



**Royal Australasian College of Surgeons 2023 Accreditation extension submission - Review**

College Name: Royal Australasian College of Surgeons  
Date of last AMC accreditation decision: 2021 via follow-up assessment  
Periodic reports since last AMC assessment: 2022  
Next accreditation decision due: 31 March 2024

**Explanation of findings**

Under the Health Practitioner Regulation National Law, the AMC can accredit a program of study if it is reasonably satisfied that:

- a) the program of study, and the education provider that provides the program of study, meet the accreditation standard; or
- b) the program of study, and the education provider that provides the program of study, substantially meet the accreditation standard and the imposition of conditions will ensure the program meets the standard within a reasonable time.

*The AMC uses the terminology of the National Law (meet/substantially meet) in making decisions about accreditation programs and providers.*

Based on the accreditation extension submission provided, the AMC finds that the College and its programs meet the accreditation standards. The findings against the ten accreditation standards are summarised in the table below. Explicit feedback is available on each standard in Part C of the report.

Standard	Finding in 2021 Follow-up visit (Including any requirements substantially met or not met)	Finding in 2023 (Including any requirements substantially met or not met)
1. Context of Education and Training	Substantially Met (Standard 1.2, 1.6, 1.7 Substantially Met)	Substantially Met (Standard 1.2, 1.6, 1.7 Substantially Met)
2. Outcomes of specialist training and education	Substantially Met (Standard 2.1, 2.2, 2.3 Substantially Met)	Substantially Met (Standard 2.1, 2.2, 2.3 Substantially Met)
3. The specialist medical training and education framework	Substantially Met (Standard 3.2, 3.2.6, 3.2.10 and 3.4.2 Substantially Met, Standard 3.2.3, 3.2.4 and 3.2.6 Not Met)	Substantially Met (Standard 3.2, 3.2.6, 3.2.10 and 3.4.2 Substantially Met, Standard 3.2.3, 3.2.4 and 3.2.6 Not Met)
4. Teaching and learning methods	Substantially Met (Standard 4.1.1 Substantially Met)	Substantially Met (Standard 4.1.1 Substantially Met)
5. Assessment of learning	Met	Met

<b>Standard</b>	<b>Finding in 2021 Follow-up visit</b> (Including any requirements substantially met or not met)	<b>Finding in 2023</b> (Including any requirements substantially met or not met)
6. Monitoring and evaluation	Substantially Met (Standard 6.1, 6.2, 6.3, 6.1.2, 6.1.3, and 6.2.3 Substantially Met)	Substantially Met (Standard 6.1, 6.2, 6.3, 6.1.2, 6.1.3, and 6.2.3 Substantially Met)
7. Issues relating to trainees	Substantially Met (Standard 7.1 and 7.3.2 Substantially Met)	Substantially Met (Standard 7.1 and 7.3.2 Substantially Met)
8. Implementing the training program – delivery of educational resources	Substantially Met (Standard 8.1.3, 8.1.5, 8.2.2 and 8.1 Substantially Met)	Substantially Met (Standard 8.1.3, 8.1.5, 8.2.2 and 8.1 Substantially Met)
9. Assessment of specialist international medical graduates	Substantially Met (Standard 9.2.1 Substantially Met)	Substantially Met (Standard 9.2.1 Substantially Met)

**Providers must satisfy conditions on accreditation in order to meet the relevant accreditation standard. The AMC provides feedback on the conditions using the following:**

- Unsatisfactory**      The College may not meet the related accreditation standard and AMC should investigate further.
- Not Progressing**      No progress or overly slow progress given the timeframe on the condition.
- Progressing**      Indicates satisfactory progress against the condition, with further reporting necessary.
- Satisfied**      The College has satisfied all requirements and can cease reporting against the condition. Condition is marked as closed.

Please note that this response contains:

- Part A**      *Summary of the overall findings relating to the College's 2023 accreditation extension submission.*
- Part B**      *Detailed responses to information reporting against the standards, including feedback to support further reporting on remaining conditions on accreditation*
- Part C**      *Report on Quality Improvement Recommendations*

## Part A – Summary of the overall findings relating to the College’s 2023 accreditation extension submissions.

### Overall Summary of Royal Australasian College of Surgeons 2023 accreditation extension submission

The College are thanked for the time and effort put into the accreditation extension submission, and for the openness and the clarity of the material submitted. These were reviewed in detail as were the RACSTA and stakeholder submissions provided as part of the accreditation extension process.

There are many areas in which the College remains exemplary. Stakeholders and trainees reported ongoing satisfaction with the level of training of surgeons.

