

Royal Australasian College of Surgeons FATES 1 (Rural Accreditation) Evaluation Report

Tony Barnett & Kehinde Obamiro, April 2026

Introduction

For health care professionals, gaining experience in rural settings during training increases the likelihood of working in a rural location when they complete their training. Rural hospitals face many barriers securing accreditation for a training post – a requirement to enable surgical trainees to gain experience at a rural location. Enabling surgeons to be trained in rural areas can help improve the distribution of the medical workforce and contribute to meeting community need in under-serviced areas.

The purpose of the Flexible Approach to Training in Expanded Settings (FATES) program is to support specialist medical college projects that address priority areas identified in the National Medical Workforce Strategy and other Government priorities. This includes addressing maldistribution and undersupply issues in regional, rural and remote (RRR) areas, as well as building capacity in the Aboriginal and Torres Strait Islander specialist medical workforce. FATES grants are available from the Commonwealth Government Department of Health and Aged Care and provided as part of the Health Workforce and Rural Access program.

The Royal Australasian College of Surgeons (RACS) was awarded a FATES grant in collaboration with the Royal Australian College of Medical Administrators (RACMA) to undertake *a review of accreditation criteria and processes* for the training of surgeons that included *extensive engagement with internal and external stakeholders*.

Since 2022, when the project commenced, there have been significant changes to the external regulatory environment. For example, in 2023 the National Health Practitioner Ombudsman reviewed specialist medical training site accreditation to achieve greater transparency and accountability. In 2024, the AMC introduced new standards for accreditation of specialist medical programs. These initiatives and other factors did impact project activities and the relevance of some project outputs that were time dependent. However, project work activities undertaken over this period were seen to contribute to this broader change process.

Project Evaluation

A requirement of FATE grants is that project outcomes be evaluated. An evaluation plan for the RACS FATES 1 (Rural Accreditation) project was provided to the Department in December 2024 and a risk management developed. An independent evaluator was engaged to undertake the work. The primary sources of data for the evaluation were: reports of workshops and focus group discussions, notes from project evaluation discussions held with project team members, minutes of meetings related to project administration and governance, and a range of documents pertaining to the RACS FATES 1 project *Final Report*. Interviews with stakeholders about the project will be conducted and reported in association with the RACS FATES 2 project evaluation.

Findings

The project aimed to review the accreditation criteria and processes for the training of surgeons and required the grantee to have an extensive engagement with internal and external stakeholders. For reporting, monitoring and operational reasons, project aims, objectives and outcomes translated into six *performance indicators* and associated outcome measures. An evaluation the achievement against each indicator follows:

Performance Indicator: Identify barriers to rural hospitals in both applying for and meeting surgical hospital training post accreditation standards.

This indicator was assessed on three well written research reports that also provided recommendations for improvement.

A literature review of 64 pages titled *Rural Accreditation – Addressing Barriers to Rural Specialist Training* was produced. With very minor edits, this quality report is of a publishable standard.

The review investigated 2 research questions: What are the unique opportunities rural training posts can provide? and How can barriers impeding Australian rural surgical training-post accreditation be overcome? Systematic searches of MEDLINE and Embase were performed using a search strategy that included terms related to ‘surgery’, ‘accreditation’, ‘rural’, and ‘barriers and incentives’. Studies, including reports sourced from the Grey literature were selected based on reference to the research questions. The search retrieved 91 studies which were then reviewed. The data extracted was subject to thematic analysis. The results were tabulated and described narratively. In addition to identifying barriers and proposing solutions to each, the report also noted that there were unique opportunities for the trainee at a rural posting such as: varied scope of practice, rural practice capability and self-efficacy as well as opportunities for the health system.

The second piece of work was a scoping review that mapped available evidence about the quantity of supervision and training outcomes (*FATES 1 Impact of the quantity of supervisor oversight on specialty training outcomes*). The review located little research on the topic and subsequently reported that: *there was no evidence for the current practice of requiring defined supervisor-to-trainee ratios*. It suggested that commonly, training outcomes were satisfactory though recommended that further research is required to inform aspects of local training and identify areas for improvement.

