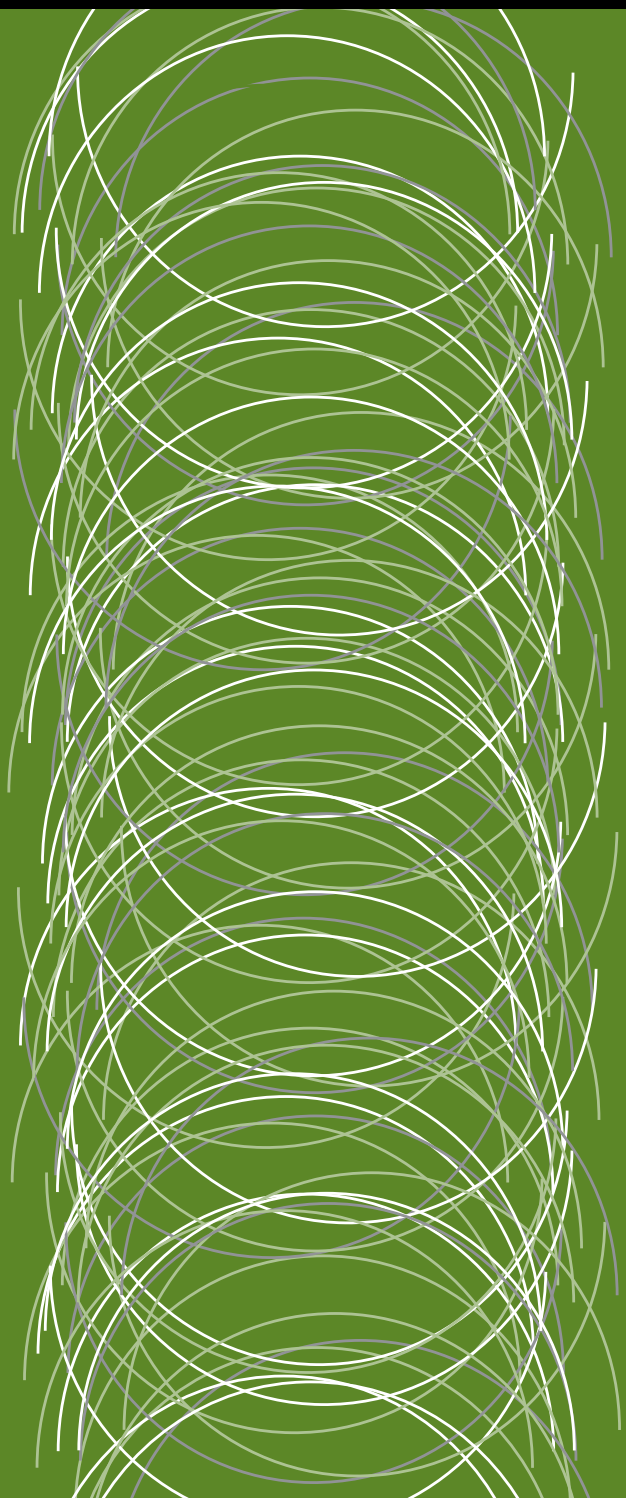
Australian Medical Council Limited

Accreditation Report: The Training and Education Programs of the Royal Australasian College of Surgeons

AMC



Specialist Education Accreditation Committee
November 2021

February 2022
ABN 97 131 796 980

ISBN 978-1-925829-53-2

Australian Medical Council Limited
PO Box 4810
KINGSTON ACT 2604

Email: amc@amc.org.au
Home page: www.amc.org.au
Telephone: 02 6270 9777
Facsimile: 02 6270 9799

Contents

Acknowledgement of Country

The Australian Medical Council (AMC) acknowledges the Aboriginal and Torres Strait Islander Peoples as the original Australians, and the Māori People as the original Peoples of Aotearoa New Zealand.

We acknowledge and pay our respects to the Traditional Custodians of all the lands on which we live, and their ongoing connections to land, water and sky.

We recognise the Elders of these Nations both past and present, and honour the traditional custodians of knowledge for these lands.

Executive Summary: Royal Australasian College of Surgeons

The Australian Medical Council (AMC) document, *Procedures for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council 2019*, describes AMC requirements for accreditation of specialist medical programs and their education providers.

The Royal Australasian College of Surgeons (RACS) was first accredited by the AMC in 2001. In 2002, the AMC granted accreditation to the College and its programs for the maximum period of six years, until July 2008.

In its 2006 monitoring submissions to the AMC, RACS outlined plans for a new Surgical Education and Training (SET) program to be phased in from 2008. The AMC decided SET was a material change to the accredited education and training programs of RACS, and therefore the plans for the SET program required a review by an AMC accreditation team before its introduction. An AMC assessment of the College's plans was completed in July 2007 and the SET program and continuing professional development program was granted accreditation until December 2011, subject to a satisfactory report responding to recommendations in the accreditation report related to implementation activities for the SET program. The assessment of the College's report was to include a follow-up visit by an AMC review team. In 2008, the AMC conducted the follow-up visit and confirmed accreditation to December 2011.

In 2011, the College submitted an accreditation extension submission. The AMC found that the College met the standards, and extended the accreditation of the College for six years until December 2017, taking accreditation to the full period of ten years.

In 2017, an AMC team completed a reaccreditation assessment of the specialist medical programs and continuing professional development programs of the Royal Australasian College of Surgeons, which lead to the award of fellowship of RACS. Based on this assessment, the AMC found that the College's programs substantially met the accreditation standards and granted accreditation with conditions until 31 March 2022. There were 35 conditions set on accreditation that the College was required to satisfy on agreed timelines. In making this decision, AMC Directors agreed to a follow-up accreditation assessment before the end of the accreditation period.

In 2018 and 2019, the College had satisfied 10 conditions in monitoring submissions to the AMC and in 2020, submitted a report on its response to COVID-19 restrictions and the impact on its education and training functions.

In June 2021, an AMC team completed a follow-up assessment of the College's programs, considering the progress against the remaining 25 conditions from the 2017 AMC assessment. Under the AMC accreditation procedures, the 2021 assessment may result in the extension of the accreditation by up to three years from the original accreditation decision until March 2024.

The 9 November 2021 meeting of the AMC Specialist Education Accreditation Committee considered the draft report to make recommendations on accreditation to AMC Directors in accordance with the options described in the AMC accreditation procedures.

This report presents the accreditation decision made by the 9 December 2021 meeting of the AMC Directors and the detailed findings against the accreditation standards.

Decision on accreditation

Under the *Health Practitioner Regulation National Law*, the AMC may grant accreditation if it is reasonably satisfied that a program of study and the education provider meet an approved accreditation standard. It may also grant accreditation if it is reasonably satisfied that the provider and the program of study substantially meet an approved accreditation standard, and the imposition of conditions will ensure the program meets the standard within a reasonable time. Having made a decision, the AMC reports its accreditation decision to the Medical Board of Australia to enable the Board to make a decision on the approval of the program of study for registration purposes.

The College continues to deliver high quality training programs with robust curriculum and assessment processes, producing proficient and skilled surgeons capable of independent practice. Since 2017, the College has made noteworthy developments in improving collaboration with internal and external stakeholders and has committed substantial resources into the alignment of the College's 13 specialty training programs in Australia and New Zealand. Positive changes were observed in College's culture, within its governance structure and similarly reflected amongst College staff, fellows and trainees, and wider stakeholders.

The AMC team reviewed a range of College activities, and noted significant accomplishments and initiatives including:

- A review of the College's internal governance structure to improve communication and collaboration between the College and specialty societies.
- Action Plans developed to enhance diversity and inclusion, and health equity.
- The high completion rate of the Operating with Respect module by fellows and trainees.
- Commissioning of a strategy paper, *Equitable distribution of the surgical workforce,* in response to the National Medical Workforce Strategy.
- The introduction of a tenth RACS competency, Cultural Competence and Cultural Safety, in the revision of the Surgical Competence and Performance Guide.
- Collaboration in the Professional Skills Curriculum Development Project and the development of the Training in Professional Skills (TIPS) course for trainees.
- The implementation of new policy, *Reconsideration, Review and Appeals regulation*, to guide trainees through fair and transparent processes to resolve training disputes.
- The incremental refinement of the selection process, and commitment by the College and speciality training boards to achieving a fair and transparent process.
- A robust and developing CPD program, Surgical Competence and Performance Framework, with high participation rates in both Australia and New Zealand.
- The publicly available policy, *Assessing an IMG's comparability to an Australian and New Zealand Training Surgical Specialist,* clearly defining assessment for comparability.

The AMC team found the staff of the College, fellows and trainees to be extremely engaged in College activities and knowledgeable about various developments. Their resilience and adaptability, amid the challenges of the COVID-19 pandemic, is commendable.

Acknowledging the complexities, the College is strongly encouraged to continue to develop synergies across its nine specialty training boards and 13 specialty training programs. While the

College has made strides in many aspects, substantial work remains in several important areas encompassing:

- Sharing of information to inform alignment across policies, procedures, and program and graduate outcomes of training programs across 13 surgical specialty training programs.
- The maturation and evolution of Building Respect, Improving Patient Safety (BRIPS) and the Diversity and Inclusion Plan.
- Continued commitment to health equity and support for Aboriginal and Torres Strait Islander and Māori communities, including cultural safety and cultural competence training.
- Improved alignment of various aspects of the curriculum and learning activities across 13 surgical specialty training programs.
- Strengthening the monitoring and evaluation framework and coordinating activities with elements of training programs to better support development in the specialty training programs, policies and procedures.
- Continued support for trainees and specialist international medical graduates through fair and transparent selection and assessment processes, support for flexible training options, transparent fee structures, equitable learning and training opportunities, and safe avenues for providing feedback.
- Determining the College's standards and expectations of its supervisors, along with avenues for supervisors to provide feedback.

The College has made important progress in its undertaking to renew and revitalise its culture, structures and training programs. Gradual evolution across the College and its training programs has been observed. The College and specialty societies are encouraged to distinguish their progress with consideration to commitment and collaboration, consultation with both internal and external stakeholders, and appropriate resourcing to support its body of work.

Findings

The AMC's finding is that it is reasonably satisfied that the training, education and the continuing professional development programs of the Royal Australasian College of Surgeons **substantially meet** the accreditation standards.

The AMC Directors resolved:

(i) That the Royal Australasian College of Surgeons' specialist medical programs and continuing professional development programs in the recognised medical specialty of **surgery** be granted accreditation for two years, until 31 March 2024, subject to satisfying AMC monitoring requirements including monitoring submissions and addressing accreditation conditions.

(ii) That this accreditation is subject to the College providing evidence that it has addressed conditions in the specified monitoring submissions as set out in the table below.

Standard	**Condition**	**To be met by**
Standard 1	1 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)	2022

Standard	Condition	To be met by
	2 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 (Standards 1.6 and 1.7)	2023
Standard 2	3 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)	2023
	4 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. (Standards 2.2 and 2.3)	2022
Standard 3	5 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)	2023
	6 As it applies to the specialty training program, expand the curricula to ensure trainees contribute to the effectiveness and efficiency of the healthcare system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of settings within the Australian and/or New Zealand health systems. (Standard 3.2.6)	2023
	7 Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs. (Standards 3.2.3, 3.2.4 and 3.2.6)	2023
	8 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)	2023
	9 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)	2023
Standard 4	10 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)	2023
Standard 5	Nil	-

Standard	Condition	To be met by
Standard 6	11 Develop an overarching framework for monitoring and evaluation, which includes all training and educational processes as well as program and graduate outcomes. (Standards 6.1, 6.2 and 6.3)	2023
	12 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)	2022
	13 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. (Standards 6.1.3 and 8.1.3)	2022
	14 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)	2022
	15 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)	2023
Standard 7	16 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. (Standards 7.1 and 6.1 and 6.2)	2022
	17 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. (Standards 7.3.2 and 10.4.1)	2022
Standard 8	18 Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standards 8.1.3, 8.1.5 and 8.2.2)	2022
	19 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)	2023
Standard 9	Nil	-
Standard 10	20 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)	2023

This accreditation decisions relates to the Colleges specialist medical programs and continuing professional development programs in the specialty of surgery and the fields of specialty practice in cardio-thoracic surgery, general surgery, neurosurgery, orthopaedic surgery, otolaryngology – head and neck surgery, paediatric surgery, plastic surgery, urology and vascular surgery.

Next steps

Subject to satisfying monitoring requirements, including progress towards meeting conditions and submission of annual monitoring submissions, the College may seek extension of accreditation in 2023 through an accreditation extension submission. The AMC will consider this report and, if it decides the College is continuing to satisfy the accreditation standards, the AMC Directors may extend the accreditation by a maximum of four years (to March 2028) taking accreditation to the full period which the AMC may grant between assessments, which is ten years. At the end of this extension, the College and its programs will undergo a reaccreditation assessment by an AMC team.

Overview of findings of the 2021 follow-up assessment

The findings against the ten accreditation standards are summarised below.

Conditions imposed by the AMC so the College meets accreditation standards are listed in the accreditation decision (pages 3 to 5). The team's commendations of areas of strength and recommendations for improvement are listed under each standard in the body of the report (pages 12 to 135).

