternative specialties where they may have an interest and would be more suitable, increasing their chances of success. By implementing this rule, the Committee aims to create more opportunities for other applicants who may have a better chance in cardiothoracic SET.

Rural Health Equity Strategic Action Plan

Attached is the rural health equity action plan dashboard report 2025 (1.27 RHESAP Dashboard Report 2025).

Attached is a summary of the FATES2 qualitative interviews described by themes including a reimagining of rural surgical training (1.28 Draft FATES2 Culture Shocks and Challenges in Surgery and Rural Surgical Training and 1.29 Draft FATES2 Qualitative Interview Summary).

Attached is the final report on Remote Asynchronous Video-based Coaching in Rural Settings February 2025 that finds favourably when addressing the non-technical competencies of SET (1.30 Video-based Coaching Final Report February 2025).

Attached is the Rural Surgical Curriculum eLearning Needs Analysis Report 28 June 2024 (1.31 Rural Surgical Curriculum eLearning Needs Analysis Report June 2024).

Attached are the results of the MTS demonstrating the significant increase in the number of SET Trainees interested in rural surgery in recent years

- 1.13 Medical Training Survey Master Data 2019-24
- 1.14 Draft Medical Training Survey Report 2024

Attached are the selection initiatives for 2024 (1.24 Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative, 1.32 Cultural Components of Selection - Māori Heritage and Cultural Training, 1.33 Aboriginal and Torres Strait Islander Selection Initiative Implementation).

CSET, at the dedicated selection workshop in February 2025, agreed across SET to the following Rural Selection initiatives (1.34 Select for Rural 2025 Update):

- Rural definitions were standardised as Residency for at least 10 years cumulatively or any 5 years consecutively in a Modified Monash Model 2-7 area or Geographical Classification for Health U2-R3 (this includes regional, rural and remote) prior to entry into medical school. The evidence for rural origin, rural medical school and rural training being the 3 strongest factors in building rural medical workforce.
- Geographic classifications were standardised. Since 2019, the Australian Government prefers Modified Monash Model for health and health workforce, replacing the remoteness area classification. In Aotearoa New Zealand, The Geographic Classification for Health, published in 2022, is replacing the Stats New Zealand functional urban area classification.
- Measure and track progress of rural Trainees was to inform further reform. (See Standard 6 MDS).

There were some bespoke differences acknowledged at the workshop related to the context and scope of practice for some the STB/Cs:

- Neurosurgery Australia and Aotearoa New Zealand have introduced selection points for rural origin, rural medical school and rural work exposure and also has an Undersubscribed Home Regions selection initiative to address geographic imbalances by prioritising applicants from underrepresented regions such as the Northern Territory and Northern Queensland.
- Otolaryngology Head and Neck Australia are dropping a selection point for rural and starting an area of workforce need and rural/regional selection and training pathway and has a competency in rural and remote. They now have a small rural subcommittee of three members. The Chair of the subcommittee sits on the Board as a rural representative.
- Paediatric Surgery has a new SET curriculum and within it a dedicated competency in RuFUS (Rural Facing Urban Surgery)
- Vascular and Neurosurgery SET curricula both articulate the responsibility of vascular and neurosurgeons to support rural surgeons in managing vascular and neurotrauma.

A training program for GPs and rural generalists is being developed in collaboration with the RACGP and ACRRM and with STP funding. The intention is to build the surgical skills of those without FRACS to deliver safe quality appropriate accessible and affordable care where either there is no FRACS on site or the community need does not warrant a FRACS on site or both.

Expanding scopes of surgical practice to meet the needs of rural communities

RACS has received confirmation of FATES 4 funding for a Health Workforce and Rural Access program, to run from August 2025 to October 2027. Activity Title: Global/Regional/Rural/Remote/Deployable Surgery (GRiD) Developing a flexible, generalist, broad and extended-scope surgical workforce to meet Regional, Rural and Remote (RRR) community need.

The GRiD Faculty will enable a flexible, responsive, culturally competent, generalist, broad and extended scope surgical workforce (across all surgical disciplines), with the skills and motivation to work collaboratively and effectively, in areas of need and limited resource environments. RACS, RANZCO, RACGP, RACMA, and ACRRM will partner to form a consortium to research and investigate the viability, feasibility and sustainability of a GRiD Fellowship Faculty, through evidence-based recommendations and extensive stakeholder engagement.

The trend to subspecialisation is reducing the availability of surgeons capable and confident of working in Regional, Rural and Remote (RRR) areas. Data (safety, outcomes, community need) will allow definition of clinical problems and procedures with better outcomes in urban or subspecialist settings, and those with equivalent patient outcomes between urban and RRR, and generalist and subspecialist settings. This will inform culture, training, workforce planning and resource allocation between urban, RRR and generalist and subspecialist services.

Example: Northern Territory Training Pathway

Following the Rural Training Models: Solutions to Rural Training Workshop in Darwin, RACS developed and the Australian Board in General Surgery (ABiGS) approved the Northern Territory Rural Training Pathway. To respond to the key actions identified in the Workshop, the Northern Territory Training Pathway Working Group was established. Funded by the FATES Rural Training Models Project, the Working Group aims to:

- Establish training networks and education opportunities for Supervisors from Royal Darwin and Alice Springs hospitals
- Transition Planning with South Australian Department of Health to update Trainee contracts to include recognition of prior service and portability of work entitlements and access to accommodation and support for relocation.
- Review of existing MOU between RACS and the Northern Territory Government
- Strengthen partnerships and engagement with private hospitals in Darwin to provide additional clinical experiences for Trainees
- Engage with rural multidisciplinary training hub: make pathways to training in the Territory visible to medical students and prevocational doctors

The Working Group will act in an advisory capacity with any recommendations for approval forwarded to the Rural Health Equity Steering Committee and endorsed by the Education Committee. This may include, but is not limited to recommendations for associated:

- Policies
- Regulations
- Processes
- Communication strategies and plans
- Activities contributing to financial sustainability
- Service agreements

Initial discussions regarding access to leave entitlements for Trainees rotating to and from the Northern Territory (NT) and South Australia (SA) are underway. On 5 May, a meeting was held between the SA Committee and the SA Australian Salaried Medical Officers Federation (ASMOF) branch (SASMOA) to explore potential mechanisms for preserving entitlements within enterprise agreements. Planning for a further meeting with the NT ASMOF branch is underway to ensure alignment and continuity of entitlements for Trainees moving between these jurisdictions. This has been identified as a critical action, aiming to guarantee that Trainees rotating from the NT to SA and back have their leave preserved in accordance with enterprise agreement provisions.

Learnings from the establishment of the NT Rural Surgical Training Hub, will inform the establishment of hubs in other locations.

Ongoing underrepresentation of Māori and/or Aboriginal or Torres Strait Islander Trainees

Please see also commentary under Standard 3 Condition 8.

CSET, following a dedicated selection workshop in February 2025, agreed across all STB/Cs specific Indigenous Selection initiatives:

- Binational programs have binational initiatives with regard to selecting Indigenous applicants from Australia and Aotearoa New Zealand
- There are guaranteed training positions available for Indigenous applicants who have meet the minimum standards for selection across all training positions
- Annual reporting of selection by STC/B's will include outcome of Indigenous selection practices and tracking of Trainee progress

All the Australian STC/Bs have the Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative (PDF 30.25KB) in their Selection regulations, but many also added other areas this year, like points for Māori courses to further enhance the recruitment of Aboriginal and Torres Strait Islander, Māori and Pasifika SET Trainees. These different additional strategies are being trialled, monitored for effect, and shared with all other STB/Cs for their consideration of appropriateness.

Variation: Cultural Advisors in Aotearoa New Zealand

Otolaryngology Head and Neck Surgery Aotearoa New Zealand have a cultural advisor on the STB/C – who is also the chair of MCNZ – who helps assess language and the socio-economic status of candidates as well as helping with developing questions for selection

Within the SET Regulations there are:

- Points specific to Māori identity / involvement in culture as opposed to personal identification
- Points awarded for university Māori immersion
- Points awarded for connection to Iwi

This is because some identify as Māori but not culturally immersed, and vice versa some don't ethnically identify as Māori but are incredibly culturally immersed.

Potential has been discussed for other societies to have cultural advisors who go to schools and speak to students

Variation: Working with AIDA to Identify and Remedy Gaps and Barriers in Selection

While the General Surgery STB has had the RACS Aboriginal and Torres Strait Islander selection initiative in its processes since 2019, it is clear this alone is not enough to promote Indigenous applicants to the specialty. The STB is committed to reviewing the selection regulations to ensure there are no hidden or unintended barriers for Indigenous doctors applying for General Surgery training. The Manager Education and Training recently attended the AIDA Cultural Competency Training with a view to work with AIDA to identify and remedy gaps or barriers in the selection process.

Specific feedback from Trainees on workload, poor work life balance, and concerningly high rates of bullying/ discrimination and harassment from senior medical staff

The MTS has revealed – both longitudinally and as against other medical specialties – that surgical Trainees work excessively long hours compared to other doctors in training. It also confirms that for SET Trainees but not so much for other medical Trainees – that this extra work is paid work and, importantly, in the Trainees' opinion it contributes to their training. It is not simply additional service work.

We note also that the MTS relies on self-assessed workload which is not confirmed with the actual hours that the health services accredited for SET have required of Trainees.

The role of flexible training is also not well utilised by SET Trainees according to the MTS, although most STB/Cs offer a range of options, as does RACS and have a different sense of how many are seeking flexible training.

Concerning entitlements, the preservation of entitlements while on rotation and recognition of prior service while on rotation are bi-national enterprise agreements that may be a way of ensuring continuity within a surgical specialty. Curiously, in an informal engagement with key areas of advocacy on behalf of Australian Trainees and new Fellows in 2025 this was not a major topic of discussion, suggesting more understanding of the Trainee experience is also required. Portability of entitlements is managed differently by each jurisdiction. RACS, RACP and the AMA are meeting with representatives from New South Wales health in late June/early July to look at opportunities to address portability issues. New South Wales is one of the areas where we have the most challenges and it's about 1/3 of our training program in Australia.

Example: Flexible Training

Following Trainee feedback, The Board of Urology committed to addressing the challenges faced by Trainees undertaking flexible training or returning from a period of interruption. These were described as including a lack of support, unclear expectations, stigma associated with flexible training, and practical difficulties with reintegration. The Board is also committed to assisting Training Supervisors in managing Trainees working flexibly or returning from interruption.

Over the next 12-18 months, the Board plans to:

- Develop accessible information outlining eligibility, application processes, and expectations for flexible training and returning from interruption. This will help reduce confusion and support informed decision-making.
- Develop a formal return-to-training program with assistance from RACS, including return-to-work planning templates and structured transition periods to help Trainees safely and confidently re-enter training and support Supervisors during the reintegration period. The Board plans to review existing approaches used by other colleges and craft groups, so as to avoid duplication of effort.
- Establish mechanisms for regular check-ins and progress monitoring for Trainees in flexible positions to ensure they are appropriately supported throughout their training.
- Promote a shift in mindset within training institutions by providing guidance and education to Supervisors around flexible training and its value. This aims to reduce stigma and improve attitudes.
- Emphasise that the success of flexible arrangements should not rest solely with the Trainee—training institutions and Supervisors must also play an active role in supporting these pathways.
- Monitor outcomes of implemented strategies through regular review and feedback with a focus on continuous improvement and responsiveness to Trainee needs

Example: Dissonant Results in Incidents of Bullying, Discrimination and Harassment

The MTS survey report does not align with the survey feedback from OHNS Trainees collected by ASOHNS. Trainees are also involved in hospital accreditation inspection interviews and no incidents have been identified during those discussions. There is clearly a lot more to do to unpack, understand and respond to this MTS finding among SET Trainees.

However, some STB/Cs are concerned that not all Trainees may be coming forward with complaints about their training experience. The reasons are well-known across medical training. Trainees are unclear who will see the report, who will action it and how well, and often wait until after the term – and perhaps training – before reporting it or forgetting about it. This means unacceptable behaviour – especially by senior surgical staff - is not addressed or rectified often enough.

In an effort to maintain confidentiality, RACS requires feedback from 5+ Trainees for a given Supervisor, meaning most Supervisors receive no or very late feedback, be it positive or negative. There is a lack of clarity about what bullying, discrimination and harassment is and is not, hence difficulty in comparing survey results of

Trainee feedback in a way that can lead to practical intervention. It is not clear to what extent the prevention or mitigation of reported bullying, discrimination and harassment is actionable at the STB/C or health service site and a more nuanced understanding might be required to better approach unacceptable behaviour from both college Fellows and health service employees.

Example: Trainee Led Feedback

Attached is the Trainee Led Feedback to AOA (1.35 AOA QORA Accreditation Report Redacted)

Following a routine AOA Accreditation Review in late 2024 an email was received from a concerned consultant from the reviewed department who had not been involved in the review. The consultant raised a number of concerns regarding both the clinical experience of Trainees and the culture of the department. None of these concerns had been raised by the Trainees interviewed by the team, nor were the issues reflected in the Trainee survey data from previous rotations. In consultation with the President of the Trainees Association, additional feedback was sought by AOA from the current and previous Trainees allocated to the training site regarding their experience. This additional feedback was sought via a representative of the Trainees Executive Committee completely anonymously. The feedback (de-identified and attached) was sobering, and in direct contrast to what had previously been shared with the Accreditation Team. As a result of this feedback, a further review of the site was undertaken prior to an accreditation decision being reached. Ultimately, this process resulted in a number of conditions being applied to the accreditation of the training site.

Via further consultation with the Trainees Executive Committee, it was recommended to the Accreditation Committee and the FTC that that Trainee led collection of feedback should be incorporated into the routine accreditation process to ensure Trainees have a completely anonymous and safe way to raise concerns in addition to the Trainee survey. In addition, the names of Trainees interviewed by the accreditation team will no longer be shared with the training site. This recommendation was supported. The process has been piloted in practice and the documentation is currently being drawn up for final approval.

2. 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 relevant to Standard 1. If a significant development has been made in response to addressing a condition, please only report on this this against the relevant condition. The development does not need to be reported twice.

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.

Examples of significant developments to report on could include:

- Governance structure and accountabilities for managing training and education activities
- Reconsideration, Review and Appeals policies and procedures
- Costs associated with reconsideration, reviews and appeals. *(If there are changes to costs for reconsideration review and appeal, please confirm the costs and describe how the College has ensured new 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 at this time)*
- Conflict of Interest policies and procedures
- Delivery of the program (I.e. changes to training resources such as administrative/technical staff and educational expertise).
- Changes to 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.*
- Interactions and/or relationships with jurisdictions
- Partnerships with communities, organisations or individuals in the Indigenous health sector

Has there been any significant developments in relation to Standard 1:	If yes, please describe the developments completed or planned *Please include any potential impacts on continuing to meet the standard in the description.*
- Yes ☐ - No ☒	-

3. Statistics and annual updates

Please provide data in the tables below showing:

- the number of reconsiderations, reviews, and appeals that were heard in 2024, the subject of the reconsideration, review or appeal (e.g. selection, assessment, training time, specialist international medical graduate 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 text in the table.

Subject of Reconsideration	**Number of reconsiderations**			
		Rejected	**Upheld**	**Varied**
Australian Board of Plastic and Reconstructive Surgery - Research point applications (Trainee)	1	0	0	1
Australian Board of Plastic and Reconstructive Surgery -Selection outcome (applicants)	7	2	5	0
New Zealand Board of Plastic and Reconstructive Surgery – SET selection application	1	0	1	0
Australian Board in General Surgery – Review of unsatisfactory rotation	2	0	2	0
Australian Board in General Surgery – Dismissal	1	0	1	0

Board of Neurosurgery – Dismissal	1	0	1	0
Australian Orthopaedic Association Federal Training Committee – Selection	42	37 – Grounds not established 4 – Ineligible	1	0
Australian Orthopaedic Association Federal Training Committee – Progression	1	0	1	0
Board of Vascular Surgery – Selection	1	0	1	0
Board of Otolaryngology Head and Neck Surgery – End of term assessment	1	0	1	0
Board of Otolaryngology Head and Neck Surgery – SET Selection CV score	1	0	1	0
Cardiothoracic Surgery Training Committee – Review of Clinical Exam	1	1	0	0
Cardiothoracic Surgery Training Committee – SET selection interview	2	2	0	0
Specialist International Medical Graduates – Rejection of extension to assessment validity period	1	0	0	1
Specialist International Medical Graduates – Unsatisfactory term result	1	0	1	0
Specialist International Medical Graduates – Comparability	36 6 – No decision yet	0	23	7
Specialist International Medical Graduates – Removal from pathway	1	0	1	0
Specialist International Medical Graduates – Supervised practice period	1	0	1	0
Specialist International Medical Graduates – Exemption from exam	1 – No decision yet	0	0	0
Specialist International Medical Graduates – Exemption from exam and to be made Substantially Comparable	1	0	1	0

Subject of Review	Number of reviews			
		Rejected	Upheld	Varied
New Zealand Board of Plastic and Reconstructive Surgery – SET selection application	1	0	1	0
Australian Board in General Surgery – Dismissal	1	0	1	0
Board of Neurosurgery – Dismissal	1	0	1	0
Australian Orthopaedic Association Federal Training Committee – Selection	5	1 – Grounds not established 4 – Ineligible	0	0
Board of Otolaryngology Head and Neck Surgery – SET Selection CV score	1	1	0	0
Cardiothoracic Surgery Training Committee – SIMG Pathway	1	1	0	0
Committee of Paediatric Surgery – CV scoring	1	0	0	1
Specialist International Medical Graduates – Comparability	4	0	3	1
Dismissal	2	0	2	0
Unsuccessful application	1	0	1	0
CV scoring	3	0	0	3

Subject of Appeal	Number of appeals			
		Rejected	Upheld	Varied
Dismissal	2	0	2	0

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. Activity against conditions

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

Please address each of these conditions individually.

<table>
<tr><td colspan="4">Condition 3</td><td>Due Date: 2023</td></tr>
<tr><td colspan="5">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)</td></tr>
<tr><td rowspan="2">Finding</td><td>Unsatisfactory</td><td>Not Progressing</td><td>Progressing</td><td>Satisfied</td></tr>
<tr><td></td><td></td><td>X</td><td></td></tr>
<tr><td colspan="5">2024 AMC commentary</td></tr>
<tr><td colspan="5">A College Stakeholder Engagement Plan is being developed for Australia with the stakeholders. A similar plan is being developed for Aotearoa New Zealand. This framework aligns health outcomes with the key stakeholders involved in the recruitment, selection, training and assessment of future surgeons.

There is a wide range of external stakeholders, but most are interested/expert parties related to education or the health sector.

AOA was the only Training Committee/Board that reported consultation on its program with consumer and community representatives, but the nature of this consultation was not described. Further, the AOA has stewarded and lead the formation of the MSK Patient Advocacy Coalition. More details would be of interest, especially further engagement with consumer groups, specifically outside the peri-operative nature.

There are consumer representatives on some Training Committee/Boards and other committees, but this is not greatly increased from the 2017 assessment. Further, there seems only a small amount of consultation with patients or lay members or the community, e.g. via documents are being sent out to consumer councils for consultation. There is a reliance on input at hospital accreditation visits, and for trainees and Fellows to provide input from their jurisdictions and the wider context. Thus, much consultation is one step removed from the community of consumers.</td></tr>
</table>

The intent of this Condition was based on the 2017 assessment team impression that there was insufficient consumer or community input into the goals and objectives of surgical training. Overall, the engagement with consumers and the community, as reported, does not seem sufficiently proactive, reciprocal or persisting in nature. At this stage, this condition is not yet satisfied.

Apart from consumers and community input, the condition also includes 'surgical and non-surgical medical, nursing and allied health stakeholders'. The College needs to address these groups in its reporting for all programs for this condition to be satisfied.

2025 College response

This section covers Condition 14 as well.

Evaluation of SET

RACS is in the final stages of engaging T4 to deliver an evaluation of SET through direct consultation with each of the participant and stakeholder groups impacting and impacted by SET. These groups include Trainees, Supervisors, Trainers, Training Managers, STB/C Chairs, health services personnel, pre-vocational doctors trying to get into SET and non-surgical health team members. The approach taken is 'consumer-centric' and the issues addressed will be those raised by those partaking in the study. The first interviews are scheduled to commence in July and the first raw data for interrogation will be shared at CSET in October 2025.

See attached the study proposal from T4 (2.1 RACS T4 Study Proposal May 2025 Redacted).

Please see attached a report on stakeholder feedback for the RACS Monitoring and Evaluation framework (2.2 CSET Report M&E Stakeholder Engagement June 2024).

RACS has developed a stakeholder engagement plan for Australia and a similar plan is in development for Aotearoa New Zealand. This will guide the purpose, prioritisation and desired outcomes from interaction with the health care sector set down for 2026. Engagement priorities were set more towards responding to external reviews and directions, such that RACS has not progressed the implementation of the framework as systematically as it will in 2026. Nevertheless, the engagement has been very extensive and includes the endeavours of the STB/Cs.

Attached is the RACS stakeholder engagement plan (2.3 Stakeholder Engagement Framework), and how RACS has commenced its implementation:

- Interaction and/or Relationships with Jurisdictions
  RACS Chief Executive Officer and State/Aotearoa New Zealand Chairs and managers have met with Aotearoa New Zealand, South Australian, Victorian, Tasmanian, and Western Australian Health CEOs and Ministers. For those with New South Wales, Queensland, and Northern Territory, scheduling is in progress.
  At least two meetings per year are held with AMC, MCNZ, AHPRA, and MBA (including with the President, CEO, Censor-in-Chief)
  CPMC and CMC – link to stakeholders including MWAC.
  MWAC – A Prof Kerin Fielding sits on this committee, focusing on workforce needs.
  Developed strategy and stakeholder engagement plan for regular and coordinated interactions.

- Community Reference Group and Supervisor Reference Groups
  The blueprints await approval and engagement with the STB/Cs, and this will be progressed by June 2026.
- Sharing Stakeholder Engagement with Council, EC, and CSET
  RACS-scheduled society engagements includes the annual roadshow and a leaders' forum held three times per year.
  Communications plan in place—post-council and key AMC/MCNZ-related updates; aiming to formalise this process.
  Council and Board have approved the strategy, external analysis, and stakeholder engagement plan.
  Reporting to Council and Council Executive has been ad hoc.

It is unsurprising that most STB/Cs are undergoing curriculum renewal as the standard of care changes reasonably rapidly in some specialties, and in doing so all are engaging with relevant community and professional stakeholders. These include other colleges, jurisdictions and all universities.

Multi-source feedback is becoming a feature of each STB/C curriculum and assessment frameworks. The feedback collection is externally administered and collected and then discussed with the Trainee by the Supervisor. Other surgeons, nursing and administrative staff are included.

Community members are often included in interview panels as are allied health professionals. STB/Cs are keen to tap into hospital-based consumer engagement committees. Most have non-surgical representation on their STB/C although some report interest in the role is not high from the community.

Social media is being used more often and offers the opportunity for wide 'crowd sourcing' that can be open-ended and proactive when used appropriately and some STB/Cs are exploring the options in practice.

Example: Proactive Direct Consumer Engagement

The NZOA consults with consumer, community and cultural groups with the cultural and community advisers sitting on the Board and on our selection interviews. They in turn communicate in the wider communities they represent and bring this back in their roles to the Board.

Through our training weekends NZOA see an average of 25-60 patients in one weekend, often this is an opportunity for NZOA to talk to our patients, and many are keen to tell their story and what care they have been given both in pre- and post- surgery (or non-operative care). This is at times fed back to Supervisors and is often directly to or with the Trainees present so insightful for them to hear this on a regular basis.

The curricula outcomes are publicly available at Curriculum Framework and NZOA Curriculum at https://www.nzoa.org.nz/nzoa-curriculum-framework

Variation: External Stakeholder Engagement as QA

AOA undertook an external stakeholder consultation in 2024–2025 as part of AOA's ongoing quality assurance activities (2.4 AOA Stakeholder Engagement Report April 2025). The consultation engaged Non-Surgical Health Professionals (Group 1), Senior Hospital Administrators (Group 2), and Consumer and Community

Representatives (Group 3), whose insights offer an important external perspective on the AOA 21 training program. Part I of this report presents the findings from Groups 1 and 2. Part II summarises consultation processes with Group 3.

The consultation confirmed strong trainee preparedness for consultant roles while also identifying variability in professional skills, communication, leadership, and systemic influences on wellbeing—insights that have informed recent program and accreditation enhancements.

Cross-Sector Engagement

The STB/Cs adopt a multisource multimodal approach to cross-sector engagement. WBAs, MSF and PPAs include a variety of de-identified work colleague and patient feedback. In selection there are nursing and allied health referees and community representatives – including rural – in the MMIs and interviews. Every curriculum has a comprehensive consumer and stakeholder engagement process.

Evaluation of SET

RACS is engaging with T4 to deliver an evaluation of SET through direct consultation with each of the participant and stakeholder groups impacting and impacted by SET. These groups include Trainees, Supervisors, Trainers, Training Managers, STB/C Chairs, health services personnel, pre-vocational doctors trying to get into SET and non-surgical health team members. The approach taken is 'consumer-centric' and the issues addressed will be those raised by those partaking in the study. The first interviews are scheduled to commence in July and the first raw data for interrogation will be shared at CSET in October 2025.

Condition 4				Due Date: 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)				
Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
			X	
2024 AMC commentary				
As mentioned above, there is now a simple and clear mapping process of the highest-level competencies or graduate outcomes for each program to the College 10 competencies. The 10 competencies are publicly available and all curricula map to these outcomes. Almost all specialty graduate outcomes are publicly available.				

There are a couple of exceptions that need to be addressed to fully meet the Condition: 1. There is reportedly one aspect of the Professional Skills Curriculum which is yet to be factored into the curriculum by the BOHNS and NZ BOHNS – by looking at the maps this might be 10.3 – promotes and inclusive and safe workplace for all colleagues and members. 2. The NZOA and NZOHNS curricula outcomes are not publicly available. Cultural Competency and Cultural Safety is currently mapped to a sub-component of the Advocacy section of the AOA 21 Foundation Competencies and will be strengthened after detailed review of the current competency statements in the AOA 21 Curriculum against the newer RACS 10th Competency statements. Incorporating uniform language between the RACS 10 Competencies and each of the subspecialty standards following the review could further strengthen consistency between college programs. It will be important to maintain mapping accuracy while curricula are rewritten, and for the panel to check this with source curriculum documents at the next accreditation visit. Could the College please reflect on the accuracy of this mapping prior to the review of the AOA 21 Curriculum and provide an update in the next submission.
2025 College response
RACS has engaged an external authority on competency-based training and assessment and this consultant, working within RACS, reports at the highest level. Each of the Professional Skills in the RACS-wide curricula have been addressed with competencies more clearly defined and competency indicators set. AOA now have a fully competency-based curriculum with additional assessment touchpoints and confirmed alignment (if not amalgamation) is expected between the two models. The further explored Professional Skills competencies not only link naturally to in-training and exam-readiness assessment but also to recruitment and selection – for SET Trainees as well as SIMGs – as they offer an objective, transparent and measurable approach to all these activities and thus enable Trainees, SIMGs and their Supervisors and assessors to structure constructive crucial and sometimes challenging conversations, meaningful actionable feedback, underpin any subsequent appeals. Attached BOHNS and NZOHNS PSC extract with elaboration (2.5 OHNS Curriculum Extract - Professional Skills). The NZOA curricula outcomes are publicly available at https://www.nzoa.org.nz/sites/default/files/NZOA%20Curriculum%202020%2030-4-24.pdf

2. 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 relevant to Standard 2. If a significant development has been made in response to

addressing a condition, please only report on this this against the relevant condition. The development does not need to be reported twice.

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.

Examples of significant developments to report on could include:

- Educational purpose of the College
- Engagement with stakeholders about educational purpose
- Program outcomes
- Graduate outcomes

Has there been any significant developments in relation to Standard 2	If yes, please describe the developments completed or planned *Please include any potential impacts on continuing to meet the standard in the description.*
- Yes ☐ - No ☒	-

3. Statistics and annual updates

Nil.

Standard 3: The specialist medical training and education framework

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

1. Activity against conditions

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

Please address each of these conditions individually.