However, underlying structural issue of devolved training lies at the heart of why so many conditions remain open, and none were satisfied. Concerns about the College governance and program management were identified by the AMC:

1. RACS, as the accredited organisation, must have clear control and oversight of the training and education programs. The structural issues of the devolved education model continue to create challenges for the College and the Specialty Societies and Associations to demonstrate how all programs address the remaining conditions, and AMC accreditation standards. While the submission acknowledges the issues created by outsourced delivery of most aspects of the training programs, there was no plan or strategy provided to provide assurance the College could address these. These concerns are longstanding but do not appear to be improving given recent examples of the General Surgical Education and Training Program where changes were communicated without adequate College engagement and the removal of accreditation at training sites, again apparently without College engagement prior to the decision. As colleges and the AMC work together to address concerns of health departments and health services, the AMC’s accreditation of programs of study and colleges’ accreditation of training sites, it will be vital that the College, as the accredited organisation has oversight and accountability. It will also be important that the College is able to build on the recent good work it has undertaken on accreditation and progress with the National Health Practitioner Ombudsman’s recommendations.
2. There was insufficient detail provided in the submission regarding the sustainability of the College. It is recognised the College is facing financial challenges with new leadership and has had to make some difficult decisions. The submission states that refining the College structure and reducing staffing related costs may impact on some initiatives but there is little detail of how core functions will be managed through these changes and what the result is intended to be. The Committee acknowledges that there were only a few months between full discussions with the College’s Council and your submission to the AMC, however in making a decision to extend your accreditation the AMC is required to assure the Medical Board of Australia and the Medical Council of New Zealand that the College will continue to meet or substantially meet the accreditation standards over the next period of accreditation (up to four years).
3. In June 2023, the College wrote to the AMC to outline that RACS were reviewing fees and the implementation of fee increases. The RACSTA submission to the AMC raised concerns regarding the impact of increased fees on trainees. While the College’s submission recognised the risks increased fees may have on overall recruitment, it does not provide any reporting or analysis on how it might impact differentially on some already underrepresented groups, or impact on those already in training.

The AMC would like to meet with the College in early 2024, to discuss the areas of concern and the remaining conditions so that there is a shared understanding to support the further information that the Committee has sought.

## Part B - Detailed feedback on standards, including remaining 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 Significant developments underway or planned that relate to the accreditation standards

##### AMC commentary – significant developments against Standard 1

Noted against Standard 1 is the financial situation which is a significant issue. While a dollar value is not mentioned, the 2022 RACS financial report indicates a deficit result of \$10M in 2022. The College response includes a range of measures to cut costs, raise revenue through increased fees and change RACS governance and structures.

Major governance changes include the creation of a skills-based board (approximately nine members) and expansion of College voting membership to include Trainees and SIMGs. Both changes will require constitutional change which won't occur until 2024.

It is noted that the College is looking to appoint a new CEO.

Close monitoring of the impacts of the financial situation is required. The AMC will need to be assured this does not impact on training quality, equity initiatives or trainee progression or welfare.

The College acknowledges the ongoing challenges inherent in the training delivery model which have been highlighted by AMC since 2017. This means most conditions are not yet able to be met as there is not yet evidence available for all 13 programs. The College has committed to reviewing this governance support/model.

A stakeholder submission from a specialty society recommended that *“RACS explore options for providing more effective conduits between the STBs and RACS/CSET. One option for achieving this could be the appointment of a senior College staff member who is allocated responsibility to attend at least one (1) STB meeting annually, for each of the 13 STBs, as well as keeping abreast of major agenda items for the STBs. This could help ensure that key decisions such as changes to program or Selection requirements are better understood and reported appropriately to CSET, and to the AMC when required.”*

##### Requests for additional information from the AMC response to the 2022 monitoring submission:

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

The response shows the College is taking action to standardise all selection regulations to ensure consistent application and clearer processes. The College report implementation by five of the thirteen STC/Bs last year, with several others advising this would be undertaken in 2023 or their existing regulations would be modified to incorporate most of the standardised clauses. An annual

review of all selection regulations is undertaken to ensure clarity.  
 The College is asked to continue to report on this in monitoring submissions to the AMC.

**2 Activity against conditions**

Condition 1		To be met by: <b>2022</b>		
<p>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)</p>				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
AMC commentary				
<p>Some evidence was provided of greater shared accountability, with signals of greater intent.</p> <p>There has been a realignment and staffing changes in the Education Partnerships portfolio, with it being moved into an Education Development and Delivery portfolio which includes responsibility for the RACS/Societies collaboration model.</p> <p>RACS reports challenges in the devolved training model and has committed to reviewing this governance/support model to identify and address inefficiencies and duplication of effort. (see also response under 1 above.</p> <p>The RACSTA submission notes <i>“The interplay between specialty training committees of the College, and the governance structure of the College itself is not always understood. Communication between those committees and the College is not visible to the Trainee membership, resulting in some Trainees feeling they are left in the dark as to why decisions which affect their training are made.”</i></p> <p>As this condition is so fundamental to RACS accreditation, continued monitoring on how the shared accountability between RACS and the societies is working is required, with provision of evidence of how each of the 13 training programs is progressing towards meeting AMC standards and conditions.</p>				

Condition 2		To be met by: <b>2023</b>		
<p>Provide evidence of effective implementation, monitoring and evaluation of the:</p> <ul style="list-style-type: none"> <li>i. Reconciliation Action Plan</li> <li>ii. Building Respect, Improving Patient Safety (BRIPS) Action Plan</li> <li>iii. Diversity and Inclusion Plan</li> <li>iv. Rural Health Equity Strategic Action Plan (Standard 1.6 and 1.7)</li> </ul>				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
AMC commentary				
<p>It is commendable that the College is continuing with such an extensive program of implementation, monitoring, evaluating and refining these flagship strategies based on feedback and evolving contexts.</p> <p>The Diversity and Inclusion plan is now within the Building Respect Improving Patient Safety</p>				

Initiative, and there is more emphasis on effecting system-wide approaches. There is a Flexible Approach to Training in Expanded Settings (FATES) Initiative within the rural health strategic action plan.