1. The outcomes of specialist training and education				This set of standards is SUBSTANTIALLY MET
governance	M	*educational resources*	M	
program management	SM	*interaction with health sector*	SM	
reconsideration, review appeals	M	*continuous renewal*	SM	
educational expertise	M			

2. The outcomes of specialist training and education				This set of standards is SUBSTANTIALLY MET
educational purpose	SM	*graduate outcomes*	SM	
program outcomes	SM			

3. The specialist medical training and education framework				This set of standards is SUBSTANTIALLY MET
curriculum framework	M	*continuum of training*	M	
content	SM	*structure of the curriculum*	SM	

4. Teaching and learning (teaching and learning)				This set of standards is SUBSTANTIALLY MET
approach	SM	*methods*	M	

5. Assessment of learning				This set of standards is MET
approach	M	*performance feedback*	M	
methods	M	*quality*	M	

6. Monitoring and evaluation				This set of standards is NOT MET
monitoring	NM	*feedback, reporting and action*	NM	
evaluation	NM			

7. Trainees				This set of standards is SUBSTANTIALLY MET
admission policy and selection	SM	*trainee wellbeing*	M	
trainee participation in provider governance	M	*resolution of training problems and disputes*	M	
communication with trainees	SM			

8. Implementing the program – delivery of educational and accreditation of training sites				This set of standards is SUBSTANTIALLY MET
supervisory and educational roles	NM	*training sites and posts*	SM	

9. Continuing professional development, further training and remediation				This set of standards is MET
continuing professional development	M	*remediation*	M	
further training of individual specialists	M			

10. Assessment of specialist international medical graduates				This set of standards is SUBSTANTIALLY MET
assessment framework	M	*assessment decision*	M	
assessment methods	SM	*communication with applicants*	M	

Introduction: The AMC accreditation process

Responsible accreditation organisation

In Australia, the Health Practitioner Regulation National Law Act 2009 (the National Law) provides authority for the accreditation of programs of study in 15 health professions, including medicine.

Accreditation of specialist medical programs is required before the Board established for the profession, in medicine's case the Medical Board of Australia, can consider whether to approve a program of study for the purposes of specialist registration.

In New Zealand, accreditation of all New Zealand prescribed qualifications is conducted under section 12(4) of the Health Practitioners Competence Assurance Act 2003 (HPCAA).

The Australian Medical Council (AMC) is the accreditation authority for medicine under the National Law. Most of the providers of specialist medical programs, the specialist medical colleges, span both Australia and New Zealand. The AMC accredits programs offered in Australia and New Zealand in collaboration with the Medical Council of New Zealand (MCNZ). The AMC leads joint accreditation assessments of binational training programs and includes New Zealand members, site visits to New Zealand, and consultation with New Zealand stakeholders in these assessments. While the two Councils use the same set of accreditation standards, legislative requirements in New Zealand require the binational colleges to provide additional New Zealand-specific information. The AMC and the MCNZ make individual accreditation decisions, based on their authority for accreditation in their respective country.

Accreditation standards applicable to the accreditation of specialist medical programs

The approved accreditation standards for specialist medical programs are the *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015.*

These accreditation standards are structured according to key elements of the model for curriculum design and development and focus on the specific context and environment in which specialist medical programs are delivered. These standards are followed by two standards relating to processes undertaken by the providers of specialist medical training programs on behalf of the Medical Board of Australia.

The relevant standards are included in each section of this report.

Assessment of the programs of the Royal Australasian College of Surgeons

The AMC first assessed the education, training and continuing professional development programs of the Royal Australasian College of Surgeons (RACS) in 2001. In 2002, the AMC granted accreditation to the College for a period of six years until 2008, with a requirement for satisfactory annual reports to the AMC.

In 2007, the College introduced a new Surgical Education and Training (SET) program. The AMC decided SET was a material change to the accredited education and training program of RACS, and therefore the plans for the SET program required a review by an AMC accreditation team before its introduction. On the basis of this assessment, accreditation was granted by the AMC until December 2011. The accreditation was subject to a follow-up assessment in 2008 which confirmed that the program had been implemented as planned and confirmed the accreditation period.

In 2011, the College submitted an accreditation extension submission to the AMC. In an accreditation extension submission, the AMC seeks evidence that the accredited college continues to meet the accreditation standards and information on plans for the next four to five years. If the AMC considers that the college continues to meet the accreditation standards, it may extend the accreditation. The assessment of the College's accreditation extension submission included a

short visit because of the number of conditions on the College's accreditation. On the basis of the accreditation extension submission review, the AMC found that the College met the accreditation standards, and extended the accreditation until 31 December 2017, taking accreditation to the full period of 10 years.

In June 2017, an AMC team completed a reaccreditation assessment of the College's programs. Appendix One contains a list of the members of the 2017 assessment team. On the basis of this assessment the AMC agreed that the College's programs substantially met the accreditation standards and granted accreditation until 31 March 2022 with 35 conditions. In making their decision, AMC Directors agreed the AMC complete a follow-up assessment before the end of the accreditation period.

In 2020, the AMC began preparations for the follow-up assessment of Royal Australasian College of Surgeon's programs. On the advice of the Specialist Education Accreditation Committee, the AMC Directors appointed Professor Phillippa Poole to chair the 2021 assessment of the College's programs. The AMC and the College commenced discussions concerning the arrangements for the assessment by an AMC team.

The AMC assesses specialist medical education, training, and continuing professional development programs using a standard set of procedures.

Below is a summary of the steps followed in this assessment:

- The AMC asked the College to lodge an accreditation submission encompassing the three areas covered by AMC accreditation standards: the training pathways to achieving fellowship of the Royal Australasian College of Surgeons; College processes to assess the qualifications and experience of overseas-trained specialists; and College processes and programs for continuing professional development.
- The AMC appointed an assessment team (called 'the team' in this report) to complete the assessment after inviting the College to comment on the proposed membership. A list of the members of the 2021 assessment team is provided at Appendix Two.
- The team met on Wednesday 28 and Thursday 29 April 2021 to consider the College's accreditation submission and to plan the assessment.
- The AMC gave feedback to the College on the team's preliminary assessment of the submission, the additional information required, and the plans for visits to accredited training sites and meetings with College committees.
- The AMC surveyed trainees, supervisors of training and specialist international medical graduates of the College.
- The AMC invited other specialist medical colleges, medical schools, health departments, professional bodies, medical trainee groups, and health consumer organisations to comment on the College's programs.
- The team met by videoconference on Tuesday 25 May 2021 to finalise arrangements for the assessment.
- The team conducted virtual meetings with training sites located in the Australian Capital Territory, Northern Territory, South Australia, Tasmania, Western Australia, Queensland, and Victoria in June 2021. Both face-to-face and virtual meetings with training sites were conducted in New South Wales and New Zealand in June 2021.

The assessment concluded with a series of meetings with the College office bearers and committees from Monday 21 to Thursday 24 June 2021. On the final day, the team presented its preliminary findings to College representatives.

Appreciation

The team is grateful to the fellows and staff who prepared the accreditation submission and managed the preparations for the assessment. It acknowledges with thanks the support of fellows and staff in Australia and New Zealand who coordinated and/or hosted the site visits, and the contribution of trainees and fellows who met team members.

The AMC also thanks the organisations that made a submission to the AMC on the College's training programs. These organisations are listed at Appendix Three.

Summaries of the program of meetings and site visits for the 2017 reaccreditation assessment are provided at Appendix Four and for the 2021 follow-up assessment at Appendix Five.

Report on the 2017 and the 2021 AMC assessments

This report contains the findings of both the 2017 and 2021 AMC assessments. Each section of the report begins with the relevant accreditation standards. The findings of the 2021 assessment team are provided as commentaries following the relevant sections of the 2017 accreditation report. It should be noted that the report by the 2021 assessment team addresses progress by the College against conditions and recommendations made in 2017.

In areas where the College has made no substantial change and no recommendations were made, the 2021 assessment team has not conducted a comprehensive assessment.

1 The context of training and education

1.1 Governance

The accreditation standards are as follows:

- The education provider's corporate governance structures are appropriate for the delivery of specialist medical programs, assessment of specialist international medical graduates and continuing professional development programs.
- The education provider has structures and procedures for oversight of training and education functions which are understood by those delivering these functions. The governance structures should encompass the provider's relationships with internal units and external training providers where relevant.
- The education provider's governance structures set out the composition, terms of reference, delegations and reporting relationships of each entity that contributes to governance, and allow all relevant groups to be represented in decision-making.
- The education provider's governance structures give appropriate priority to its educational role relative to other activities, and this role is defined in relation to its corporate governance.
- The education provider collaborates with relevant groups on key issues relating to its purpose, training and education functions, and educational governance.
- The education provider has developed and follows procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision-making.

1.1.1 Governance in 2017

The Royal Australasian College of Surgeons (RACS) was formed in 1927. RACS is a company limited by guarantee under Australian corporations' law. In New Zealand, RACS is registered with the New Zealand Companies Office.

RACS is responsible for the training, assessment, examination, qualification and continuing professional development of surgeons for standards of surgery in Australia and New Zealand. The RACS mission is to be the leading advocate for surgical standards, education and professionalism in Australia and New Zealand.

As outlined in the RACS constitution, the purpose of the College is to:

- *advance education, training and research in the practice of surgery*
- *determine and maintain professional standards for the practice of surgery in Australia and New Zealand*
- *provide an environment promoting fellowship development and support*
- *provide authoritative advice, information and opinion to other professional organisations, to governments and to the public.*

The College has one category of membership which is Fellow. There were 7373 active and retired fellows at the end of 2015, 5972 of whom were resident in Australia, 951 in New Zealand and 450 overseas. The College assesses on average 72 (based on 2012-16 RACS Activities Report) specialist international medical graduates each year. The College awards fellowship in the surgical specialty. The fields of specialty practice are cardio-thoracic surgery; general surgery; neurosurgery; orthopaedic surgery; otolaryngology – head and neck surgery; paediatric surgery; plastic surgery; urology; and vascular surgery. For the field of specialty practice in plastic surgery, trainees complete the SET Plastic and Reconstructive Surgery Program.

*The RACS **Council** is the governing body and the councillors have fiduciary responsibility for the organisation. There are 16 fellows elected from the membership at large; nine elected fellows (one*

from each of the nine specialties); three co-opted members, including two expert community advisors and the RACS Trainees' Association's (RACSTA) representative; and one co-opted representative, being the president of the Australian and New Zealand College of Anaesthetists (ANZCA). The Younger Fellows representative is an invited observer. Chairs of the New Zealand national board and regional committees are invited to attend council meetings on rotation. The full RACS Council meets three times a year.

The activities of the College are described under four portfolios, each with a senior board or committee providing oversight. These are:

1. *the delivery of the education and training program for trainees and assessment of specialist international medical graduates (**Education Board** (responsibility of the Censor-in-Chief))*
2. *the ongoing maintenance of standards and support to fellows throughout their professional careers (**Professional Development and Standards Board** (responsibility of the chair of Professional Development and Standards Board))*
3. *the ongoing nurturing of key relationships, through advocacy (the **Governance and Advocacy Committee** and **Board of Regional Chairs** (responsibility of the Vice-President))*
4. *stewardship of resources (**Resources Committee** and **Risk Management and Audit Committee** (responsibility of the Treasurer)).*

More than 100 committees report to the RACS Council. The terms of reference for all boards and committees are publicly available on the RACS website. There are more than 200 College staff with reporting lines largely mirroring the governance structure and this is shown within the RACS Governance Map at Appendix 1. The College functions and delivers its services at bi-national, national and regional levels.

***Regional Committees** and the **New Zealand National Board** were appointed by Council in 1927. Each is supported by a regional office. The committees represent the local regional fellowship in whatever forum is necessary, including:*

- *advocacy to government representatives*
- *communicating the decisions of Council to fellows and trainees in their region*
- *providing educational opportunities for fellows and trainees in their region*
- *providing advice to Council on regional issues*
- *assuming responsibility for regional issues and, if necessary, providing recommendations to Council; and supporting selection and training on behalf of the College.*

The committees assist the Council in the implementation of the continuing professional development program; a key role being the running of at least one annual regional meeting for the benefit of the local fellowship and making local arrangements for the Annual Scientific Congress of the College, as requested by the Council.

*The **Board of Regional Chairs** (BoRC) comprises the Chairs of the Regional Committees (State and Territory Regional Committees in Australia, and in New Zealand, the New Zealand National Board). The BoRC has been established to:*

- *ensure that Council receives high-level advice, informed by the Regional Committees, on the College's strategic priorities, policy development and policy implementation*
- *ensure that the College's activities meet the requirements of the fellows and trainees of the College and address key strategic issues in the fellowship*
- *advise Council on key current and strategic issues impacting the surgical workforce, informed by regional and rural fellowship and training data, regional strategies of surgical specialty societies and associations, and activities of the regional health jurisdictions*

- *provide a forum to share knowledge and skills collectively amongst the Chairs of the Regional Committees*
- *provide support to Chairs in discharging their duties.*

The College has policies and procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision making. The College's Conflict of Interest Policy complies with the Commonwealth Corporations Act 2000.

1.1.2 2017 team findings

The College's governance model is mature. It is of necessity a very complex structure as it spans two nations, nine specialties, 13 Specialty Societies and Associations with which RACS has service agreements or memoranda of understanding (MOUs). There are over 100 committees, including a Governance and Advocacy Committee. The terms of reference are defined for each committee.

The College operates within a strong policy framework, including principle-based service agreements with Specialty Societies and Associations. The College, Specialty Societies and Associations demonstrate a commitment to strong governance and continuous improvement including an overt willingness to review and articulate areas for development and improvement.