Condition 8				Due Date: 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	
2024 AMC commentary				
All curricula have graduate outcomes which address specific health needs of Aboriginal and/or Torres Strait Islanders and Māori peoples. All curricula listed training requirements/learning opportunities which ranged from specific such as: Cultural Safety eLearning courses, specific workshops, University of Otago MIHI 501 course, to general, such as hospital and speciality tutorials and courses; hospital-based programmes; tutorials, clinics, ward rounds, MDT and handover meetings; supervisor and other teaching. However, these seemed to be learning opportunities and in no case were these activities mandated. Similarly, there were examples of assessments in which cultural competence and cultural safety might be assessed (e.g. mini CEX and other WBAs, supervisor reports, 360 assessments, written exams), but extremely few where it was or will be mandated. Where assessment appeared mandated was in: • OHNS: Trainees will be assessed on their performance in all 10 RACS competencies at mid-term and end of term				

- The FEX map showed cultural competence to be an element of one Viva, but it was not clear if this is the case for the FEX in all specialties.

To satisfy the condition, a greater demonstration is needed of how all Trainees are expected to build their cultural competence and cultural safety, who is responsible for ensuring this, and how the College and Training Committees/Boards will decide that Trainees have met graduate outcomes.

Commentary as to how cultural loads are being/will be mitigated for surgical and other educators and assessors who identify as Aboriginal and Torres Strait Islander or Māori would be helpful.

2025 College response

Please also see Standard 1 Condition 21

All STB/Cs have cultural competence in their curriculum and all STB/Cs assess Trainees against all 10 professional competencies over the training period and in the FEx. Some STB/Cs also have cultural safety training as a prerequisite to selection.

There are significant differences between Australia and Aotearoa New Zealand that impact both the way the curriculum is delivered as well as assessed. In Aotearoa New Zealand, cultural competence is much more embedded in all health delivery structures and functions, so that a standalone course would seem insufficient as well as unnecessary.

Attached is the communications protocol (3.1 Accreditation Communication Protocol)

Attached is the RACS CST course for Australia (3.2 RACS Cultural Safety Training Course)

Attached is the RACS cultural enrichment approach in Aotearoa New Zealand (3.3 RACS AoNZ Cultural Enrichment MHAG Recommendation). The RACS Māori Health Advisory Group are currently reviewing a position description for a Cultural Safety role to address RACS cultural enrichment in Aotearoa New Zealand.

RACS is reviewing its MOUs with health services to improve communication and to address the resourcing of cultural safety and competency training

- Communications protocol in place
- Cultural Safety Training completion statistics
- Curated list of third parties providing cultural safety and competency training
- Developed RACS cultural safety training (CST) in Australia – developed with CMC in Aotearoa New Zealand and now recruiting a resource to deliver in partnership with societies

There is also a Recognising and Responding to Racism in the Workplace fact sheet from 2023: https://www.surgeons.org/about-racs/about-respect/information-and-updates/-/media/3FE96F060374430FACBA11217531DCFC.ashx

Indigenous Health Committee

The continued engagement of Professor Jonathon Koea in Aotearoa New Zealand has been confirmed. Jonathon leads the Te Rau Poka Māori Surgical Academy and has had significant impact on the numbers of students and medical students considering (where they would not have at first) a surgical career. Another medical educator is being sourced in Aotearoa New Zealand. RACS is aware of the significant workload in this critical area of Aboriginal and Torres Strait Islander and Māori recruitment and support. In Aotearoa New Zealand RACS has informal partnerships with the Trainees who organise their own events, which include 8 webinars and a selection workshop as well as an annual Trainee gathering. RACS also has signed formal agreements with the external Māori partners, the Pūhoro Trust and Te Oranga Māori Medical Students Association. RACS attends and presents at several roadshow events each year with over 1000 students from Secondary Schools around Aotearoa New Zealand (Pūhoro STEMM Education Roadshow) and Te Oranga Māori Medical Students Association. RACS Fellows, Trainees and staff attend Te ORA (Māori Medical Practitioners Association) Annual General Meeting and sponsors the Te Rā Tuhura Careers Day that over 80 Māori Medical Students attend each year.

RACS has continued its relationship with the AIDA Cross-College Consortia and sponsored the PriDoc conference in Adelaide. RACS continues to be involved in LIME.

RACS makes available dedicated cultural safety training courses – both on joining RACS and subsequently – but the course (or recognised alternative) is compulsory for Fellows. STC/Bs have been asked to provide an update on how the curriculum outcomes are being achieved in order to form part of the compliance training framework. Cultural safety and enrichment programs for RACS staff and Board are being developed.

1. The table below outlines the numbers of Trainees, Supervisors, assessors and educators for RACS and each of the STB/Cs who have completed a recognised cultural safety or cultural competence training as part of CPD-mandated CST in 2024.
2. Attached is the progress on the RACS RAP (3.4 RACS Innovate Reconciliation Action Plan) refencing the very specific ways RACS is engaging with Aboriginal and Torres Strait Islander communities and their surgical health care needs. [See Standard 1 Condition 21]
3. Attached is the report on the experiences of Aboriginal and Torres Strait Islander Medical Trainees with a suggested implementation approach (1.18 Towards Culturally Safe and Effective Training Pathways for Aboriginal and Torres Strait Islander Medical Specialist Trainees)
4. Attached are details of how the Aboriginal and Torres Strait Islander selection initiative is implemented (1.33 Aboriginal and Torres Strait Islander Selection Initiative Implementation) [See Standard 1 Condition 21]
5. Please see the mandated CST CPD requirements for all RACS Fellows https://www.surgeons.org/Education/Professional-Development/Cultural-safety-training

Here are the results of the CPD-mandated CST for all Fellows of RACS (including Trainers, Assessors, Supervisors and educators among this cohort) for 2024:

- There is likely some minor variation to these figures.
- There is a high probability that the figures of activities shown in column 4 are also included in column 5 (i.e. when they added that activity, they would also have ticked that competency box).
- The Supervisor subset excludes specialty Orthopaedic as they are likely to be in the AOA program.

	Total Participants	Total no. of activities logged in 2024	Total no. of activities logged in 2024 under 'cultural competence and cultural safety activity'	Total no. of activities 'Cultural Competence and Cultural Safety' competency 'yes'
All CPD Participants in RACS CPD Program	5,578	425,600	4,272	39,504
Supervisors Subset	439	35,321	368	3,314

Explanatory Notes:

- Figures include Australian and Aotearoa New Zealand Fellows and non-FRACS specialist surgeons.
- Figures do not include SIMG's on a pathway to Fellowship or PGY3+ participants, Fellows residing overseas or participants in other CPD Programs (i.e., AOA, NZOA, AMA, Osler)
- Participants can record participation in cultural safety activities in two ways – as an activity called 'cultural competence and cultural safety activity' or by selecting any other activity type and ticking the 'cultural competence and cultural safety' competency box.
- Count is of each individual instance of an activity – participants can enter recurring activities and/or recurring activities with 'cultural competence and cultural safety' competency ticked
- At time of preparing the report, the RACS CPD compliance rate is 79%
- All compliant participants must have recorded at least one activity with 'Cultural Competence and Cultural Safety' competency' ticked to be compliant.

Te Tiriti o Waitangi

RACS engaged Aotearoa New Zealand based Groundwork to deliver training on the Te Tiriti o Waitangi. This is a pre introductory course runs for approximately 2.5 hours and covers:

- Pre-treaty relationships
- Te Tiriti –the agreement
- Colonisation and its impacts
- Current issues and action

A total of 181 CPD participants completed the module, with an overall feedback score of 4.1 out of 5. Feedback suggested there was further in training to embed the learning from this module and how it impacts delivery of health services and patient care. RACS is currently exploring options.

Unsought testimonials:

"I just wanted to feedback how much I appreciated the opportunity to undertake the Groundwork: Understanding Te Tiriti Course provided by the College. From my perspective, even though I have grown up in Aotearoa New Zealand and been exposed to Te Tiriti throughout my education, this course really brought home how important restoration of sovereignty to Hapu and Iwi is in honouring Te Tiriti and in improving health outcomes for Māori."

"As a time-poor general surgeon, I wanted to feedback how useful it was for RACS to provide a link to a course that did not require time spent researching different course options, and also that would contribute to our cultural competency CPD requirement. Moving forward I would love to follow-up with further courses exploring this area more deeply and I would get a lot of value from RACS if it were able to offer a short list of recommended or endorsed courses that helped inform and educate surgeons in cultural competency, particularly with respect to health care delivery and health outcomes in Aotearoa New Zealand."

Medical Journal of Australia – Indigenous Edition (July)

The *MJA* published a Special Issue in partnership with the Lowitja Institute that implemented a range of new editorial policies and practices aimed at privileging Indigenous ways of knowing, being, and doing.

RACS worked with the MJA to publicise this edition to its CPD participants and facilitated an introduction from Prof Kelvin Kong AM FRACS.

RACS Indigenous Health and Cultural Safety Modules

Access to the RACS Indigenous Health and Cultural Safety modules were promoted to all CPD participants, with access included for the PGY3+ and non-FRACS surgeons.

Expression of Interest for MIHI 501 course (University of Otago)

An expression of interest was circulated for the University of Otago's MIHI 501 course, but did not receive a strong response. We will continue to monitor and if sufficient interest, will pursue.

Cultural Safety CPD Standard

RACS has developed a Cultural Competence and Cultural Safety CPD Standard, to support CPD participants in completing the requirement.

RACS endorsement of cultural safety activities via Indigenous Health Committee

A pathway for facilitating a review of cultural safety activities for CPD has been established (noting that the CPD Program is self-reported, and we do not formally mandate any specific activity).

Example: The Aotearoa New Zealand Experience

Attached is the NZOA Selection Day approach (3.5 Te Kahui Kahurangi). This is provided as one example of the comprehensively everyday ways SET Trainees in Aotearoa New Zealand are immersed in cultural awareness to build their cultural competence. For Aotearoa New Zealand Trainees they must live and breathe a commitment to understand and working with the Māori and Pasifika people. In terms of cultural safety and awareness New Zealanders in general normalise te reo and te ao Māori, the use of te reo mixed into English conversations, greetings e.g. kia ora, Morena used in everyday written and verbal greetings.

Trainees are assessed on cultural competence and cultural safety through our assessment process, specifically in the QRA, the TIMS Feedback Entry has this as an assessment area.

At each training event it is opened with a mihi whakatau, this has become part of the Trainees experiences from selection interviews through to leaving the programme. Selection interviews are opened with a more formal mihi whakatau from our Cultural Adviser, this involves both our Cultural Adviser, Trainees, consultants and staff (3.6 NZ Orthopaedics SET Selection Day Mihi Whakatau 2024). In 2023 our Cultural Adviser bestowed a name on the applicants more befitting their journey (3.5 Te Kahui Kahurangi).

Trainees received dedicated cultural safety training at the SET 1 Training Weekend.

NZOA consider that language adopted can be a deterrent for those they seek to attract. NZOA have an alternative approach that reflects their immersive approach to responding to Māori and Pasifika people. The cultural advisor to NZOA stated that the term 'applicants' does not properly describe this gifted and intelligent cohort that tirelessly studies and vigorously strives to advance their careers in Orthopaedics. Further, the term 'applicants is not a very captivating and mana enhancing personal identifier for the beauty of who they are, what they mean to their whānau, and what they bring to their communities.'

Concerning the load on Māori surgical and non-surgical educators and assessors, this is managed through various mechanisms, NRK provide support to Trainees and colleagues. It has been acknowledged that the load on our Māori Trainees and consultants is larger as more requests are put on them, by introducing a Cultural Adviser we have not only been able to use this position to fill a 'gap' in both formal and more informal situations but as a non-surgeon and a consumer of orthopaedics (amputee) he brings a perspective from both the Māori world but also as a user of the specialty. He also works with NRK and bridges many of the cultural gaps.

Ngā Rata Kōiwi commissioned two beautiful korowai, which were then gifted their names by NZOA's Cultural Advisor & kaumātua Ken Te Tau. These korowai are now available for use at NZOA events on request. In addition, LIONZ commissioned two pounamu pedants from Pounamu Tohunga Whakairo (master carver) Nathan Jerry, these were organised by our Cultural Adviser. The pounamu is from Te Whanga o Awarua/Big Bay in Southland.

Example: Embedding Cultural Competence and Aboriginal and Torres Strait Islander Health

ASOHNS has strong connections with the Aboriginal and Torres Strait Islander sector, especially due to the health implications in ear health and hearing loss which disproportionally affects these communities. ASOHNS employs an Aboriginal staff member to support society activities in the sector. We have created connections

with NACCHO, Aboriginal Medical Services and other Indigenous organisations. Trainees have opportunities to do outreach work and the BOHNS has a relationship with Deadly Ears, an outreach program for Indigenous ear health, where Trainees can contribute to their program.

Condition 10				Due Date: 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 3.4.1) *Previously Standard 4.1.1 – moved to Standard 3.4.1 in 2024*				
Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
			X	
2024 AMC commentary				
The wording of this condition largely aligns with Standard 3, rather than Standard 4. Condition 10 has been moved to Standard 3.4.1 in 2024. It is acknowledged there are likely to be more comprehensive maps within programs; however, on the basis of evidence provided, this is progressing but far from complete enough for the Condition to be satisfied. Only two specialties, Cardiothoracic Surgery and Paediatric Surgery, referenced Stage 1 and Stage 2 outcomes in their outcome maps. None had defined learning activities or compulsory requirements by stage of training. Demonstration of alignment of learning and assessments to graduate outcomes of the training program, by stage of training, is needed.				
2025 College response				
Graduate outcomes have been mapped against the 10 competencies with few exceptions and by stage where that is possible. At the same time, RACS has expanded its 10 professional competencies and strengthened the framework in terms of competency indicators. **Perioperative care** Perioperative Working Group TOR have been agreed and essential membership identified and under consideration.				

- Working Group has not progressed
- RACS has leveraged the relationship with ANZCA and ACORN (nurses) – to deliver training and co-develop resources (new curriculum)
- Co-hosting and promoting a perioperative conference

2028 combined scientific meeting RACS and ANZCA – one of the streams will be perioperative.

2. 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 relevant to Standard 3. If a significant development has been made in response to addressing a condition, please only report on this this against the relevant condition. The development does not need to be reported twice.

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.

Examples of significant developments to report on could include:

- Educational framework of the specialist medical program(s)
- Recognition of Prior Learning policies and procedures
- Duration of training the program(s)
- Requirements for research projects
- Program changes responding to external developments (i.e. new service delivery or care models, etc.)
- Flexible training, part time and interrupted training policies and procedures

Has there been any significant developments in relation to Standard 3?	If yes, please describe the developments completed or planned *Please include any potential impacts on continuing to meet the standard in the description.*
- Yes ☐ - No ☒	-

Requests for additional information from the AMC response to the 2024 monitoring submission	
Request	**College Comment**
Regarding Condition 9, satisfied in 2024. The College is asked to comment on how it's being mindful there are no unnecessary "time based" or "procedure number" hold ups for trainees otherwise deemed competent.	Attached is the current list of compulsory requirements for each of the STB/Cs (3.7 Mandatory Exams and Courses). Discussed in this submission is the further elaboration competency-based training, education, assessment and selection for SET Trainees and potentially SIMGs. As the STB/Cs have moved to competency-based training and assessment, compulsory elements are for the most part competency-based, so a Trainee who has not completed the activity will not be deemed competent. All the PSC competencies have now been elaborated and are ready for discussion and improvement with CSET, and the STB/Cs individually. General Surgery Australia The GSET Evaluation Strategy is monitoring all the requirements to ensure that no requirements will adversely affect Trainees. To date one decision has been made to remove an EPA as the EPA was found not to be functioning. Otolaryngology Head and Neck Surgery Australia

	The SET Program in OHNS is competency based with progression based on competency rather than time. At each level, Trainees have access to the recommended requirements, Mandatory Assessments, Compulsory Requirements and Compulsory Courses. For example, Research Requirements are recommended at Novice level and Trainees are encouraged to complete the Research competent of training before they reach Competent level when they will be studying for the Fellowship Exam. Urology Australia and Aotearoa New Zealand The SET Program in Urology is competency based, which means that progression and eligibility for Fellowship are based on the achievement of clearly defined competencies, rather than on fixed timeframes or activity-based requirements. Each stage of training has specific, transparent requirements that must be met to facilitate progression. These requirements focus on demonstrable skills, knowledge, and professional behaviours essential to the role of a urologist. Trainees are assessed on their competence and completion of the required training requirements. The program also incorporates both minimum and maximum durations for each stage and for the overall program. This structure provides flexibility while maintaining oversight and standards. Trainees who are proactive and meet all training requirements in a timely manner may complete the program within the minimum timeframe. Conversely, the maximum duration ensures appropriate time for Trainees who may need additional support or experience to achieve competency. Provided all training requirements are satisfactorily completed by the end of the Advanced Stage, a Trainee will be eligible for recommendation for Fellowship. There are no unjustified time-based or activity-based barriers to Fellowship as progression is guided by the acquisition of required competencies. Orthopaedics Aotearoa New Zealand

	NZOA Trainees will be moving onto a hybrid model of competency-based training, the 5-year program will remain with Trainees completing modules each year to progress, this progress will be monitored in TIMS (Trainee Information Management System). Each curriculum area will be covered off by the end of their training. NZOA have no requirements to have completed a specific number of procedures that affect Fellowship. With the introduction of competency-based training, Trainees must pass modules in all areas of the curriculum. Trainees must also complete assessments in TIMS, including WBAs, Feedback Entries and QRAs. All procedures are entered into TIMS via eLogs. These must be up-to-date and are regularly checked by their Supervisor and the ETM. NZOA find that most Trainees have completed these courses pre-SET, to gain points on their CV. Current Regulations for courses are: TIPS is currently under review as it has been difficult for Trainees to secure places on this course due to availability in Aotearoa New Zealand. ASSET, CCrISP, EMST, and CLEAR, courses are available from SET 1 and must be completed by the end of SET 2 TIPS available from SET 2 to be completed by the end of SET 3 (under review). OPBS is to be completed by the end of SET 3. Plastic and Reconstructive Surgery Australia Changes have been approved to regulations for research and for defining training requirements for progression through competency-based medical education (CBME) New Australian Trainees commencing since 2022 are naturally part of a hybrid model of competency-based training. Existing Trainees from before 2022 transitioned from the archived time-based 5-year program to competency-based training in 2023. The training program is now linked to the completion of milestones (entrustable professional activities, or EPAs) and clinical training time. This equates to a minimum of 4 years and maximum of 9 years to graduate from SET.

	Progression between stages of training have defined maxima (including 2 years in Early SET, 4 years in Mid SET and until time-expired in Late SET). Progress is monitored in the TMP (Training Management Platform). The assessment of progression and competence are made by regional training subcommittees (comprising Supervisors of Training). Each curriculum area is covered by the end of training with curriculum mapped to each of the 14 EPAs and some being prescribed to Early training stages (establishing a link to foundation skills) while other being available for Trainees to complete when they rotate to sub-specialty terms: • Assessments tools (workplace-based assessments). • EPAs (4 prescribed in Early SET, any 6 in Mid SET and 4 in Late SET) • Curriculum topics (surgical competencies and professional skills)

3. Statistics and annual updates

Nil.

Standard 4: Teaching and learning methods

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

1. Activity against conditions

Nil Conditions Remain.

2. 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 relevant to Standard 4. If a significant development has been made in response to addressing a condition, please only report on this this against the relevant condition. The development does not need to be reported twice.

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.

Examples of significant developments to report on could include:

- Teaching and learning approaches
- Teaching and learning methods
- Requirement for completion of university or other formal award courses

Has there been any significant developments in relation to Standard 4?	If yes, please describe the developments completed or planned *Please include any potential impacts on continuing to meet the standard in the description.*

- Yes ☐ - No ☒	-

Requests for additional information from the AMC response to the 2024 monitoring submission	
Request	**College Comment**
The College is asked to please provide updates on the robot-assisted surgery (RAS) implementation?	See Part 2 for STB/Cs comments. RACS recognises the growing role of robot-assisted surgery (RAS), more in some surgical specialities than others and applications of RAS differ between specialties (e.g. how RAS is applied in urology is very different to the role of RAS in orthopaedic surgery). While public hospitals are acquiring more RAS platforms, the number of RAS platforms accessible for training remains very limited compared to the UK, European and North American settings RACS Council has decided to expand RAS engagement in an advisory group. Draft terms of reference have been shared with stakeholders for consultation, and are aiming to convene later this year, will focus on education, training, assessment, credentialing, standards of practice, CPD and advocacy issues. The intention is to integrate RAS more seamlessly into the curriculum for each of the STB/Cs. RACS have partnered with IMRA to deliver Foundations of Robotic Surgery and RoboSET: Basic Robotic Simulation Skills training to prevocational doctors, Trainees, SIMGs and Fellows. There has been the establishment of an independent working group to develop the curriculum and review robotics in the SET curriculum. Barriers to introducing robotic curricula are lack of educational material, lack of suitable training units and lack of robotic platforms in public setting. Specialty societies are currently relying on post-Fellowship (PFET) courses to provide RAS training. In 2025-2026 specialty societies are continuing to

	develop private training settings and runs to ensure Trainees are exposed to robotics e.g. NZOA
Could the College please comment on the low third attempt pass rates for the FEX.	See PART 2 for STB/Cs comments. The trend indicates that candidates who do not pass on their first or second attempts may encounter greater difficulties in subsequent resits. The higher percentage is also attributable to a small number of candidates needing to sit the Fellowship Examination multiple times.

Repeated FEx failures commentary

Attached is the FEx pass-fail data by sub-specialty as well as for SIMGs (4.1 FEX Exam Results 2024). The numbers for SIMGs and for re-sits beyond three are very small and cannot be reliably understood from such low numbers.

Attached is the explanation of the uncoupled FEx (4.2 FEX Uncoupling Summary). Since 2025, candidates have been unable to proceed in normal fashion where they have failed one or more components. This informs the Trainee of their status mid-assessment and changes the number of Trainees undertaking a further or future component before an intervention towards improving their examination performance. Further details can be found at https://www.surgeons.org/Examinations/Fellowship-Examination

RACS is unaware if these rates for third attempts differ from those across other medical colleges.

RACS does not have exit interview information as to what happens to Trainees and SIMGs who do not re-sit beyond three attempts.

Trainees and SIMGs may exit the SET program for reasons other than FEx failure that are not documented at present. We are not aware of any material characteristics of those who continue to sit FEx and those that do not. There are no agreed guidelines as to when more than 3 attempts may or may not be made, given the small numbers involved and the unique circumstances. These cases are managed in a bespoke manner.

RACS has explored more generically the reasons why FEx candidate pass rates specifically decline markedly with the number of attempts. This has informed an open discussion about how many exam attempts may be offered as well as early identification of and support for candidates at risk of failing the FEx.

Firstly, the Fellowship Examination (FEx) is designed to assess competence at the level expected of a Fellow commencing supervised specialist practice in Australia or Aotearoa New Zealand. Surgical Trainees are deemed 'ready' for unsupervised surgical practice anywhere. Understanding exam failure among the SIMG cohort is complex.

That some Trainees eventually pass after multiple attempts may also be complex. We note at least one candidate passed on the 18th attempt and for those who persist (or are permitted to persist) do still pass and the significant investment – personal and systemic – is rewarded. The reasons for first and subsequent fails are possibly as unique as the candidates, and as part of meeting condition 23, RACS will be undertaking a closer analysis of this group of fail-then-pass as well as fail-then-fail++ candidates. This will be analysed by specialist society as well as by other demographic, selection and in-training information.

RACS has numerous ways of 'predicting' likely failures, some of them less formal than others. The on-the-ground experience of the Trainee and the Supervisors are the most paramount among these. While approaches to early intervention and mentoring are determined by the individual STB/Cs, RACS has the following mechanisms:

RACS also has this policy: Assessment of Clinical Training (PDF 84.25KB)

There is also something in each of these RACS policies/regulations:

Dismissal from Surgical Training (PDF 97.68KB)

Ill, Injured and Impaired Trainees (PDF 77.41KB)

SET Misconduct (PDF 89.58KB)

Trainee Registration and Variation (PDF 98.7KB)

1.3 Reconsideration, Review and Appeal Regulation

RACS has thorough processes for actioning multiple failures. Please see regulation 2069 attached (4.3 Fellowship Examination Eligibility and Examination Regulation). An excerpt is provided here:

Second or Subsequent Examination Attempt 4.4.1. Candidates must be interviewed by the STB/C Chair or nominated representative and current Supervisor/s (if applicable). The interview should include a review of examination performance, the candidate's training or clinical assessment (if applicable). At the end of the interview a remediation plan should be implemented if necessary, and a signed copy must be sent to the STB/C (for a Trainee) or the SIMG Team (for a SIMG). 4.4.2. If the relevant STB/C has concerns regarding patient safety and believes a candidate should be reported to the Australian Health Practitioner Regulation Agency (AHPRA) or the MCNZ, it will recommend this to the Chair of CSET and the Censor-in-Chief in accordance with the mandated guidelines. 4.4.3. Recommendations of the STB/C must be communicated in writing to candidates. A copy must be provided to the SIMG Manager if concerning a SIMG under a pathway to Fellowship. A copy must be provided to the Executive Officer for SIMGs Aotearoa for SIMGs on a pathway to Vocational Registration with the MCNZ. 4.4.4. For a SIMG under a pathway to Fellowship, the STB/C may request a. an independent review of the assessment post; and/or b. a reassessment of the SIMG's specialist qualifications, training and experience. 4.4.5. Any recommended changes to an Interim Assessment Decision of a SIMG under a pathway to Fellowship will be considered by RACS. Before any final decisions are made, this is likely to be a future CSET workshop topic prior to June 2026.

Some STB/Cs have a more active role than others in the support offered following a failed FEx for either a SIMG or a SET Trainee, with the role of RACS increasing or decreasing accordingly.

3. Statistics and annual updates

Nil.

Standard 5: Assessment of learning

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

1. Activity against conditions

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

Please address each of these conditions individually.

<table>
<tr><td colspan="4">Condition 22</td><td>Due Date: 2026
(New Condition added 2024)</td></tr>
<tr><td colspan="5">Document how assessments are blueprinted to curriculum outcomes, by stage of training, for all RACS training programs (standard 5.1.1 and 5.2.2)</td></tr>
<tr><td rowspan="2">Finding</td><td>Unsatisfactory</td><td>Not Progressing</td><td>Progressing</td><td>Satisfied</td></tr>
<tr><td colspan="4">New Condition</td></tr>
<tr><td colspan="5">2024 AMC commentary</td></tr>
<tr><td colspan="5">New Condition: Commentary found in AMC Findings – 2024 Monitoring Submission</td></tr>
<tr><td colspan="5">2025 College response</td></tr>
<tr><td colspan="5">The new condition has been shared with the STB/Cs. A RACS-wide project has not commenced formally and will fall within the remit of the newly appointed Executive General Manager of Education Pathways, the STB/C Training Managers and CSET. However, most – if not all – of the STB/Cs are already well ahead in this endeavour. Please see earlier comment about the competency-based approach undertaken with the assistance of external expertise being populated for all professional skills in a way that can be assessed against competency indicators.
The format for the elaboration follows this sample from the framework. There are multiple descriptors for each competency.</td></tr>
</table>

1.0 RACS Competency –Medical Expertise			
1.1 Demonstrates medical skills and expertise.			
Descriptor – Within scope of practice and level of expertise, synthesise pertinent knowledge, clinical skills and professional behaviours to make clinical decisions and carry out diagnostic and therapeutic interventions to deliver compassionate, safe, and effective patient care.			
Context of service delivery	Core Skills	Competency outcome	Competency Indicator

At this stage of development, the unique positioning of each of the STB/Cs is critical and reported here. CSET will take up this requirement in 2025 – 2026.

Cardiothoracic Surgery Australia and Aotearoa New Zealand

The current cardiothoracic training program is time-based. Work has commenced on drafting a new curriculum which will ensure that it incorporates a clear and uniformly articulate program with clear graduate outcomes that will be mapped to the 10 RACS competencies. This will include a more comprehensive assessment of Trainee competence and technical/non-technical skills, clearly defined expectations and training outcomes for each stage of training (early SET and late SET) and structured and constructive feedback strategies to support ongoing development. The updated training regulations and revised assessments forms will follow soon after.

General Surgery Australia

General Surgery has completed this with a thorough Curriculum map attached (5.1 General Surgery Curriculum Map).