A target of 50% women trainees by 2027 (RACS centenary) has been proposed by the Women in Surgery Committee.

The College's excellent work is recognised by the RACSTA in their submission, but notes the need for more widespread use of multi-year, multi-region employment contracts and better flexible training options, as these remain barriers.

It is acknowledged that the broader culture changes being guided by these documents will take many years to come to fruition. It is noted that DBSH continues to feature significantly in the MTS survey responses, at a rate similar to previous years. Concerning is that most alleged perpetrators are senior staff in the team or supervisors.

It is noted in a stakeholder submission that it is, recommended, as a priority, that RACS continue to develop an updated organisational Reconciliation Action Plan (RAP) to drive the changes that are still needed, including in trainee recruitment, cultural safety and addressing institutional racism.

Condition 16 is related to Condition 2 and both require multiple sources of evidence including data, surveys, and a range of interviews and site visits, to satisfy the conditions.

### **3 Statistics and annual updates**

#### **AMC commentary – statistics and annual updates against Standard 1**

The high number of requests for reconsideration relating to selection is acceptable, particularly noting that nearly a third (11) resulted in a variation. Other reconsiderations are reported to be very low.

There is no cost for a reconsideration but a considerable cost for an appeal (\$9600), but this does not cover costs.

It is reported that Cultural Competency Training has been provided to the chairperson of all STC/Bs via the Committee of Surgical Education and Training (CSET).

RACS Aboriginal and Torres Strait Islander Cultural Safety course Module 1 is offered to new RACS staff but is not compulsory.

No comment has been made about cultural training for AoNZ staff.

There are major changes to governance which are in transition.

#### **Summary of College performance against Standard 1**

This Standard remains Substantially Met.

The structural issue of the devolved education model continues to create challenges in being able to show how all programs meet the remaining conditions, and AMC and MCNZ standards.

The College is making efforts to address and mitigate the financial impacts and these need close monitoring to ensure minimal impacts on achievement of strategic plans or training.

## 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 Significant developments underway or planned that relate to the accreditation standards

AMC commentary – significant developments against Standard 2
<p>Commendably detailed commentary was provided.</p> <p>The College’s educational purpose and priorities, including “serving all communities equitably” are embedded in its strategic plans and business plans. These were provided as attachments.</p> <p>Focus for the next five years will be on:</p> <ul style="list-style-type: none"> <li>• Ongoing review and continuous improvement</li> <li>• Future courses in new technology – including training in robotic surgery</li> <li>• Increasing diversity in training.</li> </ul> <p>Noted to be an issue is that while program and graduate outcomes are reportedly defined for each of the Specialty Training Programs, the link to the RACS outcomes needs to be clearer and more visible.</p>

### 2 Activity against conditions

Condition 3		To be met by: <b>2023</b>		
Broaden consultation with consumer, community, surgical and non-surgical medical, nursing and allied health stakeholders about the goals and objectives of surgical training, including a broad approach to external representation across the College. (Standard 2.1)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
AMC commentary				
<p>This condition relates to broad consultation on the goals and objectives of surgical training.</p> <p>As mentioned in the 2022 submission, and confirmed in the document itself, the PCS curriculum was developed by College-related bodies and experts, and did not appear to involve outside stakeholders.</p> <p>Examples were given:</p> <ol style="list-style-type: none"> <li>1. A stakeholder matrix developed for the M and E framework to which the framework will be sent for feedback which contains a wider range of non-surgical stakeholders.</li> <li>2. Development of standards for Hospital Training Process (HTP) accreditation.</li> </ol> <p>While these are commendable engagements, the College might consider whether sending a document out for review/ feedback is sufficient, or are other forms of consultation needed in some settings.</p>				

Condition 4	To be met by: <b>2022</b>
Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available, reflecting community needs and mapped to the ten RACS competencies. (Standard 2.2 and 2.3)	

	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	

**AMC commentary**

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

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

In this document it states that “safe, high standard surgical practice necessitates Fellows of RACS to be competent across all ten RACS competencies”.

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

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

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

Also of note:

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

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

**Summary of College performance against Standard 2**

This Standard remains Substantially Met.

There is slow progress, but progress nonetheless, especially with the publication of the PCS as an agreed high-level framework.

The structural issues of the devolved education model continue to affect the provision of evidence of linking of outcomes of specialty programs with those of RACS; particularly whether or not mandatory outcomes such as cultural safety and cultural competence appear in every program.

The RACSTA submission notes *‘Trainees feel proud that RACS and its specialty training committees deliver extremely well-trained surgeons that provide safe, competent and comprehensive care to their communities.’*

No stakeholders raised major concern with the outcomes of surgical training.