The third high quality research report was titled: *Rural accreditation – addressing barriers to rural specialist training. Synthesis of Qualitative Data*.

In this study, thirty semi-structured qualitative interviews were conducted with hospital administrators and Fellows of the Royal Australasian College of Surgeons (FRACS) who had experience in regional, rural and remote (RRR) practice across Australia. Each interview focused on specific accreditation standards, the hospital training-post accreditation application process, support provided in the application process for rural hospitals, what this might entail, and the benefit and unique opportunities afforded by rural surgical training.

Interview data highlighted that the opportunities and benefits of rural surgical training include individualised teaching, closer supervision, stronger relationships and teamwork, less competition for cases, more hands-on experience, exposure to a broader scope of cases, and greater experience of acute and emergency surgery. It was also found that trainees have the

opportunity to be more involved in their communities, were able to undertake holistic and patient-centred care and gained confidence to deal with the unknown.

Data from the interviews were combined with that from the literature reviews, rural accreditation workshop reports (workshops were grant activities) and a report generated from a detailed and comprehensive review of hospital training-post accreditation standards and processes. From this synthesis and analysis, the report describes barriers faced by rural hospitals in both applying for and in meeting the requirements for hospital training-post accreditation. These were addressed thoroughly, with the report highlighting a multi-dimensional set of barriers across administrative, structural, and cultural domains. Importantly, as part of the report, solutions are then proposed for each barrier that reflect the findings from the various data sources.

However, the identification and assessment of barriers is primarily descriptive and a comparison of the importance of each was not made. Understanding their relative importance may be useful in prioritizing which barriers to address first.

Performance Indicator: Design an administrative model that provides support and engagement for rural hospitals during the hospital training post accreditation process.

This indicator was assessed on a report that outlines the features of an administrative model including required personnel and systems necessary to overcome barriers to hospital post accreditation. The report (*FATES 1 Rural accreditation Administrative Model – addressing barriers to rural specialist training Administrative model*) presents a conceptual administrative model to support rural hospitals engage in the accreditation process. The model aimed for a streamlined, transparent, and supportive accreditation process that reduced duplication and administrative burden. It details a succinct (dot point) description of four components or ‘Functional Domains’: Centralised accreditation administration; Rural hospital support and engagement; Information management, data and reporting; Governance and assurance. The collation of key features of the model drew on expert opinion and evidence from a number of other project activities including a medical administrators focus group discussion. The conclusion to the report asserts that the model:

provides a robust, principle-based future-ready framework for supporting rural hospitals through training-post accreditation, while avoiding new structures, controlling cost and aligning governance with CSET and the future CSET Accreditation Subcommittee

Components of the model are operationalised through the development of structured accreditation resources (the Hospital Training Post Accreditation Part A Application Form; Hospital Training Post Accreditation Application Form Part B – Surgical Specialty). Support mechanisms such as the RACS Hospital Training Post Accreditation project are also described. These initiatives underly the practical benefit of this work.

While the model demonstrates strong alignment with identified barriers and reflects contemporary principles of co-design and system integration, it remains largely conceptual. There is no evidence within the report of: pilot implementation; operational testing; or identification of measurable outcomes or key indicators for evaluation of the model. These are important considerations to achieving project goals and sustaining any change that may be made to training post accreditation.

Future work (including some current FATES projects) could interrogate, further explain and test the utility of the model.

Performance Indicator: Create a 'supporting evidence' resource to assess performance against hospital training post accreditation standards, within a rural context.

The measures associated with this performance indicator included the identification of *core surgical training post requirements* and to report on *unique rural hospital post training opportunities*, and how these *can meet core hospital training post accreditation standards*.

Compilation of the resource pack for rural hospitals containing 'supporting evidence' to support their training-post accreditation applications proved a little challenging. This, in part, may be attributed to some confusion about some differences in requirements listed as project 'deliverables' in the project grant schedules though were most likely to be related to difficulties encountered as a result of the changes happening around 'accreditation' that were occurring in the external environment over the course of the project.