General Surgery has a program of assessment as well as what is required per stage of training and completion, which is attached (5.2 General Surgery GSET Regulations 2024) (Section 2.6, 16.4, 16.5, 16.6. 17, 20)

The current Supervisor of Trainee with performance issues is actively involved in the learning and development of Trainees as outlined in the General Surgery L&D process. If a Trainee has a Below Performance Expectation end of term rating, the Supervisor of the next term is involved in the counselling session in order to understand the issues as well as actively participate in the L&D Plan. Beyond this it is not legally defensible to inform future Supervisors of past performance if the issues have been remedied. However, the GSET program has a well-defined goal setting process at the start of the term whereby Trainees are encouraged to set goals through the online TIMS system and discuss areas for learning with their Supervisor. The GSET program has been established to allow and encourage increased

formative feedback throughout the term to enable conversations and lower-level remediation to occur with the Trainee and Supervisor. Details can be found in the attached (5.2 General Surgery GSET Regulations 2024) (Section 16.7, 19.1)

In 2022, the General Surgery Education and Training (GSET) Program was launched with 81 Trainees commencing clinical training in Term 1 – 2022. The GSET Program permitted Trainees to apply to present for the Fellowship Examination for the first time in GSET4.1 on the condition that various requirements were met. Of the cohort that commenced in Term 1 - 2022, two (2) Trainees withdraw from the program and one (1) was dismissed.

Following interruptions, Research interruptions, Not accredited, and Below Performance Expectation rotations between Term 1 – 2022 and Term 2 – 2024, 58 of the remaining 78 Trainees that commenced in Term 1 – 2022 would be in GSET4.1 in Term 1 – 2025 and eligible to present for the Examination in May 2025 if the requirements had been met. This would be the first opportunity for Trainees in GSET4.1 to present. Following the application period, of the 58 Trainees that were eligible only 17 (29%) elected to apply to present for the Fellowship Examination in May 2025. To determine the rationale behind the decision not to present, a survey was sent to the 41 Trainees. The response rate for the survey was 70.7% with 29 Trainees responding.

The main reason Trainees elected not to present for the May 2025 exam was due to not feeling confident as well as wanting to obtain more clinical experience. It is vital to consider that the point at which a Trainee can present for the Examination in GSET, i.e. during their fourth year of training, is the same as SET (old program), that is both cohorts are in their fourth clinical training year. Based on the data and survey responses, it appears that many GSET Trainees have made a conscious decision not to present for the Fellowship Exam at the first opportunity. What was not asked in the survey was how the Trainee came to the decision not to present and whether this decision reflected the GSET Work based Assessments (EPAs and PBAs) and the Curriculum/Assessment milestones or if there were other factors involved. This question will be explored further. However, it should be noted that the WBA and milestones are a considerable difference in the two programs.

The report is attached (5.3 General Surgery Examination Review).

Neurosurgery Australia and Aotearoa New Zealand

The graduate outcomes are mapped to the assessments within the SET Program in Neurosurgery curriculum. The technical competencies have also been integrated into specific learning outcomes for different training levels within the curriculum modules.

Orthopaedics Australia

The AOA 21 assessment strategy was developed to align to the competencies contained in the AOA 21 curriculum and the expected performance of Trainees at each stage of training. A broad Assessment Matrix (5.4 AOA Assessment Matrix) and the Expectations of Performance (5.5 AOA Expectations of Performance), in relation to each Foundation Competency and Medical and Surgical Expertise as defined for each stage of training, are attached. Training Program Requirements for each Stage of Training link to the Expectations of Performance for that stage across the curriculum competencies.

The Expectations of Performance are due for review as part of the AOA 21 Review Implementation Action Plan. A more detailed assessment blueprint, by stage of training, will be developed in conjunction with that work (5.5 AOA Expectations of Performance).

Otolaryngology Head and Neck Surgery Australia

The graduate outcomes have been mapped to the curriculum and assessments are integrated at different stages of competency.

Paediatrics Australia and Aotearoa New Zealand

We are working to create a prompt within TMP for Trainees to release their 360-degree evaluation feedback to current Supervisors as well as to set a meeting to discuss it.

Plastic and Reconstructive Surgery Australia

Curriculum outcomes in Section 1 are mapped to the PRSSP which must be completed in the Early Training stage of training.

Skill-based curriculum outcomes and selected knowledge-based outcomes in Section 2 and 3 are mapped to 14 Entrustable Professional Activities (EPAs) and five kinds of Workplace Based Assessments (WBAs). There are 4 specific EPAs which must be completed in Early Training and 10 others that are completed in Mid and Late Training. The order in which EPAs are completed during Mid and Late Training stages is dependent on the order of rotations that Trainees undertake. This ensures a flexible approach. Outcomes are mapped for EPAs across the 10 RACS Core Competencies. Further to feedback in 2020, EPA mapping has been updated, to include Cultural Competence and Cultural Safety. An Assessment Matrix (drafted in 2025) clearly identifies which essential competencies (non-technical) are assessed by each kind of WBA, EPA and examination. These have been in place since 2022 but were not communicated previously (5.6 ASPS Assessment Matrix Draft May 2025). In concert with the revision to the Curriculum conducted during 2024/2025, Cultural Competence and Cultural Safety is now a stand-alone assessable outcome of the curriculum –implementation is planned for the second half of 2025 or early 2026 (5.7 ASPS EPA Mapping).

Throughout training, quarterly professional performance assessments assess the technical and non-technical competencies commensurate with the relevant stage of training. All knowledge-based curriculum outcomes in Section 2 and 3 are assessed by the Fellowship Examination as a summative assessment in Late Training.

Workplace based assessments:

- Clinical Feedback
- Operative Feedback
- Case-Based Discussion
- Multi-source Feedback
- Presentation Evaluation

Approaches to teaching and learning are mapped to skills and knowledge (5.8 ASPS Teaching and Learning Matrix Draft May 2025) to align these with the revised curriculum.

Plastic and Reconstructive Surgery Aotearoa New Zealand

In instances where candidates are not progressing satisfactorily, the NZBPRS follows a protocol involving supportive Supervisor meetings, the development of supported learning plans, case-based discussions, performance review meetings, and the provision of mentors. It otherwise follows the RACS protocol for failing FEx Trainees.

Urology Australia and Aotearoa New Zealand

Assessments within the training program are blueprinted to the curriculum to ensure alignment with expected competencies but are not tied to specific stages of training. Trainees are encouraged to take advantage of opportunities available during their clinical rotations and complete EPAs when they have sufficient exposure and experience, regardless of their stage. This flexible approach allows for progression based on individual learning opportunities rather than rigid timelines. In addition, the Fundamentals of Urologic Care are assessed continuously throughout training via all Feedback Tools and the In-Training Assessments. The Board is also working closely with the Urology Court of Examiners to map which components of the Fundamentals of Urologic Care that are assessed in the Fellowship Examination (FEx).

Attached is a document which outlines how assessments are blueprinted to the Urology curriculum (5.9 Urology Assessment Blueprint).

Implementation of the New Urology Training Program

In 2024, the Board of Urology introduced a new training program, representing a significant change in how training is delivered and assessed. The new program introduced a competency-based model supported by a restructured curriculum and updated assessment tools, designed to ensure more robust and multi-faceted evaluation of Trainee progression.

This new program offers:

- A more comprehensive assessment of Trainee competence and technical/non-technical skills
- Clearly defined expectations and training outcomes for each stage of training
- Structured and constructive feedback mechanisms to support ongoing development

Transitioning to the new program has required considerable adaptation from all involved as Training Supervisors, Trainers, and Trainees have had to familiarise themselves with:

- Updated assessment methods, including Entrustable Professional Activities (EPAs) and Feedback Tools.
- New performance monitoring processes and structured feedback systems
- Adjusted progression criteria based on the demonstration of competence, not solely time or activity completion

Recognising that this major program change has been challenging, the Board has taken a proactive and consultative approach to implementation. Regular feedback from Regional Training Committees, Trainers, Trainees, and other stakeholders has been critical in identifying areas requiring clarification or adjustment.

An example of this was in response to feedback from Trainees and Supervisors about the expectations outlined in EPA 9 (Neurogenic Bladder). EPA 9 required Trainees to *perform* an ileal conduit, despite this being a procedure designated for independent performance at the level of a first-year consultant in EPA 10 (Muscle-Invasive Bladder Cancer). In response to this concern, the Board amended EPA 9, changing the requirement from "Perform formation of ileal conduit" to "Describe the principles, indications, technique, and complications of an ileal conduit." This revision has brought greater consistency between the two EPAs and will ensure that Trainees first acquire essential theoretical knowledge in EPA 9 before progressing to the procedural component in EPA 10.

The first year of the new training program has now concluded, and preliminary feedback indicates positive outcomes from all stakeholders, including Training Supervisors, Trainers, and Trainees. The vast majority successfully managed the new requirements and tools introduced. Training Supervisors have approached the EPA sign-off process with care and consideration, while RTC Committees have effectively navigated the revised approach to approving Trainees' competence across a range of urological conditions. To further enhance understanding and support, a comprehensive communication plan will be implemented in 2025, aimed at providing clear guidance to all USANZ members involved in training, ensuring they are fully informed about the program's components.

One of the components of this communication plan will be a workshop, or presentations during a plenary or concurrent session of the USANZ ASM dedicated to the training program. The aim is to provide members with comprehensive information about the program and is part of the Board's broader goal to professionalise the training program and ensure it receives broad visibility. By presenting this information at the ASM, the Board aims to foster greater engagement and understanding among members, reinforcing the program's importance within the urological community.

Vascular Australia and Aotearoa New Zealand

Competency-based training regulations are in development. The competency-based curriculum maps learning objectives and application of knowledge to stages of training, i.e. by Early - Mid- and Late-SET. Training Regulations detail requirements for Fellowship, including In-training assessments, WBAs, logbooks and exam assessments. A public curriculum is available for download on the ANZSVS website and the full Trainee/Supervisor version may be accessed via member log-in. Competency based Training regulations are under development.

The current vascular training program is time-based. Work has commenced to transition to competency-based training and competency Training Regulations are under development. The ANZSVS anticipate implementing these in 2027/2028.

The Vascular Surgery Competency Curriculum, introduced in 2022 is used in conjunction with the RACS Professional Skills Curriculum (PSC). Both the RACS PSC and the Vascular Curriculum describe graduate outcomes and are mapped to demonstrate all 10 RACS competencies.

The vascular surgical curriculum has two sections, 1) Knowledge and principles of Vascular surgery and 2) Vascular Surgery Competencies. The curriculum documents the core learning objectives and graduate competencies and outlines the expected competency standards, providing more specific guidance to Trainees and Supervisors as to the depth of knowledge and skills needed for the different stages of training. Key milestones are identified for assessing progression.

The RACS PSC describes the knowledge, skills and behaviours expected of surgical Trainees in eight of the 10 RACS Surgical competencies.

After a trial period in 2024 and advance notification to Trainees, the ANZSVS mandated the following WBA assessments for Trainees in 2025 replacing former DOPs and mini CEX assessments:

- Consultation Observation;
- Endovascular Procedure Observation;
- Open Surgery Observation;
- Ultrasound Observation; and
- Case Based Discussion.

2. 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 relevant to Standard 5. If a significant development has been made in response to addressing a condition, please only report on this this against the relevant condition. The development does not need to be reported twice.

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.

Examples of significant developments to report on could include:

- Assessment program and completion requirements
- Special consideration policy and procedures
- Remediation and reassessment of trainees policies and procedures
- Format or methods of any examinations and work-based assessment
- Mechanisms for providing timely feedback to trainees on assessment performance
- Policies and processes for informing employers and registration authorities of patient safety concerns that arise from trainee assessment
- Examination contingency plans
- Mechanisms for informing supervisors of assessment performance of trainees

Has there been any significant developments in relation to Standard 5?	If yes, please describe the developments completed or planned *Please include any potential impacts on continuing to meet the standard in the description.*
- Yes ☐ - No ☒	-

3. Statistics and annual updates

Please provide data **for 2024** 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.

	1st attempt			2nd attempt			3rd and subsequent attempt			Total		
Assessment Activity	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)	573	402	70.2%	120	51	42.5%	150	44	29.3%	843	497	59.0%
Clinical Examination (CE)	163	128	78.5%	55	36	65.5%	17	13	76.5%	235	177	75.3%
Cardiothoracic Surgical Sciences and Principles Examination Part 1	10	6	60.0%	1	0	0	0	0	0	11	6	54.5%
Cardiothoracic Surgical Sciences and Principles Examination Part 2	6	4	66.7%	0	0	0	0	0	0	6	4	66.7%
Orthopaedic Principles & Basic Science Examination	67	65	97.0%	2	1	50.0%	0	0	0	69	66	95.7%

Otolaryngology, Head and Neck Surgery Surgical Science Examination	28	22	78.6%	6	6	100.0%	2	1	50.0%	36	29	80.6%
Paediatric Anatomy and Embryology Examination	6	4	66.7%	0	0	0	0	0	0	6	4	66.7%
Paediatric Pathophysiology Examination	3	3	100.0%	0	0	0	0	0	0	3	3	100.0%
Plastic and Reconstructive Surgical Science & Principles Examination	23	16	69.6%	8	7	87.5%	1	1	100.0%	32	24	75.0%
Urology Surgical Sciences Examination	32	32%	100.0	0	0	0	0	0	0	32	32	100.0%
Vascular Surgical Sciences Examination	7	4	57.1%	2	1	50.0%	1	1	100.0%	10	6	60.0%
Cardiothoracic Fellowship Examination	10	5	50.0%	2	0	0	5	1	20.0%	17	6	35.3%
General Surgery Fellowship Examination	126	87	69.0%	39	22	56.4%	25	7	28.0%	190	116	61.1%
Neurosurgery Fellowship Examination	7	5	71.4%	2	1	50.0%	1	1	100.0%	10	7	70.0%
Orthopaedic Fellowship Examination	67	50	74.6%	20	15	75.0%	12	1	8.3%	99	66	66.7%
Otolaryngology Fellowship Examination	22	18	81.8%	4	1	25.0%	2	0	0	28	19	67.9%
Paediatric Fellowship Examination	6	4	66.7%	2	1	50.0%	3	1	33.3%	11	6	54.5%
Plastics Fellowship Examination	19	13	68.4%	7	3	42.9%	6	1	16.7%	32	17	53.1%

Urology Fellowship Examination	23	14	60.9%	3	3	100.0%	3	1	33.3%	29	18	62.1%
Vascular Fellowship Examination	10	7	70.0%	4	3	75.0%	3	0	0	17	10	58.8%
TOTAL	**1208**	**889**	**73.6%**	**277**	**151**	**54.5%**	**231**	**73**	**31.6%**	**1716**	**1113**	**64.9%**

In the table below, please provide combined summative assessment data **for 2024** showing the number and percentage of the cohort who passed at their first, second, third and subsequent attempts.

	1st attempt			2nd attempt			3rd and subsequent attempt			Total		
Cohort	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	10	6	60.0%
Māori Trainees	23	17	73.9%	6	3	50.0%	4	2	50.0%	33	22	66.7%
Pasifika Trainees	14	12	85.7%	1	1	100.0%	0	0	0	15	13	86.7%
Specialist International Medical Graduates	15	9	60.0%	8	2	25.0%	13	6	46.2%	36	17	47.2%

Standard 6: Monitoring and evaluation

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

1. Activity against conditions

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

Please address each of these conditions individually.

Condition 12				Due Date: 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)				
Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
			X	
2024 AMC commentary				
This Condition arose from the 2017 accreditation assessment where the team formed the view that a more direct first-hand means of collecting confidential input from all supervisors was needed. The relevant standard includes '…the education provider systematically seeks, analyses and uses supervisor feedback in the monitoring process'. The Training Committee/Board self-assessment shows a range of practices: each of the societies collects feedback from some supervisors formally via survey and informally, via workshops or meetings. Some of these are confidential. There is good evidence of supervisor input into each of the training programmes, particularly from those who are on Boards or Directors of Training. There is a reliance on confidential feedback at accreditation inspections, but it is unclear if this is feedback on the training program itself. The College has begun mapping how each STC/B incorporates trainee and supervisor feedback in the development of the training programs. Some options being considered for supervisor feedback are to conduct a supervisor survey using a method similar to the RACSTA survey. Another is to use the TMP for survey administration, but as mentioned in Standard 3, the TMP is used currently by only three programs. Some mentioned the College Supervisor self-assessment survey as a method of providing confidential feedback. As presented to AMC, this looks to be more a tool for supervisors to reflect on their own performance as supervisors, rather than as a channel to provide feedback on the training programme itself. To meet this Condition, the College needs to demonstrate a systematic approach so that individual supervisors can provide feedback on the respective training programme which is then analysed and used to enhance training. The development of additional documents or resources like the map referenced, along with documentary evidence (e.g. of surveys) would be very helpful in determining whether this condition is satisfied. Additionally, the College could consider the development of a single resource to be used by the College and subspecialties to provide a uniform guidance tool.				
2025 College response				

RACS has completed a Supervisor feedback survey and has aligned the finding with those of the STB/Cs who elected to deliver their own survey.

Attached are the results of the RACS Feedback from Supervisors survey by surgical specialty (6.1 Draft Supervisor Self-Assessment Report 2024). These need to be aligned with the results of the independent surveys undertaken by NSA and AOA surveys.

Attached is the report summarising the results of the NSA feedback survey (6.2 Neurosurgery Supervisor Evaluation Report 2024).

Condition 13				Due Date: 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	
2024 AMC commentary				

There was a very detailed RACS response and Training Committee/Board self-assessments showing the range of ways that trainees may give feedback on their posts and on the programmes. For example:

- There are trainees on all Training Committees/Boards with the exception of the Board of Urology.

Regular confidential trainee surveys are conducted by:

- Board of Neurosurgery
- Board of Urology
- Board of Vascular Surgery
- Australian Board in General Surgery

- New Zealand Board in General Surgery
- Board of Otolaryngology Head and Neck Surgery
- Australian Board of Plastic and Reconstructive Surgery
- Australian Orthopaedic Association Federal Training Committee
- New Zealand Board of Orthopaedic Surgery

But not by:

- Cardiothoracic Surgery Training Committee
- Committee of Paediatric Surgery
- New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee
- New Zealand Board of Plastic and Reconstructive Surgery

The small size of these specialties and difficulty maintaining confidentiality in a survey were cited as reasons. Instead, interviews are used which are not confidential. Another issue reported is the delay in full implementation of the TMP which is currently used by two of these four specialties. Being a specialty of a small size is not reason enough to not obtain feedback. The AMC suggests consideration of other ways to obtain confidential feedback for small specialties, which could include multi source feedback and discussion with other small colleges and/or training programs on confidential and safe feedback processes used.

MTS and RACSTA surveys; however neither of these surveys are specific enough to meet this condition or the standards.

- Confidential feedback at accreditation inspections; again this is not regular enough or systematic enough to meet the condition.

The Hospital Training Post (HTP) Accreditation Standards provide detail as to what needs to be in place for trainees to be able to raise concerns or make a complaint, and that the hospital shares this information with RACS. Specifically, Standard 14.3.2 states “Feedback is sought from Trainees in de-identified manner as part of the process” (the process being that all surgical staff complete performance appraisals).

As part of the M&E framework there is a 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

Further, trainee feedback on supervision is one of the monitoring indicators for the output of "skilled, supported and engaged Supervisors".

Appx 6.5 showed a draft for a pilot of a confidential Trainee Evaluation of Supervision Survey with structured questions and free text options. This looked useful. The first Trainee feedback process will occur in November 2024 with reporting in February 2025.

Appendix 6.8, outlined the information security policy includes the following principle "Ensure that accurate information is provided on a "need to know only" basis to the appropriate people. This policy also needs to apply in the specialty societies."

However, MTS and RACSTA surveys showed RACS trainees still have concerns about safe mechanisms for trainees to raise concerns (>30% of trainees unfavourable or RACS> 5% below national response, see Standard 7).

To meet the Condition, there needs to be systematic and confidential approaches used across the College, as well as trainee verification that these pathways are safe. As noted in the commentary under Condition 12, the College could consider the development of a single college-wide resource to be used by the College and subspecialties to provide a uniform guidance tool.

Please also see also commentary under Condition 19.

2025 College response

Please see Standard 1 Condition 21 and the STB/C methods of collecting feedback in Part 2.

RACS, RACSTA and each of the STB/Cs undertake multiple ways to access Trainee feedback. This includes surveys on specific cohorts and issues. Specifically related to the FEx, please see:

1. Attached is the FEx feedback tool (6.3 FEX Candidate Feedback Survey September 2024)
2. Attached are the results of the latest FEx Trainee evaluation (6.4 FEX Candidate Feedback Survey Results September 2024)
3. Attached are the May 2024 survey results concerning the FEx (6.5 FEX Candidate Feedback Survey Results May 2024)

Variation: An Elected Trainee Committee in Neurosurgery

NSA have established a Trainee Representative Committee as a platform to amplify Trainee perspectives and to ensure their voices contribute to the development as well as delivery of the SET program, as well as other NSA activities that may impact them. This Trainee Committee consists of eight Trainees, including the current Trainee Representative, the past Trainee Representative, and six Trainees elected by their peers. The Committee's terms of reference include diversity clauses to ensure representation from both Australian and Aotearoa New Zealand Trainees, ensuring a broad range of perspectives are considered.

Condition 14				Due Date: 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		

2024 AMC commentary

See also commentary under the related Condition 3.

Progress to meet this Condition intersects with the response to the NHPO review recommendations and the development and implementation of the M&E framework.

Ways in which programs report collecting feedback include:

1. New curricula:
    - posting drafts for feedback on public websites
    - seeking specific input from stakeholders
2. Multisource feedback tool and in SET selection re: individual trainees
3. The HTP standards and visits are mentioned as a way of getting wider feedback on the program, but it is not clear how this happens
4. External representatives on Training Committees/Boards
5. Engagement with health services and government

To meet the 3 standards under Standard 6.2, deeper and more reciprocal engagement with non-surgical stakeholders, consumers and the wider community is needed, to ensure the respective programs as a whole, and not just curricula, reflect community needs and wider health practice.
2025 College response
Please see Standard 2 Condition 3 where we have addressed Condition 14 inclusively.

Condition 15				Due Date: 2023
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)				
Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
			X	
2024 AMC commentary				
It is important the College has a shared view of what is needed to meet the condition and the standard, and how it relates to the M&E framework. e.g. It is important this the reporting is proactive and does not rely on stakeholders requesting reports. Several good small-scale examples were provided; however, the implementation of the M&E Framework is key to meeting this condition.				
2025 College response				
Training Management Platform The RACS training management platform (TMP) has had four major releases since the last AMC monitoring submission, the most recent on 15 April 2025. All STB/Cs chairs have been involved, and their feedback actioned and formal UAT commenced 21 April 2025. Areas where the TMP records RACS-wide data are now site accreditation, Trainee requirements and Supervisor performance data that meets AMC standards. A roadmap of must-haves and could-haves has been developed and is being tested with users.				

The roadmap has a number of must-haves and could-haves. These requests are being considered as part of an evaluation of the implementation of features to date and how this contributes into a broader IT system roadmap, the financial investment and commercial arrangements are also under review as the system is not used by all STC/Bs.

Currently only 4 STB/Cs are entering their data in TMP and are using TMP for Trainee assessments. For these STB/Cs, their Supervisors and Trainees can access this data as well in relation to in-training assessments.

All the Supervisors of all specialties will have to use TMP to access Supervisor reports that are the outcome of the assessments survey (Supervisor Self-assessment, Trainee Evaluation of Supervisor). We are currently working with PLA NZ to onboard and are expected to be onboarded in 2025.

TMP is also used by RACS to record:

- Supervisor data (excluding AOA)
- All the Hospital accreditation data (including MMM information)
- Trainee rotation information (outcome – all specialties)
- New Trainee intake, including status – start year/expected and actual end year/active (all Specialties)
- Billings and orders – this tool can pull information from TMP so we can bill Trainees their annual SET fees (all specialties)
- Early access to Skills course enrolments (October prior to February intake date)
- RACS Supervisor Trainee Evaluation and Supervisor Self-assessment (except those that opted out - AOA, Neurosurgery and ABPRS)

It is important to note that while the TMP is not used by all STB/Cs and there is not yet a data sharing 'flow' tool to allow direct data transfer via uploading from other platforms, RACS does have full line of sight over SET as it applies to Trainees, Supervisors and sites. It is the double handling of this data that the TMP aims to minimise when fully implemented.

Monitoring and Evaluation

The minimum data set (MDS) is agreed and implemented – no fit-for-purpose database to have line of sight across all critical information across RACS and the STB/Cs. The M&E framework is not implemented. RACS is aware there is no IT solution as yet for the sharing of information across platforms to create a single source of truth. The STB/Cs mostly consider this formal requirement to sit with RACS. However, every STB/C undertakes monitoring and evaluation of all or most aspects of SET – formally and less formally – and with the necessary data protections in place have indicated their support for sharing all but the most personalised information pertaining to M&E overall. This data sharing agreement is still in negotiation, but the intention is well accepted.

The evaluation of SET overall currently includes the following evaluation questions for short-term, intermediate-term and long-term outcomes and will inform / elaborate condition 22. There are clear links also to the MTS and thus the responses will inform the RACS and the STB/Cs' action to improve Trainee responses into the future.

Short-term Outcomes

Trainees achieve the professional skills competencies

Do the assessment outcomes demonstrate the development of the professional skills competencies?

Trainees achieve the technical expertise competencies

Do the assessment outcomes demonstrate the development of technical expertise competencies?

Trainees achieve the medical expertise competencies

Do the assessment outcomes demonstrate the development of medical expertise competencies?

Supervisors, trainers and educators are competent in supporting and educating the Trainees

Do trainers facilitate a safe and effective training environment?

Do educators facilitate a safe and effective training environment?

Do Supervisors facilitate a safe and effective training environment?

What is the impact of training on Trainees' wellbeing and mental health?

Is the HTP program mee□ng its requirements in ensuring accredited hospitals provide a suitable environment for training?

Selection Process selects candidates that are likely to graduate

Is the selection process identifying candidates who go on to complete surgical training?

Trainees complete research requirements

Are Trainees provided with appropriate resources and support to complete the research requirements?

Intermediate Outcomes

Trainees complete the assessment and training requirements for Fellowship and are supported into safe practice

Are assessment and training requirements fit for purpose?

Do hospitals consider graduates are prepared to transition to safe practice?

Do Fellows consider graduates are prepared to transition to safe practice?

Do other stakeholders consider graduates are prepared to transition to safe practice?

Do graduates feel prepared for practice?

Trainees achieve all of RACS competencies to become a competent and safe surgeon

Are graduates ready to practice safely in their scope of practice?

What is the evidence that the performance of graduates' meets the healthcare needs of consumers and others in the health care setting?

There are specific issues that are raised in Standard 1 Condition 21 that will be addressed in the M&E Framework design. These include outcome data - selection, diversity and inclusion, rural equity, relocation, flexible training, completion of cultural training.

Status: As At February 2025

- The final version of the Monitoring report was sent to the STB/Cs on 22nd January for their feedback by 17th February 2025.
- Documentation has been prepared to send the report to CSET via circular resolution on 28th February for a response by 7th March. STB/Cs have been asked to direct all feedback to Penny Williamson, Senior Project Researcher who will compile the feedback. The final report to be sent to you as EGM for approval before sending the CSET.

Please note we are already receiving feedback that RACS data does not correlate with STB/C data, however we can only go on what data reported into CSET. Any updates proposed by the STB/C/s will be forwarded to Mirya.

Monitoring Indicators

- Please note that monitoring indicators sent for CSET approval in July 2024 were missing outputs 6 (Contemporary curriculum and training resources) and output 11 (Trainees are supported to complete research requirements). These have now been incorporated into the Monitoring report and were discussed with the STB/Cs when the omission was noted in November.
- Updated draft Monitoring and Evaluation Questions are attached (6.6 Draft Monitoring and Evaluation Questions).
- Whilst CSET has approved the 11 outputs, RACS is unable to collect some data against outputs for the 2023 report; these were documented in the future reporting requirements that were sent to February CSET for noting.

Next steps:

- Progress report sent to CSET for M&E Update (6.7 CSET Progress Report on Monitoring and Evaluation Improvements)

- Following feedback from all STB/Cs by 17th February, forward the 2023 Monitoring Report to CSET for approval via circulate resolution (1.16 Monitoring Report 2023).
- Commence work on the 2024 Monitoring Report in the second half of 2025.
- Work to commence on the Evaluation plan from June 2025 for development and consultation with STC/Bs.
- Suggest a workshop in 2025 with CSET and the Training Managers to discuss following:
    - Will each STC/B self-evaluate and report to RACS findings?
    - Are there any questions that would benefit from a group approach - e.g. those requiring stakeholder input? Desktop reviews?
    - What are minimum requirements of evaluation?
    - Do we need standardised evaluation indicators?
    - What are timeframes for evaluation?
    - What are reporting requirements for evaluation
    - What will be the outcomes of the evaluation?
    - What aspects of evaluation can be shared with stakeholders and put on website?