### 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 Significant developments underway or planned that relate to the accreditation standards

AMC commentary – significant developments against Standard 3
<p>Again, there is commendable level of detail in the commentary, all of which seems appropriate.</p> <p>Not all specialties will use the College Trainee Management Platform (TMP), this will add complexities in reporting and analysis. More details on this issue should be provided in future submissions.</p> <p>As mentioned earlier, the mapping is heterogenous, so ways need to be found to make it easier to show how the curricula meet RACS outcomes and AMC standards.</p>

#### 2 Activity against conditions

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

Condition 6		To be met by: <b>2023</b>		
As it applies to the specialty training program, expand the curricula to ensure trainees contribute to the effectiveness and efficiency of the healthcare system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of settings within the Australian and/or New Zealand health systems. (Standard 3.2.6)				
	Unsatisfactory	Not progressing	Progressing	Satisfied

Finding			X	
AMC commentary				
<p>Under Health Advocacy in the RACS PCS there is an appropriate behavioural marker, as well as associated Stage 1 and 2, and Stage 3 Graduate Outcomes. The marker is:</p> <p>Demonstrates a commitment to the sustainability of the healthcare system. Gives due consideration to the financial and environmental effects relating to healthcare sustainability. Does not undertake investigations or procedures that are shown to have minimal or marginal improvement possibilities for patients.</p> <p>To satisfy this condition evidence of how each program is reflecting this material in their outcomes and curricula elements is required.</p>				

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

Condition 8		To be met by: <b>2023</b>		
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)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
AMC commentary				
<p>Cultural competence and cultural safety is a separate competency in the RACS PCS. This is described as:</p> <p>Demonstrates a willingness to embrace diversity among all patients, families, carers and the healthcare team and respects the values, beliefs and traditions of individual cultural backgrounds which are different to their own. Promotes self-reflection, acknowledges their own biases, prejudices and stereotypes and works to mitigate their effects. Promotes a safe and inclusive healthcare environment and works to eliminate health inequities.</p> <p>There are three behavioural markers with associated Stage 1 and 2 Learning Outcomes and Stage 3 Graduate Outcomes.</p> <p>The RACSTA submission states that <i>“the introduction of Cultural Competence and Safety as a 10th competency has been a positive step in driving education in this oft-underdeveloped domain. RACS has made steps to develop online modules which will allow Trainees to satisfy this competence and direct further learning by individual Trainees. Two modules are currently available, with a further two in development. The roll-out of these modules to all Trainees is an ongoing process and RACSTA is supportive of this process.”</i></p> <p>The curricular material provided shows how some programs are incorporating this competency:</p> <ul style="list-style-type: none"> <li>• USANZ: map has a cultural competence / safety tab and lists associated competencies. The</li> </ul>				

teaching and learning blueprint indicates cultural competence and safety are covered in tutorials and online modules, clinical rotations and formative feedback tools. Assessment blueprint includes cultural safety and competence in the EPAs on prostate cancer and stone disease, and cultural safety is included in the neurogenic bladder EPA.

- AOA: map has a cultural competence / safety tab and lists competencies. No specific related learning or assessment activities listed as yet.
- PRS: cultural competence and safety are included in the public list of competencies. In the curriculum map cultural safety appears under health advocacy, and is part of EPA1, EPA4 and EPA6.

RACS has developed several eLearning modules for use in Australia and Aotearoa (NZ). It will be important to see how knowledge gained is put into practice and assessed by the programs.

Module completion data give but no denominator to determine percentage.

To satisfy the condition evidence that outcomes and curricular activities are embedded as core in each program is required. A clarification of the responsibility for educating trainees in Cultural competence and cultural safety and assuring achievement would be helpful.

**Condition 9** **To be met by: 2023**

In conjunction with the Specialty Training Boards, develop a standard definition across all training programs of 'competency-based training' and how 'time in training' and number of procedures required complement specific observations of satisfactory performance in determining 'competency'. (Standard 3.4.2)

Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	

**AMC commentary**

This condition originated in 2017 and reflects RACS's intent that training be 'competency-based' yet there did not seem to be a shared view of the implications of this pedagogy nor reflection in program documents. A 2016 review had shown that workplace-based assessment in SET was not being used appropriately, with the relationship between work and end-of-term assessment poorly understood. Finally, a particular concern of the accreditation team in 2017 was feedback that competent trainees could be held back from progressing for minor time- or number of procedure-based breaches.

Considerable work has been done by RACS and the Specialty Training Boards to develop an extensive and informative report which comes up with three evidence- and experience- based recommendations for the definition, which are principle-based. A set of principles is identified in Figure 4 of the submission.

These are currently under consideration and the result will be of great interest.

Given prior concern, the College could consider whether mitigation of unnecessary delay in training is encapsulated adequately in the principles and recommendations.

**Summary of College performance against Standard 3**

This Standard remains Substantially Met.

Overall, there seems to be progress in satisfying the conditions against this standard. Not enough evidence was provided to determine if progress has been made against Condition 7 and therefore was found to be 'not progressing'.

## Standard 4: Teaching and learning methods

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

### 1 Significant developments underway or planned that relate to the accreditation standards

AMC commentary – significant developments against Standard 4

The response shows commendable breadth and depth of educational expertise in the College, and a proactive approach to addressing impacts of technology in education and training.