The requirement to build a '*supporting evidence*' resource (or 'compendium of supporting evidence') included reports describing: the unique [strengths and] training opportunities that rural hospitals can provide; indicators to inform the accreditation standards of Specialty Training Boards inclusive of rural training sites and a set of generic recommendations [to assist] rural training posts meet accreditation standards.

Elements of each of these requirements was evident in the *Final Report*, either as an attachment or embedded in the body of the report. For the purposes of meeting grant deliverables, these three elements of the 'Evidence resource' could be described and identified a little more clearly in the Executive summary of the *Final Report* and also extracted. Then, if still relevant, these resources could be presented in a form that could be shared with and used by stakeholders to the project eg. the Part A and Part B accreditation application forms/supporting evidence resource to assist hospitals in applying for accreditation.

Further steps could include an assessment of the validity and reliability of the resources when used by rural hospitals and the impact they may have on accreditation success rate.

Performance Indicator: Establish foundation for design of a system that distributes training posts based on community need through trainee workforce data.

The measure for this indicator was the establishment of a consortium of stakeholders who held trainee and service registrar workforce data, and to negotiate data sharing protocols.

A range of stakeholders were involved in regular project team meetings, workshops, the development of project activity work plans, project administration and governance. Consortium partners were welcomed to key committee meetings such as the RACS Rural Health Equity Steering Committee (RHESC), consulted when reports were generated and their approval was usually sought before these were submitted to the Department or released for wider distribution.

Whilst the external consortium partner for FATES 1 was the RACMA (and the internal partner the ASERNIP-s), there was clear and detailed evidence from the start of the project that there was engagement of multiple stakeholders to progress the rural surgical training agenda (vide: RHEST meetings). This included RANZCO, RACMA, ANZCA, RACP, both the Northern Territory and Victoria Departments of Health, Flinders Northern Territory Regional Training Hub, the

Australian Society of Plastic Surgeons (ASPS) and General Surgeons Australia (GSA). MOUs were established with other medical colleges over the course of the project and these links strengthened through the FATES 2 project. This suggests a strong ‘buy-in’ to the FATES 1 (accreditation) project from many stakeholder groups as well as RACS Fellows and trainees.

This work laid a solid foundation for the design of a system that distributes training posts based on community need though trainee data sharing protocols were not detailed or evidenced strongly in the *Final Report* or in minutes of meetings provided by the RACS for this evaluation.

Performance Indicator: System mapping of RACS trainee workforce data, and allocation of trainees.

This indicator was measured through the development of a system map of the workforce data that RACS holds, describing how it is collected and how RACS allocates its trainees by specialty.

The RACS FATES 1 *Final Report* includes a display of graphs clearly illustrate the distribution of surgical trainees for each MM location across 2019–2025, compared to the Australian population distribution. With the exception of Orthopaedic Surgery, all surgical specialties are represented. This mapping provides a clear visual and descriptive representation of workforce maldistribution that supports the case for redistributing training posts. Further analysis of the data presented could consider analytical predictive modelling for forecasting and future work planning purposes.

Within this section of the *Final Report*, there is no narrative that discusses the selection of trainees or offers an interpretation the graphs in the context of the FATES program. The *Final Report* does state however, that RACS is collaborating with the Department’s Health Workforce Data Intelligence Unit around workforce data collection and reporting as well as data-sharing protocols. The College has also implemented rural selection initiatives and plans to assess these against ‘rural’ targets that include the geographic distribution of accredited training sites and the geographic distribution of the surgical workforce (including trainees). The current RACS Rural Health Equity Strategic Action Plan describes plans to *select, train, retain* and *collaborate* for rural.