Refer to the attached draft Monitoring and Evaluation Questions (6.6 Draft Monitoring and Evaluation Questions).

Example: Fully Utilising the RACS TMP

Vascular Surgery actively monitors and reports to RACS on the M&E Framework. Mitigation of risk strategies form part of this process to allow for timely and corrective action. Vascular reports all required data to CSET. Vascular anticipates the RACS TMP will provide data not previously collected. ANZSVS will work with RACS to achieve improved data reporting.

Example: Neurosurgery SET Program Quality Improvement and Development Plan

This Plan focuses on continuous monitoring, evaluation, and quality enhancement, aligning improvements with best practices, accreditation requirements, and stakeholder feedback. The Plan will be discussed at a SET Board workshop in late June, for approval by the NSA Board in August 2025.

2. 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 relevant to Standard 6. If a significant development has been made in response to addressing a condition, please only report on this this against the relevant condition. The development does not need to be reported twice.

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.

Examples of significant developments to report on could include:

- Monitoring and Evaluation plan/strategy/framework
- Processes to evaluate program and graduate outcomes
- Mechanisms to manage concerns about, or risks to, the quality of the training program(s) effectively and in a timely manner
- Mechanisms to collect and analyse trainee, feedback to improve the training program(s)
- Stakeholder contribution to evaluation of program and graduate outcomes
- Mechanisms to collect and analyse supervisor, feedback to improve the training program(s)
- Mechanisms for making monitoring and evaluation results available to stakeholders

Has there been any significant developments in relation to Standard 6?	If yes, please describe the developments completed or planned *Please include any potential impacts on continuing to meet the standard in the description.*
Yes ☐ No ☒	

3. Statistics and annual updates

Please provide data for 2024 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.

Evaluation activity	Issues arising	College response to issues
Medical Training Survey	Bullying, discrimination and harassment in the workplace	Refer to attached feedback from specialties (1.15 MTS 2024 and RACSTA Survey Feedback From Specialties)

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?	- Refer to attached feedback from specialties (1.15 MTS 2024 and RACSTA Survey Feedback From Specialties)

How is the College reflecting on its performance in the MTS?	
What are the future directions and planning of the College based on MTS results?	

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. Activity against conditions

Nil conditions remain.

2. 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 relevant to Standard 7. If a significant development has been made in response to addressing a condition, please only report on this this against the relevant condition. The development does not need to be reported twice.

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.

Examples of significant developments to report on could include:

- Selection into training policies and procedures
- Strategies to enable a supportive learning environment
- Trainee Committee frequency or format of meetings
- Support and funding provided by the College to its Trainee committees
- Mechanisms for trainee representatives or committees to communicate with other trainees
- Trainee participation in education provider governance
- Policies relating to bullying, discrimination and sexual harassment
- Processes to nominate or elect trainee representatives to College committees
- Strategies and mechanisms for communication with trainees
- Policies and strategies for recruitment and selection of Aboriginal and/or Torres Strait Islander, Māori and Pasifika trainees
- Trainee representation on major College committees
- Opportunities for trainees to meet senior College officers
- Policies to support trainees in fee distress
- Mechanisms to support trainees to address problems with training supervision and requirements, and other professional issues
- Changes to training fees *(Please describe how the College ensures its costs associated with training and education meet the outcomes of the National Registration and Accreditation Scheme, and are not prohibitive for potential trainees)*

Has there been any significant developments in relation to Standard 7?	If yes, please describe the developments completed or planned *Please include any potential impacts on continuing to meet the standard in the description.*
Yes ☐ No ☒	

SET Training Fees

- Attached in the table of all fees charged by RACS in Australia and Aotearoa New Zealand (7.1 RACS Fee Table 2025)
- Attached is a summary of SET fees charged by the specialist societies (7.2 RACS SET Training Fees 2025)
- The Hardship Policy has been drafted and discussed with broad support from Executive Leadership Team (ELT). RACSTA will be consulted and input sought before full approval of the policy is given.

- Communication Plan to Trainees (7.3 MCNZ Information Gathering Health and Safety Advice December 2024)

RACS and the STB/Cs note there are no conditions to this standard pending.

Key issues and developments relating to this standard have been reported under other standards where a condition is in place. Most notably these conditions are 13, 19 and 21.

The impact of the diversity and inclusivity framework in selection outcomes is documented in detail in Standard 1 Condition 2. Mechanisms for obtaining a diverse range of Trainee feedback are discussed in Condition 13 and 19. In condition 21 and tin the dedicated AMC table, the RACS MTS results and subsequent actions are addressed.

Fees Transparency

https://www.surgeons.org/about-racs/college-fees#SET%20fees

Fees are calculated on a cost recovery basis: Specialty Surgical Education and Training Fee (PDF 93.97KB)

The pre-Fellowship Education program of RACS is funded from training fees and associated fees for skills courses and examinations and is not subsidised by Fellowship member subscriptions: Surgical Education and Training (SET Fee) (PDF 106.32KB)

Fee Increases

- Changes to fees and how costs associated with college NRAS (National Registration and Accreditation Scheme) compliance are not prohibitive for Trainees.
- Currently reviewing RACS training fee – is there opportunity for efficiency/differentiated models?
- We discussed the need for a fee setting principle-based policy to be developed for both RACS and society fees
- Developing a hardship policy for Trainees
- Scholarships and grants are available to assist
    - RACS did not increase the RACS training fee in 2025
    - RACS introduced a Trainee member category in 2025
- RACS has noted the MTS response as the worst for RACS of all colleges and expects an improvement in this metric in the 2025 MTS
    - RACS and the STB/Cs have addressed this feedback in their MTS action plans (1.15 MTS 2024 and RACSTA Survey Feedback From Specialties)

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 2025, 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 2025

- The number of trainees, including Aboriginal and Torres Strait Islander, Māori, and Pasifika trainees who exited the training program in 2024 (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 2024

— The number of Fellows of the College in 2024

Number of trainees entering training program in 2025											
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	0	1	4	0	4	1	8	3	0	21	37
New Zealand Board of Plastic and Reconstructive Surgery	0	0	0	0	0	0	0	0	4	4	10
New Zealand Board of Orthopaedic Surgery	0	0	0	0	0	0	0	0	4	4	53
Australian Board in General Surgery	0	21	52	0	7	0	30	9	0	119	116
New Zealand Board in General Surgery	0	0	0	0	0	0	0	0	19	19	25
Board of Neurosurgery	0	2	4	0	2	0	2	0	1	11	28
Australian Orthopaedic Association Federal Training Committee	2	19	25	0	3	0	8	6	1	64	218
Board of Vascular Surgery	0	2	2	0	1	1	2	0	3	11	21

Board of Urology	0	6	5	0	1	0	2	2	3	20	33
Board of Otolaryngology Head and Neck Surgery	0	5	6	0	4	0	5	4	0	24	47
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	0	0	0	0	0	0	0	0	1	1	16
Cardiothoracic Surgery Training Committee	0	3	2	0	0	0	2	1	0	8	32
Committee of Paediatric Surgery	0	1	0	0	0	0	0	0	5	6	10
Aboriginal and/or Torres Strait Islander Trainees										0	
Māori Trainees										8	AoNZ Specialty Orthopaedic Training Board – 3 New Zealand Board in General Surgery – 5
Pasifika Trainees										4	AoNZ Specialty Orthopaedic Training Board – 1 New Zealand Board in General Surgery – 1 New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee – 1 Cardiothoracic Surgery Training Committee – 1

Number and gender of Trainees undertaking each training program in 2025					
Training program	**Male**	**Female**	**Non-binary**	**Not stated**	**Total**

Australian Board of Plastic and Reconstructive Surgery	64	38	0	0	102
New Zealand Board of Plastic and Reconstructive Surgery	1	3	0	0	4
New Zealand Board of Orthopaedic Surgery	53	22	0	0	75
Australian Board in General Surgery	52	66	0	1	119
New Zealand Board in General Surgery	38	38	0	0	76
Board of Neurosurgery	48	16	0	0	64
Australian Orthopaedic Association Federal Training Committee	216	67	0	0	283
Board of Vascular Surgery	35	17	0	0	52
Board of Urology	77	26	0	0	103
Board of Otolaryngology Head and Neck Surgery	63	28	0	0	91
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	17	9	0	0	26
Cardiothoracic Surgery Training Committee	27	13	0	0	40
Committee of Paediatric Surgery	3	3	0	0	6

Trainees exiting from program in 2024 (prior to attaining Fellowship)		
Training Program	**Number**	**Reason for exiting**
Australian Board of Plastic and Reconstructive Surgery	1	Resigned or withdrew (voluntary)
Australian Board in General Surgery	5	Resigned or withdrew (voluntary)
Board of Neurosurgery	1	Trainee dismissed
Australian Orthopaedic Association Federal Training Committee	2	Resigned or withdrew (voluntary)
Board of Urology	1	Resigned or withdrew (voluntary)
Board of Otolaryngology Head and Neck Surgery	1	Resigned or withdrew (voluntary)
Aboriginal and/or Torres Strait Islander Trainees	0	*Please include reason/s for exiting*
Māori Trainees	0	*Please include reason/s for exiting*

Pasifika Trainees	0	*Please include reason/s for exiting*

Could the College please provide comment on its reflections on the withdrawal rate to ensure there is no systemic issue, such as discrimination, bullying or harassment, lack of resources, or lack of support, which could cause withdrawals.

Number of Trainees completing training program in 2024 (attained Fellowship)											
Training program	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	O/S	Total
Cardiothoracic Surgery Training Committee	0	0	1	0	0	0	2	2	1	0	6
Australian Board in General Surgery	1	42	1	15	6	0	26	4	0	2	97
New Zealand Board in General Surgery	0	0	0	0	0	0	0	0	13	0	13
Board of Neurosurgery	0	1	0	2	1	0	2	1	0	1	8
Australian Orthopaedic Association Federal Training Committee	3	13	0	8	2	2	12	5	0	6	51
New Zealand Board of Orthopaedic Surgery	0	0	0	0	0	0	0	0	14	0	14
Board of Otolaryngology Head and Neck Surgery	0	4	0	5	2	0	2	1	0	0	14
New Zealand Otolaryngology Head and Neck Surgery Training Subcommittee	0	0	0	0	0	0	0	0	1	0	1
Committee of Paediatric Surgery	0	2	0	1	0	0	0	0	1	0	4
Australian Board of Plastic and Reconstructive Surgery	0	4	4	0	0	0	2	0	0	0	10
New Zealand Board of Plastic and Reconstructive Surgery	0	0	0	0	0	0	0	0	2	0	2
Board of Urology	0	5	0	3	1	0	2	0	2	4	17
Board of Vascular Surgery	0	2	0	1	2	1	2	0	1	0	9
Aboriginal and/or Torres Strait Islander Trainees											0
Māori Trainees											3
Pasifika Trainees											1

Number of Fellows in 2024		
Australia	New Zealand	Other
5,784	910	346

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

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

1. Activity against conditions

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

Please address each of these conditions individually.

Condition 19				Due Date: 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)				
Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
			X	
2024 AMC commentary				
As was noted in the 2023 monitoring submission, a supervisor framework and standards were developed and made available to satisfy the initial part of the Condition, however a process for reviewing individual supervisor performance across all specialty training programs was required to satisfy the condition. The supervisor framework and standards were provided in Appx 8.2. For each of the five domains there is a list of core competencies as well as higher level competencies to develop over time. The College reports the following initiatives: 1. Supervisor self-assessment (has been piloted? evaluated) 2. Multi-source feedback (mix of patient/colleague/peer and self-assessment) also piloted, yet to be evaluated. 3. The bulk of supervisor performance rests with the hospital training site. There is a clear requirement in the College HTP standards for the hospital to ensure supervisor performance development, appraisal, reporting and management of performance concerns, (Standard 14.3 and 14.4) including a process for de-identified Trainee feedback.				

Progress in implementation:

- From the speciality societies, the Board of Neurosurgery and Board of Otolaryngology Head and Neck Surgery report that SET evaluation includes feedback on supervisor performance and informs training post accreditations.
- 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 – it is not clear what these processes are.
- All other STC/Bs have opted for the College to implement the Supervisor self-evaluation templates and to collect data on their behalf. There is no data to support any implementation or success of this approach.

The AMC does not consider that supervisor self-evaluation is adequate to meet this standard, nor is expecting the hospital to monitor the surgical supervisor's performance and advise the STB/C 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. Even though there is an HTP standard is that 'Feedback is sought from Trainees in a de-identified manner as part of the [annual performance review] process,' it is not clear yet how RACS would see this routinely. The information sharing protocol (Appx 6.3) seems to relate to complaints rather than routine monitoring.

While these may all be part of the evaluation of supervisor effectiveness, there still does not seem a mechanism involving routine trainee feedback on individual supervisors which is what is needed to meet the condition and the standard. Also needed is how supervisor effectiveness is managed in the M&E framework. A systematic and confidential solution is needed to meet Conditions 19 and 13 and the associated standards.

2025 College response

Supervisor performance across all STB/Cs

Please see Standard 6 Condition 13 where the results and consequential action are described.

1. Attached RACS Trainee survey results concerning supervision (8.1 Draft Trainee Evaluation of Supervisors Report 2024)
2. Attached NSA Trainee survey results concerning supervision (6.2 Neurosurgery Supervisor Evaluation Report 2024)
3. Attached is a draft report on the Multi-Source Feedback program (8.2 Draft Multi-Source Feedback Survey Report 2024)

RACS is also aware that site accreditation standards form the basis of reciprocal, respectful relationships between each of the STB/Cs and those providing the training on site. While there are of course 'contractual' obligations on the part of both parties, there is enormous mutual benefit when trust allows one or other party to raise any concerns early with a contact who they 'know' will work collaboratively, if at all possible, to prevent, resolve or mitigate the issue. The role of each of the STB/Cs is this critical, even if a site is accredited for one or more surgical speciates. This will be an ongoing conversation about the seen and unseen roles of site accreditation RACS will facilitate with all involved parties.

RACS has been an early adopter of the NHPO Miller Blue review of training site accreditation standards. RACS has commenced aligning the Miller Blue derived site accreditation standards with the RACS HTP standards. RACS has been on the working group with RACS and STB/C representation. Recognising the on-the-ground

experience of the STB/Cs, RACS requested a representative of the STB/Cs is member of the HTP accreditation working group whose role is to assist RACS with defining their roles within HTP accreditation processes.

STB/Cs are collaborating on responsibilities for future accreditation models (Part A / Part B).

Attached is the draft alignment of site accreditations standards (8.3 Draft RACS Model Standards Mapped)

Attached are the draft timelines for implementation (8.4 Draft RACS Timelines for Implementation)

RACS also have Supervisor and Trainer policies:

Surgical Supervisors (PDF 102.2KB)

Surgical Trainers (PDF 104.68KB)

Supervisors of Specialist International Medical Graduates in Australia and Aotearoa New Zealand (PDF 202.36KB)

2. 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 relevant to Standard 8. If a significant development has been made in response to addressing a condition, please only report on this this against the relevant condition. The development does not need to be reported twice.

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.

Examples of significant developments to report on could include:

Processes for the selection and removal of supervisors

- Criteria and processes for accreditation of training sites

Supervisor training, development and support

- Processes for ensuring that training sites that are undergoing accreditation are Culturally Safe

- Mechanisms for evaluating supervisor effectiveness and processes for providing feedback

Has there been any significant developments in	If yes, please describe the developments completed or planned

relation to Standard 8?	*Please include any potential impacts on continuing to meet the standard in the description.*
- Yes ☐ - No ☒	-

3. Statistics and annual updates

Data for Standard 8 will be collected separately as part of NHPO reporting.

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. Activity against conditions

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

Please address each of these conditions individually.

Condition 20				Due Date: 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 9.2.1)				
Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
		X		
2024 AMC commentary				
The College has provided minimal developments since the previous report to the AMC against the work to satisfy this condition. The College has finalised an EVOPP policy (Appendix 1.26) 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. Six of 9 were judged ready for independent practice. A range of issues has been identified including selection of candidates, resourcing, psychometrics, reliability, and validity. The College reports working closely with the AMC, MCNZ and MBA, and plans to undertake a formal evaluation of EVOPP as part of its QI to ensure that it can affordably and accessibly deliver good performance. In the QI section, the need for work across the College and the wider colleges to meet both AMC standards and aspects raised in the Kruk report seemed well understood.				

If the EVOPP is not implementable, it is suggested that the College looks at SIMG assessment(s) that will meet AMC standards and the relevant recommendations of the Kruk review.

There is no mention of investigating or working with other colleges who already undertake alternative assessments in place of an examination.

Although work to satisfy this condition is aligned with developments in the wider sector, progress is occurring at a very slow rate. The AMC expects evidence of greater progress of these initiatives in the next monitoring submission.

2025 College response

The immediate and pressing focus for RACS since June 2024 has been on addressing the compliance breach in relation to SIMG comparability assessments. RACS has prioritised the implementation of new assessments for the SIMG cohort directly impacted by the compliance breach and these assessments are being undertaken in parallel with the comparability assessments for SIMGs currently in the process of applying for specialist registration. More information on the steps that RACS has undertaken in terms of this work is presented below. This has delayed implementation of EVOPP and exploration by RACS of alternative external assessment processes developed, implemented, and undertaken by other medical colleges.

By July 2025 and after further consultation with the STB/Cs, RACS will have a completed business case, implementation plan, evaluation plan and stakeholder engagement plan with a view to a roll out of phase 2 trial in Q3. As part of the EVOPP feasibility study, RACS is also undertaking a review of external alternative assessment processes delivered by other specialist medical colleges. RACS will also be undertaking analysis of the current workplace assessments utilised in the SIMG specialist pathway

The Phase 2 trial of EVOPP is intended to lead into a staged implementation of EVOPP in Q3 of 2025, informed by the findings of the feasibility study and review of other college alternative assessment processes. Broader implementation across all surgical specialities is intended for first quarter of 2026. We look forward to sharing the progress of the Phase 2 EVOPP trial and results of the feasibility study with AMC in future progress meetings.

RACS, together with the Societies, offers support to SIMGs not only to assist in terms of their specialist pathway but also in terms of career advice and help in navigating entry into working in the Australian and Aotearoa New Zealand health systems. Both RACS and the STB/Cs are aware that this support needs to be leveraged further, particularly in terms of more effective coordination of communication and support between not only RACS and specialist societies but also working with the employing health services.

There are numerous contact points for SIMGs, starting from first enquiries about moving to Australia, through to application for comparability assessment and entry onto the specialist pathway and onto Fellowship and post Fellowship opportunities. These contacts are often made with the individual society and/or RACS, and include provision of information, career advice, matching with potential jobs and facilitating contacts as well as learning opportunities such as access to learning modules, tutorials and workshops. An ongoing important piece of work is ensuring that these contact points work seamlessly between RACS and the society so that the SIMG is receiving accurate current information and everyone is on the same page in terms of what support is being provided and what further support is needed to assist the SIMG in their career journey. A recent workshop was held in May 2025 with RACS and the STC/B training managers to explore how the support for SIMGs can be enhanced. Data sharing and better information sharing was highlighted as a quality improvement area to be addressed.

Each society has a SIMG representative on the SIMG Committee and these representatives, together with other speciality members, are actively involved in the assessment of SIMGs as well as recruitment of new assessors (attach Terms of Reference SIMG Committee). Once a SIMG has received their interim comparability assessment outcome, the RACS SIMG team provides each society with the SIMG's information. A significant variation is that AOA has a dedicated IMG subcommittee and the IMG committee members proactively reach out to offer support to new SIMGs.

Each society provides SIMGs with information on the tutorials, trial exams, learning modules and resources that are available for SET Trainees. Attendance at training courses run by each society is optional for SIMGs except for Bone School run by AOA which is mandated by AOA. This is a significant variation, based on evidence that it significantly improved SIMG performance. RACS has a list of mandated courses for SIMGs including cultural awareness training and Operating with Respect.

SIMGs have access to a number of benefits available for Fellows, as listed here https://www.surgeons.org/Resources/Member-benefits. There are benefits for those who are on the SET program (since the end of 2024)

Benefits for Trainees | RACS

RACS also runs a find-a-Fellow service for RACS Fellows, but career advice and support is available informally via individual societies. SIMGs get access to CPD, professional development, library access, Journal of Surgery, Surgical News, Fax Mentis, and EAP through RACS Converge. A significant variation is that in 2025 RACS launched the membership category for non-FRACS vocationally registered Aotearoa New Zealand surgeons: Email regarding launch of new membership category

Whilst under clinical assessment, RACS provide SIMGs on the specialist pathway with MALT logbook access.

The vast majority of NZ Orthopaedic SIMGs go through a vocational pathway already. SIMGs who are required to sit part 2 exam have been able to attend mock exam and pre-exam course.

Condition 23				Due Date: 2025 *(New Condition added in 2024)*
In relation to RACS specialist international medical graduate assessment processes develop and implement quality assurance processes within the RACS monitoring and evaluation framework to ensure ongoing all-specialty compliance with Medical Board of Australia and Medical Council of New Zealand standards. (Standards 9.1.1 and 6.1.1)				
Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
	New Condition			
2024 AMC commentary				

New Condition: Commentary found in AMC Findings – 2024 Monitoring Submission

2025 College response

A formal and comprehensive SIMG Assessment QA Framework is under development and throughout 2024 and 2025 the identification of variation in how RACS delivered and delivers SIMG assessments in partnership with the STB/Cs has provided many PDSA opportunities for learning and reflection. Each variation has been assessed as to whether it reflects a systemic problem, as if so, it has informed the QA Framework as it is formalised. This Framework and QA process is being developed throughout 2025 and will be supplied when completed. This ground-up and well as top-down approach to the development of the framework is a solid way to ensure the Framework is entirely fit-for-purpose and becomes part of every decision made in SIMG assessment.

RACS-Wide Framework

To address the known issues, a SIMG Working Group committed to the development of the overarching RACS Monitoring and Evaluation Framework, so that the SIMG Quality Assurance processes are an inherent and not separate part of the RACS Monitoring and Evaluation Framework.

Ensuring Accurate Information and Rapid Response

For instance, recognising there was no clear and reliable conduit to identify and respond to changes at the regulator level, RACS is currently developing a better process for monitoring of the external environment to enable rapid response to changes in MBA/Ahpra requirements. This process is focusing on enabling proactive changes to policies/regulations.

Correcting Variations and Preventing Future Ones

To assist the development of the QA Framework, RACS has considered every way that it could prevent like occurrences in the future, as it has moved to adjust its assessment processes to align fully with those of the MBA:

A SIMG Working Group was created and developed:

- Regulation 2085 Specialist International Medical Graduate Transition
- Reg 2038 Assessing Specialist International Medical Graduate Comparability
- Guidelines for Assessment of International Medical Graduates (9.1 Guidelines for Specialist International Medical Graduates New Assessments)
- Developed and delivered updated Assessor Training package for existing and new SIMG assessors. The new training package reflects the current MBA/MCNZ requirements.

Ensuring Trained Sufficient Resourcing

Following a period of significant change at RACS and within the SIMG team, the team is fully resourced. In the period since March 2025 the SIMG team have significantly progressed applications for Specialist Assessment, including new assessment applications, and applications for short term training. Processes are undergoing continuous review and enhancement to support the work of the team.

Actions planned/in progress:

- Review and development of processes for support of SIMG applicants, including planned interactions/engagement with specialty societies
- An audit is underway to determine if there are any other breaches of consequence – both pre-and post- the change in the regulations – in order not only to correct but to learn and to develop for the future robust, defensible, compliant assessments of SIMGs.

Impact of variation of RACS SIMG assessments to the MBA requirements:

- Identified applicants assessed between January 2021 to July 2024
- Developed a communication plan to contact all SIMG applicants. A standard email was sent to all SIMGs who may have been affected advising them of the misalignment and their opportunity to have a new assessment without penalty.
- Applicants were split into relevant groups based on outcome of original assessment, progress through pathway, and status at the time of the communication. Each group received a personalized email providing further advice based upon their individual situation and advising whether they were eligible to request a new assessment.
- Delays in finalising the updated regulations, guidelines for assessment, and assessor training meant assessments could not commence until late March 2025. In preparation for the assessment commencement the team had prepared all required documents and were able to progress promptly once the regulations and process were approved.
- Ongoing delays are anticipated due to a shortage of assessors and a high volume of BAU applications, in addition to the new assessment applications.

RACS identified that correction of the variation was an immediate priority as discussed. In order to ensure ongoing compliance with MBA, AMC and MCNZ standards RACS has commenced auditing its SIMG assessment processes. This is an essential step in the implementation of a QA plan for SIMG assessment. Up until now RACS has not had the opportunity to audit its own process across the whole assessment lifecycle. This audit enables RACS to move beyond reacting to variation to determine that it is fully compliant. RACS recognises that it needs to be demonstrate to regulators and its Fellows that there is confidence in decisions being made. The audit includes SIMGs impacted by the compliance breach between 1 January 2021 and 31 July 2024 and who have applied and are undergoing new comparability assessments, as well as SIMGs who have been assessed since 1 August 2024 to 31 July 2025. RACS looks forward to sharing the progress of this audit with AMC in future progress updates.

Find attached the latest SIMG report to the MBA (9.2 Update on New Assessment Progress May 2025).

2. 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 relevant to Standard 9. If a significant development has been made in response to addressing a condition, please only report on this this against the relevant condition. The development does not need to be reported twice.

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.

Examples of significant developments to report on could include:

- Policies and procedures for assessment of specialist international medical graduates
- Support offered to specialist international medical graduates undergoing assessment
- Methods of assessment for specialist international medical graduates
- Policies and processes for informing employers and registration authorities of patient safety concerns that arise in assessment
- Mechanisms for communication of assessment processes

Has there been any significant developments in relation to Standard 9?	If yes, please describe the developments completed or planned *Please include any potential impacts on continuing to meet the standard in the description.*
- Yes ☐ - No ☒	-

3. Statistics and annual updates

Please provide data showing the numbers of applicants and outcomes for Specialist IMG assessment processes for 2024, broken up according to the phases of the specialist international medical graduate assessment process (e.g. paper-based assessment, interview, supervision, examination). If a binational 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 Specialist International Medical Graduate Assessment	
Number of new applicants in 2024:	Numbers
	101

Assessment of Specialist International Medical Graduates	
Phase of IMG Assessment	Numbers
Interim Assessment*	129
Interim Assessment Decision: • Not Comparable • Partially Comparable • Substantially Comparable	Not comparable**: 41
	Partially comparable: 48
	Substantially comparable: 40
Ongoing Assessment***	Cardiothoracic Surgery: 20
	General Surgery: 45
	Neurosurgery: 8
	Orthopaedic Surgery: 32
	Otolaryngology Head and Neck Surgery: 17
	Paediatric Surgery: 8
	Plastic & Reconstructive Surgery: 11
	Urology: 10
	Vascular Surgery: 7

	Total on Clinical Supervision: 158
Final Assessment****	Recommended for specialist recognition (full scope): 22
	Recommended for specialist recognition (limited scope): 1
	Not recommended for specialist recognition: 6
Total***:**	29

*Note, this does not match the above number as not all applications received in 2024 received an outcome in the same year. This figure also represents outcomes from applications prior to 2024.
**Note, includes those not comparable at document-based assessment.
***Total number of SIMGs on the specialist pathway, by specialty (status: accepted recommendation, under supervision, completed supervision pending admission) as of 31 December 2024, who have not yet been issued a Report 2.
****Outcome of final assessment in 2024 (as recorded in Report 2). Final assessment completed as per MBA Report 2.
*****Note, this is a total of SIMGs that received a final assessment in 2024.

New Zealand processes

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

Preliminary (paper-based) advice		
Outcome	**Vocational scope 1**	**Vocational scope 2**
Equivalent	0	
As satisfactory as	7	
Neither equivalent to, nor as satisfactory as	7	
Unable to make a recommendation	3	
Total	17	

Interview advice		
Outcome	**Vocational scope 1**	**Vocational scope 2**
Equivalent	7	
As satisfactory as	17	
Neither equivalent to, nor as satisfactory as	4	
Total	28	

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.

Please provide a brief summary update of the College's response to the Quality Improvement Recommendations. The AMC is asking the College to report on activities in years three, six and nine of the accreditation cycle.