Membership of Council and its committees is becoming more inclusive of women, trainees and community representatives. Community advisors sit as full members of key RACS boards, with two community advisors on the RACS Council. For example, of the 28 members on the 2017 Council, nine are women, and there are two external co-opted representatives. Fellows on the RACS Council are regularly trained in good governance, strategy and the role of the board through the Australian Institute of Company Directors. Some of the challenges of the College are the different legislative, social and healthcare environments in Australia and New Zealand. Yet, the team found that College governance works well in New Zealand, for several reasons: it is relatively small; the New Zealand office takes a strong coordinating role; and there is a close relationship between the Specialty Societies and Associations and RACS in New Zealand. New Zealand members feel well represented in RACS governance in Australia for the most part.

The College operates according to a constitution, along with a large raft of relevant policies, all of which are publicly available on the RACS website. This includes the Conflict of Interest Policy.

There are relevant conflict of interest policies and they are mentioned in the RACS code of conduct. However, the team recommends that the College considers broadening its definition of conflict of interest to include reflection upon an individual's demography, committee roles, public positions or research interests that may bias decision making in areas such as selection or specialist international medical graduate assessment.

1.2 Program management

The accreditation standards are as follows:

- The education provider has structures with the responsibility, authority and capacity to direct the following key functions:
    - planning, implementing and evaluating the specialist medical program(s) and curriculum, and setting relevant policy and procedures
    - setting and implementing policy on continuing professional development and evaluating the effectiveness of continuing professional development activities
    - setting, implementing and evaluating policy and procedures relating to the assessment of specialist international medical graduates
    - certifying successful completion of the training and education programs.

1.2.1 Program management in 2017

The College's education, training, and continuing professional development programs are overseen by the following boards and committees.

*The **Education Board** is the senior board responsible for overseeing RACS' education policy, maintaining standards of surgical education, training and assessment standards and approving doctors eligible for admission to fellowship. The chair is the Censor-in-Chief, the most senior fellow on the RACS Council responsible for educational issues. The Censor-in-Chief is supported by other councillors, who chair the committees that report to the Education Board. Together, they and the New Zealand Censor form the Education Board Executive. The authority of the Education Board to develop, regulate and approve all education activities is delegated by Council.*

Some of the roles of Education Board are to:

- *advise the Council with regard to its educational activities*
- *be responsible to Council for developing, coordinating and monitoring the implementation of the College Strategic Plan for education*
- *be responsible for quality assurance in respect of the delivery of surgical training programs as determined by the Partnering Agreements or Partnering Deeds with Specialty Societies and Associations*
- *be responsible for developing the educational standards which guide and direct the delivery of the surgical education programs and the assessment of international medical graduates*
- *ensure that examinations conducted by the College are in accordance with requirements for accreditation and authorisation and key College policy documents including the Strategic Plan*
- *develop the educational framework and standards for the delivery of the training programs in accordance with AMC and MCNZ requirements and educational best practice*
- *approve doctors eligible for admission to fellowship*
- *advise on budget priorities for educational activities and to make recommendations to the Resources Committee on the budgetary implications of new educational initiatives and existing programs*
- *advise on education policy issues brought forward by other Boards and Committees to ensure adherence to College policy and standards for education*
- *receive reports and other information from the Board of Surgical Education and Training, the Court of Examiners, the Prevocational and Skills Education Committee and other Boards and Committees*
- *review of specialty training board decisions prior to progressing to an appeals committee.*

The Board holds three face-to-face meetings per year and such other meetings as it deems necessary. The Executive meets by teleconference, usually fortnightly.

The College delivers surgical education and training in a devolved model, working closely with 13 Specialty Societies and Associations in Australia and New Zealand. Each surgical specialty has a Specialty Training Board. Activities such as curriculum development, eLearning development, monitoring and evaluation occur across the nine specialties depending on the critical mass and expertise of the specialty concerned, in collaboration with RACS' departments, such as the Education Development and Research Department.

***Specialty Training Boards**, or their Regional Subcommittees (where they exist and if delegated), are responsible for some or all of the following activities as specified in the relevant Terms of Reference and other associated College policies and procedures.*

- *Approval, without reference to superior boards:*
    - *standards to be achieved for eligibility to apply for fellowship*
    - *curricula content for technical competencies*
    - *training regulations within approved principle-based policies (developed by the Board or adoption of College model regulations)*
    - *selection of trainees*
    - *accreditation of clinical training posts*
    - *assessment of performance in clinical rotations*
    - *criteria to be achieved by trainees to be eligible to present for the Fellowship Examination*
    - *status of trainees in the program (interruption, deferral, probation, etc.)*
    - *quality assurance reporting to the Education Board, as agreed in the Partnering Agreement with the College*
    - *assessment of clinical practice of international medical graduates*
    - *review of poor performance in an examination*
    - *changes to individual training requirements resulting from failed rotations, examination reviews, etc.*
    - *recommendation of dismissal from training.*
- *Recommendation to superior and other boards and committees:*
    - *recommendation of changes to international medical graduate pathways to fellowship*
    - *appointment of Board representatives to the Surgical Sciences and Clinical Examinations Committee, who represent the views of the Specialty Training Board*
    - *changes to existing and draft College policies.*

Support of the Specialty Training Boards is provided by either RACS or Specialty Societies, in accordance with the relevant Service, Collaboration or Partnering Agreement. Where supported by a specialty society that society is responsible for the provision of data (as specified in the Agreement) to enable the College to meet its internal and external reporting requirements.

Depending on the training program, a Specialty Board may cover both Australia and New Zealand or be limited to Australia or New Zealand. The Chair is elected from the fellows of that specialty in the relevant country. Specialty Boards report directly to the Board of Surgical Education and Training.

Four of the training boards are bi-national (Australian and New Zealand) with no subsidiary regional boards/committees:

- *Board of Cardiothoracic Surgery*
- *Board of Neurosurgery*
- *Board of Paediatric Surgery*
- *Board of Vascular Surgery.*

Three are bi-national (Australian and New Zealand) boards with regional subsidiary boards and committees:

- *Board in General Surgery*

- *Board of Otolaryngology Head and Neck Surgery*
- *Board of Urology.*

One has subsidiary regional boards and committees:

- *Australian Board of Plastic and Reconstructive Surgery.*

There are two New Zealand boards, which have no regional boards/committees:

- *New Zealand Board of Orthopaedic Surgery*
- *New Zealand Board of Plastic and Reconstructive Surgery.*

For orthopaedic training in Australia, RACS has delegated the powers of a RACS Specialty Training Board to the Federal Training Committee of the Australian Orthopaedic Association (AOA). Further detail on training programs are provided in the surgical specialties section of this report.

The Chairs of each of the Specialty Training Boards sit on the ***Board of Surgical Education and Training*** *(BSET). This Board monitors and coordinates activities associated with each surgical training program. The Board proposes policy to the College's Education Board for review and approval. In turn, the Board is accountable to Council through the Education Board for fulfilment of the duties and responsibilities. BSET meets in February, June and October.*

Other College committees relevant to program management include:

The ***Court of Examiners*** *reports to the Education Board and is responsible for conducting the summative fellowship examinations. The Court is comprised of surgeons representing the nine specialties in which the College conducts fellowship examinations. Individual surgeons are members of one of nine specialty courts that report to the Court of Examiners.*

The ***Royal Australasian College of Surgeons Trainees' Association (RACSTA)*** *reports directly to the Education Board and represents trainees in all specialties, regions, states and New Zealand. The Association plays a role in advocating for trainees through representation to external organisations, the activities of the RACSTA Board and as trainee representatives on RACS' boards and committees.*

The ***Professional Standards Committee*** *oversees the development of the RACS continuing professional development program and monitors the compliance of all fellows. It also oversees the development of standards documents and position papers relevant to the practice of surgery in Australia and New Zealand. The Committee reports to the Professional Development and Standards Board.*

The ***International Medical Graduate Committee,*** *formed in 2016, is responsible for reviewing and developing international medical graduate assessment tools and overseeing assessment to ensure consistency between specialties. The Committee reports to BSET and the chair is a member of the Education Board. The committee includes representatives from all Specialty Training Boards, two international medical graduates who have completed the pathway, and a community representative.*

1.2.2 2017 team findings

The College enjoys considerable respect locally, regionally, nationally and internationally for its standards and training.

Education and training have a strong focus in the College. Yet, the team found there were several issues with the current governance structure, especially as it related to training curricula, site accreditation and specialist international medical graduate assessment. These issues are discussed in more detail in subsequent standards. Of note, the team found considerable heterogeneity in the specialty training programs, with some more easily meeting AMC accreditation standards than others. Moreover, there is ongoing uncertainty for the College over the direction of curricula development and timeframes for delivery. Several stakeholder groups felt under-represented in decision making.

The devolved model and service agreements operating on 'principle-based' policies have resulted in a lack of clear accountability for critical program elements such as curriculum design, evaluation, management of underperforming trainees, accurate data collection and data sharing. Some agreements are working better than others. There was dissonance expressed as to whether the specialty training programs were more similar or different from the programs prior to devolution five years ago. Individual Specialty Training Boards have more autonomy than previously. There were differing views within RACS as to whether this was desirable or not. The team considers that there are more aspects of curricula that could be common, given that all graduates earn a FRACS. These would include the curriculum and assessment of non-technical (professional) aspects of surgical practice, including cultural competence. This is also discussed under standard 3.

The team found the Board of Surgical Education and Training (BSET) to be a critically important committee in the governance structure. The College can only know what is happening in the jurisdictions by relying on the specialty training boards to feed back through BSET. BSET is the forum for discussion on training and learning from each other. There is usually agreement at BSET; however, members have concern with the lack of transparency as to what is then discussed at the Education Board or College Council, with the possibility that conclusions may be different to the original sentiment.

Several societies, associations, regional boards and other stakeholders expressed frustration with the current governance structure which they described as excessive, rigid, unresponsive or too expedient in approvals without due consideration. An example was the rapid development and implementation of the Operating with Respect (OWR) and Foundation Skills for Surgical Education (FSSE) face-to-face courses. Information regarding these mandatory modules were not felt to have been adequately communicated to all fellows.

Some New Zealand fellows and staff commented to the team that the College needs to remember that it is an Australasian College. The time difference and New Zealand statutory holidays need to be borne in mind when meetings are scheduled. Most of the meetings/pilots/workshops and face-to-face interactions occur in Australia. This places extra time demands on New Zealanders to travel and may disadvantage the New Zealand-based programs from both a time commitment and financial perspective. Greater use of teleconferencing would reduce time demand as well as costs and carbon utilisation. In its response to the draft accreditation report, the College advised that it strives to rationalise and balance the needs of all parties when scheduling meetings.

Several specialty societies and associations commented that the College does not fully understand, or value, the role they play in the administration of the surgical training programs. Nor do they consider they are sufficiently involved in the development of policy which affects the training programs. Further, societies and associations consider there are insufficient mechanisms for senior society personnel to meet with key RACS personnel and other society/association peers. Senior professional staff in the New Zealand office and CEOs in societies reported feeling excluded from some relevant communication, which may go only to the Specialty Board chair who is voluntary and elected. As such, Society CEOs and senior staff may be under-utilised in the implementation of RACS' initiatives.

Timelines for reporting do not always consider the complexity and volume of data from societies. A suggestion to improve the veracity of data as well as efficiency was that the College might recognise the training data provided by societies as the one source of truth for the specialty, and not duplicate the entry of this data into other systems. The double-handling and duplication of data leads to the risk of errors and inconsistencies in aggregate data, which is then reported to internal and external stakeholders. Another suggestion to reduce duplication is for societies to have at least 'read' access to the RACS database, the integrated management information system (iMIS), or any future trainee database. Societies are dependent on the College for information regarding their trainees (for example, course completion). Having limited 'write' access would allow trainee information (for example, term completion) to be uploaded by the societies directly to the RACS database.

Trainees relate and pay training fees to both their Specialty Society and the College. Many trainees commented on a far closer association with their Specialty Society/Association than with the College, although they acknowledged and recognised the role of the College and the excellent RACS library and online resources. Despite this, many questioned the level of RACS annual fees. This is also covered under standard 7.3.

The team considers that the responsibility for evaluation of the College's training programs and assessment functions is not sufficiently clear. Further details are covered under standard 6. The team considers that the College needs an overarching, efficient evaluation framework for all training programs and assessment that makes it clear what information is collected and why, from whom, by whom and when; in addition to how that information is received, collated, acted upon, and results disseminated. This is not to say that the College has to do it all, see it all, or act on it all. The College must take the lead on the collaboration with specialty societies/associations on the development of the overall plan and in its delivery.

The team considers the College must review the relationships between Council, the Education Board, BSET and the Specialty Training Boards to ensure that the governance structure enables all training programs meet College policies and AMC standards.

Given that the College is delegating some or all of the administration of the training programs and some aspects of assessments of international medical graduates to Specialty Training Boards, the College must provide a stronger process for ongoing evaluation as to whether each of the specialty training programs remain consistent with the education and training policies of the College. This is discussed under standard 6.