Performance Indicator: The project evaluation identifies achievements and outcomes against the FATES objectives and outcomes

Much of the work undertaken relates to the problem of rural hospital training site accreditation and the potential to locate trainees at these sites as part of the part of their surgical training pathway. The achievements and research focussed outputs from the project described in the *Final Report* provide a solid foundation for ongoing work that will help reduce some of the barriers and effect solutions to help improve the distribution and supply of specialist medical training in rural and remote communities. The work activities undertaken as part the project (and those supported through the STP) also provide insights that may, in the mid to longer term, support and encourage more Aboriginal and Torres Strait Islander specialists to be trained to then provide services to their communities.

Project Governance

The RACS FATES 1 *Final Report* indicates that the project was the responsibility of the RACS Manager Accreditation, Research and Scholarships; the Manager STP and FATES; and the General Manager, Research, Audit and Academic Surgery. Professional oversight and governance were provided by the RACS Rural Health Equity Steering Committee (RHESC). This committee met regularly and discussed FATES projects, noting achievements and reporting requirements, changes in project personnel, administrative and organisational changes as well as disruptions to project activities necessitating requests for extensions to deadlines. The FATES Manager as well as some project team members attended RHESC meetings as observers and responded to questions and comments from members of the Committee.

Whilst there was relative consistency in membership of the RHESC from commencement to completion of the FATES 1 project, membership of the project team often changed. This resulted in some discontinuity and loss of 'corporate knowledge' about the project and caused disruption in communications with stakeholders who, at times, needed to be re-engaged to enable project work to continue.

Data Quality

A large number of documents were reviewed as part of this evaluation. The majority of these were of a very high quality. Most notable, was the research reports generated as part of the project, reports and summaries of workshops and the minutes of meetings.

The RACS FATES 1 Rural Accreditation *Final Report* is a little over 400 pages. In its current form, it can be difficult to digest. Helpfully, the 50+ recommendations listed from the work undertaken appears in the executive summary (though these do include some recommendations from work completed for a FATES 2 grant).

The reach, effectiveness and adoption of the key recommendations arising from the project could be improved by reducing overall length and addressing the structure of the report. For example, there is some excellent material presented in earlier sections of the report that provide a background to and context for the project. Much of this could be summarised and drawn together more effectively to 'set the scene' for the presentation of the findings. Similarly, the research papers produced could be summarised a little more judiciously within the body of the *Final Report*. Locating these papers in full, as Attachments, would preserve their integrity as independent pieces of scholarship. Embedding the learnings or key messages from this research in a more focussed way within the report may emphasise the importance of this work to the project as a whole.

Additional suggestions for improvement of the *Final Report* have been listed in the Supplementary file to this evaluation.

Conclusion

The project successfully completed a *review of accreditation criteria and processes* for the training of surgeons that *engaged a range of internal and external stakeholders*.

The research outputs from the project provide a solid foundation to support ongoing work that, in the longer term, will help improve specialist medical training in regional, rural and remote

communities. Barriers to rural hospitals applying for and meeting surgical hospital training post accreditation standards were clearly identified and ways to address these barriers were proposed. An 'administrative model' and tools were developed to help facilitate rural hospital accreditation for surgical training.

This evaluation was conducted in accord with the approved protocol though project delays meant that not all reports and associated documents were available for review when originally scheduled. The evaluation considered a range of reports and other documents, though a full audit of project documentation was not undertaken. Some data sources may therefore have been omitted from the review process. Out of scope for this evaluation was an assessment of project 'value for money'.

Project Commendations

- Quality and rigour of the research reports, undertaken by a very capable team.
- The practical utility of work associated with designing an administrative model to support rural hospitals during the accreditation process such as the Hospital Training Post Accreditation Application Forms A and B
- Engagement with stakeholders and use of workshops for consultation, the generation of ideas, consensus building and contributing to the socialisation of the benefits of implementing a rural pathway for surgical trainees.

Recommendations for Improvement

- Further work is needed to develop data sharing protocols and arrangements within and across colleges. Such protocols could also include agencies that collect data about health professionals such as Aphra and the ABS.
- A short, high impact RACS FATES 1 Final Report, providing: a brief background to and aims of the project; the methods used, a summary of key findings and subsequent recommendations be produced in a user-friendly format to make project outcomes more accessible to a broader audience.