The College is in **YEAR 8** 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? *If yes, please describe below*	If no activities have occurred, will the College be considering this recommendation in the future? *If yes, please indicate below when the College is likely to consider the recommendation* *If no, please comment below on why the College has decided not to adopt the recommendation*
Standard 1: The context of training and education		
Nil Remain	☐ Yes ☐ No	☐ Yes ☐ No
Standard 2: The outcomes of specialist training and education		
Nil Remain	☐ Yes ☐ No	☐ Yes ☐ No
Standard 3: The specialist medical training and education framework		
Nil Remain	☐ Yes ☐ No	☐ Yes ☐ 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)	☐ Yes ☐ No	☐ Yes ☐ No
Standard 5: Assessment of learning		
Nil Remain	☐ Yes ☐ No	☐ Yes ☐ No
Standard 6: Monitoring and evaluation		
Nil Remain	☐ Yes ☐ No	☐ Yes ☐ No
Standard 7: Issues relating to trainees		

Nil Remain	☐ Yes ☐ No	☐ Yes ☐ No
Standard 8: Implementing the program – delivery of education and accreditation of training sites		
Nil Remain	☐ Yes ☐ No	☐ Yes ☐ No
Standard 9: Assessment of specialist international medical graduates		
FF The College and specialty training boards are strongly encouraged to consider: 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)	☐ Yes ☐ No	☐ Yes ☐ No

PART 2 Detailed Commentary from the Specialist Societies, STB/C Chairs and Training Managers

All Training Managers and several others from each of the specialty societies have contributed to the commentary under each standard and condition. All Specialty Training Boards and Committees (STB/Cs) have been engaged in this process—most have submitted written responses, and all were represented at the recent national face-to-face meeting of training managers. Although not all individual contributions have been explicitly documented, they have informed both this submission and RACS' broader continuous improvement initiatives related to SET. This section is intended to illustrate the nuanced, but not necessarily substantially divergent, ways in which each STB/C approaches its role within the framework of SET delivery.

Please note also the attachments provided here underpin the approach taken by each STB/C.

Standard 1 Condition 1 Governance Policies RRA and SLAs

Service Level Agreements and Shared Governance

General Surgery Australia and Aotearoa New Zealand

General Surgeons Australia (GSA) and the New Zealand Association of General Surgeons (NZAGS) has worked collaboratively with RACS on a matrix of services for the SLAs, to provide greater transparency and accountability for delivery of education and training between the College and the Society.

General Surgeons Australia (GSA) and the New Zealand Association of General Surgeons (NZAGS) will implement a General Surgery Leaders Forum in 2025, with the intention for the following Australian and Aotearoa New Zealand representatives to meet at least twice a year, and discuss issues affecting the specialty of General Surgery in both countries:

- Society Presidents
- Training Board Chairs
- RACS Specialty Elected Councillor
- Society CEOs
- Training Managers
- Senior Examiners
- Trainee Representatives
- Sub-specialty Representatives (as required)

The outcomes and recommendations from these meetings will be reported back through to RACS Council via the Specialty Elected Councillor.

Neurosurgery Australia and Aotearoa New Zealand

The most recent version of the draft agreement received was on 27 November 2024; however, key sections—including Training Funds (Section 5), Governance (Section 7), Compliance (Section 8), Reporting (Section 9), and Insurance (Section 14)—had not yet been included. The Draft Schedule 1 (Services) was received on 27 February 2025; however, this should not be considered in isolation, as it forms part of the complete agreement.

Orthopaedics Australia

AOA, NZOA and RACS have formed a tripartite working group to investigate four potential models for engagement going forward- ultimately seeking to identify the best way for our three organisations to work collaboratively together towards delivery of training while reducing costs for Trainees. While this work is underway the AOA and NZOA service agreements are unlikely to change. Preliminary feedback from AOA is that the updated format and common clauses are not yet fit for purpose for Orthopaedics.

Following a routine AOA Accreditation Review in late 2024 an email was received from a concerned consultant from the reviewed department who had not been involved in the review. The consultant raised a number of concerns regarding both the clinical experience of Trainees and the culture of the department. None of these concerns had been raised by the Trainees interviewed by the team, nor were the issues reflected in the Trainee survey data from previous rotations. In consultation with the President of the Trainees Association, additional feedback was sought by AOA from the current and previous Trainees allocated to the training site regarding their experience. This additional feedback was sought via a representative of the Trainees Executive Committee completely anonymously. The feedback (de-identified and attached) was sobering, and in direct contrast to what had previously been shared with the Accreditation Team. As a result of this feedback, a further review of the site was undertaken prior to an accreditation decision being reached. Ultimately, this process resulted in a number of conditions being applied to the accreditation of the training site.

Via further consultation with the Trainees Executive Committee, it was recommended to the Accreditation Committee and the FTC that that Trainee led collection of feedback should be incorporated into the routine accreditation process to ensure Trainees have a completely anonymous and safe way to raise concerns in addition to the Trainee survey. In addition, the names of Trainees interviewed by the accreditation team will no longer be shared with the training site. This recommendation was supported. The process has been piloted in practice and the documentation is currently being drawn up for final approval.

Otolaryngology Head and Neck Surgery Australia

The current agreement between ASOHNS and RACS is due to expire on 31 December 2025.

A draft of the service matrix has been shared which outlines the responsibilities for each party to the agreement for training activities.

ASOHNS anticipate the negotiation of the contract will occur prior to the end of the year.

ASOHNS staff deliver training program activities and actively support the BOHNS.

Where RACS Regulations or Policies are in place, these are applied by ASOHNS and the BOHNS.

Where there is capacity for adaptation and delivery of training at a specialty level, the BOHNS and ASOHNS determine the most appropriate method to achieve the necessary outcome which supports the Trainees, Supervisors, Trainers and BOHNS.

For example, ASOHNS implemented a training platform including an App over three years ago as the development of TMP slowed and independent development allowed prompt adaptation. This platform has since been expanded to include an online logbook.

When skills courses are approved for training, accessibility, affordability are considered alongside skills-based knowledge appropriate and necessary for the training outcome.

ASOHNS staff and the Board Chair attend RACS Committee of Surgical Education and Training (CSET) meetings. An increase to the number of meetings and inclusion of workshops on specific areas are expected to achieve more productive and informative meetings.

Plastics and Reconstructive Surgery Australia

This SLA is under negotiation.

RACS President attended the ASPS STB meeting in October 2024.

Annual 'Roadshow' meeting with RACS and ASPS took place.

Plastic and Reconstructive Surgery Aotearoa New Zealand

NZ PLA is due to have their roadshow meeting with RACS in July to discuss the revised SLA and negotiate the terms. RACS will continue to collect administration fees on behalf of NZBPRS however the Board would like line of sight as to where this money is held.

NZ PLA routinely keeps RACS informed about specialty matters through CSET reports, BRIPS feedback, and by utilizing RACS templates. Furthermore, the RACS Education Committee is regularly provided with updates and amendments to the NZ PRS and SET Selection Regulations for their review, feedback, and endorsement.

Urology Australia and Aotearoa New Zealand

In 2024, the Board of Urology undertook a complete rewrite of the SET Urology Training Regulations. The main goal was to make the Regulations clearer, more practical, and aligned with current standards in medical education.

To do this, the Board benchmarked regulations from other medical and surgical specialties and referred to definitions and guidelines from key healthcare regulators such as the AMA and AHPRA. This helped ensure the updated Regulations reflected modern terminology and best practices.

Key improvements included:

- Clear definitions of key terms in an easy-to-read table
- Logical structure with headings, subheadings, and numbering

- Simplified wording and removal of confusing or unnecessary content
- Grouping of background information into a definitions section for better clarity

The RACS Education Committee Executive were supportive of the updated regulations, and thought they were considered orderly, clearer, and simpler than before. They commended the Board on such an approach.

Vascular Surgery Australia and Aotearoa New Zealand

RACS/ANZSVS Collaboration Agreement had an initial term 1/09/2022- 31/08/2025.
The agreement automatically continues for a further period of 1 year to 31/08/2026 (rolling term) and will extend for further rolling terms unless terminated in accordance with the terms of the agreement.

Review Reconsiderations and Appeals

General Surgery Australia

All decisions that are communicated to Trainees, applicants for selection, hospitals, as well as SIMGS in General Surgery include the process by which the person/organisation is able to commence the RRA process. It is at this critical time when a person/organisation receives an adverse outcome that it is pertinent to include how to instigate the RRA process.

Neurosurgery Australia and Aotearoa New Zealand

This information is available on the NSA website, and references to the policy are included when key decisions are communicated to Trainees.

Orthopaedics Aotearoa New Zealand

The RRA process is available to SET applicants and Trainees. This is publicly available at RRA Policy within https://www.nzoa.org.nz/set-application-regulations and also available in the Trainee section of the website.

Otolaryngology Head and Neck Surgery Australia

The Reconsideration Review and Appeal (RRA) regulation has been utilised for Reconsideration in for SET selection. One Review was undertaken in 2024. The BOHNS has not had an Appeal for over ten years. The RRA has not been required in relation to hospital accreditation as no disputes have arisen.

The RRA policy – along with RACS selection polices and processes – is included on ASOHNS website on the SET Application & Selection webpage.

Plastics and Reconstructive Surgery Australia

The adapted final RRA regulation has been integrated into PRS frameworks (policy documents and procedures).

The training regulations that were updated in 2024 included:

- Hospital Training Post Accreditation (version 1) to comply with NHPO and AMC Communication protocol.
- Research during SET (version 6) widening the methods by which Trainees can obtain research points.

- Training Requirements and Progression (version 2) enabling clarity around process matters for applications to progress to higher stages of training or graduation from SET.

RRA policy compliance has been in place for many years. The RRA process is available to SET applicants and Trainees. This is publicly available at RRA Policy of RACS website and is embedded within the Selection Regulations and all Training Regulations including hospital training post accreditation.

Plastics and Reconstructive Surgery Aotearoa New Zealand

NZBPRS updated its website to reflect hospital training post accreditation information as well as the link to RRA process as per request from RACS https://plasticsurgery.org.nz/hospital-training-post-accreditation/

Vascular Surgery Australia and Aotearoa New Zealand

Training regulations were updated in 2024 to include option for Board Chair (or delegate) to report on behalf of the Trainee (with their consent) if concerns are identified during Trainee interviews. Vascular will contribute to and be guided by RACS systems resulting from Miller Blue/NHPO recommendations. Complaint numbers are low. No matters have progressed to appeal.

Flagged NHPO and AMC advice for updating of regulations where applicable. ANZSVS adopts the RACS REG-2053 Reconsideration, Review and Appeal regulation
The SET Trainee agreement includes how to appeal and independent of the society- the RRA is visible and applicable for candidates and for everyone else publicly.

RACS and the specialist societies make these policies and others relevant publicly available through the website to reduce any barrier and ensure Trainees, SIMGs and prevocational doctors considering a surgical career have access: Policies | RACS

Standard 1 Condition 21 Impact of Frameworks and MTS

[See also Standard 6]

STB/Cs Feedback on MTS Results 2024

General Surgery Australia

The ABiGS has considered the MTS survey results at its meeting in March 2025. Given the short time since the release of the results (four months) there has not been much opportunity to introduce any substantial changes. A response and a plan to address the results will take time and resources.

The General Surgery Training Board does have the following processes already incorporated:

- the Training Manager visits all capital cities to meet and induct all first-year Trainees prior to commencing their first rotation. This creates a point of contact for any questions or concerns.
- There are state based Trainee representatives who all have voting rights on their relevant regional training committee. Through these representatives, regular feedback is sought and provided at the committee meetings (5 per year)
- There are Trainee Representatives on each of the Hospital Inspection visits and they meet with the Trainees separately to surgeon or hospital executive meetings – this is to provide a safe space for Trainees to speak with their colleagues.

Trainee input is received through:

- Bi-Annual Trainee Surveys at the end of each training rotation.
- Regional Training Committee Trainee Representatives for each meeting (four to five per year)
- Regular contact with Training Manager and Regional Executive Officers

Given that the MTS covers all surgical specialties, it is difficult to determine the prevalence of bullying and harassment in General Surgery alone. From experience, where concerns about bullying, sexual harassment were raised in anonymous Trainee Feedback surveys, the ABiGS undertook an out of cycle hospital inspection visit, following processes outlined in its regulations. Trainee and patient safety is paramount, as is early identification of issues. In our experience these are best managed as early as possible to avoid the significant disruption that removing Trainees/or accreditation can have on the system and individuals.

As revisions to the national model of hospital accreditation are considered, it is critical that the role of Colleges and STB/Cs in safeguarding training quality and Trainee wellbeing is not diminished.

Otolaryngology Head and Neck Surgery Australia

The BOHNS has considered the MTS survey results, included in the Board papers.

In January 2025, the Training Manager visited Adelaide, Brisbane, Melbourne, Perth and Sydney to meet with all first-year Trainees in their home state prior to commencing their first rotation. This creates a point of contact for any questions or concerns. Regular meetings e.g. Annual Trainee Meeting, Society Annual Scientific Meeting and support during each term creates a relationship which builds as Trainees progress over the time in training. This is a safe space for Trainees to communicate any concerns.

Trainee input is received through:

- Bi-Annual Trainee Surveys at the end of each training rotation.
- End-of-term meetings are held with the Chair of Regional Training and Surgical Supervisors from other hospitals.
- Regular contact with Training Manager

Neurosurgery Australia and Aotearoa New Zealand

The NSA and SET Board collect information from Trainees on a biannual basis, which includes these aspects. The de-identified evaluation reports are shared with Supervisors and Trainees, and are discussed at the NSA Board, SET Board, and NSA Trainee Representative Committee levels. The actions resulting from these evaluations will be incorporated into the NSA SET Program Quality Improvement and Development Plan (the Plan).

This Plan outlines future-oriented initiatives and actions derived from comprehensive evaluations related to the SET Program. It places continuous monitoring, evaluation, and quality at the forefront of program development, ensuring that all enhancements align with best practices, accreditation standards, and stakeholder feedback.

Diversity and Inclusion

Cardiothoracic Surgery Australia and Aotearoa New Zealand

Attached are the selection regulations for Cardiothoracic Surgery (1.26 Cardiothoracic Selection Regulations 2025). The number of selection attempts permitted has been limited to 3 from 2026 but the count towards the maximum only commences with applications made from 2026. The Aboriginal and Torres Strait Islander initiative is implemented but limited to one position. The Cardiothoracic Training Committee introduced the 3-strike rule to prevent repeat unsuccessful applicants from applying year after year, thereby saving their time and money.

It also encourages applicants to consider alternative specialties where they may have an interest and be more suitable, increasing their chances of success. By implementing this rule, the Committee aims to create more opportunities for other applicants.

General Surgery Australia

The ABiGS 2024 Selection Review report published on the GSA website (https://generalsurgeons.com.au/home/become-a-general-surgeon/selection-reviews/) indicated the following for 2024 process:

2024 was the first year that the number female applicants was greater than male applicants. From 2016, the number of female applicants has increased by 54.67% whereas male applicants have decreased by 25.5%, 21.14% of eligible applicants were from rural or remote locations (Modified Monash Model 2-7) noting that location was taken from address which may be indicative of where the candidate was living at the time as opposed to their rural origin. In 2024, the number of Aboriginal and Torres Strait Islander applicants was three (3) with all being eligible having met the minimum eligibility requirements. However, all three applicants were not eligible to proceed to interview, that is they ranked in the bottom 20% of applicants and were not eligible for interview. In reviewing the scores, Aboriginal and Torres Strait Islander applicants scored lower than average for both the CV and Professionalism Referee Reports, however they scored significantly higher for Rurality and were slightly higher for SJTs.

When reviewing gender differences between selection scores, the following is noted:

- There is no significant difference in CV scores
- Female applicants scored higher in Rurality
- There is no significant difference in Professionalism Referee Report scores
- There is no significant difference in SJT scores however female applicant on average did score marginally higher
- Female applicants continue to perform better at the MMI compared to male applicants.

In 2024, the Board introduced Rurality as a standalone selection component. This included Rural Origin, Rural Medical School, and Rural Surgical Experience. The majority of applicants (70.4%) scored points for Rurality. In 2024, 122 offers were made representing 67% of applicants interviewed. Female applicants represented 56.56% of offers made and male applicants 43.44%. This is again the first time that the number of offers to female applicants was higher than male applicants. Of the 40 applicants that were in rural or remote areas MMM2-7, 75% (30) were made offers. For applicants who were made an offer, we note that 83% (101) achieved points for Rurality.

Please see the 2024 Selection Review : https://generalsurgeons.com.au/home/become-a-general-surgeon/selection-reviews/

In 2025, the ABiGS introduced an Interviewer Training Module for all interviewers. This also includes instructions to complete at least one Implicit Test from Harvard. This will ensure that all interviewers are trained equally and conduct the interviews as required. The completion rates are monitored and interviewers followed up. The interviewer training module for ABiGS is on-line and therefore not available as an attachment.

Selection attempts for General Surgery **are not** limited. General Surgery has not introduced limits on applying. Please note the public announcement that has been on the GSA website regarding this: https://generalsurgeons.com.au/home/become-a-general-surgeon/selection-regulations/

Neurosurgery Australia and Aotearoa New Zealand

As part of the selection process, the NSA has three diversity initiatives which are in the Selection Regulations:
https://www.nsa.org.au/Public/Public/SET_Program/Application_and_Selection.aspx

1. Aboriginal and Torres Strait Islander Selection Initiative

This initiative aims to increase representation of Aboriginal and Torres Strait Islander doctors in the SET Program. Eligible applicants who meet minimum standards are exempt from shortlisting and automatically progress to the next selection stage. The top-ranked eligible Aboriginal or Torres Strait Islander applicant is prioritised for a selection offer. Confidentiality is maintained, with identity disclosed only to staff and board members directly involved in selection.

2. Diversity and Gender Equity Initiative

Aligned with the RACS Diversity and Inclusion Plan, this measure seeks to improve gender equity in SET selection. Where female applicants are suitably ranked, their success rate will be at least proportionate to their representation in the total applicant pool.

3. Undersubscribed Home Regions Initiative

This initiative addresses geographic imbalances by prioritising applicants from underrepresented regions. To be eligible, applicants must nominate and have worked in the region for at least two postgraduate years. The top-ranked suitable applicant from each undersubscribed region is preferenced for a selection offer, conditional on remaining in that Home Region for the majority of their training.

Orthopaedics Aotearoa New Zealand

In 2024 a total of 53 applications were received for 2025, 18 females and 35 males, and 32 were interviewed: 25 males and 7 females. Of those, 2 females and 15 males, were successful. We had 6 applicants who identified as Māori and of those 2 were selected.

In 2025 a total of 53 applications were received, 29 females and 34 males, ethnicity data is not yet available, but this will be reviewed post selection.

The NZOA removed selection attempts from their Regulations several years ago after having it there for 2 years, this did not impact any registrar as the time it was in place did not take any registrar to that cutoff point.

Attached are the NZOA selection regulations demonstrating diversity and inclusion elements (10.1 NZ Orthopaedic Selection Regulations 2025)

Orthopaedics Australia

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.

In order to promote diversity within the training program and address the workforce needs of rural communities, the FTC has implemented the following initiatives with the Selection process:

- Aboriginal and Torres Strait Islander
- Gender Equity
- Rural Equity

Otolaryngology Head and Neck Surgery Australia

The SET Program recognises prior learning for skills courses. Requests for RPL are considered once a Trainee has commenced training.

Selection initiatives and tools are reviewed annually. There is no perfect selection tool, and selection is a highly competitive process, however there is an ongoing search for ways to achieve equity of access for disadvantaged groups, including Aboriginal and Torres Strait Islanders, rural, female and gender diverse applicants.

Selection interview questions are carefully considered to provide insight into applicants' responses on diversity, equity and inclusion.

In terms of gender diversity, ASOHNS monitors the diversity of the Board, Supervisors, and Trainees and reports this annually. For selection, interview panels for referee reports and final interviews are monitored for gender balance.

Plastic and Reconstructive Surgery Australia

Rural Selection points were introduced in 2024 as part of the CV tool (10.2 PLA AU Summary of Trends in Data of Selection Applications 2025). A high number of applicants received rural points, so when reviewed for the 2025 round (2026 intake), the Board increased the 6-month test to 12 months test for pre-vocational experience. That seemed to reduce points for rural experience by > 50%. This appears to favour applicants with longer exposure and deeper roots in MM2 or higher regions.

The STB is considering a revision of selection tools to reduce institutional barriers for Indigenous doctors who appear not to apply for selection into the plastic surgery program to then be selected into SET. This work is to be conducted in 2025 through the selection subcommittee of the STB. Zero applicants, zero Trainees and zero Fellows identify as Indigenous.
We have an Indigenous selection initiative, based on RACS policy, which defines a single position is set aside to preferential selection for Indigenous doctors.

No points are provided for Indigenous identification. Indigenous applicants, if they were to identify themselves as Indigenous to ASPS, and having been being invited to interview would need to achieve the minimum selection standard and then be preferentially selected before the general selection pool.

The minimum standard for selection was defined many years ago as 3 Standard Deviations below the average lowest score of a successful applicant. Equating to 650 points out of 1,000 or (65%).

Plastic and Reconstructive Surgery Aotearoa New Zealand

The Board appointed a working group to review the RACS Managing Bias document and to integrate relevant components into the PRS SET selection process. The Selection Regulations are reviewed annually.

The Community Advisor contributes to the drafting and updating processes for both PRS Regulations and SET Selection Regulations.

Urology Australia and Aotearoa New Zealand

There is diversity on all Boards and Sub-committees by gender and rurality.

Interview panels are a diverse mix (14% of the interviewers are female)

- Mix of seniority
- Mixed ethnicity

Interview questions involve questions on Māori and/or Australian-centric cultural questions to determine relative understanding of cultural contexts.

Aotearoa New Zealand are looking at a Māori strategy for selection points.

Vascular Surgery Australia and Aotearoa New Zealand

The SET Program in Vascular Surgery includes mandated RACS skills courses for training. It is noted however, that in an effort to reduce the financial cost of the selection process, future applicants will not be awarded points on their CV for having completed courses mandated for training which should be completed during training. Applicants will be granted RPL if successfully selected and have already invested in a mandated course.

Rural Health Equity

General Surgery Australia

The Australian Board in General Surgery has developed the Northern Territory Training Pathway. The Pathway provides an opportunity for General Surgery Trainees to experience extended training in rural and regional settings across Darwin and Alice Springs. The aim of the pathway is to provide a strong set of General Surgery skills and knowledge and an opportunity to experience the lifestyle in a rural setting. It is envisaged that this pathway will encourage Trainees to consider settling in regional centres once their training is complete. The Northern Territory Rural Training Pathway will involve the selected Trainee/s undertaking the following:

- 60% of rotations in Northern Territory: 40% at Royal Darwin Hospital and 20% at Alice Springs Hospital.
- The remaining 40% of rotations would be undertaken in a metropolitan setting in one of the five Training Regions.
- Trainee's metropolitan setting would be assigned according to the Region offered during Selection. This will allow for the Training Region to plan well in advance.

Further information on the pathway can be found here: https://generalsurgeons.com.au/home/for-trainees/training-program/gset-program/nt-rural-training-pathway/

Neurosurgery Australia and Aotearoa New Zealand

The NSA has a Top End Neurosurgery Project which has resulted in the establishment of two new accredited neurosurgical training posts in regional areas, Darwin and Townsville, starting in 2025. The project supports locally driven training models, accreditation flexibility, and service development to retain Trainees and build sustainable local capacity.

Neurosurgery also has the Undersubscribed Home Regions Initiative as part of its Selection Regulations. This initiative addresses geographic imbalances by prioritising applicants from underrepresented regions. To be eligible, applicants must nominate and have worked in the region for at least two postgraduate years. The top-ranked suitable applicant from each undersubscribed region is preferenced for a selection offer, conditional on remaining in that Home Region for the majority of their training. This initiative has already resulted in the selection of applicants from North Queensland and Northern Territory.

As part of selection, neurosurgery also awards selection points for rural origin, rural medical school and rural work exposure in both Australia and Aotearoa New Zealand.

Orthopaedics Aotearoa New Zealand

Attached is a rurality survey (10.3 NZ Orthopaedics Rurality Survey Results) showing the strongly positive impact of rural training experience even for those without a rural background.

NZOA has a current project looking at whether there is currently rural equity in selection onto the NZOA training program.

Further enhancing rural equity in training: With the increase in focus on rural equity the Aotearoa New Zealand Orthopaedic Training Board will be looking at the 2026 training regulations to include possible points for rural upbringing, schooling and/or work. This is still to be discussed. Due to the geography of Aotearoa New Zealand, it is not as bigger issue as in Australia, but we recognise the need to consider this and encourage Trainees to look at returning to a rural area to practice. A rurality survey was recently sent to Trainees; this will be reviewed and Trainees who did not respond followed up for discussion at the Board.

Orthopaedics Australia

AOA has developed a Regional Orthopaedic Surgery Strategic Plan with a vision to provide the regional community with the same high level of care and access to specialist orthopaedic services as those in metropolitan areas via the training, recruitment and retention of Australian-trained surgeons.

As noted above AOA has introduced a Rural Equity Selection Initiative with a view to encouraging rural doctors to apply for training. For several years AOA has also offered a Far North Queensland Rural Training Pathway which involves a Queensland Trainee spending up to 80% of their training time in rural Queensland. As part of the Strategic Plan, AOA hopes to expand the concept of a rural/regional training pathway across all training regions of Australia. While discussions across the country are at varying stages of progress, a draft proposal for a rural pathway in New South Wales has been developed and is currently being socialised amongst the New South Wales Training Committees.

Paediatric Surgery Australia and Aotearoa New Zealand

The STC has been regularly discussing how to improve rural, regional and Indigenous Trainee numbers as we go into this year's selection.

Plastic and Reconstructive Surgery Australia

Attended FATES2 workshop in Darwin Oct 2024 and socialised the strategic themes with STB members for updates to the Selection Regulations.
ASPS and STB representatives attended this FATES workshop in Oct 2024 in Darwin and socialised the strategies with STB members for development into strategic improvements to selection, supervision and hospital accreditation in rural and regional sessions. Work is ongoing at a strategic level.

The ASPS partnered with a network of highly skilled plastic surgeons, the Top End Health Department and others to facilitate the establishment of a sustainable service in Darwin. Since its inception in 2020, the Royal Darwin Hospital applied in 2024 and was approved as an accredited SET training site for the specialty commencing 2025. See ASPS Website for more.

Rural Selection points were introduced in 2024 as part of the CV tool. A high number of applicants received rural points, so when reviewed for the 2025 round (2026 intake), the Board increased the 6-month test to 12 months test for pre-vocational experience. That seemed to reduce points for rural experience by > 50%. This appears to favour applicants with longer exposure and deeper roots in MM2 or higher regions.

Urology Australia and Aotearoa New Zealand

Urology award points for rural origin, rural medical school, and rural work experience.

Selecting Aboriginal and Torres Strait Islander and Māori Trainees

Cardiothoracic Surgery Australia and Aotearoa New Zealand

Candidates are asked to complete a minimum 2 x RACS modules and courses 1, 2, 3 of the Aboriginal and Torres Strait Islander Cultural Safety courses (RACS) that will include Māori from next year.

There is a mixture of male and females, there is currently 1 x Aboriginal Trainee in Cardio who has almost completed SET.

There is an observer for all interviews.

General Surgery Australia

The ABiGS has implemented the Aboriginal and Torres Strait Islander Selection Initiative since 2019. Whilst no applicant has been successful in progressing to the offer stage, it is encouraging that in 2024 there were three applicants. The ABiGS was also interested in the fact that these applicants scored higher in the SJTs than the average.

Details can be found at:
Section 3.1 of Selection Regulations: 10.4 General Surgery Selection Regulations 2025
2024 Selection Review: 10.5 General Surgery Selection Review 2024

While the STB has had the RACS Aboriginal and Torres Strait Islander Selection Initiative in its processes since 2019, it is clear this alone is not enough to promote Indigenous applicants to the specialty. The STB is committed to reviewing the selection regulations to ensure there are no hidden or unintended barriers for Indigenous doctors applying for General Surgery training. The Manager Education and Training recently attended the AIDA Cultural Competency Training with a view to work with AIDA to identify and remedy gaps or barriers in the selection process.