1.3 Reconsideration, review and appeals process

The accreditation standards are as follows:

- The education provider has reconsideration, review and appeals processes that provide for impartial review of decisions related to training and education functions. It makes information about these processes publicly available.
- The education provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

1.3.1 Reconsideration, review and appeals process in 2017

The College's accreditation submission describes its considerable effort in reviewing and improving the systems for making complaints, and requesting reconsideration or review of a decision, or making a formal appeal over the past two years. The College has developed a 12-page Complaints User Guide.

The College plans to report annually on complaint metrics and progress on the program, which will be analysed to identify any problems needing to be addressed. The handling of all complaints is being progressively centralised along with associated resourcing and infrastructure. All complaints are referred to the Manager, Complaints Resolution, and are registered, assessed and assigned for resolution. A key role of the Manager, Complaints Resolution is to establish policies and processes, as well as undertake education about correct processes.

The College has an Appeals Mechanism policy which is publicly available on the RACS website. This details the mechanism and grounds for appeal by any person or organisation adversely affected by a College decision that is inconsistent with College policy.

1.3.2 2017 team findings

Longstanding and significant concerns have been expressed about the management of training problems or inappropriate behaviour within surgical workplaces. The team heard comments throughout the visit about the need for the College and Specialty Societies and Associations to

increase the transparency and independent external scrutiny of their educational operations including complaints management.

In 2015, the College commissioned an Expert Advisory Group (EAG) to undertake the substantial review of concerns relating to discrimination, bullying and sexual harassment in surgery. Inter alia, the EAG report highlighted a lack of trust in College mechanisms for handling complaints. As a result, improved complaints handling is a major pillar of the Building Respect, Improving Patient Safety (BRIPS) program.

The team was impressed with the implementation in January 2016 of a centralised complaints management process and database managed by an experienced staff member. Complaints relating to bullying, harassment or clinical competence may be received via a hotline or email from trainees, fellows, jurisdictions, public or others. Complaints may be made anonymously, in confidence or with full disclosure. Anonymous complaints are logged so that they may be used in the future if there are repeated problems. The Manager, Complaints Resolution, works closely with senior staff in the College, in particular, the Executive Directors for Surgical Affairs.

There is increased awareness of the new complaints system with the number of complaints received increasing, from 17 as at March 2016, to a total of 60 by April 2017. The team considers this could place pressure on the Manager and College staff and it is important that the College continues to provide sufficient resources to fully implement the new complaints management system.

Trust in the system is not yet complete. Trainees would like more assurance that the new system is a safe one in which to make a complaint. Through AMC interviews and from extensive comments in the trainee survey, the team found that trainees consider they may be disadvantaged in career progression if they are to be a 'whistle blower'. There are concerns that it is impossible to report without being identified. Given their key role in training matters, it will be important for Specialty Training Boards to work closely with the College with respect to how complaints are resolved according to best practice and RACS' policies and processes. This is also discussed under standard 7.5

The team considers there is not a clear enough process outlined for each of the three phases of reconsideration, review and appeal in either the RACS Appeals Mechanism or the material provided by the surgical specialties. In particular, reconsideration and review processes are only briefly referred to, and seem to be a blend of reconsideration and review into a single process, rather than two distinct processes. Reconsideration by the original decision maker in the light of new information does not seem to be explicitly stated. The College should review its Appeals Mechanism to make it explicit that Specialty Training Boards must have clear reconsideration, review and appeals processes. The team notes that the Australian Orthopaedic Association has a clearly defined reconsideration, review and appeals policy which could be considered by the Specialty Training Boards.

The rate of appeal is low given that every College or society/association decision is appealable. With only five appeals in the past three years, the team was left with the impression that there may be a fear of making an appeal or that there may be processes happening at other levels, of which the College is unaware. The team recommends that the College continue to monitor and evaluate the types of appeals and complaints.

1.4 Educational expertise and exchange

The accreditation standards are as follows:

- The education provider uses educational expertise in the development, management and continuous improvement of its training and education functions.
- The education provider collaborates with other educational institutions and compares its curriculum, specialist medical program and assessment with that of other relevant programs.

1.4.1 Educational expertise and exchange in 2017

Many surgeons have formal educational qualifications and other postgraduate academic qualifications. The College has established the Academy of Surgical Educators (ASE) to foster excellence in surgical education as a core component of ongoing professional development. The ASE now has more than 700 members and promotes formal training of fellows involved in the education and training of trainees. The College has placed particular emphasis on the recognition, support and training of surgeons in their role as educators. The ASE provides for the generic education needs of surgeon-teachers, trainers, supervisors, assessors and examiners in all surgically-related areas. The ASE actively engages international educational and standards bodies of excellence, as well as individuals, to enable ongoing benchmarking and exchange of ideas. It provides links through in-house educational programs, such as the mandatory Foundation Skills for Surgical Educators, and to graduate programs in surgical education with the University of Melbourne. The development of the ASE and its involvement with international surgical education and postgraduate medical education has been important in ensuring that local and national needs in health care and health-related education are highlighted and incorporated into programs across the College.

RACS was an initial partner in the development of the tri-nations (RACS, Royal Australasian College of Physicians and the Royal College of Physicians and Surgeons of Canada) educational forum and has maintained close ties with the other founding partners.

Examples of the use of expertise and educational exchange given were:

- *RACS awards scholarships and grants to examiners within the Court of Examiners to review examination processes internationally.*
- *The Australian Orthopaedic Association engaged a fellow of the Royal College of Physicians and Surgeons of Canada to conduct a comprehensive review of its curriculum and engage with the development of the AOA21 educational program.*
- *The Early Management of Severe Trauma (EMST) course is based on the international equivalent Advanced Trauma Life Support (ATLS™) from the US.*

1.4.2 2017 team findings

The College enjoys high levels of commitment and educational expertise from the Specialty Training Boards, and a wide range of fellows and professional staff who are engaged in the training of surgeons.

The team was impressed with the level of educational expertise in the College, as well as the College's interaction and collaboration at multiple levels with an extensive network of postgraduate medical colleges, universities, and professional organisations in Australia and New Zealand. The College conducts its own well-attended scientific meetings and participates in international surgical meetings where all international surgical colleges discuss issues of surgical standards and education. This is repeated among the nine surgical specialties of the College. The College in Australia interacts through the Council of Presidents of Medical Colleges (CPMC). The networks for medical educators and those responsible for international medical graduate assessment are particularly strong and the colleges work together on initiatives. In New Zealand, all medical colleges interact through the Council of Medical Colleges (CMC).

1.5 Educational resources

The accreditation standards are as follows:

- The education provider has the resources and management capacity to sustain and, where appropriate, deliver its training and education functions.
- The education provider's training and education functions are supported by sufficient administrative and technical staff.

1.5.1 Educational resources in 2017

The College continues to expand its management and educational resources to support education and training activities. The Digital College initiative was to enhance online interaction with the RACS and its educational activities. The College has developed substantial resources and expertise in this area, however, pressure to update and improve the infrastructure and function, while providing strict data security and privacy protection, is considerable, and has increased the costs of delivering education activities.

The College funds this through a number of means, predominantly through trainee fees and fellow subscriptions. Trainee fees are reviewed annually to ascertain funding requirements for surgical education and training.

Service agreements with specialty societies stipulate funding to ensure the provision of adequate resources so the specialty societies can support the educational requirements of their trainees.

1.5.2 2017 team findings

The team was impressed with the large amount of pro bono work undertaken by fellows. The work of fellows is complemented by over 200 staff, many of whom have roles and expertise in education and training. The College appears to have adequate capacity within its administrative team, and has processes to ensure the most appropriate use of its members and human resources.

There are two specific RACS education divisions: Education Development and Assessment, and Education and Training Administration. These outreach to the specialty societies and associations as needed. The Dean of Education is a fellow with a 0.8 FTE position who reports to the Chief Executive Officer.

With regard to the RACS website, the Specialty Societies and Associations repeat much of the key education material also on their websites. This has the potential to duplicate work, or introduce errors when material changes, and is an issue that the College should continue to monitor.

The College's educational resources are contemporary and appropriate, and the Digital College initiative is commended. Among the resources are those designed to help fellows and trainees improve their skills, including online courses such as Operating with Respect. The Digital College concept has been broadly welcomed by fellows and trainees.

1.6 Interaction with the health sector

The accreditation standards are as follows:

- The education provider seeks to maintain effective relationships with health-related sectors of society and government, and relevant organisations and communities to promote the training, education and continuing professional development of medical specialists.
- The education provider works with training sites to enable clinicians to contribute to high-quality teaching and supervision, and to foster professional development.
- The education provider works with training sites and jurisdictions on matters of mutual interest.
- The education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education.

1.6.1 Interaction with the health sector in 2017

The College's management team and fellows regularly engage with health departments, district health boards and ministries in their jurisdictions and at a national level. As RACS is represented in New Zealand and in each state and territory of Australia, the local committee/board chair and regional manager regularly meet with health ministers, senior department staff, and opposition

health representatives. These meetings have a strong focus on advocacy for surgical services and also on the requirements for surgical standards, education and training, relevant public health issues and the workforce pipeline. The College has worked with the private health insurance industry, and Medicare to provide reports to surgeons about key measures of performance relating to hospital admissions, complications and fee charges. The College meets frequently with the Australian Health Practitioner Regulation Agency, the Medical Board of Australia and the Medical Council of New Zealand on a range of issues and responds to requests for data or information.

To increase effective interactions with individual hospitals, the College has formed the Surgical Directors Section with a particular focus on the development of surgical leadership and the ability to influence organisations. The College aims to ensure the senior surgeons within hospitals have the leadership skills and access to appropriate surgical resources, position papers and policy to ensure improvements are achieved in surgical services and the culture of the health sector. Although the College does not have line management or employment-based authority in hospitals, RACS recognises its role and responsibility in setting the expectation of professional behaviour of fellows and trainees in their educational and clinical activities.

Within the BRIPS Action Plan, specific initiatives have been aimed at hospitals, with the College fostering a collaborative model with health departments and district health boards and many hospitals across Australia and New Zealand. Several formal agreements have been signed.

The College has a longstanding relationship with the Australian Indigenous Doctors' Association (AIDA). As part of the RACS Reconciliation Action Plan 2016–2017, RACS has committed to maintaining and enhancing its partnership with AIDA and developing at least two new partnerships with organisations working in its sphere of influence.

In New Zealand, the College has a longstanding relationship with Te Ohu Rata o Aotearoa - Māori Medical Practitioners Association (Te ORA). RACS supports Te ORA's annual Hui-a-Tau and the 2016 Pacific Region Indigenous Doctors Congress hosted by Te ORA. Te ORA is represented on the RACS Indigenous Health Committee, as well as on selection panels for scholarships offered to Māori medical students or junior doctors. As part of the RACS Māori Health Action Plan 2016–2018, RACS seeks to develop genuine partnerships with Māori organisations and Iwi (tribes). A Māori Health Steering Group, comprised primarily of Māori surgeons and Māori trainees, advises on activities required by the Māori Health Action Plan.

The RACS Indigenous Health Committee reports via Fellowship Services to the Professional Development and Standards Board. It oversees the implementation of RACS' position statement and strategic commitments in Indigenous health in Australia and New Zealand.

1.6.2 2017 team findings

The team heard from a wide range of stakeholders that the College interacts well with others in the health sector. There are multiple channels of communication between the College and jurisdictions. In contrast, some external stakeholders expressed views which may be summarised as a lack of clarity and transparency in relation to accountability, responsibility and control of key roles of the College, especially those which are shared with specialty societies.

An interface issue that came up several times is that the College undertakes a selection process into training which is separate to that of the recruitment into employment. The College advises hospitals of the trainees who have been 'allocated' to their hospital, and assesses the trainees but does not share referee reports with jurisdictions. This requires ongoing attention. This is also discussed under standard 7.1.

The BRIPS Action Plan has been received well. It has necessitated an increase in RACS' interactions with the health sector and will continue to do so for many years. At every site, most interviewed by the team were aware of many of the BRIPS initiatives, and the posters were visible. It was evident that the RACS-led initiative in surgery is having flow on effects into other areas of the hospitals.

The team could not state it any better than was expressed in the EAG report:

> *With the active support of all Fellows, the College and Specialty Societies can lead the way to a future in which there is no place for discrimination, bullying and sexual harassment in the practice of surgery. This will take courage, resources and a commitment to change. It will take enforcing the law and imposing sanctions as needed. It will take the College showing how to prevent and address discrimination, bullying and sexual harassment and how to hold people to account for their behaviour, working with the medical profession, employers and the healthcare sector more widely. Effective partnerships will be essential. It will take witnesses ending their silence and speaking out. To achieve the necessary fundamental cultural change, the College must also shine the light of independent scrutiny and greater transparency on its own assumptions and approaches. Critical self-reflection, fearless questioning of old habits and inherited practices, and a looser grip on tradition will be needed to shift the status quo.*

An important recent initiative is the College's Diversity and Inclusion Plan (November 2016). This arises from the fourth goal in BRIPS which is to embrace diversity and foster gender equity.

The team met with members of the Women in Surgery Group. The group confirmed that there is not yet widespread acceptance that more flexibility in training and work is compatible with being a good surgeon. It is still a struggle to find examples of flexible training to offer as positive stories, and interruption of training is much more common than training part-time. The team heard varying accounts of where the problem lies with respect to the lack of part-time jobs, with the jurisdictions and the Specialty Training Board both being cited. The team does not agree with the view that trainees do not want or seek part-time posts but concurs with the Women in Surgery Group that the top priority is to establish a culture that fosters flexible training opportunities. This will require efforts by the College, Specialty Training Boards and jurisdictions. It is encouraging that flexible training is now a standing item on the Board of Surgical Education and Training agenda.