Also commendable is the new Supervisor Support Hub is via the RACS website [Supervisor Support Hub | RACS \(surgeons.org\)](https://www.racs.org.au/supervisor-support).

Other plans look appropriate, but noting the possible impact of the changes as a result of the financial situation.

Requests for additional information from the AMC response to the 2022 monitoring submission:

*Please comment on the issues with robot-assisted surgery (RAS) including more details on estimated numbers and specialties of surgeons performing RAS, and how it is intended to manage the maintenance of their professional standards.*

The College provided a very detailed reply which seemed appropriate.

Use of RAS is growing exponentially across several specialties, with the most surgeries in Urology and General Surgery. The table in the submission P.37 states 'surgeons' and the total in 2022 being 19,989, but this most likely refers to procedures. Orthopaedic surgeons use navigation systems.

Incorporation of RAS into SET is being considered by Council, but this would be via simulation training.

The standards for surgeons are maintained via RACS CPD Home, but there are no plans to add specific CPD requirements. Instead, individuals would seek their own CPD activities.

RACS is recommending a three step credentialing framework and for this to be overseen by a RAS governance committee at each institution.

1. Proctor supervised robotic surgeon
2. Provisionally accredited robotic surgeon
3. Fully accredited robotic surgeon

An update on implementation would be helpful in future annual reports.

### 2 Activity against conditions

Condition 10

To be met by: **2023**

For all specialty training programs develop curriculum maps to show the alignment of learning activities and compulsory requirements with the outcomes at each stage of training and with the graduate outcomes. This could be undertaken in conjunction with the curricular reviews that are currently planned or underway. (Standard 4.1.1)

Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
<b>AMC commentary</b>				
<p>Similar to the comments earlier (Standard 3), the AOA Federal Training Committee, the Board of Urology, the Australian Board of Plastic &amp; Reconstructive Surgery, the Australian Board in General Surgery and the Board Of Otolaryngology Head And Neck Surgery have completed their mapping. Mapping is underway for the remaining STC/Bs.</p> <p>It is notable that the New Zealand Board of Orthopaedic Surgery, the Board of Cardiothoracic Surgery, the Board of Vascular Surgery and the Committee of Paediatric Surgery have confirmed they will implement the PSC. Other STC/Bs are mapping their curricula to the RACS PSC.</p> <p>To close this condition needs a satisfactory map for each of the 13 programs.</p>				

### 3 Statistics and annual updates

AMC commentary – statistics and annual updates against Standard 4
<p>A clear table was provided for 8 specialties.</p> <p>It is noted that Neurosurgery regulations were changed in 2023 from minimum case numbers broken down by training level, to totals overall during training with milestones at each training level. The overall total required during training is unchanged. This provides increased flexibility for trainees so that excess cases from one training level can be carried over and applied in the next training level milestone (rather than only being applicable to that level).</p> <p>Orthopaedics and PRS look to have no minimum numbers, but a satisfactory assessment of performance on specified procedures or in EPAs respectively.</p> <p>Impacts are noted to be minimal.</p>

Summary of College performance against Standard 4
<p>This Standard remains Substantially Met.</p> <p>The College is making progress against this standard.</p>

### Standard 5: Assessment of learning

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

#### 1 Significant developments underway or planned that relate to the accreditation standards

AMC commentary – significant developments against Standard 5

Developments to improve assessment were reported. There are no major changes to exam formats planned, except for an evidence-based decision to uncouple the written components from the viva components of the Fellowship exam, as only 1.9% of those who failed both written components passed the exam overall.

There is a particular focus in the next year on implementation of the RACS Guide to Assessing Professional Skills and confirmation of the RACS definition of Competency Based Education (see Condition 9).

## 2 Activity against conditions

Nil remain.

## 3 Statistics and annual updates

### AMC commentary – statistics and annual updates against Standard 5

From the summative data provided it is noted that pass rates are over 70% for first attempts at the four main RACS examinations.

Indigenous trainee pass rates are difficult to interpret owing to small numbers but appear consistent with the cohort. 21/23 IMGs (52%) passed the Fellowship exam on first attempt which may be significantly lower.

There are no contingency plans for examinations at this stage.

### Summary of College performance against Standard 5

This Standard remains Met.

## Standard 6: Monitoring and evaluation

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

### 1 Significant developments underway or planned that relate to the accreditation standards

#### AMC commentary – significant developments against Standard 6

Significant developments are noted in the conditions against this standard.

### 2 Activity against conditions

Condition 11

To be met by: **2023**

Develop an overarching framework for monitoring and evaluation, which includes all training and educational processes as well as program and graduate outcomes. (Standard 6.1, 6.2 and 6.3)

Unsatisfactory

Not progressing

Progressing

Satisfied

Finding			X	
AMC commentary				
The College continues with the large and complex task of development of a Monitoring and Evaluation framework. The College has noted it has now approved the Monitoring and Evaluation framework as of 22 September 2023.				

Condition 12				To be met by: <b>2022</b>
Establish methods to seek confidential feedback from individual supervisors of training, across the surgical specialties, to contribute to the monitoring and development of the training program. (Standard 6.1.2)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
AMC commentary				
This is an element of the Monitoring and Evaluation framework. Further details are needed as what feedback comes back to the program and what to RACS, and how it is used.				