Neurosurgery Australia and Aotearoa New Zealand

In 2021, the SET Board introduced the Aboriginal and Torres Strait Islander Selection Initiative, with further enhancements made in 2024. Under the updated approach, eligible Aboriginal and Torres Strait Islander applicants who meet the minimum standard for each selection tool automatically progress through the selection process without ranking, and the highest-ranked eligible applicant will be offered a position. These changes were communicated to relevant RACS committees on 1 May 2024, along with a request for feedback on extending a similar initiative to Māori applicants.

The NSA has introduced three grants that aim to increase access to neurosurgical education and professional networks for Māori and/or Pasifika, Aboriginal and/or Torres Strait Islander and rural, regional and remote medical students and prevocational doctors in Australia and Aotearoa New Zealand who are interested in a career in neurosurgery. The grants provide funding to support participation in the Neurosurgical Society of Australasia Annual Scientific Meeting.

Orthopaedics Aotearoa New Zealand

Further enhancing the numbers of Indigenous Trainees: The NZOA has worked to increase the numbers of Māori Trainees, including points in our CV, working to include culture safety into the selection process and support for Trainees. NRK Ngā Rata Kōiwi provide support for Trainees. A member of NRK sits on the Education and Aotearoa New Zealand Orthopaedic Training Board and provides advice to members of both. A total of 52 applications have progressed through to the next stage, of those 22 are female and 30 are male. 6 applicants identified as Māori (2 female, 4 male). Anecdotally we have noticed an increase in eligible points being claimed for the te reo section.

The NZOA SET Selection Application has achievable points available for te reo or te ao Māori (10.1 NZ Orthopaedic Selection Regulations 2025). Applicants are also able to make their application in te reo (a translation must be attached).

As we have more Māori applying and getting onto the training programme it is seen as more achievable. Māori are seeing themselves mirrored as Trainees and consultants, so it is attracting more applicants.

We recently had our first two Māori wahine complete training and pass the FEX, this was celebrated LIONZ blog and NRK Blog (https://www.nzoa.org.nz/nga-rata-koiwi-korowai)– Korowai a significant event for the NZOA and the two Trainees.

Orthopaedics Australia

The FTC has implemented an Aboriginal and Torres Strait Islander initiative with the Selection process for a number of years. Despite this initiative, application numbers remain low with no Indigenous applicants in 2024. Pleasingly, all previous successful Indigenous applicants have competently moved through the training program with no attrition, and are now Fellows.

AOA recognises that strategies for attracting Indigenous doctors to orthopaedics are needed. AOA has been an Associate Organisation member of Australian Indigenous Doctors Association (AIDA) since 8 March 2022.

AOA supports and actively participates in initiatives led by the AIDA, including its annual conference, where AOA regularly attends as a not-for-profit trade exhibitor. As part of its contribution, AOA delivers the Exposure and Skills in Orthopaedics workshop for AIDA delegates. This workshop combines hands-on practical skills stations with a presentation and Q&A component, offering delegates a valuable insight into the field of orthopaedic surgery. Facilitated by AOA members and supported by industry partners, the workshop provides an engaging and informative experience that showcases what a career in orthopaedics can look like. It also plays a key role in supporting emerging Aboriginal and Torres Strait Islander doctors by providing access to surgical education, mentorship, and professional networks.

AOA is also an invited guest of the Specialist Trainee Support Program (STSP) Cross College Meeting and has been attending since 2024. This initiative aims to foster meaningful collaboration and shared learning between Aboriginal and Torres Strait Islander communities and other specialist colleges. The insights gained through these partnerships will help the AOA enhance its approach to Indigenous health and contribute to building a more inclusive and sustainable surgical workforce.

Otolaryngology Head and Neck Surgery Australia

The BOHNS was the first to implement the Indigenous Selection Initiative and has one current surgical Trainee from the Torres Strait Islands.

There are concerns that the GSSE is a potential barrier for entry to Surgical training which has recently impacted one potential applicant.

This issue was discussed at a recent CSET meeting April 2025 and a review of GSSE has commenced.

Otolaryngology Head and Neck Surgery Aotearoa New Zealand

There is a cultural advisor on the Board – who is also the chair of MCNZ – who helps assess language and the socio-economic status of candidates as well as helping with developing questions for selection
Within the SET Regulations there are:

- Points specific to Māori identity / involvement in culture as opposed to personal identification
- Points awarded for university Māori immersion
- Points awarded for connection to Iwi

This is because some identify as Māori but not culturally immersed, and vice versa some don’t ethnically identify as Māori but are incredibly culturally immersed

There is potential for other societies to have cultural advisors who go to schools and speak to students.

Plastic and Reconstructive Surgery Aotearoa New Zealand

NZBPRS has increased allocation of CV points for Māori / cultural for 2025 selection (2026 intake).

In order to incorporate relevant aspects of the RACS managing bias document into the PRS SET selection process, NZBPRS has appointed a working group. Moreover, the SET Selection Committee includes a Cultural Advisor who provides a mihi whakatau (welcome) at the commencement of the interview and is tasked with asking every applicant a question specifically addressing cultural competency. As part of a recent revision to the PRS SET Selection Regulations, NZBPRS has increased the CV points awarded for cultural professional development that demonstrates Māori identification.

Urology Australia and Aotearoa New Zealand

Since launching the Aboriginal and Torres Strait Islander Selection Initiative many years ago, the Board of Urology has faced ongoing challenges, particularly with no applicants formally identifying as Aboriginal and Torres Strait Islander to date. To address this barrier USANZ will seek an Aboriginal cultural advisor to assist with the strategy and initiatives moving forward. Similarly, in terms of attracting Māori candidates, there is a need for clear, coordinated guidance from Māori stakeholders as the Board recognises that it is not best placed to design solutions alone. Work is underway to establish a Māori-specific selection initiative, which is likely to be introduced for the 2027 intake.

Vascular Surgery Australia and Aotearoa New Zealand

Vascular complies. Points are awarded during the selection process to applicants who identify as Aboriginal, Torres Strait Islander, Māori and Pasifika and to date, two Indigenous applicants have been successfully selected.

Relocation Workload and Flexible Training

RACSTA report to CSET – June 2024

RACSTA continues to advocate on behalf of Trainees experiencing difficulty recouping costs associated with relocation and/or having issues with accommodation offered by hospitals for relocating Trainees. This is further exacerbated by the recent increases in the cost of living to which many Trainees are particularly exposed owing through increases in mortgage cost, childcare and household expenses. The President and CEO recently informed RACSTA regarding the advancement of recognition of prior service to enable access to entitlements such as parental leave. The initiative has also been tabled at HWT and CPMC where it has been received positively and will continue to be discussed. RACSTA looks forward to further updates and progression in this space.

At the October 2022 CSET meeting, it was unanimously decided that relocation costs and access to leave entitlements be made a priority for the College. RACSTA has continued to raise this at the 2023 CSET meetings. The RACS President and CEO were set to have discussions at state and federal level, whilst that has occurred, progress is still awaited.

General Surgery Australia

Flexible training is readily taken up by both male and female Trainees and there is a large uptake of flexible training. Between 2009 – 2024, 136 requests were received by the Board with 99.26% of requests being approved. The reason the one request was not approved, was due to the request being submitted very late and therefore could not be accommodated by the accredited hospital.

Concerning relocation, Trainees are typically appointed to one state and stay in that state for the duration of their training. If they transfer states, it is usually to transfer back to their home state at the request of the Trainee (if they were offered a place on the training program that is not their first preference). The Board is supportive of jurisdictions committing to address access to leave entitlements.

Neurosurgery Australia and Aotearoa New Zealand

The NSA conducted a Relocation and Entitlements Survey of SET Trainees in Neurosurgery in March 2025, with a response rate of over 95%. The survey is designed to help the NSA and SET Board understand the impact of relocation on neurosurgical Trainees and explore ways to mitigate challenges related to relocation and leave entitlements. Actions arising from the survey are being incorporated into the NSA SET Program Quality Improvement and Development Plan. This Plan focuses on continuous monitoring, evaluation, and quality enhancement, aligning improvements with best practices, accreditation requirements, and stakeholder feedback. The Plan will be discussed at a SET Board workshop in late June, for approval by the NSA Board in August 2025.

Orthopaedics Aotearoa New Zealand

Trainee workload and relocation issues are not as large an issue as in Australia as Te Whatu Ora reimburse Trainees for relocation expenses. Generally, we find that the majority of Trainees are placed in their desired location from SET 3 where there is greater choice (they select in SET years starting with SET 4 going down to SET 2, while SET 1 receive their preference given at selection only if still available).

Plastic and Reconstructive Surgery Australia

ASPS have implemented length of training contracts for SET Trainees in New South Wales, in accordance with NSW legislation, enabling Trainees to rotate for six months in private sector positions for appropriate training, rotate into another state (for example, the Northern Territory) or otherwise interrupt their public service without penalty. In other jurisdictions, legislative reform could lead to similar improvements in protecting entitlements for Trainees.

Otolaryngology Head and Neck Surgery Australia

The BOHNS has been able to fulfil all Trainee requests for flexible training. Part time training has been available to eleven Trainees in the past 2 years. The BOHNS SET program allows for flexible training. Over the last two years there have been eleven Trainees who have taken up flexible training for either 6 or 12 months. Trainees who have requested flexible training have always been accommodated.

In addition, the BOHNS has approved all parental leave and several requests for interruption for research or other personal circumstances.

Relocation and access to leave entitlements are stand-outs for RACS Trainees and the STB/Cs have responded.

The Trainee Representative raised the relocation issue with the BOHNS at its meeting in February 2025. The increase in regional training positions has led to more Trainees being required to relocate, though mostly within their home state. Some of these training positions have STP funding, so the Trainee is able to access

relocation costs, however only Darwin provides accommodation while the Trainee is working at that hospital. New South Wales and Queensland Trainees have a broader geographic spread of training hospitals.

The BOHNS is focused on increasing regional training and Trainees are aware that relocation is required based on the spread of hospital locations. Advocacy for support of accommodation could be led by RACS, however the BOHNS is also realistic in expectations due to pressures on hospital funding.

Urology Australia and Aotearoa New Zealand

Following Trainee feedback, The Board of Urology committed to addressing the challenges faced by Trainees undertaking flexible training or returning from a period of interruption. These were described as including a lack of support, unclear expectations, stigma associated with flexible training, and practical difficulties with reintegration. The Board is also committed to assisting Training Supervisors in managing Trainees working flexibly or returning from interruption.
Over the next 12-18 months, the Board plans to:

- Develop accessible information outlining eligibility, application processes, and expectations for flexible training and returning from interruption. This will help reduce confusion and support informed decision-making.
- Develop a formal return-to-training program with assistance from RACS, including return-to-work planning templates and structured transition periods to help Trainees safely and confidently re-enter training and support Supervisors during the reintegration period. The Board plans to review existing approaches used by other colleges and craft groups, so as to avoid duplication of effort.
- Establish mechanisms for regular check-ins and progress monitoring for Trainees in flexible positions to ensure they are appropriately supported throughout their training.
- Promote a shift in mindset within training institutions by providing guidance and education to Supervisors around flexible training and its value. This aims to reduce stigma and improve attitudes.
- Emphasise that the success of flexible arrangements should not rest solely with the Trainee—training institutions and Supervisors must also play an active role in supporting these pathways.
- Monitor outcomes of implemented strategies through regular review and feedback with a focus on continuous improvement and responsiveness to Trainee needs.

Bullying, Discrimination and Harassment from Senior Staff

Cardiothoracic Surgery Australia and Aotearoa New Zealand

All interviewers must do the BRIPS courses, and other courses are offered prior to interviews.

General Surgery Australia

Regional representatives have day-to-day engagement with Trainees. Under GSA training regulations, if there are concerns raised in Trainee feedback, that can trigger an out of cycle hospital accreditation visit.

Neurosurgery Australia and Aotearoa New Zealand

As part of the bi-annual Trainee survey in March 2025 questions were asked relating to bullying, discrimination, and harassment to better understand the experiences of Trainees across the SET Program.

In May 2025, in response to concerning themes identified in the survey results, the NSA Board resolved to engage an external consultant to undertake a confidential review. The purpose of this review is to explore Trainee perceptions and reported episodes of bullying, discrimination and harassment, with the goal of identifying patterns and potential systemic issues. This proactive measure reflects the NSA's commitment to creating a safe, respectful, and inclusive training environment, and to ensuring any structural or cultural contributors to negative behaviours are addressed through evidence-informed strategies.

The results of the review will be presented to the NSA Board, SET Board of Neurosurgery and NSA Trainee Representative Committee in late 2025. The findings will be used to inform targeted actions aimed at addressing any identified patterns of concern and improving the training environment.

Otolaryngology Head and Neck Surgery Australia and Aotearoa New Zealand

The MTS survey report does not align with the survey feedback from OHNS Trainees collected by ASOHNS. Trainees are also involved in hospital accreditation inspection interviews and no incidents have been identified during those discussions.

It is likely that bullying, discrimination and harassment is picked up in the training site setting, but any concerns raised by the Trainee Representative are taken to the STB/C.

There are voluntary questions concerning induction, bullying, discrimination and harassment and other MTS-relevant issues and the STB/C is considering making these questions mandatory.

Orthopaedics Australia

AOA is developing an online module "Respect in Orthopaedics – if its broken, lets fix it" which will be available on the learning management system. The module will cover equivalent material to the RACS Operating with Respect workshop, targeted at Orthopaedic Surgeons, and will be mandatory for all Directors of Training and Trainee Supervisors. Estimated release is in the second half of 2025.

Paediatrics Australia and Aotearoa New Zealand

There is a Trainee Representative that brings issues of concern to the STC.

Plastic and Reconstructive Surgery Australia

Feedback received from Trainees in confidential Trainee interviews (during four out of cycle inspections conducted in Oct 2024 and one in-cycle re-accreditation inspections) resulted in multilateral discussions at all levels of the health service (unit leadership, hospital executives, health service jurisdictions and the Trainees and their junior colleagues) about the allegations of bullying and unprofessional conduct. External reviews were conducted by the hospital and de-identified reports would be returned to the Board in a reasonable timeframe.

Conditions have been applied to accreditation statuses or reduced certification periods were approved enabling the Board to monitor psychosocial harm to Trainees and its obligations within the scope of its shared duties with the health service.

Plastic and Reconstructive Surgery Aotearoa New Zealand
There is a Trainee Representative that brings issues of concern to the STB/C.

Vascular Surgery Australia and Aotearoa New Zealand
Every Trainee has an end-of-term meeting with the Chair who can then raise such reported concerns with the hospitals.

Standard 2 Conditions 3 and 4 Community and Stakeholder Engagement

[See also Standard 6 Condition 14]

Community Consultation

Cardiothoracic Surgery Australia and Aotearoa New Zealand
The STC has included a Community Representative (who is a voting member) on the STC for several years now. This representative plays an integral role in providing invaluable advocacy for both the SET Trainees as well as the wider community and actively participating in a range of committee activities, including observing SET selection interviews, contributing to hospital accreditation visits and reporting, and engaging in important educational initiatives where appropriate.

Stakeholder feedback will be invited during the consultation period of the updated Competency Based Curriculum, which will include the defined graduate outcomes and will be mapped to the ten RACS competencies. A public curriculum is available for download here: https://www.surgeons.org/Trainees/surgical-specialties/cardiothoracic-surgery/curriculum-modules

General Surgery Australia
The STB has a Community Representative who has full voting rights.

As part of the redevelopment of the General Surgery Curriculum, a broad stakeholder engagement consultation process was undertaken. Attached is the stakeholder engagement consultation on the General Surgery curriculum (10.6 General Surgery Curriculum Stakeholder Engagement).

In 2024 the STB introduced the Professionalism Referee Report as part of the selection process. This report seeks feedback from non-surgical referees across five groups – clerical staff, nurses, allied health practitioners, ED/ICU/HDU practitioners and junior doctors.

Multisource feedback surveys are used frequently in General Surgery Training as part of the learning and development process. Trainees and Supervisors provide the contact details of five people working in the hospital – not necessarily surgeons – to participate in providing feedback to assist and complement the Trainee's learnings.

The Board invites all state health departments to be involved in the annual hospital inspection process as being members of the inspection teams. In 2025 all hospitals in Queensland will undergo a hospital inspection visit in June, although to date no response from Queensland Health has been received.
The Board has a Community Representative on the Board who has participated in all meetings since June 2022.

Orthopaedics Aotearoa New Zealand

The NZOA consults with consumer, community and cultural groups with the cultural and community advisers sitting on the Board and on our selection interviews.

They in turn communicate in the wider communities they represent and bring this back in their roles to the Board.

Through our training weekends, NZOA sees an average of 25-60 patients in one weekend, often this is an opportunity for NZOA to talk to our patients, and many are keen to tell their story and what care they have been given both in pre- and post-surgery (or non-operative care).

This is at times fed back to Supervisors and is often directly to or with the Trainees present so insightful for them to hear this on a regular basis.

The curricula outcomes are publicly available at Curriculum Framework and NZOA Curriculum at https://www.nzoa.org.nz/nzoa-curriculum-framework

Orthopaedics Australia

AOA undertook an external stakeholder consultation in 2024–2025 as part of AOA's ongoing quality assurance activities (2.4 AOA Stakeholder Engagement Report April 2025). The consultation engaged Non-Surgical Health Professionals (Group 1), Senior Hospital Administrators (Group 2), and Consumer and Community Representatives (Group 3), whose insights offer an important external perspective on the AOA 21 training program. Part I of this report presents the findings from Groups 1 and 2. Part II summarises consultation processes with Group 3.

The consultation focused mostly on an evaluation of Trainees' professional skills, as well as broader perceptions of the training program's efficacy and its accreditation standards. The emphasis on professional skills reflects AOA's longstanding commitment to strengthening foundational competencies, first prioritised through curriculum reforms introduced in 2017. It also aligns with current efforts to further embed and assess these capabilities across the training program.
This consultation builds on a major program review conducted in 2022–2023 by an international team, which gathered extensive feedback from internal stakeholders, including Trainees, Trainers, Directors of Training, governance representatives, education and training staff, and other involved parties. Collectively, these consultation processes contribute to a more complete, 360-degree view of the program's strengths and areas for development.

A number of key themes emerged from the external consultation with Groups 1 and 2, in spite of variability in ratings within and between responses from these groups. Notably, there is a shared belief that, upon completion of training, most AOA Trainees demonstrate a commendable level of preparedness for junior consultant roles. Trainees are generally viewed as professionally capable. At the same time, these stakeholders noted inconsistencies in communication and teamwork, engagement with feedback, and a need for stronger leadership in multidisciplinary contexts. Feedback also reflected a wide spectrum of experiences with Trainees, ranging from extremely positive to highly critical. The AOA concludes that multi-source feedback would be more effective if embedded as a formative assessment tool, supporting Trainee development and addressing disparities in performance throughout the training continuum, rather than as tool for retrospective, collective reflection. A further insight, mostly from free-text comments from groups 1 and 2, suggest that systemic issues such as culture, expectations, workload, and a perception of insufficient support systems negatively influence AOA 21 Trainee performance, behaviour and wellbeing.

With regard to Group 3, an initial attempt to capture and benchmark patient and community views yielded insufficient data for meaningful analysis. However, the exercise reinforced the importance of deeper, more systematic integration of patient voices. The AOA is currently exploring ways to embed this perspective more systematically within program design and quality assurance processes.

In response to the insights gathered through this and related consultation processes, AOA is already taken a number of actions, including:

- Enhancing the teaching and assessment of professional skills throughout the training program
- Providing advanced training focused on recognising and addressing unacceptable behaviour
- Revising AOA accreditation standards to align more closely with national frameworks and stakeholder feedback
- Embedding multi-source feedback into Trainee assessment during the core stage of training
- Considering how best to integrate patient feedback in program design and quality assurance
- Strengthening the emphasis on Trainee wellbeing within surgical Supervisor role descriptions and support resources

Plastic and Reconstructive Surgery Australia

The STB has an external representative with medical education expertise. This role has been filled since 2017.

The Selection Committee seeks and reviews feedback from stakeholders through the post event surveys for referee reports which includes nurses. In 2025 interviews will include observers (non-members, non-medical) who will be tasked assessing the process and consistency in the application of competency based interviews. Their feedback will be reported in 2026.

Feedback is invited from hospital training post stakeholder such as hospital executive, health service executive and unit members. Allied health stakeholders are inconsistently available for inspections, but are asked for feedback during inspections.

The 2019 Curriculum and its 2024 review included stakeholder engagement in both Australia and New Zealand including Trainees, Supervisors, specialty craft groups, Indigenous doctors, and associated medical specialties (anaesthetists).

Vascular Surgery Australia and Aotearoa New Zealand

A Community Representative sits on the Board of Vascular Surgery. The representative is actively involved in Vascular Surgery's educational activities. Other interactions and relationships are primarily through hospital accreditation and advocacy for Trainees. This is also aligned to heading Regular Curriculum Updating and Continuing SET Alignment.

Stakeholder feedback was invited during the consultation period of the updated Competency Based Vascular Curriculum, which has defined graduate outcomes and is mapped to the ten RACS competencies. A public curriculum is available for download on the ANZSVS website and the full Trainee/Supervisor version may be accessed via member log-in. Competency Based Training regulations are under development.

The ANZSVS will continue to monitor and engage as innovation and technological advancements are made. Following the implementation of the competency training program, a schedule will be established for review and updates. Provision will be made for a notice period before any significant changes to the program are applied.

Cross-sector Collaboration

Neurosurgery Australia and Aotearoa New Zealand

On 22 August 2024, the NSA held a workshop in Darwin for Neurosurgery SET Supervisors and Heads of Training Units (or their delegates), following the Annual Scientific Meeting. Attended by 50 neurosurgeons—including 21 Supervisors and 17 unit heads—representatives from 29 of the 32 accredited training sites across Australia and Aotearoa New Zealand participated. The agenda featured a guest speaker and legal expert from AVANT discussing supervisory legal issues, along with sessions on professional performance assessments, Supervisor feedback, workforce and training post-accreditation standards, updates on the Fellowship Examination, and review of the selection process and tools. The workshop served as a valuable platform for collaboration, with the NSA now progressing several actionable initiatives that emerged from the discussions.

Top End Neurosurgery Project: This project run by the NSA has resulted in the establishment of two new accredited neurosurgical training posts in regional areas, Darwin and Townsville, starting in 2025. The project supports locally driven training models, accreditation flexibility, and service development to retain Trainees and build sustainable local capacity.

Undersubscribed Home Regions Selection Initiative: This initiative prioritises applicants for training from underrepresented regions (e.g. Northern Territory, Northern Queensland, Western Australia). The initiative preferences them in the selection process for training and bonds them to their home region for most of their training. It aims to grow the workforce in areas of shortages from within and improve long-term retention.

SIMG Assessment Improvements: The NSA conducted a benchmarking review of international neurosurgical training programs to support more efficient SIMG assessment pathways. While assessments are managed solely by the RACS, this work provides the foundation to support the safe and timely integration of qualified SIMGs into areas of need.

NSA 2024 Workforce Snapshot Report (10.7 NSA Workforce Snapshot Report 2024): This report, published in June 2024, was developed primarily using data purchased from Ahpra. It confirms that Australia's neurosurgeon-to-population ratio currently sits at 1.09 per 100,000—exceeding the global target of 1 per 100,000 for high-income countries. This evidence base plays a critical role in guiding workforce planning and selection initiatives, helping to identify and prioritise areas of neurosurgical workforce shortage, which are now primarily located in Darwin, Townsville, and Western Australia. The next report, to be released in June 2025, will again draw on Ahpra data and will also incorporate Trainee data to strengthen long-term planning and ensure a more sustainable workforce pipeline.

General Surgery Australia

Attached is stakeholder engagement consultation on the general surgery curriculum (10.6 General Surgery Curriculum Stakeholder Engagement).

Otolaryngology Head and Neck Surgery Australia

The BOHNS has a community representative member with voting rights.

Plastic and Reconstructive Surgery Australia

The 2019 Curriculum was revisited in 2024 to be reflective of current practices. Currently in consultation phase with key stakeholders (March/April 2025) and includes updates for contemporary practice as well as integration of gaps identified with the RACS Professional Skills Curriculum.

Examples of consultation include these activities:

- MSAC Application 1754
- Curriculum Review 2024
- Rural workforce mapping with ASPS members
- Expedited SIMG pathway

Plastic and Reconstructive Surgery Aotearoa New Zealand

The NZBPRS Board benefits from the presence of a Community Advisor who is a regular attendee at all Board meetings. Furthermore, this advisor serves as an independent observer during SET Selection interviews, tasked with ensuring the process and interviews maintain fairness and transparency, and subsequently submits a report with feedback to the Board. For the year 2025, the Community Advisor has also been requested to act as an independent observer during referee interviews to assess the transparency and fairness of this process.

The Community Advisor contributes to the drafting and updating processes for both PRS Regulations and SET Selection Regulations.

The NZ PRS Trainees annually hold a conference and engage community members/patients in the mock examination process.

ASPS and NZBPRS are in the process of the final draft of the 2019 PRS curriculum which was reviewed in 2024. Stakeholder feedback was invited during the consultation period of the curriculum review to identify any gaps. The update has defined graduate outcomes mapped back to the RACS competencies.

Urology Australia and Aotearoa New Zealand

Broad input was sought from relevant parties when the curriculum for the new training program was developed. 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. The process of periodic review of the curriculum will incorporate further input from these relevant parties, and any others as appropriate.

The Board of Urology has recently appointed an external representative, who will commence in the role in May 2025. This position is intended to bring a non-surgical perspective, particularly in areas such as Trainee management and program oversight. Having someone from a non-medical background will bring a broader view to discussions and decision-making. The Board sees this as a practical step to strengthen governance and ensure the training program remains relevant, well-managed, and responsive to the needs of both Trainees and the wider community.

The Board is also keen to strengthen the training program through collaboration with other specialty groups, given the shared commitment to improving clinical education and patient outcomes. A notable example is the recent discussions with the Abdominal Radiology Group of Australia and New Zealand (ARGANZ), which has expressed strong interest in contributing to both curriculum development and Trainee education. In addition to offering to review and align the imaging components of the urology training curriculum and examination with current radiology standards, ARGANZ has also shown enthusiasm for supporting the annual Trainee Week, with the intention of suggesting relevant imaging topics and contributing expert speakers. This collaboration represents a valuable opportunity to strengthen cross-disciplinary education and ensures urology Trainees receive accurate, relevant, and high-quality imaging training.

Regular Curriculum Updating and Continuing SET Alignment

Cardiothoracic Surgery Australia and Aotearoa New Zealand

The CSTC will ensure that the new curriculum currently under review, will ensure that it incorporates a clear and uniformly articulate program with clear graduate outcomes. Prior to its final completion, it will be widely disseminated to key stakeholders and be publicly available, reflecting community needs and mapped to the ten RACS competencies. EMST and CCriSP courses (or equivalent) have now been turned into a preselection mandatory requirement.

Please refer to 7.2.3 of the 2025 SET Selection Regulations (1.26 Cardiothoracic Selection Regulations 2025).

All SET Selection Candidates are required to complete a minimum of two RACS e-Learning modules and Courses 1, 2 and 3 of the RACS e-Learning Aboriginal and Torres Strait Islander cultural Safety Courses or other Intercultural Competency course as a mandatory pre-selection requirement.

General Surgery Australia

General Surgery Australia has completed an update using a thorough Curriculum map (5.1 General Surgery Curriculum Map).

All successful applicants to the General Surgery (in Australia) training program are required to undertake the RACS Cultural Competency Modules 1 and 2.

Section 14.3.3c of Selection Regulations: (10.4 General Surgery Selection Regulations 2025)

The General Surgery Curriculum will be reviewed in 2026 following the end of the first cohort of Trainees to complete the GSET program. This will involve the review of both technical and professional competencies. The review will be undertaken at this time due to the structure of the milestones which require the program to have had at least one cohort pass through in order to effectively evaluate the curriculum.

The curriculum's GSET1 and GSET2-3 milestones have been continuously reviewed and evaluated through the Evaluation Strategy however this is only one step/process in the entire review of the curriculum.

Neurosurgery Australia and Aotearoa New Zealand

The updated curriculum for the SET Program in Neurosurgery was approved in August 2024. This update included a comprehensive review of the technical curricula. It was released on the public-facing website, as well as disseminated to key stakeholders, including Trainees and Supervisors.

In response to ongoing concerns about the cost and relevance of the CCrISP course to neurosurgical training, the NSA surveyed Trainees, revealing limited perceived value. Only 5.5% found the course highly relevant to SET training, while 78.2% deemed it not or only slightly cost-effective, and just 21.8% supported its continued mandatory inclusion. Based on these findings, the SET Board is moving forward with the removal of CCrISP as a SET Program requirement, with proposed changes to the regulations to be submitted for approval in 2025. Although 40% supported making it a pre-selection requirement, concerns about cost, accessibility, and impact on eligibility led the SET Board to reject its inclusion as a selection requirement.