The Reconciliation Action Plan is another impressive initiative. The team met with Indigenous doctors from the RACS Indigenous Health Committee who confirmed that there has been a philosophical change, with Indigenous health now at the forefront of College business. The theme of Indigenous health has been part of RACS conferences. The College has demonstrated strong engagement with the two Indigenous doctors' organisations AIDA and Te Ora.

It was not yet clear to the team that either the Diversity and Inclusion Plan or the Reconciliation Action Plan had been adopted in full by the Specialty Training Boards or the Specialty Societies and Associations. The team recommends that the College continue maintaining its momentum on the implementation of the Reconciliation Action Plan, BRIPS and the Diversity and Inclusion Plan.

1.7 Continuous renewal

The accreditation standards are as follows:

- The education provider regularly reviews its structures and functions for and resource allocation to training and education functions to meet changing needs and evolving best practice.

1.7.1 Continuous renewal in 2017

RACS is an organisation based on the quality principles of continuous improvement, which recognises that it will always be evolving. The College regularly updates its strategic plan and business plan. The strategic plan is updated on a four-yearly cycle and the business plan annually. RACS is accredited within the ISO 9001 standard.

1.7.2 2017 team findings

There is ample evidence that the College addresses this standard. The College has made major changes in structure and function in each of the last two AMC accreditation cycles. In the current

cycle, step changes in direction have occurred with respect to surgical culture and use of technology. There is evidence from multiple sources that the BRIPS program is an excellent initiative and the culture of surgical training is changing. The College is commended on its leadership with the initiative. The College is well aware that several of its action plans 'are not universally embraced, requiring complex change management approaches.'

With so many initiatives underway, the College is encouraged to keep these efficient and aligned, both to maintain momentum, as well as to minimise change fatigue. Further, the initiatives need to be properly evaluated and reported upon. This is discussed in further detail under standard 6.

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College addressed the following condition in AMC monitoring submissions.

Conditions to satisfy accreditation standards

3 Develop a common policy that makes it explicit that all Specialty Training Boards must develop and implement defined reconsideration, review and appeals policies, which clearly outline the processes for each of the three phrases. (Standard 1.3)

In 2019, the College developed a new common policy outlining how an applicant may apply for Reconsideration, Review or Appeal of the following decisions:

a Selection, training, or admission to Fellowship

b Specialist assessment and clinical assessment of International Medical Graduates (IMGs)

c The accreditation of training posts or IMG clinical assessment posts

d Accreditation of Post Fellowship Education and Training programs and Accreditation of Courses

e Decisions of the Professional Conduct Committee (Appeal only)

f Such other decisions of RACS, its Boards or Committees (including conjoint Committees), or its agents as the CEO may determine from time to time.

The policy includes all decisions by Specialty Training Boards.

B 2021 team findings

The follow-up visit considered progress towards the remaining conditions and whether the College had responded to the recommendation for quality improvement.

Conditions to satisfy accreditation standards

1 Review the relationships between Council, the Education Board, the Board of Surgical Education and Training and the Specialty Training Boards to ensure that the governance structure enables all training programs to meet RACS policies and AMC standards. (Standard 1.2)

To be met by 2019.

2 RACS must develop and implement a stronger process for ongoing evaluation as to whether each of the specialty training programs remain consistent with the education and training policies of the College. (Standard 1.2)

To be met by 2020.

4	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. (Standards 1.6 and 1.7) *To be met by 2021.*
Recommendations for improvement	
AA	Broaden the definition of conflict of interest to include reflection on an individual's demography, committee roles, public positions or research interests that may bias decision making in areas such as selection or specialist international medical graduate assessment. (Standard 1.1.6)

The College has 13 distinct training programs, operated under a delivery model which devolves training to Specialty Training Boards and specialty societies. Five programs are bi-national with four programs run separately in Australia and Aotearoa New Zealand. There is a range of program size in terms of trainees, supervisors and professional staff to support training. Moreover, all programs are at various stages of curriculum development/renewal. Graduates of the training programs earn a Fellowship of the Royal Australasian College of Surgeons (FRACS). The main bodies involved with designing and delivering training are the Education Board (EB), Board of Surgical Education and Training (BSET) and the Specialty Training Boards (STBs), overseen by RACS Council.

The governance structure of the College is extensive and complex. Condition 1 from the 2017 reaccreditation assessment specified that the College's governance arrangements for training be reviewed. The RACS Governance Committee was formed to conduct a review of College structures and relationships between RACS Council and committees. After considerable engagement and feedback, it was decided that merging BSET and EB was not practical, with one of the main reasons being that EB oversees other functions such as the Fellowship examinations. The College has implemented more formal reporting processes to facilitate collaboration and more cohesive decision-making and strategies between RACS Council, EB and BSET. The College has also commissioned a training audit by KPMG to inform a further review and revision of training policies to better align specialty training programs to overarching College policies.

The team found that there were now enhanced channels of communication between the CEOs and education staff of the College and the specialty societies with evidence provided of an improving relationship between the College and the Societies. The formation of the Specialty Society CEO Forum and fortnightly operational meetings are good initiatives to foster collaboration between the College and specialty societies. In 2019, a Policy Officer was appointed in the Education portfolio, working closely with the newly-formed role of Education Governance Specialist. The team heard from several STBs and the College that earlier notification of new initiatives or requests between parties, with realistic timelines for consultation and feedback, would be helpful.

New service or partnering agreements for education and training were signed with six societies or associations, with seven agreements yet to be signed. These agreements include the principle of joint accountability between RACS and the societies for recognising obligations to external stakeholders, including the AMC.

However, documentation provided to the team and discussion at the visit made it clear that there is not yet a sufficient shared understanding among the College's education committees and each of the specialty societies that all specialty training programs must meet AMC standards. In order to meet the remaining AMC conditions, the team believes the delegations and accountabilities between the College and STBs need to be better defined, operationalised, and evaluated.

On the other hand, the College education model, which devolves the training to specialty societies or associations, affords significant opportunities to share good educational practices, and to leverage off successful initiatives. There is considerable educational expertise in the College and in many societies. The team suggests greater sharing may assist in areas such as formatting of public graduate outcome statements, implementing competency-based assessment, and sharing of curricular elements in the professional skills domains. Other areas to explore might include sharing of some selection processes, learning platforms and management systems. College education staff might consider working more closely with those STBs embarking on curricular reform or who are having challenges in meeting the AMC standards. The short periods of appointment of Fellows to training committees, and the turnover in the College's educational leadership may be risks to momentum of curricular development.

Over the past few years, the College has embarked on an ambitious program of cultural change. Many internal and external stakeholders were impressed with the progress made and the team commends the College on the work done so far. The team encourages continued implementation of the policies and consolidation of the gains that have been made.

- The Building Respect, Improving Patient Safety (BRIPS) Action Plan is well-known and highly regarded at all levels of the College, and in the health and clinical education sectors. Over 98% of Fellows, Trainees and SIMGs have completed the Operating with Respect online module, with over 85% also taking the face-to-face module. Trainees, supervisors, allied health staff, hospital management and regulators all report a steep improvement in workplace behaviour and that it is now far easier to address inappropriate behaviour. A 2020 survey of College trainees (with 536 respondents) showed improvements from the year before:
    - 75% reported bullying, harassment, and discrimination was not tolerated at their workplace.
    - 85% knew how to raise such concerns.
    - 24% had experienced bullying, harassment, or discrimination.
    - 33% had witnessed it in the last 12 months.

  It is widely-recognised there is still more work to do, and, in a limited number of cases, this may take generational change. A Phase 2 Evaluation of BRIPS is about to get underway.
- The approach to developing the 2020 Innovate Reconciliation Action Plan (RAP) through consultation with the RACS Indigenous Health Committee and RACS Reconciliation Working Group is appropriate and exemplary.
- In terms of enhancing health equity, the College now has four Action plans: the Reconciliation Action Plan; the Diversity and Inclusion Plan; Te Rautaki Māori 2020 – 2023 and the Rural Health Equity Plan. These have been developed in partnership with stakeholders and are generally well-received. The team found many examples of good practice and encourages full implementation across all specialties and jurisdictions. The team commends these initiatives in particular and all involved in the development of these policies.
- Within the Rural Health Equity Plan are the three strategies: Select for Rural, Train for Rural and Retain for Rural. The team encourages the College and the STBs to consider the balance of generalism and sub-specialisation within each specialty training program to ensure new Fellows are prepared for practice in regional and smaller centres.
- While women now comprise 30% of trainees, this is below the agreed College target of 40% by 2021. The proportion of women in training programs ranges from 12% in orthopaedics to over 50% in paediatric surgery.
- While there is a gradual increase in the number of Indigenous trainees, there were no new trainees identifying as Aboriginal & Torres Strait Islander in 2020 (compared with four Māori trainees in Aotearoa New Zealand).

- The College might consider whether or not the long periods spent in PGY years pre-SET selection and the high costs involved in both getting onto training and during training (see Standard 7) may be working against equity initiatives.
- Flexible training is more widely discussed. Hospitals provide information as to whether flexible training posts can be accommodated. This information is collected as part of the accreditation reports when posts are inspected, and the provision of flexible employment options are a minimum requirement for hospitals in accreditation. The data provided suggest that most requests for flexible training are able to be accommodated, but these data include both part-time and interrupted training. Surgeons and trainees report that there is still more work to do to normalise flexible training in the form of part time training. This may be a factor in the low numbers of trainees seeking part time posts. The remaining structural barriers seem to be within the gambit of STBs, local training committees, hospital management and clinical services.

In response to Recommendation AA, the College established a working group in 2020 to undertake a review of the RACS Conflict of Interest Policy to ensure a breadth of potential conflicts are captured. The new policy was approved in November 2020. Specialty training boards require any conflicts of interest to be declared at each board meeting and members will leave the meeting when a conflict of interest is declared relating to an item of discussion. A similar approach is applied for the selection of interview panel members.

As reported in the 2019 monitoring submission to the AMC, the College has revised its reconsideration, review and appeals process for decisions made in training and these have been incorporated into the training regulations. The AOA Federal Training Committee (AOA FTC) also has a similar policy. The team was unable to check the extent to which the policy is operationalised at each level in each program, however, it heard some concerns regarding the procedural fairness of the complaints process and equity of application of the process by College trainees across specialties, and by specialist international medical graduates. The College should monitor the implementation of the new policies and address any concerns regarding procedural fairness.

The College has made significant progress and the team was left in no doubt that in education and training, the College is positively engaged in continuous renewal. However, the College and the specialty societies must continue on their current trajectory of improved collaboration and commitment to provide cohesive training programs and experience for all trainees.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

A The strong policy framework within which the College operates, including principle-based service agreements with Specialty Societies and Associations.

B The College's contemporary and appropriate educational resources, in particular the Digital College initiative.

C The Reconciliation Action Plan, and the Diversity and Inclusion Plan and progress made to date with regard to their implementation.

D The enormous courage and leadership shown by the College in 2015 in establishing a broadly constituted Expert Advisory Group to undertake the substantial review of concerns relating to discrimination, bullying and sexual harassment. This resulted in the development and implementation of the Building Respect, Improving Patient Safety (BRIPS) program which is an excellent initiative and is evidencing a change in the culture of surgical training.

2017 Conditions to satisfy accreditation standards

1 Review the relationships between Council, the Education Board, the Board of Surgical Education and Training and the Specialty Training Boards to ensure that the governance structure enables all training programs to meet RACS policies and AMC standards. (Standard 1.2)

2 RACS must develop and implement a stronger process for ongoing evaluation as to whether each of the specialty training programs remain consistent with the education and training policies of the College. (Standard 1.2)

3 Develop a common policy that makes it explicit that all Specialty Training Boards must develop and implement defined reconsideration, review and appeals policies which clearly outline the processes for each of the three phases. (Standard 1.3)

4 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. (Standards 1.6 and 1.7)

2017 Recommendations for improvement

AA Broaden the definition of conflict of interest to include reflection on an individual's demography, committee roles, public positions or research interests that may bias decision making in areas such as selection or specialist international medical graduate assessment. (Standard 1.1.6)

2021 Accreditation Commendations, Conditions and Recommendations

In 2018 and 2019, the College addressed condition 3 in their monitoring submissions to the AMC.

In the 2021 follow-up assessment, the team considers conditions 1, 2 and 4 to be progressing and recommendation AA to be considered and addressed by the College The remaining conditions from the 2017 reaccreditation, conditions 1 and 2, are merged and replaced as condition 1, and condition 4 has been amended and replaced as condition 2.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

1 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)

2 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)

2021 Recommendations for improvement

Nil

2 The outcomes of specialist training and education

2.1 Educational purpose

The accreditation standards are as follows:

- The education provider has defined its educational purpose which includes setting and promoting high standards of training, education, assessment, professional and medical practice, and continuing professional development, within the context of its community responsibilities.
- The education provider's purpose addresses Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand and their health.
- In defining its educational purpose, the education provider has consulted internal and external stakeholders.

2.1.1 Educational purpose in 2017

The RACS website contains information, policies and publications about the purpose of the College.