Condition 13				To be met by: <b>2022</b>
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)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
AMC commentary				
At the attachment level, trainees report they “continue to be concerned about recrimination if they provide negative feedback or criticise the specialty training committees or the College itself. Anonymous reporting structures are in place, but in smaller specialties, the complainant can often be easily identified, simply by naming a time and training post location”.				
There is more trainee engagement in the RACSTA survey which provides some high-level feedback on overall training experience, but which is not specific enough to meet this condition.				
A pilot is underway for a trainee survey via the TMP. This looks promising, but is yet to be fully and safely implemented, which is what is needed to meet this condition.				

Condition 14				To be met by: <b>2022</b>
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)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
AMC commentary				
This is an element of the M and E framework. Further details are needed.				

Condition 15		To be met by: <b>2023</b>		
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	
AMC commentary				
This is an element of the M and E framework. The stakeholder matrix identifies key external stakeholders to be informed of findings and associated actions.				

### 3 Statistics and annual updates

AMC commentary – statistics and annual updates against Standard 6
<p>Nothing of concern comes from the small and varied sample provided.</p> <p>The MTS results apply only to Australian trainees. NZ trainees are surveyed by RACSTA.</p> <p>The College has focussed on DBSH and culture which continue to feature significantly in the survey responses, at a rate similar to previous years, and mainly by senior staff in the team (I checked survey data filtered by RACS).</p> <p>The major training and examination committees in the College have looked at the data, as has Council. As yet no specific new actions seem to have been taken, except to publish a resource on “Recognising and responding to racism in the workplace”.</p> <p>The AMC needs to monitor the RACS-specific MTS results as it is another line of evidence for the effectiveness of the RACS strategies in this area.</p>

<p><b>Summary of College performance against Standard 6</b></p> <p>This Standard remains Substantially Met.</p> <p>Satisfying conditions against this standard relies on a successful implementation of the Monitoring and Evaluation framework.</p>
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### 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 Significant developments underway or planned that relate to the accreditation standards

AMC commentary – significant developments against Standard 7
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Commendably, there is evidence of significantly increased trainee engagement with RACS. RACS is looking to introduce voting rights for trainees. The increase in focus on trainee wellbeing that came in during COVID continues. There is a new Wellbeing Action Plan and external support program.

A major concern of RACSTA submission relates to the impact of the increased fees. RACS has noted that it recognises the risks this may have on overall recruitment but not that it might impact differentially on some already underrepresented groups. There is no report on the impact on those already in training.

RACS also recognises that refining its structure and reducing staffing related costs may impact on some initiatives. Ongoing reporting on these impacts is required.

Work continues to harmonise selection processes, recognise prior learning and use validated tools. The College partnered with Monash to develop and introduce a tailored SJT mapped to RACS competencies. This was used for selection into two programs in 2023 and another is planned for 2024.

There are several other minor changes to selection policies and processes.

A stakeholder has suggested in its submission that the training program supports family friendly training, including provision of maternity and paternity leave, and additional support for trainees returning to training after periods of extended leave.

Requests for additional information from the AMC response to the 2022 monitoring submission:

*Please comment on how the work the College is doing on unconscious bias in selection will impact the policy that restricts the number of selection attempts.*

RACS has reviewed the various limits to selection attempts (attachment 7.1). An analysis of exam performance by selection attempts showed that a maximum of 3 could be justified, which was concordant with international literature.

An analysis compared results for male and female candidates separately and found no statistically significant differences between genders across the exams, suggesting that limiting the number of attempts for selection is unlikely to introduce gender bias into Trainee performance.

There is a 'managing bias' working party due to report in late 2023. An update might be requested for the next annual report.

## 2 Activity against conditions

Condition 16		To be met by: <b>2022</b>		
Promote, monitor and evaluate the Diversity and Inclusion Plan through the College and Specialty Training Boards to ensure there are no structural impediments to a diversity of applicants applying for, and selected into all specialty training programs. (Standard 7.1 and 6.1 and 6.2)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
AMC commentary				
Commendably, the College's 2023 response reflects renewed commitment to make trainee				

cohorts and College bodies even more diverse, and to monitor progress. The College is aware of the need to sustain this during the governance review.

To meet Condition 2 and Condition 16 will require multiple sources of evidence including data, surveys, and a range of interviews and site visits.

Condition 17		To be met by: <b>2022</b>		
Increase transparency in setting and reviewing fees for training, assessments and training courses by the College and all specialty training boards, while also seeking to contain the costs of training for trainees and specialist international medical graduates. (Standard 7.3.2 and 10.4.1)				
	Unsatisfactory	Not progressing	Progressing	Satisfied
Finding			X	
AMC commentary				
<p>This is an ongoing issue which is likely exacerbated by RACS's financial situation. In the RACSTA survey, trainees expressed concern re: the rising fees for training and courses. Societies mentioned need for more transparency in how fees are set, costs are allocated, and revenues associated with activities; as well as reducing unnecessary duplication of activity.</p> <p>The material provided did not show how the fees and course costs are determined but mentioned the principle of cost recovery.</p> <p>For example, the website indicates:</p> <p><i>Not all training related fees will need to increase. Only training activities that are not recovering costs will incur fee increases above CPI. The fee increase will be 25% above current amounts. The final percentage figure has yet to be confirmed. We will add a final figure to this page as soon as possible. RACS Fellows have also been notified of an increase in subscription fees in the order of 25% which will minimise a disproportionate rise in Fees for Trainees.</i></p> <p>RACS reports it will communicate the outcomes of a fees review to all Trainees and prospective Trainees as a matter of transparency, with a summary of the breakdown contributing to the costs.</p> <p>Progress is being made, but the financial situation and fees increases are confounding progress towards meeting this condition.</p>				