Orthopaedics Australia

The AOA FTC is working through the AOA 21 Review Implementation Action Plan which includes actions across the breadth of the Training Program including in assessment and curriculum. The action plan is currently staged for delivery across the next 2-3 years and updates will be provided as decisions are made. The FTC has approved in principle the development of a new professional skills module, with an update on progress due to be presented to the FTC in June 2025. As part of this work, the FTC resolved to remove completion of the ASSET course as a training program requirement, as the course was not considered fit for purpose for the Trainee level of competence. Inclusion of TIPS as a training requirement is under review. Whilst the content of the course is considered imperative the cost of attendance is prohibitive for Trainees.

Otolaryngology Head and Neck Surgery Australia

Concerning the AMC requirement for professional skills curriculum, that the BOHNS must articulate better 'an inclusive and safe space for all colleagues and members' please refer to page 152 of the OHNS Curriculum (2.5 OHNS Curriculum Extract - Professional Skills)

ASOHNS staff, on behalf of the BOHNS, actively review the training program and consider whether there is an impact on the curriculum to ensure that all training documents are kept up to date. BOHNS recognise innovations and evolving community expectations. A full review of the Curriculum document is planned for 2026 to ensure it has been reviewed prior to the next full AMC Accreditation.

Recent changes include the introduction of 3D printed models which have been developed as an alternative for novice Trainees to learn early stages of dissection skills prior to advancing to cadaver bone dissection.

ASOHNS engages with a community representative who has a voting position on the BOHNS.

Plastic and Reconstructive Surgery Australia

The 5-year curriculum has been reviewed. It was shared with ANZCA and AIDA for consultation (AIDA declined due to "colonial loading", but a submission can be made to request review if you are an AIDA member). It was reviewed using the CANMEDS framework as the base – and thus has Canadian input and an Indigenous perspective. Focus groups with Supervisors in all states and with Trainees in Australia and Aotearoa New Zealand were undertaken and changes made accordingly. Community feedback was received from hospitals.

Concerning selection, 25% of referees are from nursing and allied health and standardised reference checks are provided to the jurisdictions. MMIs included rural representatives.

Plastic and Reconstructive Surgery Aotearoa New Zealand

PRS Graduate outcomes are mapped to the curriculum. The PRS graduate outcomes statement is publicly available on the NZAPS website.

Urology Australia and Aotearoa New Zealand

As part of an ongoing review of mandatory courses, and following consultation with RACS regarding skills course requirements, the Board has determined that the ASSET course appears to no longer be relevant for urology Trainees and will be removed as a training requirement in 2026. In addition, the Clinical Examination (CE) is likely to be removed as a prerequisite for selection into the training program for the 2027 intake. These changes reflect the Board's commitment to ensuring all mandatory training components are relevant, purposeful, and aligned with the needs of urology Trainees. A broader review of all other mandatory courses has also been undertaken to confirm their continued value and relevance to the training pathway.

Standard 3 Condition 8 SET Framework Specific Health Needs of Aboriginal and Torres Strait Islander and Māori and Cultural Competency

Cardiothoracic Surgery Australia and Aotearoa New Zealand

The CTS is in the process of reviewing and developing their new curriculum and will be implementing the 10th RACS Competency- Cultural Competency and Cultural Safety to this, the training regulations and updated assessment forms.

At the registration stage of the SET Selection Process, all candidates must complete a minimum of two RACS e-Learning modules and Courses 1, 2 and 3 Courses 1, 2 and 3 of the RACS e-Learning Aboriginal and Torres Strait Islander Cultural Safety Courses or other Intercultural Competency courses that are relevant. Each of the Courses must be of a minimum duration of one day- (8 hours) and documentary evidence must include the certificate of completion, it must clearly indicate the Applicant's name, the date/s of the course, the offering institution and the mode of delivery. Should this requirement not be attained, the candidate is deemed ineligible and does not progress to the next stage of selection. Details regarding this, can be viewed in Clause 7.2.3 of the 1.26 Cardiothoracic Selection Regulations 2025.

Following discussions with the CSET Committee regarding Culture Diversity and Rurality, the CSTC have decided to include the Māori and Pasifika Initiative with one position available each year and using the RACS suggested Māori and Pasifika definitions to their Selection Regulations. This initiative will be implemented in 2027.

General Surgery Australia

The General Surgery Curriculum has been updated to include the 10th Competency- Cultural Competency and Cultural Safety. This competency domain has now been published in the Curriculum as well as communicated to Trainees and Supervisors. The 10th competency has also been incorporated into the Mid and End of Term In-Training Assessments from 2025. Before commencing on the program all successful applicants are to complete the RACS Cultural Competency Modules as per Section 14.3.3c of the Selection Regulations. The staff check this as all candidates are to send in their certificates prior to commencing.

A copy of the Curriculum is publicly available on the GSA website here: GSET Curriculum

Senior General Surgery staff are exploring options for enrolment in the AIDA training program 'Cultural Awareness – An Introduction to Cultural Safety' as a supplement to resources already available via RACS. If successful, the Society will explore including this training for all staff and continue to investigate other opportunities for development.

Neurosurgery Australia and Aotearoa New Zealand

The updated curriculum for the SET Program in Neurosurgery was approved in August 2024 and incorporates cultural safety and competence as integral components within both the curriculum content and the expected graduate outcomes.

The 2024 review of the Australia and New Zealand PRS Curriculum has resulted in the creation of a standalone chapter dedicated to Cultural Safety and Competence. Some elements were embedded within Health Advocacy in the previous version of the curriculum, with more development in this area to align the curriculum with RACS core competencies. It should be noted that the RACS core competency *Cultural Safety and Competence* was developed after the 2019 version of the Curriculum was approved, explaining the reason for its absence as a curriculum topic until now.

Orthopaedics Australia

This work is scheduled as part of the AOA 21 Review Action Plan – anticipated for late 2025. Current format of competency statements maps to RACS 10th competency. Cultural Safety and Cultural Competency training is mandatory for both orthopaedic Trainees and Fellows involved in training in Australia.

Orthopaedics Aotearoa New Zealand

Currently the NZOA staff do not do Cultural Safety Training but would be open to this. With regards to cultural safety training for staff, this could be discussed at the Council level during 2025. As noted elsewhere, in Aotearoa New Zealand cultural awareness and competency training is immersive, continuous and long-standing, and thus of likely greater (if not complete) impact than through compulsory standalone courses.

Attached is the NZOA Selection Day approach (3.6 NZ Orthopaedics SET Selection Day Mihi Whakatau 2024). This is provided as one example of the comprehensively everyday ways SET Trainees in Aotearoa New Zealand are immersed in cultural awareness to build their cultural competence. For Aotearoa New Zealand Trainees they must live and breathe a commitment to understand and working with the Māori and Pasifika people. In terms of cultural safety and awareness New Zealanders in general normalise te reo and te ao Māori, the use of te reo mixed into English conversations, greetings e.g. kia ora, mōrena used in everyday written and verbal greetings.

Trainees are assessed on cultural competence and cultural safety through our assessment process, specifically in the QRA, the TIMS Feedback Entry has this as an assessment area.

At each training event it is opened with a mihi whakatau, this has become part of the Trainees experiences from selection interviews through to leaving the programme. Selection interviews are opened with a more formal mihi whakatau from our Cultural Adviser, this involves both our Cultural Adviser, Trainees, consultants and staff (3.6 NZ Orthopaedics SET Selection Day Mihi Whakatau 2024). In 2023 our Cultural Adviser bestowed a name on the applicants more befitting their journey (3.5 Te Kahui Kahurangi).

Trainees received dedicated cultural safety training at the SET 1 Training Weekend.

Concerning the load on Māori surgical and non-surgical educators and assessors, this is managed through various mechanisms. NRK provide support to Trainees and colleagues. It has been acknowledged that the load on our Māori Trainees and consultants is larger as more requests are put on them. By introducing a Cultural Adviser we have not only been able to use this position to fill a 'gap' in both formal and more informal situations but as a non-surgeon and a consumer of orthopaedics (amputee), he brings a perspective from both the Māori world but also as a user of the specialty. He also works with NRK and bridges many of the cultural gaps.

Ngā Rata Kōiwi commissioned two beautiful korowai, which were then gifted their names by NZOA's Cultural Advisor & Kaumātua Ken Te Tau. These korowai are now available for use at NZOA events on request. In addition, LIONZ commissioned two pounamu pedants from Pounamu Tohunga Whakairo (master carver) Nathan Jerry, these were organised by our Cultural Adviser. The pounamu is from Te Whanga o Awarua/Big Bay in Southland.

Otolaryngology Head and Neck Surgery Australia

ASOHNS has strong connections with the Aboriginal and Torres Strait Islander sector, especially due to the health implications in ear health and hearing loss which disproportionally affects these communities.

ASOHNS employs an Aboriginal staff member to support society activities in the sector. We have created connections with NACCHO, Aboriginal Medical Services and other Indigenous organisations.

There is ongoing work to improve cultural competency of members and Trainees. Currently RACS CPD requires completion of cultural training and hospitals have requirements for all staff members. ASOHNS staff members presented to the annual Trainee meeting in October 2024 on cultural safety.

An Indigenous Health Workshop is held annually which is well attended by Trainees and members.

The OHNS Curriculum embeds cultural competency throughout as well as dedicated modules on Aboriginal and Torres Strait Islander health.

Trainees can build their cultural safety and cultural competence during training by attending presentations during the Annual Trainee Meeting and Indigenous Health Workshop that is held annually. Trainees have opportunities to do outreach work and the BOHNS has a relationship with Deadly Ears, an outreach program for Indigenous ear health, where Trainees can contribute to their program. The BOHNS has an Indigenous Selection Initiative for SET Selection.

Plastic and Reconstructive Surgery Australia

To the best of their knowledge, AUS PRS has no Indigenous doctors as educators or Trainees.

No work has been undertaken at a specialty level to ensure all Trainees are culturally competent. We feel it is a whole of college piece of work and we are awaiting direction from RACS on how to measure and monitor these outcomes in cultural competence and cultural safety.

The 2024 review of the PRS curriculum has highlighted specific changes to the structure including the addition of the RACS Core Cultural Competency (was previously

embedded into health advocacy in 2019 and is now standalone). We acknowledge more work in this area is needed both in terms of establishing approaches to learning and measuring their outcomes. Please see RACS Professional Skills Curriculum (PSC) and Guide to Assessing Professional Skills (GAPS), both of which were considered and integrated into the 2024 Curriculum review.

The ASPS National Education and Training Manager has registered and enrolled in the AIDA Introduction of Cultural Competence course (online) in April 2025. The Course must be completed in 12 months to obtain a certificate of completion.

Plastic and Reconstructive Surgery Australia and Aotearoa New Zealand

All site accreditations specifically assess the cultural safety of the site against HTP standards. Site inspectors are directed to validate any claims made by hospitals around the completion of cultural competence training. Specialty Society staff have undertaken cultural safety awareness training.

In the recent updated curriculum review, NZBPRS and ABPRS have incorporated a section addressing cultural competency and cultural safety.

Trainees are assessed with cultural competence and safety and monitored in mid-run and end of run assessment meetings and PPA forms.

Vascular Surgery Australia and Aotearoa New Zealand

New Competency Regulations are under development. RACS PSC includes cultural safety and competency.

Standard 3 Condition 10 SET Framework Curriculum Maps and Outcomes by Stage of Training

Neurosurgery Australia and Aotearoa New Zealand

The updated curriculum for the SET Program in Neurosurgery was approved in August 2024. The eight professional competencies and two technical competencies have been integrated into specific learning outcomes for different training levels within the curriculum modules.

Orthopaedics Aotearoa New Zealand

NZOA do not use TMP but rather their own assessment system that contains the necessary information regarding the Trainee journey and progress, including WBAs, Feedback Entries, QRAs, eLogs, learning, research, track their progress and rotations. In 2025- 2026 NZOA will deliver the upgraded TIMS App and desktop platform for enhanced reporting and addition of module forms.

NZOA have made curriculum outcomes publicly available. Further modules, including the cultural safety module, will be completed in 2025-26. The curriculum outcomes have been published publicly here: NZOA Curriculum Framework

Otolaryngology Head and Neck Surgery Australia

The BOHNS SET program is a competency-based program consisting of three levels. The maximum length of training is 7 years, however as the program is competency based the majority of Trainees finish training sooner. Trainees cannot advance to the next level until they have met the performance criteria and requirements. The criteria and requirements for each level are clearly published and available to Trainees.

The SET program requirements change in response to external developments as required. An example of this is the introduction of using 3D Artificial Bones rather than cadaver for some of the exercises require as part of training for a temporal bone course.

Plastic and Reconstructive Surgery Australia and Aotearoa New Zealand

A mapping of learning and assessment was conducted in the past and updated in 2025 to include revisions from the Curriculum review of 2024 including maps of outcomes to stages of training for teaching, learning, assessments and EPAs. This work is not for publication or release to AMC at this stage.

The PRS Oversight Committee is authorised to approve binding decisions on Australian and Aotearoa New Zealand STBs for Plastic Surgery. Both Australia and Aotearoa New Zealand use the same curriculum.

Urology Australia and Aotearoa New Zealand

A significant aspect of the competency-based training program has been the introduction of clearly defined Entrustable Professional Activities (EPAs). Each EPA outlines the competencies and that a Trainee must be able to demonstrate independently at the level of a first-year consultant.

To ensure the assessment of a Trainee's competence, each EPA comprises a specific number and type of feedback tools which also include the nature of the procedure or condition being treated.
These tools have been designed to assess the relevant competencies required for each EPA. The tools enable Supervisors and Trainers to offer focused, actionable feedback, directly aligned with the expectations of the EPA in question.

A minimum data set of completed feedback tools is required to determine whether a Trainee has reached the competence threshold for each EPA. However, Trainees are strongly encouraged to engage with these tools beyond the minimum requirements to support their development.

Perioperative care

General Surgery Australia

The Australian General Surgery Training program has a SEAM module entitled Peri-Operative Care is mandatory for all Trainees. This includes peri-operative care.
Information on SEAM: https://generalsurgeons.com.au/home/for-trainees/training-program/set-program/seam/
A module overview is attached (10.8 General Surgery SEAM Module - Peri-Operative Care).

Plastic and Reconstructive Surgery Australia and Aotearoa New Zealand

Perioperative care has been in place in the curriculum since its 2019 publication. The 2024 review of curriculum has bolstered "Peri-Operative Care". A revised draft curriculum is in consultation (2025).

Standard 4 Teaching and Learning Methods

[No Conditions]

Commentary: Robotics

Cardiothoracic Surgery Australia and Aotearoa New Zealand

Robotic heart surgery has shown encouraging outcomes in terms of effectiveness, safety, and patient recovery. The STC will be investigating the possibility of including this as a module in their curriculum rewrite.

General Surgery Australia

ABiGS has included an option in the logbook for Trainees to enter if a procedure was undertaken using Robotics. Whilst this is not a mandatory field, it will assist in capturing data on what type of procedures are being undertaken using robotics, where, and the supervision level of Trainees.
GSA has met with IMRA to explore ways that robotic surgery training programs can be delivered for Trainees, Younger Fellows and consultant GSA Members.

Orthopaedics Aotearoa New Zealand

NZOA is working with RACS in this space and developing more sites where competence with robotics can be trained.

Otolaryngology Head and Neck Surgery Australia

Trans-oral robotic surgery (TORS) is used in head and neck reconstruction within the OHNS specialty.

Consideration has been given to the relevance of TORS for surgical training.

This is a highly specialised area and is a post-FRACS fellowship training model.

Trainees are required to have knowledge of TORS, which can be examined at the Fellowship examination, however, is not (at this point in time) a standard hands-on surgical training competency expected at the end of the training program.

Plastic and Reconstructive Surgery Aotearoa New Zealand

NZBPRS does not use robotics in plastic and reconstructive surgery.

Plastic and Reconstructive Surgery Australia

The specialist society ASPS sought feedback from its membership in 2023. None was provided to ASPS.

ASPS hosted a two-hour webinar on 5th December 2023 on the topic of "Robotic Microsurgery: Exploration into the unknown". This exploratory session indicated that

plastic surgeons do not currently use RAS in a training setting. The curriculum specifies general level information for Trainees in core knowledge as follows: 'Discuss the development of super-microsurgery and other future developments, including robotic micro-anastomoses'.

ABPRS has updated the Curriculum for contemporary practice including updates to peri-operative care sections. The 'Draft 2025 Curriculum' 15 Apr 2025 with partial feedback incorporated is not yet ready for publication.

Urology Australia and Aotearoa New Zealand

The Board is evaluating the integration of robotic surgery into the training program, in response to the increasing trend of performing major cases robotically. Current observations show that the need for consultants to upskill on robotic systems is limiting Trainees' opportunities to perform major cases, impacting their development of essential laparoscopic and open surgical skills. The Board is considering how to balance the benefits of robotic surgery with the need for comprehensive training in both robotic and traditional techniques, including establishing clear benchmarks for skill development in all approaches.

The Board is also exploring the development of an introductory robotic surgery training or induction module that would meet hospital credentialing requirements. This initiative aims to streamline access to robotic training for Trainees by enabling them to complete foundational components—such as wet and dry lab training—prior to or early in their rotation. This would minimise delays and ensure Trainees can maximise their exposure to robotic procedures during their rotation. The proposed model would be similar in structure to existing mandatory training modules, such as laser safety or fluoroscopy training. To progress this work, the Board will establish a dedicated working party comprising robotic surgery experts and Trainee representatives. This group will assess various training models, their feasibility, cost implications, and alignment with the credentialing standards of different hospitals. The ultimate goal is to develop a standardised, practical, and accessible pathway that supports both Trainee development and hospital compliance.

Vascular Australia and Aotearoa New Zealand

Vascular do not use robotics as yet.

Commentary: FEx Repeated Failures and Action

Cardiothoracic Surgery Australia and Aotearoa New Zealand

All candidates who fail their exams are invited to attend a feedback interview with two members of the Committee. At this feedback session they receive detailed feedback and guidance on the appropriate timing for their next attempt, along with access to support and study groups. This same process is extended to SIMGs (Specialist International Medical Graduates) who are unsuccessful in their examinations. The Committee aims to prevent repeated unsuccessful attempts by encouraging candidates to take sufficient time to prepare thoroughly before re-sitting. However, despite this support and guidance, some candidates do not follow the Committee's advice and proceed to sit the exam again prematurely. This often results in increased stress and ongoing failure—outcomes the Committee seeks to avoid by recommending candidates wait until they are fully ready.

Supervisors who believe their Trainees are ready to re-sit the exam are also provided with the same advice. The Committee strongly encourages Supervisors to attend the examinations themselves, to gain a clearer understanding of the current standards expected of candidates.

General Surgery Australia

Since 2020, GSA has offered a national Online Fellowship Exam Preparation Course, which is open to all Trainees and SIMGs sitting the FEx in General Surgery in May or September each year. The course includes practice exams, case based discussions, and small group practice viva sessions with General Surgery tutors- typically younger Fellows who have recently passed the FEx.

Faculty provide invaluable teaching, insight, and support for candidates sitting the General Surgery FEx, as well as targeted feedback on how candidates can improve their technique when answering practice surgical vivas.

Feedback is given in a safe and supportive teaching environment, where candidates can feel free to make mistakes and improve their exam technique. Trainees and SIMGs who are unsuccessful in their exam attempt are also counselled as to the areas of deficiency and assisted with study plans and mentors to ensure they are supported in sitting their next attempt.

Orthopaedics Aotearoa New Zealand

Currently we have one exam pending Trainee (outside of his 5 years on their 6th attempt). This particular Trainee has been given advice on not sitting, along with advice to consider remaining in a non-consultant position but has been determined to sit each time. The Trainee continues to attend the pre-exam course with the current SET 5 group, receives additional teaching regularly and takes part in teaching sessions. Age could be a factor but that remains unproven. Within the last 8 years this is only the second Trainee who has not passed within the 5-year training program or taken more than 3 sittings to pass.

With the introduction of competency-based training, we envisage that the blueprinting will be more transparent with the curriculum and with the use of TIMS we will be able to further track progress and readiness for sitting the FEX and have robust discussions with the Trainees who are not considered ready.

Orthopaedics Australia

AOA FTC discussed the current practice of support/education for unsuccessful FEX candidates in light of the RACS response including the role out local mentoring for candidates who have repeated failed attempts.

The Committee agreed that the readiness to sit assessment needed to be stronger and that Trainees shouldn't be allowed to automatically sit again following a failed attempt. These assessments are conducted by Regional Training Committees and this position was included on each RTC meeting agenda for February 2025.

With a view to better supporting failed FEX candidates, the FTC resolved to convene a working group to develop a further action plan. Expressions of interest have been sought, and close shortly.

Otolaryngology Head and Neck Surgery Australia

No OHNS Trainee has been unsuccessful for 3+ FEX attempts for the last 5 years (up to 2024). One Trainee was able to commence part-time training to assist with study and exam preparation after they were unsuccessful on their second attempt.

Information is shared regularly with all Trainees on the services available through Converge.

Assessments and completion of training requirements are well documented for Trainees and accessible. Trainees have access to the ASOHNS Mentoring Program. This is an informal opt in / opt out program which is mentee driven. The BOHNS encourages Trainees to consider participation in the first year of SET or for re-located Trainees.

Trainees are provided with timely feedback on their performance including work-based assessments with immediate feedback, as well as mid-term and end-of-term assessments. There is space provided on assessment forms for comprehensive feedback. End of Term Assessments include meetings with the Supervisor of Training and the Regional Training Chair. Supervisors of training meet with the Regional Training Chair to discuss the progress of Trainees and to provide additional support where required. Supports can include 360 degrees and Learning Action Plans. Learning Action Plans are devised in conjunction with the Trainee.

Trainees are provided with Progress Reports throughout training. There is a dashboard within the training platform allowing for a quick overview.

Special Consideration policies and procedures align with RACS.

Plastic and Reconstructive Surgery Australia

In 2024, a few Trainees and 1-2 SIMGs have had 3 or more failed attempts at the examination. The anecdotal themes from their feedback interviews with Board members appear to be:

- Reluctance of a candidate to accept expert feedback in examination reports and lack of drive to implement changes in their approach to learning and examination attempts.
- Lack of adequate medical knowledge in the candidate.
- Lack of confidence from previous unsuccessful attempts. Some anchoring to their previous lack of achievement.
- Variability in performance between successive attempts for candidates who originate from outside Australia and Aotearoa New Zealand (SIMGs)

The Australian Board of Plastic and Reconstructive Surgery is monitoring the impact of the FEx decoupling.

Plastic and Reconstructive Surgery Aotearoa New Zealand

In instances where candidates are not progressing satisfactorily, the NZBPRS follows a protocol involving supportive supervisor meetings, the development of supported learning plans, case-based discussions, performance review meetings, and the provision of mentors. The NZBPRS follows the RACS protocol for Trainees failing the FEx.

Vascular Surgery Australia and Aotearoa New Zealand

RACS regulations are referenced for Exam Assessments. Feedback is provided during in-training assessments and WBAs. Supervisors and the Board of Vascular Surgery support failing exam candidates through discussions on examination performance. Management plans with goals may be agreed to by the Trainee in preparation for their next attempt.

The board chair or representative meets with each candidate who has failed to give feedback and support. There are a number of relevant policies.

RACS regulation (REG-2071) (10.9 Exceptional Circumstances and Special Consideration Policy)
RACS regulation (REG-2011) (10.10 Fellowship Examination Regulation)
RACS regulation (REG-2069) (4.3 Fellowship Examination Eligibility and Examination Regulation)

Standard 5 Condition 22 Assessment

STB/C comments are retained in the body of the report given this is a new condition not due until 2026

Standard 6 Condition 12 M&E Feedback from Supervisors

Cardiothoracic Surgery Australia and Aotearoa New Zealand

The STC is currently working with the RACS TMP Team to investigate the possibility of incorporating a Supervisor survey via the TMP platform.

As we are a small specialty, this option might be concerning to our Trainees for fear that they can be easily identified (one or two Trainees at any one year at each hospital) but the Committee is happy to work with the TMP team to review the questions that will be asked and provide Supervisors with a final report possibly every three to five years. This is still under consideration.

Supervisors are actively involved in helping define and prepare the new curriculum. They are also used extensively as interviewers for the new potential Trainees. This provides time with the committee members where training / selection issues are always discussed. The committee chair provides feedback to the Executive at regular meetings. The committee chair formally presents an outline of the Trainees / training program at our Annual Scientific Meeting with regular feedback from the wider members of our specialty including Supervisors and HOD.

Trainees also meet with the Chair at their Trainee weekend (two per year) to provide feedback regarding their training/operative exposure, any training related difficulties they are experiencing which require the Committee's involvement and any obstacles personal or professional they are encountering regarding their progression throughout their training. It is meant to be an informal discussion but one which leads to positive outcomes.

The CTSC also has a Trainee representative who effectively advocates for all the SET at each Committee meeting and their views are discussed and positive outcomes are made. The Trainee representative position is elected by the Cardiothoracic SET Trainees.

The CTSC strongly encourages written feedback from all Trainees (confidential or otherwise). This feedback is taken seriously and investigated further. There have been several instances which have required intensive follow up, intervention and due process been followed but specifics cannot be disclosed to protect the individual Trainees.

General Surgery Australia

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. Data from the online TIMS platform is also analysed. To date two reports have been published reviewing the results of the evaluation and monitoring of GSET. The reports as well as the strategy are publicly available at: https://generalsurgeons.com.au/home/for-trainees/training-program/gset-program/gset-evaluation/

Following the Evaluation several key changes have been approved by the ABiGS based on the evaluation evidence. This includes changing of the ratings for Procedure Based Assessments, as well as the removal on one EPA and changes to the logbook procedures/points. The Board has also finalised a report reviewing Trainee Movement from 2009- 2023 including interruptions, dismissal, withdrawals, extension to training, flexible training, and transfers to a different training region. The report is updated yearly to analyse trends and to enable the ABiGS to undertake modelling for Selection offers. The report was presented to CSET in October 2024.

The reports as well as the strategy are publicly available https://generalsurgeons.com.au/home/for-trainees/training-program/gset-program/gset-evaluation

First year evaluation report: (10.11 General Surgery GSET Evaluation Report 2023)
Second year evaluation report: (10.12 General Surgery GSET Evaluation Report 2024)
2024 Report Reviewing Three years' worth of data: This document is currently under review and is not available for publication.
Trainee Movement Report: (10.13 General Surgery Trainee Movement Report 2024)

Neurosurgery Australia and Aotearoa New Zealand

NSA did their own Trainee and Supervisor surveys. The Annual Supervisor Evaluation was undertaken by the NSA in February 2025 to gather feedback on the 2024 training year. Of the 32 Supervisors invited, 30 responded, reflecting a 93.75% participation rate.

The findings have been distributed to RACS and are also made available to all Supervisors (6.2 Neurosurgery Supervisor Evaluation Report 2024).

Actions arising from the evaluations are being incorporated into the NSA SET Program Quality Improvement and Development Plan. This Plan focuses on continuous monitoring, evaluation, and quality enhancement, aligning improvements with best practices, accreditation requirements, and stakeholder feedback. The Plan will be discussed at a SET Board workshop in late June, for approval by the NSA Board in August 2025.

Plastic and Reconstructive Surgery Australia

The ASPS agreed to RACS sending the Supervisor Survey to all Plastic Surgery Supervisors in Australia.

Regular informal feedback occurs during training subcommittee meetings several times per year and in focus groups coordinated during 2024 as part of the curriculum's review. Supervisors are encouraged to contribute feedback through:

- Regional Subcommittee discussions
- Webinars and presentations at Section meetings
- Sessions during the ASPS Plastic Surgery Congress (PSC)

To support continuous improvement of the training program and ensure Supervisor perspectives are effectively incorporated, there is bidirectional regular feedback between STB and Supervisors through the regional subcommittee mechanism.

In May 2025, the inaugural feedback survey to Supervisors seeking feedback on their hospital's training post was sent through the RACS TMP system. Of the 54 invitations 9 responses have been received to date. Feedback is not yet ready for analysis. Participation rates may be affected by:

- The system being not user friendly
- Trust and confidentiality concerns
- Reporting is not yet developed limiting the STB's ability to identify trends or compare responses to similar questions asked of Trainees.