There are various documents/places that describe the overarching purpose of the College, including:

RACS Constitution	*The purpose of the College is to:* • *advance education, training and research in the practice of surgery* • *determine and maintain professional standards for the practice of surgery in Australia and New Zealand* • *provide an environment promoting fellowship development and support; and* • *provide authoritative advice, information and opinion to other professional organisations, to governments and to the public.*
RACS website	*The College's purpose is to be the unifying force for surgery in Australia and New Zealand, with FRACS standing for excellence in surgical care.*
RACS Business Plan 2016-17	*Statement of Purpose:* *The leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand.*
RACS Strategic Plan 2014-18	*RACS Purpose:* *Excellence in surgical practice and education.*
RACS Strategic Plan and Business Plan 2017-2018	*Vision:* *Leading surgical performance, professionalism and improving patient care.* *Mission:* *The leading advocate for surgical standards, education and professionalism in Australia and New Zealand.*
College's accreditation submission to AMC	*The College's vision is to be 'the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand.'*

The College has a long history of setting and promoting high standards of training, education and assessment. The RACS Code of Conduct defines the professional behaviour for all surgeons and

reflects the College's values. The College reviewed the Code in 2016 in consultation with the specialty societies and associations, as well as relevant RACS education sections, committees and boards.

There are nine RACS competencies adapted from Canadian Medical Education Directives for Specialists (CanMEDS) that apply across all specialties and these are well documented. More recently, the College has invested great time and energy on a culture change program, the Building Respect, Improving Patient Safety (BRIPS) program, which targets professional behaviours and practices. The BRIPS program is couched in a patient safety context.

The College recognises the disadvantage experienced by Indigenous peoples in Australia and New Zealand. As discussed under standard 1.6, the College has specific health action plans for Aboriginal and Torres Strait Islander peoples and Māori. The Reconciliation Action Plan 2016-2017 is certainly much broader in its focus.

The College displays a commitment to the needs of both Australian and New Zealand stakeholders and to regular communication through publications, the RACS website and social media.

The College's policy External Co-opted Members on Committees and Boards describes the role, responsibilities and selection criteria for external co-opted members (community representatives and honorary advisors) on its committees. Two community advisors sit as full members on the RACS Council and some of its major committees. In 2017, the College undertook an expression of interest process to recruit additional community representatives to College boards. A nominations committee is assisting the Specialty Training Boards and other committees appoint suitable community members. This is discussed further under standard 6.2.

2.1.2 2017 team findings

The team was impressed by the amount of positive feedback from multiple sources that the College sets and promotes high standards of training, education, assessment, professional and medical practice, and continuing professional development. There is evidence of focused work across the specialties to maintain and extend the high standards expected by the College and its members.

The team could not find sufficient evidence that these high standards are consistently applied within the context of RACS' community responsibilities. The College must define how its educational purpose connects to its community responsibilities. The team has made a number of recommendations under this standard and standard 6.2 that will assist the College to meet this requirement.

The College's commitment to continuing professional development is admirable and while the College's long-standing strength in clinical education and development is noted, this strength needs to be complemented by a similar focus on non-technical skills. The team is of the view that improvement in non-technical skills is vital and needs to be applied to existing fellows as well as to the specialty training programs. This is discussed further under standard 3.

The team was impressed with the College's willingness to be a strong leader in the culture and leadership change required across surgery and other medical professions, noting that culture change takes time and consistent focus.

The College has numerous versions of a vision statement or statement of purpose as shown in the table above. None of the statements provides a clear link to the breadth of RACS' community responsibilities, including providing services that the various populations and communities across Australia and New Zealand require.

Whilst the College states its commitment to Aboriginal and Torres Strait Islander peoples of Australia and Māori of New Zealand and their health, the team found that there is still opportunity to strengthen action in this area significantly. In terms of education, the team found that cultural competence training needs to be built into teaching and education programs across all specialties and RACS' programs. Cultural competence should form part of training, education and continuing professional development. The current methods reported are not in line with contemporary expectations of cultural competence and this needs to be addressed as a priority. This is discussed

further under standards 3.2 and 9.1. Current methods do not provide trainees with an understanding of the generational or disadvantage-related health issues that Indigenous peoples in Australia and New Zealand face, or the cultural support required as part of their care.

It is pleasing to see the beginnings of programs to support the selection of and support for Aboriginal and/or Torres Islander peoples, in a small number of specialties. More effort and commitment across the nine specialties are required. As detailed under standard 7.1, the team also noted that the RACS Māori Health Advisory Group had advised that it does not seek preferential selection of Māori candidates for the Surgical Education and Training (SET) program.

The College communicates well with its internal stakeholders and increasingly well with a narrow range of external stakeholders. Breadth and depth of external stakeholder engagement on the whole needs to be expanded. For this standard, the College needs to broaden and deepen its engagement with external stakeholders about connecting its educational purpose to its community responsibilities and the goals and objectives of surgical training. The College should also review its engagement strategy to ensure that external representatives are appropriately represented on College and associated committees.

2.2 Program outcomes

The accreditation standards are as follows:

- The education provider develops and maintains a set of program outcomes for each of its specialist medical programs, including any subspecialty programs that take account of community needs, and medical and health practice. The provider relates its training and education functions to the health care needs of the communities it serves.
- The program outcomes are based on the role of the specialty and/or field of specialty practice and the role of the specialist in the delivery of health care.

2.2.1 Program outcomes in 2017

According to the College's accreditation submission, the Surgical Education and Training (SET) program is intended to produce an independent and competent specialist surgeon capable of providing the highest standard of safe, ethical and comprehensive care. The College reports that new fellows should be able to practise across the generality of their specialty, provide emergency care and hold the nine RACS competencies. The College also notes that many new fellows undertake post-fellowship training or experience.

As detailed under Standard 1, there are nine specialties within surgery and each of these has a single Specialty Training Board, except Orthopaedic Surgery and Plastic and Reconstructive Surgery, where there are separate Specialty Training Boards for Australia and New Zealand. Each Specialty Training Board has delegated authority from RACS to determine the program and graduate outcomes for its specialty.

The College monitors surgical workforce data. The College conducts a census of fellows every two years which provides feedback on workforce numbers and distribution. The Australian and New Zealand Surgical Workforce Projections to 2025 Report provides long-term national projection requirements of the surgical workforce. These reports serve as the basis for the College's efforts to ensure adequate growth of the surgical workforce to meet future population demands.

2.2.2 2017 team findings

The team findings for standard 2.2 are provided in combination with those of standard 2.3.

2.3 Graduate outcomes

The accreditation standards are as follows:

- The education provider has defined graduate outcomes for each of its specialist medical programs including any subspecialty programs. These outcomes are based on the field of specialty practice and the specialists' role in the delivery of health care and describe the attributes and competencies required by the specialist in this role. The education provider makes information on graduate outcomes publicly available.

2.3.1 Graduate outcomes in 2017

The nine RACS competencies adapted from CanMEDS are articulated in the document, Becoming a competent and proficient surgeon: Training Standards for the Nine RACS Competencies (2012). These competencies are clearly defined and underpin the College's training, education and professional development programs, and are as follows:

- *Medical Expertise: Medical Expertise relates to the acquisition, integrating and application of medical knowledge, clinical skills and professional attitudes in the provision of patient care.*
- *Judgement – Clinical Decision Making: Involves making informed and timely decisions regarding assessment, diagnosis, surgical management, follow-up, health maintenance and promotion.*
- *Technical Expertise: Technical expertise relates to safely and effectively performing surgical procedures conducted in the unit in which they are training.*
- *Professionalism and Ethics: Involves demonstrating commitment to patients, the community, and the profession through the ethical practice of surgery.*
- *Health Advocacy: Health Advocacy involves responding appropriately to the health needs and expectations of individual patients, families, carers and communities.*
- *Communication: All surgeons are required to be able to communicate effectively with patients, families, carers, colleagues and other staff.*
- *Collaboration and Teamwork: Involves developing a high level ability to work in a cooperative context to ensure that the surgical team has a shared understanding of the clinical situation and can complete tasks effectively.*
- *Management and Leadership: Involves leading the team and providing direction, demonstrating high standards of clinical practice and care, and being considerate about the needs of team members.*
- *Scholar and Teacher: As scholars and teachers, surgeons demonstrate a lifelong commitment to reflective learning, and the translation, application, dissemination and creation of medical knowledge.*

The complete definitions of each of the nine surgical specialties are documented in the Guide to SET 2016 and are described under section 11 Surgical Specialties.

Each specialty has the responsibility for determining the graduate outcomes for its program which underpin the nine competencies.

2.3.2 2017 team findings

The College's strength is in the Specialty Training Boards and their expertise in outlining the requirements of their particular specialty. This arrangement has created a number of challenges however for RACS to meet this standard, as there are not clear program and graduate outcomes for each specialty and the outcomes that are available are not in a uniform style and therefore not easily comparable.

In its accreditation submission, the College notes that 'the RACS Surgical Education and Training Program produces independent surgeons who have specialty knowledge and skills, as well as broad medical professional expertise'. Feedback from trainees and supervisors indicated that many new fellows consider they require some type of fellowship program to consolidate skills and confidence on the path to independent practice. The team reiterates the current lack of clarity around what a new fellow can and cannot do in terms of independent practice and the pressing need to clarify and communicate this. The team notes that the College plans to undertake a survey to evaluate preparedness for practice. It will be important to identify whether the issue is one of trainee competence or confidence, and what supports might be put in place to aid the transition to independent practice. This could include preparation of trainees to recognise their own CPD needs. The team also recommends that the College in conjunction with the Specialty Training Boards, review and report on the reasons for the pervasiveness of post-fellowship training and any potential impact on the appropriateness of the SET program.

As noted above, the team draws the College's attention to the need under Standard 2.1 to relate the training and education functions to the health needs of the communities it serves. In particular, the College is encouraged to consider needs associated with Indigenous communities, rurality and areas with workforce challenges.

The team notes that a number of the specialties have curricula that are overdue for review and documenting outcomes is aligned with this review for a number of specialties. The College through the Specialty Training Boards must clearly articulate program and graduate outcomes for all specialties, which are publicly available and reflect community needs. The College will need to work with the Specialty Training Boards to agree on timeframes for ongoing curricula review and how the program and graduate outcomes are presented. The team also recommends that the College benchmark its training programs and graduate outcomes internationally.

The team received feedback from a number of senior fellows that the focus on safe working hours was diminishing the quality of graduates. This perception needs to be tested by the College and addressed as appropriate. There were also various reports from trainees that trainees are working hours additional to those recorded formally to bypass safe working hours requirements. Most of the trainees with whom the team met were in favour of additional hours to gain experience and practice. The team recommends that the College and Specialty Training Boards monitor this through the accreditation of training post process.

The College plans to survey new fellows five years post training to determine if their training was fit for purpose and meets community needs. The team agrees this will be a useful tool to guide curricula review leading to program and graduate outcomes. This is discussed further under standard 6.

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College addressed the following condition and recommendation in AMC monitoring submissions.

Conditions to satisfy accreditation standards

5 Define how the College's educational purpose connects to its community responsibilities. (Standard 2.1)

Recommendations for quality improvement

DD In conjunction with the Specialty Training Boards, review and report on the reasons for the pervasiveness of post fellowship training and any potential impact on the appropriateness of the Surgical Education and Training (SET) program. (Standard 2.3)

In 2019, the College defined within its 2019 – 2021 Strategic Plan as its first objective "To support the training and sustaining of the surgical workforce to address the needs of the Australian and New Zealand communities". A number of key actions followed relating to improving selection policies to diversify the workforce, support greater geographic spread of training posts, the implementation of BRIPS and the RAP, increasing training on cultural competence and safety, and including an external community member on each specialty training board.

In 2018, the College reported pervasiveness of post-fellowship training remained a topic of discussion and was being reviewed by the specialty training programs. Different approaches were noted between specialties as a result of differing requirements and identified gaps. In 2019, the College reports it continues to review the situation with regard to post fellowship training and sub-specialty programs that are either sub-specialist or represents opportunities for advanced experience. Post Fellowship Training (PFET) programs may be proposed, having obtained sponsorship from the relevant specialty society, in both countries where necessary. The necessity for PFET programs need to be justified with clearly stated objectives and evidence of specialised technical or scientific knowledge. The College has accredited these PFET programs – Colorectal Surgery, Craniomaxillofacial Surgery, Gastric and Oesophageal Surgery, Hand Surgery, Hepatic, Pancreatic and Biliary Surgery, and Transplantation Surgery.

B 2021 team findings

The follow-up visit considered progress towards the remaining conditions and whether the College had responded to the recommendations for quality improvement.

Conditions to satisfy accreditation standards

6 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)

To be met by 2021.

7 Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available, reflect community needs and which map to the nine RACS competencies. (Standard 2.2 and 2.3)

To be met by 2021.

Recommendations for improvement

BB Benchmark the graduate outcomes of each of the surgical training programs internationally. (Standard 2.2 and 2.3)

CC 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)

The College and specialty training boards' training and education programs continue to deliver high-quality training, equipping surgeons for independent practice.

The College and most specialty societies make reference to serving the community and health systems to deliver high standards of safe, ethical comprehensive health care and leadership. For example, the College's Rural Health Equity Strategic Action Plan states "RACS is committed to its social responsibility and mission to address health inequity, through the levers of representation, selection, training, retention, and collaboration for rural surgical services for rural communities."