### 3 Statistics and annual updates

AMC commentary – statistics and annual updates against Standard 7
<p>It is concerning that despite intentions and strategies, no Aboriginal and/or Torres Strait Islander, or Pasifika trainees entered a program in 2023. Only one Māori trainee entered in Aotearoa NZ.</p> <p>Numbers of trainees exiting were not unduly high and none were Indigenous or Pasifika.</p> <p>The proportions of women in training programs ranged from orthopaedics (18.6%) to paediatric surgery 57.7%, with a mean of 32.9%. Most programs remain below the goal of 40% set in 2017 and well below the 50% target set by the Women In Surgery group.</p>

#### Summary of College performance against Standard 7

This Standard remains Substantially Met.

There is a concerning persisting lack of trainees who identify as Indigenous with no new strategies

noted by the College.

Other than this issue, progress against this standard is being made, but the full impacts of the fees and cost reductions on trainees and RACS's mission need to be closely monitored.

## Standard 8: Implementing the training program – delivery of educational resources

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

### 1 Significant developments underway or planned that relate to the accreditation standards

#### AMC commentary – significant developments against Standard 8

The large RACS Hospital Training Post accreditation project is a priority but continues to be challenging and may be further confounded by the Dept of Health 'How Accreditation Practices Impact Building a Non-General Practice Specialist Medical Workforce' report.

The proposed Hospital Training Post Accreditation Standards (appx 8.4) will need to be agreed among RACS and the Specialty societies.

More details are needed in subsequent submissions to the AMC.

There is now a Supervisor Consensus Statement detailing requirements to support supervisors, and a supervisor self assessment form has been piloted.

Stakeholders have made several comments in their submissions for this assessment which suggest RACS could be doing more to foster workforce development:

#### **Communication / numbers of trainees:**

One jurisdiction sought enhanced communication between RACS and the department of health to ensure that any changes to training program/accreditation requirements consider impacts on the medical workforce.

Other stakeholders report a good working relationship, but the example was given of the Australian Board in General Surgery (ABGS) deciding to limit new general surgical training offers by 25% nationally during 2023 and 2024, with no consultation. A lack of consultation was also noted before withdrawing all general surgery trainees from a training site in 2023.

Feedback received also indicates that regional hospitals have difficulties obtaining training positions. Boards of training do not send trainees to regional areas if there are insufficient numbers of trainees to go around.

The inadequacy of training numbers in key specialties where there are significant regional shortages (e.g., urology, otolaryngology, plastic and reconstructive surgery) was mentioned and concern expressed that the number of specialist trainees has not been adjusted recently to adjust for population growth.

#### **RACS Role in upskilling GPs and rural generalists:**

Some GPs are undertaking surgical procedures and ongoing continuing professional development and support especially for GPs in rural and remote areas would be welcome.

It was suggested that RACS needs to *'take a full-hearted approach in supporting rural*

*generalists (RGs) wanting to undertake surgical advanced skills training, as they are a great solution in providing surgical procedures in rural and remote areas, where metropolitan surgeons often do not want to go.'*

## 2 Activity against conditions

Condition 18		To be met by: <b>2022</b>		
Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standard 8.1.3, 8.1.5 and 8.2.2)				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
AMC commentary				
<p>The College is gradually aligning educational activities including CPD towards the Cultural Competency and Cultural Safety competency in the PCS.</p> <p>RACS's plan to identify appropriate resources to mandate for training, as well as to mandate 3 hours annually of CPD seem appropriate.</p> <p>This needs to be reflected across all specialties including AOA and NZOA who run their own CPD.</p> <p>Once training is mandated, this condition can be satisfied.</p>				

Condition 19		To be met by: <b>2023</b>		
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	
AMC commentary				
<p>The 2022 review noted that standards were now available and that to satisfy this condition, a process for reviewing individual supervisor performance across all specialty training programs is required.</p> <p>A supervisor self-assessment survey has been piloted, as has a TMP based trainee feedback pilot. The supervisor survey is designed to assist self-reflection on role as a RACS Supervisor.</p> <p>There was not enough evidence provided to see the extent of the implementation across all programs and the process by which the data is synthesised and acted upon.</p>				

## 3 Statistics and annual updates

AMC commentary – statistics and annual updates against Standard 8
<p>There was a continued busy program of site (354) and post (409) accreditations in 2022. A very small number (%) are at risk/ lost accreditation.</p> <p>The College reports it has revised site/ post accreditation standards to include Cultural Safety. This appears under Standard 5 in the RACS standards (appx 8.4), but not yet adopted by the societies.</p> <p>The Accreditation Advisory Panel (AAP) will include representation from the RACS Indigenous</p>

Health Committee.