Urology Australia and Aotearoa New Zealand

To support continuous improvement of the training program and ensure Supervisor perspectives are effectively incorporated, the Board of Urology has implemented a multi-faceted approach to seek feedback from Training Supervisors. Several forums have facilitated valuable input, and efforts have been made to ensure confidentiality with certain feedback mechanisms.

Supervisors are encouraged to contribute feedback through:

- Regional Training Committee (RTC) discussions
- Webinars and presentations at Section meetings
- Sessions during the USANZ Annual Scientific Meeting (ASM)

Although feedback in these settings is not confidential, they offer opportunities for discussion, clarification, and collaborative problem-solving.

The Sub-Committees of the Board of Urology, composed of USANZ members, meet regularly to share insights and feedback on training delivery. Additionally, ad hoc working parties are formed to examine specific components of the program. These groups play a pivotal role in generating suggestions and advising on program enhancements.

To specifically address the need for confidential feedback, targeted and concise surveys have been developed and distributed to Supervisors. These surveys focus on particular elements of the training program and are designed to encourage honest, anonymous responses. This method has proven effective in gathering candid feedback and has directly contributed to informed, meaningful changes by the Board. Copies of these surveys have also been shared with RACS for transparency and alignment.

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Standard 6 Condition 13 M&E Feedback from Trainees

[See also Standard 1 Condition 21]

Cardiothoracic Surgery Australia and Aotearoa New Zealand

In addition to the comments provided in condition 12, all SET Trainees at a hospital that is being inspected are confidentially interviewed as part of the hospital accreditation process.

General Surgery Australia

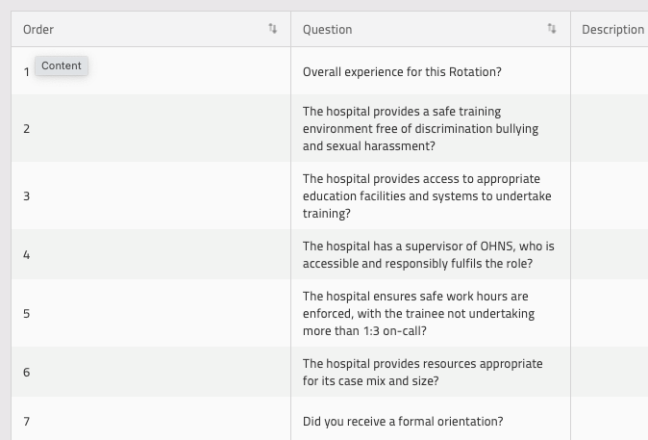
In addition to the comprehensive GSET evaluation discussed in Condition 12, general surgery Trainees are surveyed at the end of term to obtain their anonymous feedback on training posts, Supervisors, and Trainers. This data is utilised to review training posts in a safe way and to ensure the standards are being met. Where a potential issue with a hospital post is identified this is reviewed as part of the Hospital Accreditation process.

Orthopaedics Australia

AOA has implemented a new Trainee-led process of collecting feedback on Accredited Training Sites / Posts as part of Accreditation Reviews that allow Trainees currently in training posts and those previously allocated there to anonymously provide their frank feedback on their training experience via a representative of the Trainees Executive Committee, who will compile and report collectively to the Accreditation Team on Trainee experience. This process does not replace Accreditation Team interviews with Trainees but enhances it so that Trainees have a completely anonymous avenue of raising concerns in a way where they feel protected from any potential negative consequences of speaking up about their Supervisors or environment.

Otolaryngology Head and Neck Surgery Australia

The BOHNS requests rotation feedback at the completion of each rotation from Trainees. Questions include:



Order	Question	Description
1 Content	Overall experience for this Rotation?	
2	The hospital provides a safe training environment free of discrimination bullying and sexual harassment?	
3	The hospital provides access to appropriate education facilities and systems to undertake training?	
4	The hospital has a supervisor of OHNS, who is accessible and responsibly fulfils the role?	
5	The hospital ensures safe work hours are enforced, with the trainee not undertaking more than 1:3 on-call?	
6	The hospital provides resources appropriate for its case mix and size?	
7	Did you receive a formal orientation?	

In addition, Trainees participate in hospital inspections where they can provide information regarding their training environment. Supervisors of training can contact the BOHNS directly or through the Regional Training Chair to provide feedback. They also take part in hospital inspections. Accredited training posts are listed on ASOHNS website.

The BOHNS regularly reviews the Training Regulations to evaluate the training program outcomes and processes.

The BOHNS supports RACS with their Supervisor Evaluation Survey. The Training Manager monitors BRIPS educational programs and ensures Surgical Supervisors have completed the required courses.

Neurosurgery Australia and Aotearoa New Zealand

The Bi-Annual Trainee Evaluation was conducted by the NSA in November 2024. A total of 59 Trainees were invited to participate, with 57 completing the evaluation, resulting in a participation rate of 96.61%. Feedback from Trainees is regularly sought and acted on. Two have required intensive follow-up and intervention. These are complex and not detailed here to protect the individuals here, but due process has been and is being followed.

The findings have been provided to RACS and are distributed to all Supervisors and Trainees (10.14 Neurosurgery Trainee Evaluation Report 2024).

Actions arising from the evaluation are being incorporated into the NSA SET Program Quality Improvement and Development Plan. This Plan focuses on continuous monitoring, evaluation, and quality enhancement, aligning improvements with best practices, accreditation requirements, and stakeholder feedback. The Plan will be discussed at a SET Board workshop in late June, for approval by the NSA Board in August 2025.

Concerning a specific topic raised in the MTS and by Trainees, the NSA conducted a Relocation and Entitlements Survey of SET Trainees in Neurosurgery in March 2025, with a response rate of over 95%. The survey is designed to help the NSA and SET Board understand the impact of relocation on neurosurgical Trainees and

explore ways to mitigate challenges related to relocation and leave portability. Actions arising from the survey are being incorporated into the NSA SET Program Quality Improvement and Development Plan. This Plan focuses on continuous monitoring, evaluation, and quality enhancement, aligning improvements with best practices, accreditation requirements, and stakeholder feedback. The Plan will be discussed at a SET Board workshop in late June, for approval by the NSA Board in August 2025.

Orthopaedics Aotearoa New Zealand

Attached is the confidential annual Trainee survey (10.15 NZOA Confidential 2024 SET Trainee Survey Summary March 2025). NZOA has very detailed feedback from Trainees at each site which is not provided here for its very specific content and thus for confidentiality reasons. However, all concerns were followed up with Trainees where they occurred. Where there were concerns expressed, they were more training program related, differed somewhat across stage of training and were mostly very individual; there were none reported concerning bullying, discrimination and harassment or overwork. The de-identified survey is attached. This survey will be repeated in December 2025. The de-identified survey addresses the culture of training and the workplace.

There is a mentoring program for Trainees in SET 1-2, at SET 1 they are assigned a mentor, at SET 2 they can remain with that mentor or choose their own, they set goals and have regular documented meetings.

The Trainees have regular meetings with the Chair of the Education Committee at one of the training meetings per year, these meetings discuss research, progress, assessment and any concerns Trainees or Supervisors have. During the training weekends (each Trainee has 2 per year), mock and pre-exams Trainees have opportunity to talk with the wider supervisor group, their peers and the education training manager.

The Trainee representative is available to Trainees at all times, they also have 2 meetings per year attached to the senior training weekends, the Trainee rep can bring any concerns back to the Committee or Board (and the Trainee representative sits on the Board).

Plastic and Reconstructive Surgery Australia

Trainees are requested to provide their feedback on the training posts (not the program) at the conclusion of each rotation. Participation rates may be affected by:

- The system is not user friendly
- Trainees do not trust the information will remain confidential and private.
- Reporting is not yet developed limiting the STB's ability to identify trends or compare responses to similar questions asked of Supervisors.

The STB is considering alternative methods for obtaining feedback, including moving to other systems that are not intrinsically linked to the Training Management Platform (TMP) thereby ensuring no linkage between Trainees and their individual comments.

Feedback from Trainees is regularly sought (6 monthly). In 2024, 167 surveys were sent. The participation rate was 39% (65) a further 85 (51%) have either not commenced of partially completed the feedback. Access to the data is limited due to delays in survey system development, the Trainee Management Platform (TMP). There was a complex issue in Western Australia, commencing 2023, which necessitated careful engagement through the out of cycle inspection mechanism in October 2024 with Supervisors and surgical leadership during 2024, as well as with Trainees, registrars and jurisdictional representatives. Confidentiality was maintained for all parties including the original complainants from 2023. RACS has not disclosed complainants' names to any party including ASPS and the STB.

An Annual Supervisor Evaluation was scheduled for early 2024 but was delayed due to development halting in the survey system, the TMP. There are no actions arising to date.

Plastic and Reconstructive Surgery Aotearoa New Zealand

The NZBPRS has authorised RACS to conduct Supervisor evaluation surveys for NZ PLA. However, due to the small size of the specialty, Trainees are hesitant to participate, fearing a lack of anonymity.

Neurosurgery Australia and Aotearoa New Zealand

NSA has established the NSA Trainee Representative Committee as a platform to amplify Trainee perspectives and ensure their voices contribute to the development and delivery of the SET Program, as well as other NSA activities that impact them. This Trainee Committee consists of eight Trainees, including the current Trainee Representative, the past Trainee Representative, and six Trainees elected by their peers. The Committee's terms of reference include diversity clauses to ensure representation from both Australian and Aotearoa New Zealand Trainees, ensuring a broad range of perspectives are considered.

The NSA also amended its Constitution in 2024 to include a Trainee representative on the Board of Directors and that has now been implemented. The Trainee representative is also on the SET Board.

Regular newsletters are sent to Trainees. Twice a year during training seminars, Trainees are also provided with the opportunity to ask questions and receiving an update from a SET Board representative.

Otolaryngology Head and Neck Surgery Australia and Aotearoa New Zealand

The BOHNS has 2 Trainee representative members, one from Australia and one from New Zealand. They attend each Board meeting to report on Trainee matters and provide their input to Board matters. The Trainee representative position is elected by Trainees.

Plastic and Reconstructive Surgery Aotearoa New Zealand

To ensure fair representation, NZ PLA strongly encourages all Trainees to participate in both these surveys and the RACSTA survey, as the latter offers more secure anonymity. The Trainee representative is also tasked with encouraging participation and serving as a confidential point of contact for any Trainee concerns, as they hold a position on the board. Additionally, Trainee feedback on Supervisors of Training (SOTs) and their units is collected during HTP accreditation inspections, though these occur every five years.

Urology Australia and Aotearoa New Zealand

Following Trainee Feedback: Supporting Trainees in Flexible Training and Return from Interruption:
Following Trainee feedback, The Board of Urology committed to addressing the challenges faced by Trainees undertaking flexible training or returning from a period of interruption. Please see Standard 1 Condition 21 for implementation details.

Standard 6 Condition 14 M& E Feedback from Non-surgical Stakeholders and the Community / Consumer Representatives

[Please see Standard 2 Condition 3]

Standard 6 Condition 15 M&E Results Reporting

Training Management Platforms

General Surgery Australia

GSA does not use the RACS TMP platform as GSA developed its own platform for GSET program. The work on this commenced in 2020 and launched in 2022 with the commencement of GSET.

GSA is exploring with RACS the possibility of utilising the RACS TMP platform for management of General Surgery SIMGs, post initial assessment.

Otolaryngology Head and Neck Surgery Australia

The BOHNS does not use the RACS training management platform (TMP). The TMP took too long to implement. The BOHNS has its own software system in place that works well for the Trainees. The system in use records training requirements including logbook procedures.

Plastic and Reconstructive Surgery Australia

After a hiatus in development (2023 to mid-2024), enhancements commenced end of 2024 and new feature development is currently in train with business cases on phased new features in 2025 and 2026, subject to financial constraints.

All Trainers and Supervisors involved in Plastic and Reconstructive Surgery training are engaged in the TMP. An analysis of 2024 assessment records in the TMP demonstrate that 283 Fellows undertook 2,652 assessments on Trainees equating to approximately 63 working days of Fellows' pro bono contributions to training. This system enables CBME through its functional handling of programmatic assessments (WBAs, EPAs) and regular performance assessments (PPAs).

ASPS provides all RACS requested data e.g.

- Selection e.g. vacancies, geography, applicant and appointment demographics
- Training progression e.g. accredited posts, vacancies, Trainees in flexible posts / interrupted training / probation / dismissal / presenting for and passing FEX
- Training activities and assessments e.g. type and mapped to competencies assessment and outcomes
- Survey data e.g. access, support and opportunities for safe suitable training, supervision, flexibility, support, FEX preparation

Vascular Surgery Australia and Aotearoa New Zealand

Vascular Surgery is working in collaboration with RACS and has adopted the RACS Training Management Platform (TMP) for maintaining records and reporting via the RACS Monitoring and Evaluation Framework.

Standard 7 Trainees [No Conditions]

Orthopaedics Aotearoa New Zealand
NZOA Trainee fees increased by 1% in 2024, this includes the Trainee fees, TIMS fee and NZOA membership fee. This fee is reimbursed by Health New Zealand.

Neurosurgery Australia and Aotearoa New Zealand
The NSA applied only a CPI increase to fees in 2024 and no increase to fees in 2025.

Plastic and Reconstructive Surgery Aotearoa New Zealand
Fees are set annually following a budget analysis

General Surgery Australia
Fees for General Surgery AU are published on the GSA website. The website also includes a breakdown of how specialty training fees are used to support core functions of training. https://generalsurgeons.com.au/home/for-trainees/training-program/gset-program/training-fees/

Otolaryngology Head and Neck Surgery Australia
OHNS Training Fees were increased by CPI for 2025 which was communicated with Trainees at the start of the year. Fees are reviewed annually, benchmarked to other training programs.

Plastic and Reconstructive Surgery Australia
ASPS has not applied an increase to the Training Fees since 2018. Educational courses are run to be cost neutral, or at a minor loss. In 2013 an activity-based costing exercise, modelled on the service agreement with RACS, was conducted to identify the actual cost in the delivering training. Fees were set accordingly. This means educational courses (Trainee conference week) are run to be cost neutral, or at a minor loss. ASPS refunds surpluses to Trainees.

Vascular Surgery Australia ad Aotearoa New Zealand
No change: VAS Training Fees are published on the RACS website. VAS fees are billed and collected by RACS.

Trainee Hardship Policy

General Surgery Australia
The GSA Board would consider any request for relief of Specialty Training fees due to financial hardship. In 2025, the Specialty Training fee has been waived (without the need for a formal request) for one Trainee, due to extenuating circumstances outside of the Trainee's control.

Orthopaedics Aotearoa New Zealand
Financial hardship is a consideration for the NZOA and 2-3 per year hospitals have opted to pay Trainee fees directly to us which helps the Trainee in terms of wait times to be reimbursed and finding the initial funds. Trainees can also pay on instalment with no additional fee incurred.

In 2024 we had 3 Trainees paying on instalments, 2025 we have no Trainees paying on instalment and as of A we have 3 outstanding fees.

Trainees can claim all fees, course costs, training event costs back from Health New Zealand (this includes accommodation and travel costs).

Orthopaedics Australia

Working with the Trainees Executive Committee, AOA has developed a Financial Hardship policy to compliment the process outlined in the AOA constitution regarding fee relief. A draft is due to be considered at the July meeting of the AOA Board.

Plastic and Reconstructive Surgery Australia

ASPS would consider any request for relief of Specialty Training fees due to financial hardship. To date no requests have been made to the Society. ASPS has successfully advocated for changes to the fractional adjustments to Trainee fees for those on flexible training or commencing / interrupting training at peculiar intervals.

Unexpected Changes to Selection Requirements

At the 8 April 2025 CSET workshop all STC/Bs agreed that mandatory courses will not be changed until 2028 selection for 2029 intake.

Standard 8 Condition 19 Supervisor Performance and Training Sites

Cardiothoracic Surgery Australia and Aotearoa New Zealand

The Executive Officer monitors the tenure and eligibility of the appointment for all Surgical Supervisors in Cardiothoracic Surgery and ensures that all mandatory BRIPS courses such as the following have been completed.

- Operating with Respect eLearning module
- Training in adult education principles (the Foundation Skills for Surgical Educators (FSSE) course or approved comparable training)
- Advanced training in recognising, managing and preventing Discrimination, Bullying and Sexual Harassment

Refer to 8.2 of the Cardiothoracic Training Regulations.

Prior to and during Hospital Accreditation visits, each site is expected to provide documentary evidence of their hospital's policies and procedures with regards to building and maintaining a culture of respect for patients and staff.

The specific criteria assessed can be found in (10.16 CAR Hospital Accreditation Inspection Report Template)

Feedback is also sought through the RACS MTS and RACSTA survey.

The Committee also relies on the compulsory CPD activities through RACS for all Supervisors, Trainers, assessors and educators. and is notified when a Fellow/Supervisor is not compliant. The Committee is guided by and collaborates with RACS in identifying, monitoring and reporting on this. Resources are available via the RACS website https://www.surgeons.org/Education/Professional-Development/Cultural-safety-training

The Committee will be investigating the possibility of seeking future feedback through the formal Supervisor survey via TMP platform which is currently used by ASPS.

Neurosurgery Australia and Aotearoa New Zealand

The SET Board has established Surgical Supervisor Regulations that define the terms and conditions for the appointment and removal of Surgical Supervisors. Feedback on supervision is regularly gathered through the Bi-Annual Trainee Evaluation, providing Trainee perspectives on the quality of supervision received.

In addition, the Annual Surgical Supervisor Evaluation, administered by the NSA, is a key component of the quality assurance framework. This evaluation collects detailed feedback from Supervisors and offers valuable insights into both the training environment and the challenges encountered by Supervisors in fulfilling their roles. It serves as an essential tool for assessing and continuously improving the standard of surgical training.

General Surgery Australia

General Surgery participated in the RACS Supervisor Performance process. The ABiGS also surveys Trainees at the end of term to obtain their anonymous feedback on training posts, Supervisors, and Trainers.

This data is utilised to review training posts in a safe way and to ensure the standards are being met. Where a potential issue with a hospital post is identified this is reviewed as part of the Hospital Accreditation process.

See: Hospital Accreditation and Trainee Feedback Regulations: REG 2025-01 Hospital Accreditation and Feedback- 2025 (Section 10) (10.17 General Surgery Hospital Accreditation and Feedback Regulation).

Otolaryngology Head and Neck Surgery Australia

The Training Manager monitors BRIPS educational programs and ensures Surgical Supervisors have completed the required courses.

Hospital Accreditation Criteria (Standard 1 Condition 21) includes hospital culture, respect and professionalism and requires responses on the hospital's policies and procedures. The accreditation form requires the policy title, publication date and accessibility.

The Training Manager monitors BRIPS educational programs and encourages Surgical Supervisors to complete requirements. The Training Manager monitors the tenure of Supervisors. Hospitals have processes within their department to appoint Supervisors of training and advise the BOHNS. New Supervisors of training are provided with a detailed outline of requirements, including the BRIPS educational program.

Orthopaedics Aotearoa New Zealand

RACS surveyed NZOA Supervisors as agreed to in CSET concerning compulsory cultural safety training. No feedback has been received on this survey. Cultural safety training to continue to occur at training weekends.

Trainees are surveyed in December each year and includes Supervisor feedback, and this feedback –whatever its content – is fed back to the Supervisor themselves.

Orthopaedics Australia

Concurrent to development of new online learning modules for Directors of Training, AOA undertook a review and update of the Director of Training Role Description. This update was approved at the last FTC meeting and subsequently ratified by the AOA Board. The overall requirements and intent of the Role Description remains unchanged however the document emphasises the overarching requirement of the DoT role to:
Be familiar with, and help to ensure that, AOA 21 training is delivered according to AOA policies and procedures and the AOA Accreditation Standards for Hospitals and Training Positions.

A new section "Monitor Trainee Wellbeing" has been included in recognition of the recent changes to psychosocial safety laws which identify training organisations as jointly responsible for trainee wellbeing alongside employers.

More recent training requirements, including cultural competency and cultural safety and advanced operating with respect have been included in the requirements of the role with the expectation that any DoT who has not completed these training activities at the time of taking up the role will do so in the 6 months following appointment.

Updates to the accompanying Trainee Supervisor Role Description are due to be considered in June 2025.

Plastic and Reconstructive Surgery Australia

Feedback is sought through formal Supervisor surveys (via the RACS training management platform or TMP), in business meetings (regional subcommittees) and various networking opportunities. The TMP includes a survey module for collecting feedback. At this stage, no feedback has been collected as the TMP development was paused in 2024, and so no themes can be drawn from these data. Limitations of the TMP currently have effectively hidden these data from education managers at ASPS as reporting on these data has not been developed.

ASPS and the ABPRS do monitor cultural safety training for Supervisors, assessors, educators, through its assessment of Standard 1 of the hospital training post accreditation at regular and out of cycle inspections. RACS is leading cultural safety compliance through a project within its CPD activities. The ABPRS would expect reporting from RACS to it in relation to Supervisor compliance with the CPD mandate.

RACS initiated Supervisor self-performance on Wed 27 Nov 2024. Analysis of the feedback has been occupying RACS to date.

Plastic and Reconstructive Surgery Aotearoa New Zealand

The BRIPS report is managed by the training manager, who also communicates pertinent information to the STB. NZBPRS stipulates the completion of mandatory RACS courses for Supervisors of Training and Trainers. All current Supervisors have completed these requirements. Incoming Supervisors are provided with the RACS Supervisor policy and access to the RACS Supervisor HUB via website links. Feedback is also received through HTP accreditation processes.

Vascular Surgery Australia and Aotearoa New Zealand

RACS monitors compulsory training for Trainers, assessors and educators through RACS CPD for Fellows. Resources are available via RACS website https://www.surgeons.org/Education/Professional-Development/Cultural-safety-training. The ANZSVS is guided by and collaborates with RACS in identifying, monitoring and reporting on educational resources.

Standard 9 Condition 20 SIMGs Support

Cardiothoracic Surgery Australia and Aotearoa New Zealand

The STC does not consider the current design of EVOPP as fit-for-purpose and is open to alternative methods of assessing SIMGs

General Surgery Australia

The SIMG process is managed by RACS. Whilst at GSA we facilitate communication between RACS and our SIMG Rep, the processes all belong to RACS i.e. forms, processes, interviews, final recommendation. The Training Board and GSA are only involved in terms of processes from the time the SIMG commences clinical assessment. However, recently the Director- Education and Training has assisted RACS in rewriting the final recommendation letters that are sent to SIMG to ensure that the recommendations are clear.

GSA is committed to ensuring that SIMGs are provided with the same opportunities as Surgical Trainees particularly in relation to Exam Preparation. This includes being invited to all GSA Exam Preparation courses; regional educational courses, access to the online learning modules SEAM I and SEAM II.

The STB has been proactive in recruiting additional SIMG assessors to assist with the new assessment process that resulted from the incorrect regulations.

Neurosurgery Australia and Aotearoa New Zealand

The NSA conducted a benchmarking review of international neurosurgical training programs to support more efficient SIMG assessment pathways. While assessments are managed solely by the RACS, this work provides the foundation to support the safe and timely integration of qualified SIMGs into areas of need.

Orthopaedics Australia

As a mechanism for supporting orthopaedic SIMGs on a pathway to Fellowship via FEX, AOA recommended to CSET, that these SIMGs should have a requirement to attend Bone School alongside AOA Trainees included in their conditions. Bone School is the regionally delivered weekly lecture and tutorial program that covers the content of the AOA curriculum over an 18-month cycle. Bone School incorporates exam preparation, including trial exams, and facilitates inclusion in exam study groups.

A review of previous SIMG records indicated that SIMGs who voluntarily engaged with bone school were more likely to pass the FEX, and more likely to do so on their first or second attempt. Of 46 SIMGs:

- 16 SIMGs passed the FEX on their first attempt whilst attending Bone School
- 10 SIMGs passed the FEX on their second attempt whilst attending Bone School

Only 2 SIMGs have passed on their first FEX attempt without registering for Bone School, and 5 in total passed (the other 3 on latter attempt) without registering for Bone School. 4 SIMGs did not register for Bone School and failed exam attempts (in some cases several). They later registered for Bone School and subsequently passed the FEX.

Otolaryngology Head and Neck Australia

Often prior to application, SIMGs interested in locating to Australia contact ASOHNS to request information about the SIMG process. We direct them to the Medical Board and RACS' websites outlining the requirements and process.

When SIMGs for OHNS apply to RACS, there is an SIMG Representative on the BOHNS. That representative is a member of ASOHNS; however, the assessment process and interview of applicants is conducted on behalf of RACS.

Once an SIMG is on the pathway to Fellowship, they are eligible to apply to be members of ASOHNS. As members, they have access to CPD resources and Trainee tutorials to support their learning if they are preparing to sit the Fellowship Examination. Through this membership, the specialty Society establishes them in the OHNS community in Australia, which converts to Full membership on receiving FRACS.

In the last 2 years, the application process has been handled in a prompt manner by the RACS SIMG Team. KPIs were introduced to meet shorter timelines from application date to interview date. Interviews were converted to online delivery, reducing the impost for travel by SIMG applicants. These changes have made significantly improved the timeline for applicants and there is no current backlog for OHNS SIMGs as far as we are aware.

However over 2 years ago, the backlog was significant and some SIMGs were waiting for 18 months to 2 years for their application to be reviewed. During that time ASOHNS was contacted directly by SIMGs to request assistance with progressing their application. ASOHNS staff were in regular contact with the RACS SIMG team to follow up their application and get an indication of where their application was in the process. While the majority of those are now FRACS and provide an excellent service to the Australian community, the delays did deter some potential applicants.

Looking to the future, we strongly recommend individual assessment of SIMGs as this is the only way to assess whether SIMGs have the necessary skills to deliver safe, quality and appropriate surgical care for Australian patients. The concept that someone who trained in one country has received the same quality of training as another is simply not the case. In the UK for example, Trainees sub-specialise early, so will not have an equivalent breadth of training in all aspects of the specialty as an Australian or New Zealand trained surgeon.

In order to ensure there are sufficient numbers of assessors, ASOHNS has recruited a number of members as SIMG Assessors. The BOHNS was asked by RACS to identify 2 – 3 Assessors. Instead, we have expressions of interest from nine members from a cross-section of backgrounds, including surgeons who were SIMGs themselves, which will provide an understanding of many of the training regions.

We acknowledge that SIMGs contribute greatly to the Australian medical system. We also note that surgery is high risk, and the Society has expressed its concerns to all State and Territory Ministers about the risks of a potential expedited pathway for surgery not overseen by the College. In the wrong hands, surgery can cause death or serious injury.

It is our view that individual assessment is necessary to assess whether the applicant requires further training and where the shortfalls are in experience. As acknowledged by the AMC, RACS has transformed the efficiency of the assessment process. Delivery of EVOPP, or a similar program whereby an SIMG works for 12 months in a public tertiary hospital with oversight, work-based assessments, logbooks and 360-degree assessments. It will provide access to cultural safety training and learning how the Australian system works, prior to working independently. This is essential for patient safety and consistent delivery of the world class care expected in our country.

Becoming part of the community of OHNS surgeons is important to ASOHNS members. They connect professionally to collaborate and share knowledge. They often work together in practice or in hospitals. Through a common training experience, they recognise each other's knowledge. If a two-tier system was created, some with FRACS and others through the Medical Board, this may cause division and lack of public trust should anything go wrong.

There is a willingness to support, train and educate in the OHNS community. It would be surprising if the government chose to ignore that opportunity. The long-term benefit of a better and trusted system is worthwhile.

Plastic and Reconstructive Surgery Australia

SIMG assessments are managed solely by the RACS as defined by the Collaboration Agreement with ASPS.

Once an SIMG is on the pathway to Fellowship, they are eligible to apply to be an Associate member of ASPS.

Plastic and Reconstructive Surgery Aotearoa New Zealand

Unlike other processes, the Specialist International Medical Graduate (SIMG) pathway in New Zealand is handled by the MCNZ and RACS. NZBPRS does not participate directly, except through an SIMG representative.

Vascular Surgery Australia and Aotearoa New Zealand

Resulting from ministerial decisions, the AMC is proposing to expedite SIMG applications from specific countries resulted in the evaluation of UK and Ireland qualification. Feedback has been provided on the comparability of these programs and includes a recommendation to place emphasis on identified gaps/differences in training e.g. Ultrasound logbooks and WBA during the period of oversight.

Standard 9 Condition 23 sits with RACS with some representation from the STB/Cs