The team notes curriculum revisions by some specialist training boards include statements on graduate outcomes, and a minority of specialty training programs do make these graduate

outcome statements publicly available. To meet Standard 2.3 and condition 7, the team considers that a set of graduate outcomes for all programs must be clearly defined and mapped to the ten RACS competencies. The team encourages the College and all training boards to agree on the mutual purpose, competencies and format of the graduate outcomes to be publicly available on the College and society websites. Bi-national specialty training boards need to ensure program and graduate outcomes are aligned to community needs in both Australia and Aotearoa New Zealand.

Throughout the process of accreditation, the College and specialty training boards have demonstrated effort undertaken to ensure broad community and stakeholder engagement. The College and specialty training boards are able to clearly articulate the range of stakeholder and community input. There is specific consumer representation on various College Committees and specialty training boards and collaboration with other specialist colleges. A specific example of collaboration with other colleges is in the process of training site accreditation. Regular consultation processes with Indigenous communities, consumers and other stakeholder groups appear to be in the early stages of development. Embedding these stakeholder consultation processes within various mechanisms for program review will ensure that program outcomes continue to address the health care needs of the community.

The revision of the Surgical Competence and Performance Guide to introduce the tenth competency, Cultural Competence and Cultural Safety, is commendable. However, there is a need to improve the communication strategy in relation to the tenth competency, as the majority of trainees and fellows indicated a lack of awareness. The team found there was a greater cognisance about the tenth competency in Aotearoa New Zealand than in Australia.

Recommendation BB is being addressed through the review of curricula and benchmarking against relevant training programs as part of the process. The College indicates a number of specialty training programs incorporate benchmarking against international training programs to focus on community focused graduate outcomes and a similar approach will be undertaken by other specialty training boards reviewing their curriculum.

Recommendation CC is being addressed through revision of the RACS Surgical Competence and Performance Framework and work is being undertaken by each specialty training board to align curricula accordingly. The College and specialty training boards should note alignment and development of graduate outcomes is not limited to development of professional skills by surgeons as outlined in the RACS Surgical Competence and Performance Framework and should extend to development of technical skills as well. The College and specialty boards are encouraged to have a uniformed approach to how these requirements are presented and made available on the College and specialty society websites to facilitate access to information easily and provide coherent representation of expectations by the College as a whole.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

E The College's commitment to producing surgeons who are viewed by supervisors, hospital administrators and other health professionals as being well-trained and surgically capable.

2017 Conditions to satisfy accreditation standards

5 Define how the College's educational purpose connects to its community responsibilities. (Standard 2.1)

6 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)

7 Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available, reflect community needs and which map to the nine RACS competencies. (Standards 2.2 and 2.3)

2017 Recommendations for improvement

BB Benchmark the graduate outcomes of each of the surgical training programs internationally. (Standards 2.2 and 2.3)

CC 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. (Standards 2.2 and 2.3)

DD In conjunction with the Specialty Training Boards, review and report on the reasons for the pervasiveness of post fellowship training and any potential impact on the appropriateness of the Surgical Education and Training (SET) program. (Standard 2.3)

2021 Accreditation Commendations, Conditions and Recommendations

In 2019, the College addressed condition 5 and recommendation DD in their monitoring submission to the AMC.

In the 2021 follow-up assessment, the team considers condition 6 to be progressing and condition 7 to be not progressing. Recommendation BB and recommendation CC are considered to be progressing in their activities. The remaining conditions and recommendation for improvement under Standard 2 from the 2017 reaccreditation are replaced with condition 3 and 4, and recommendation AA and BB in 2021.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

3 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)

4 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. (Standards 2.2 and 2.3)

2021 Recommendations for improvement

AA Benchmark the graduate outcomes of each of the surgical training programs internationally. (Standards 2.2 and 2.3)

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. (Standards 2.2 and 2.3)

3 The specialist medical training and education framework

3.1 Curriculum framework

The accreditation standard is as follows:

- For each of its specialist medical programs, the education provider has a framework for the curriculum organised according to the defined program and graduate outcomes. The framework is publicly available.

3.1.1 Curriculum framework in 2017

The College introduced the RACS Surgical Education and Training (SET) program in 2007. The training programs are as follows:

- *Cardiothoracic Surgery*
- *General Surgery*
- *Neurosurgery*
- *Orthopaedic Surgery – Australia*
- *Orthopaedic Surgery – New Zealand*
- *Otolaryngology Head and Neck Surgery*
- *Paediatric Surgery*
- *Plastic and Reconstructive Surgery – Australia*
- *Plastic and Reconstructive Surgery – New Zealand*
- *Urology*
- *Vascular Surgery.*

As discussed under standard 2, the College has developed a competency framework, published under the title of Surgical Competence and Performance (2011). This document is complemented by Becoming a Competent and Proficient Surgeon (2012) which defines the nine competencies around which all specialties are expected to structure their training and assessment:

- *Medical Expertise*
- *Judgement – Clinical Decision Making*
- *Technical Expertise*
- *Professionalism and Ethics*
- *Health Advocacy*
- *Communication*
- *Collaboration and Teamwork*
- *Management and Leadership*
- *Scholar and Teacher.*

These competencies are demonstrated through clinical skills, patient care and professional judgement across five domains.

- *Cognitive - Acquisition and use of knowledge to recognise and solve real-life problems.*
- *Integrative - Appraisal of investigative data against patient needs in clinical reasoning, manage complexity and uncertainty, application of scientific knowledge in practice.*
- *Psychomotor - Procedural knowledge, technical skill, manual dexterity, and adaptability.*

- *Relational - The ability to communicate effectively, accountability, works with others, consultative, resolving.*
- *Affective/moral - Self-awareness, ethical, critically reflective, responsible, healthy, safe.*

In the RACS competency framework, progressive development through five stages of increasing complexity is described for each of the nine competencies. The stages are as follows:

- *Pre-vocational - the behavioural markers that describe a level of performance which would be expected of a doctor applying for selection into surgical training.*
- *Novice - the behavioural markers that describe a trainee who has commenced surgical training and who has an aptitude for their surgical specialty.*
- *Intermediate - the behavioural markers that describe the performance of a surgical trainee who is clearly progressing but who still needs a reasonable amount of supervision, has some way to go before being regarded as competent, and thus ready for more independent surgical practice.*
- *Competent - the behavioural markers that describe the performance of a trainee nearing the end of their training program and who can be trusted to perform with a minimum of supervision unless the situation is complex.*
- *Proficient - the behavioural markers that describe the performance expected of a Fellow. They represent a maturity beyond the previous stage and a consolidation of the competencies that have been acquired during training, together with an increasing inventory of experience.*

Each surgical specialty determines the required technical skills and expertise for its program and is expected to make these publicly available. It is noted that a number of specialties have initiated and are undergoing curricular review with plans to update as required.

Curriculum documents	***Curriculum review timeline***
Cardiothoracic Surgery Curriculum, August 2006	*The Board of Cardiothoracic Surgery will be reviewing the curriculum in the coming 24 months. This review will assist with the development of clearer guidelines for competency-based training.*
General Surgery Curriculum Subject Outlines, January 2015	*The Board in General Surgery will move to competency-based training in 12 to 18 months.*
Neurosurgery Curriculum – Syllabus Modules, January 2014	*The Board of Neurosurgery has already introduced competency-based training. It introduced three levels of training with maximum time frames set at each level but flexibility to allow trainees to progress at different speeds.*
Australian Orthopaedic Association SET Syllabus, 2011	*The Australian Orthopaedic Association has commenced a progressive implementation of the revised curriculum. The competency-based training program, AOA 21 begins in Australia in 2018. The New Zealand Orthopaedic Association continues to utilise the Australian Orthopaedic Association SET Syllabus, from pre 2011.*
Otolaryngology Head and Neck Surgery, Training Modules, February 2012	*The curriculum is currently under review with the anticipated launch of the revised curriculum in February 2018.*

Curriculum documents	***Curriculum review timeline***
SET in Paediatric Surgery Curriculum	*The Board completed the formulation of a competency based curriculum in 2013. The Board will review this curriculum in the next 1-3 years.*
Curriculum in Plastic and Reconstructive Surgery	*The Australian Board of Plastic and Reconstructive Surgery has completed a curriculum review with drafts distributed to the specialty groups and external stakeholders for feedback (Australia and New Zealand) by end of 2017. Final documents will be published in 2018 for approval by the College. Implementation will take place in 2019. The New Zealand Board of Plastic and Reconstructive Surgery is collaborating with the Australian Board on the curriculum review and looking at competency-based outcomes.*
Modular Curriculum Portfolio, Surgical Education and Training Urology, September 2013	*Revision of the syllabus/curriculum is underway. In terms of the non-technical competencies, negotiations have commenced with other subspecialty groups (Orthopaedic Surgery) with a view to sharing a common curriculum.*
Vascular Curriculum Modules	*The Board of Vascular Surgery reported that a number of training modules need reviewing and this process has commenced. There has been progress on moving towards competency-based training. The expected levels of performance for each level of training have been developed.*

The SET program has a defined structure combining aspects of time (rotations and duration of training) and competence (the progressive attainment of skills and expertise). Generally, each year of surgical training is comprised of six- to twelve-month clinical rotations (with three-month rotations for some specialties in the first year of training). The surgical specialties differ slightly in structure and in the time required to achieve independent practice, as shown in the following table:

		SET Program										
	PGY 1-4/5	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***	***11***
JDocs												
Cardiothoracic Surgery		*Expected duration of clinical training*						*Maximum time available to complete all requirements*				
General Surgery commencing pre-2017		*Expected duration of clinical training*						*Maximum time available to complete all requirements*				
General Surgery commencing from 2017		*Expected duration of clinical training*				*Maximum time available to complete all requirements*						
Neurosurgery		*Basic training 1 -2 years*		*Intermediate training 3-4 years*				*Advanced training 1-3 years*				
Orthopaedic Surgery Australia		*Intro 1 year*		*Core 3 years*		*Transition 1 year*		*Maximum time available to complete all requirements*				
Orthopaedic Surgery NZ		*Expected duration of clinical training*						*Maximum time available to complete all requirements*				
Otolaryngology Head and Neck Surgery		*Expected duration of clinical training*						*Maximum time available to complete all requirements*				
Paediatric Surgery		*SET 1*		*Early SET*		*Mid SET*		*Senior SET*		*Maximum time available to complete all requirements*		
Plastic and Reconstructive Surgery Australia		*Expected duration of clinical training*						*Maximum time available to complete all requirements*				
Plastic and Reconstructive Surgery New Zealand		*Expected duration of clinical training*						*Maximum time available to complete all requirements*				
Urology commencing pre-2016		*Expected duration of clinical training*						*Maximum time available to complete all requirements*				
Urology commencing from 2016		*Expected duration of clinical training*						*Maximum time available to complete all requirements*				
Vascular Surgery		*Expected duration of clinical training*						*Maximum time available to complete all requirements*				

There are several specialties which now emphasise expected standards of performance at particular stages, a move away from the definition of training by number of years. For example, neurosurgery and otolaryngology head and neck surgery are introducing minimum and maximum periods of time in which competencies at each level must be achieved. General surgery has reduced the specified duration of training from five to four years and expects the competence of entry-level trainees will be evidenced by procedure-based assessments and other basic skills. The structure and framework for each specialty are found in the individual specialty regulations and in the RACS Guide to SET.

3.1.2 2017 team findings

There has been good progress made with the SET program since its introduction in 2007. The training, education and assessment programs of the College are well-respected locally, nationally and internationally. The fellowship of RACS is a designation sought after and valued by trainees and fellows. The College has defined its competency framework which is publicly available on the College's website. The Specialty Training Boards, with support from specialty societies and associations, create and deliver the curricula, which are also published either on the College or specialty society/association website. Although cumbersome, both the College and most Specialty Training Boards see benefit in this arrangement.

Standard and maximal times are set out for each specialty training program and differ between specialties. Maximal times in some specialties include time taken for research and other degrees (PhD etc.).

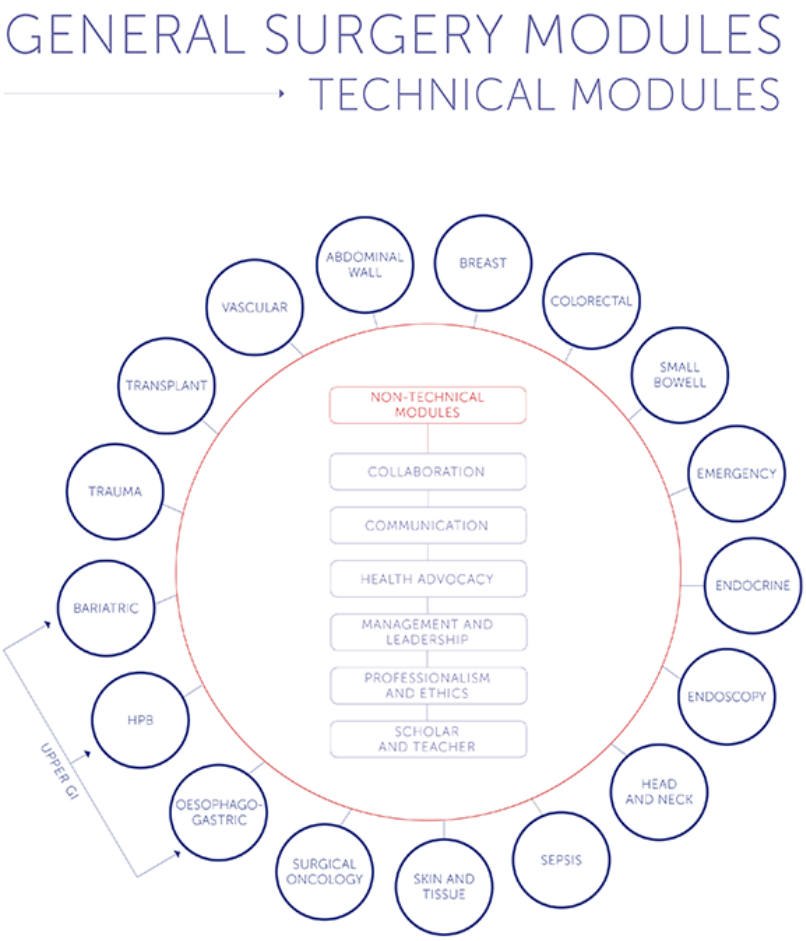
The team heard of concerns related to the length of training, including the time taken to gain entry into surgical training programs. The team agreed with a view expressed by some stakeholders outside the College that the time to train a surgeon is long, possibly too long. This has consequential effects: first, a lessening of the years in which surgeons may operate independently; second, being a deterrent to potential applicants; and finally, the effect on the workforce pipeline. The team commends the specialties of general surgery and urology for recently shortening training by a year, and the College for ensuring that competency-based training remains on the agenda.