### Summary of College performance against Standard 8

This Standard remains Substantially Met.

Several initiatives aligned with the College strategy and with AMC and MCNZ standards continue, but are not complete.

## 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 Significant developments underway or planned that relate to the accreditation standards

#### AMC commentary – significant developments against Standard 9

Comments on delays were noted in several stakeholder submissions. RACS reports there was a backlog, however, that time has gone down from 12 to 5 months which is presumably an average, and the range was not provided.

There remains a focus on refining internal processes, along with an introduction of a new application portal.

In the submission from one jurisdictional stakeholder it was noted that *“RACS currently does not engage with the department on assessment of specialist international medical graduates (SIMGs). The department would like greater access to data and information on SIMGs. This would ensure greater transparency about its training requirements for SIMGs and its assessment processes, which would assist workforce planning including SIMG recruitment.”*

#### Requests for additional information from the AMC response to the 2022 monitoring submission:

- *Please provide the outcomes of the research study comparing performance of SIMGs with locally trained Fellows at completion of the SET.*
- *The College is asked to comment on the large number of SIMGs not graduating and the reasons for this.*

The research project has not been progressed, for a number of reasons.

The submission notes that “RACS has undertaken an analysis of Fellowship exam data and SIMG candidate progress. The reason that SIMGs are not graduating from surgical training is linked to candidates failing the FEX before the expiry date. Examination data from 2022 shows that, of a total of 61 candidates sitting the Fellowship exam, 27 passed while 34 failed. This equates to an overall pass rate of 44%, significantly lower than the 71.8% pass rate for non-SIMG candidates sitting in 2022 ( $p < 0.001$ ). RACS continues to review the EVOPP program and the role of the

Fellowship exam in assessing SIMGs”.

This suggests an ongoing significant systemic issue with potentially many contributing factors (e.g. exam material, candidate, assessors etc.) and emphasises the urgent need for better ways to assess SIMGs.

## 2 Activity against conditions

Condition 20		To be met by: <b>2023</b>		
Develop and implement alternative external assessment processes such as workplace-based assessments to replace the Fellowship Examination for selected specialist international medical graduates. (Standard 10.2.1)				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
AMC commentary				
There is continued development of EVOPP as an alternative to the FEx for selected IMGs, but this is not yet fully implemented, but seems urgent. More information is required to be able to close this condition.				

## 3 Statistics and annual updates

AMC commentary – statistics and annual updates against Standard 9
The College is to provide data on the following: In Australia, 60 SIMGs were assessed, of whom only 8 were substantially comparable. The process appears completed for 24/60 No information was provided for Aotearoa NZ – this information is needed in the next submission.

### Summary of College performance against Standard 9

This Standard remains Substantially Met.

There are incremental improvements. There seems a need for continued emphasis on the improving the time to initial assessment of SIMGs, and the validity of measures to judge whether or not at Fellowship level.

## Section C – Report on Quality Improvement Recommendations.

Quality Improvement Recommendation	AMC Comment
<b>Standard 1: The context of training and education</b>	
Nil remain.	
<b>Standard 2: The outcomes of specialist training and education</b>	
AA Benchmark the graduate outcomes of each of the surgical training programs internationally. (Standard 2.2 and 2.3)	Response is noted. This recommendation is closed.
BB Improve the uniformity of presentation of training program requirements and graduate outcomes for each of the surgical specialties (particularly on the website), taking into account feedback from trainees, supervisors and key stakeholder groups. (Standard 2.2 and 2.3)	Response is noted. This recommendation is closed.
<b>Standard 3: The specialist medical training and education framework</b>	
CC Develop explicit criteria to consider whether training periods of less than the standard six months can be approved, and ensure that prior learning, time and competencies acquired in non-accredited training are fairly evaluated as to whether they may count towards training. (Standard 3.3 and 3.4.2)	Response seems appropriate and is covered under Competency based ME. This recommendation is closed.
<b>Standard 4: Teaching and learning approach and methods</b>	
DD Consider mechanisms to support better access to training identified as lacking in parts of Australia and New Zealand (Standard 4.2.1)	The response under Standard 1 is noted, however, appears this appears to be an ongoing issue – eg rural skills, gastroscopy, non Fellow training.
<b>Standard 5: Assessment of learning</b>	
EE For all surgical specialties, adopt behaviour-related reporting (i.e., descriptive of the key features) rather than simple scoring for all work-based assessments. (Standard 5.2.3)	Response is noted. This recommendation is closed.
<b>Standard 6: Monitoring and evaluation</b>	
Nil remain.	
<b>Standard 7: Issues relating to trainees</b>	
Nil remain.	
<b>Standard 8: Implementing the program – delivery of education and accreditation of training sites</b>	
Nil remain.	
<b>Standard 9: Assessment of specialist international medical graduates</b>	
FF The College and specialty training boards are strongly encouraged to consider: <ul style="list-style-type: none"> <li>i. Ways to improve timelines and transparency in communicating assessment decisions to SIMGs.</li> </ul>	Please see comments against Standard 9, SIMG assessment is an ongoing focus for the College.

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)	
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