For many years, the College has planned to introduce competency-based surgical education and training. However, the definition and understanding of what this actually means is variable, and it is not yet fully implemented. The team considers the College must better define what it means by 'competency-based training' and how 'time in training' and 'procedure numbers' complement specific observations of satisfactory performance in determining 'competence'. The establishment of College-wide definitions would promote progress on this initiative for all specialties and for those who have started the journey (Paediatric Surgery, Vascular Surgery).

The team encourages the College to look at further ways to increase the efficiency of training, such that 'competence' is achieved with fewer hours over a reduced time period. Time-based criteria have led to repeating significant portions of rotations and experiences. The team heard that Specialty Training Boards are able to use their discretion in accrediting a period of training for well-performing trainees even when they had not met the minimum number of weeks. However, the team considers the criteria for such decisions are not sufficiently explicit. Furthermore, trainees perceived that none of a six-month period would be granted if they exceeded the maximum weeks of leave. The College should continue to look at whether periods of less than the standard six months could 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.

The curricula of the individual specialties were provided to the team as part of the assessment with further information submitted in response to questions asked by the team. Owing to the variety in the way curricula were presented, it proved a challenge for the team to compare each specialty with others, with the RACS competency framework, and with each of the AMC standards. Some curricula had not been revised since 2006. All had considerable detail on the technical competencies of the specialties expected at the completion of training, and most had a list of graduate competencies in the non-technical domains. Few specialties had outlined non-technical competencies at each stage of training/SET level.

General Surgery was an example of a curriculum where the competency framework shows an explicit link between the non-technical and the specialty-specific standards for each topic that incorporates Judgement/Clinical Decision Making, Clinical Assessment, Investigations and Principles of Management, and Technical Expertise.



The team agreed with stakeholders that all surgeons, regardless of specialty, should have a similar set of broad professional knowledge, skills and behaviours. It is not sufficient to assume that this will be brought forward from medical school or the early postgraduate period, or acquired from the healthcare environment. These aspects of surgery must be signalled as important by the Specialty Training Boards and reinforced and role modelled in the context of surgical training and practice.

The team accepts that a certain level of heterogeneity is inevitable, especially for the specialty-specific aspects. However, the team considers that the College, through the Specialty Training Boards, should develop more consistency in certain curricular aspects, such as:

1 *a uniform and concise statement of program outcomes by specialty*

2 *defined graduate outcomes by specialty which map to the nine RACS competencies*

3 *how these (items 1 and 2) are portrayed publicly*

4 *clear learning outcomes at each stage of training which map to the graduate outcomes, thence the RACS competency framework, as well as to assessments*

5 *defined coverage of the subject areas in standard 3.2 below*

6 *greater concordance in the non-technical competencies across all surgical specialties.*

With respect to the last point, the College might look to other specialist medical colleges. Some colleges have a number of different specialty programs yet only one professional qualities curriculum.

Finally, the team suggests that the College and the Specialty Training Boards address the issues raised in standard 2, i.e. confirming program and graduate outcomes of surgical training, as a necessary first step in alignment of surgical curricula.

3.2 The content of the curriculum

The accreditation standards are as follows:

- The curriculum content aligns with all of the specialist medical program and graduate outcomes.
- The curriculum includes the scientific foundations of the specialty to develop skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge.
- The curriculum builds on communication, clinical, diagnostic, management and procedural skills to enable safe patient care.
- The curriculum prepares specialists to protect and advance the health and wellbeing of individuals through patient-centred and goal-orientated care. This practice advances the wellbeing of communities and populations, and demonstrates recognition of the shared role of the patient/carer in clinical decision-making.
- The curriculum prepares specialists for their ongoing roles as professionals and leaders.
- The curriculum prepares specialists to contribute to the effectiveness and efficiency of the health care 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 health settings within the Australian and/or New Zealand health systems.
- The curriculum prepares specialists for the role of teacher and supervisor of students, junior medical staff, trainees, and other health professionals.
- The curriculum includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, so that all trainees are research literate. The program encourages trainees to participate in research. Appropriate candidates can enter research training during specialist medical training and receive appropriate credit towards completion of specialist training.
- The curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia and Māori health, history and cultures in New Zealand as relevant to the specialty(s).
- The curriculum develops an understanding of the relationship between culture and health. Specialists are expected to be aware of their own cultural values and beliefs, and to be able to interact with people in a manner appropriate to that person's culture.

3.2.1 The content of the curriculum in 2017

The SET framework emphasises self-directed learning aligned to supervised clinical work. The formal elements of the curriculum framework are outcome-focused as trainees demonstrate acquisition and performance of the nine RACS competencies. As detailed under standard 3.1, the standards of performance through SET, leading to progressive independence, are indicated in the document, Becoming a competent and proficient surgeon (2012) and Surgical Competence and Performance (2011).

The program and graduate outcomes are discussed in further detail under standard 2 of this report. The curriculum underpins these outcomes and alignment is achieved using the nine RACS

competencies as the framework. Each specialty determines the required technical skills and expertise for the relevant program.

Scientific and technical competencies

The Training Boards determine the specialty-specific technical requirements to practise as generalists in the specialty. The specialty curricula set the foundation for the scientific and technical knowledge required for practice in that specialty, along with the core professional competencies required of all surgeons.

The curriculum covers aspects of professionalism and technical expertise that prepare trainees to become surgeons and contribute to the healthcare system across a range of settings. All specialties train for the generalist outcomes of the specialty, with formal post-fellowship training and/or experiential sub-specialisation occurring in the early years of practice as a surgeon, after admission to fellowship.

Surgical training typically occurs across several hospitals and networks, across several states if training in Australia and, for some specialties, a trainee may train in both Australia and New Zealand. The College reports that this exposes trainees to a wide variety of patients across different populations. Exposure across language, education and socio-economic status levels can be discussed by supervisors and trainers. The College acknowledges that in a patient-centred approach, practice in a capital city tertiary referral hospital is not the same as practice in a major regional hospital, or practice in an outer-urban or provincial hospital.

Health Advocacy

The health advocacy competency expects trainees to identify and respond to the health needs and expectations of individual patients, families, carers and communities.

Surgical trainees work in multidisciplinary teams with a focus on patient-centred care. The clinical basis of SET, in which trainees combine supervised clinical practice with graduate learning, means that trainees work and train in the healthcare system. Components of clinical practice involve developing a working knowledge of this system.

Quality and safety in healthcare

Ensuring quality and safety in surgery is expected of trainees as part of the management and leadership competency. The specialty curricula contain references to quality and safety and are examined in some fellowship Examinations.

Since 2013, all applicants for surgical training must complete the Hand Hygiene Australia eLearning module, and from 2016 applicants must also complete the Operating with Respect eLearning module.

Professionals and leaders

As part of the professionalism competency, trainees are expected to demonstrate a commitment to patients, the community and the profession through the ethical practice of surgery.

In the management and leadership competency, trainees are expected to lead, provide direction, promote high standards, match resources to demand for services and show consideration for all members of staff. Leadership training is provided in learning modules, skills courses and assessments. The College has recently developed a Leadership in Everyday Practice course open to trainees, fellows and specialist international medical graduates. Two courses will be run in 2017.

Teacher and supervisor

In the scholar and teacher competency, trainees are expected to demonstrate a commitment to reflective learning, and the creation, dissemination, application and translation of medical knowledge. Trainees are encouraged to contribute as skills course instructors, teachers of their

juniors, and by engaging with junior doctors seeking a career in surgery through the JDocs Framework. Trainees can attend the Foundation Skills for Surgical Educators course and apply for membership of the Academy of Surgical Educators. Several trainees are enrolled in the master of surgical education program.

The collaboration and teamwork competency, expects trainees to work cooperatively with peers, other trainees and other health professionals to develop a shared picture of the clinical situation and facilitate appropriate task delegation, to ensure the delivery of safe, effective and efficient surgery.

Scientific foundations and research

Research is encouraged in all specialties. All surgical trainees undertake one or more research projects during SET. The research requirement may include (but is not limited to): presentation of a paper/poster display to a meeting for which abstracts are subject to review and selection; publication in a peer-reviewed journal; dissertation with a written review of a clinical problem, together with a critical literature review; period of full-time research; research higher degree at Masters level or above.

The College offers a Critical Literature Evaluation and Research (CLEAR) course in evidence-based medicine which is compulsory for some disciplines. This is described further under standard 4.2.

Culture and Health

As part of the health advocacy competency, trainees are expected to identify and respond to the health needs and expectations of individual patients, families, carers and communities.

The College provides resources to assist trainees, fellows and specialist international medical graduates to recognise their own and others' cultural values and beliefs. The College has developed an Intercultural Competence for Medical Specialists eLearning resource.

Aboriginal and Torres Strait Islander and Māori health

Aboriginal and Torres Strait Islander and Māori health and culture are primarily included as part of the health advocacy and communication competencies. The Standards of Clinical Performance Guide and Becoming a Competent and Proficient Surgeon state that trainees are expected to:

- *provide care with compassion and respect for patient rights*
- *recognise that culture and beliefs affect patients and their expectations*
- *adapt patient care according to their concerns and expectations*
- *consistently deal with the challenges presented by different value systems*
- *adapt practices and care of patients from diverse backgrounds according to their culture and beliefs.*

The College has developed an Australian Indigenous Health and Cultural Learning eLearning Module. The Board of Otolaryngology Head and Neck Surgery is currently developing a curriculum module specific to Aboriginal and Torres Strait Islander and Māori health. New Zealand trainees are encouraged to complete the Ministry of Health's online module, Foundation Course in Cultural Competency and to utilise the Medical Council of New Zealand's cultural competency resources.

3.2.2 2017 team findings

Trainees, supervisors and healthcare providers consider that the product of RACS training is a well-trained surgeon in the designated specialty. Those involved in training take pride in the training programs. Based on the documents presented, stakeholder interviews, the emphasis on attendance at courses and conferences, the suite of RACS courses, and the nature of the Fellowship Examination,

the team was in no doubt that the scientific and technical aspects of surgical training are very well covered by the College and the Specialty Training Boards.

As mentioned in standard 3.1 above, the team found considerable heterogeneity in other curricular aspects, such as whether material was covered at all, or in how well it aligned with graduate outcomes and assessments. The College with the Specialty Training Boards must show that all areas of the curriculum are important, through College-based or approved learning activities and assessments which map to relevant competencies.

The team has not reported on every strength and weakness in curricula content, but outlines several areas for enhancement. The team considers the College through the Specialty Training Boards must 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.

Curricula could be more explicit about how trainees learn to take into account the broader patient context. For example, this could include consideration of patient-family support and the patient's living situation. Another is how surgeons decide when it is best not to operate, and how this is communicated.

It was a perception of the team that the management of peri-operative comorbidities and complications are often delegated unnecessarily to medical or other consulting services. Management of common and straightforward comorbidities and complications in surgical patients should be specifically included in the curricula for all specialties.

At the site visits, the team heard that positive interprofessional communication needs continuing emphasis.

Progress has been made in the area of cultural competence but this is not yet sufficient to meet this standard. Often coverage of this aspect has been assumed from the basic medical degree curriculum or the employing hospital's orientation program, and it is not a formal element in every curriculum.

The Medical Council of New Zealand has a module on cultural competence that is required by some specialties but not others, despite cultural competence training being mandatory in New Zealand. The College's eLearning module on Australian Indigenous Health and Cultural Learning is not compulsory in all Australian curricula. Trainees reported to the team that cultural competence training is an area of deficiency in all specialty curricula. More work and attention will be required of each specialty in appropriately addressing cultural competence in its curriculum.

In addition, cultural competence with regard to Aboriginal and Torres Strait Islanders and/or Māori, needs to be an essential component in its own right in all curricula, and have ongoing emphasis. This includes an understanding of the determinants of the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori.

In the wake of the expert advisory group recommendations regarding discrimination, bullying and sexual harassment, there have been several initiatives to facilitate both trainee and fellow learning in practice. Online modules are available and mandatory for fellows and should be available to all trainees. While the undertaking of courses is a good start, it is imperative that corresponding assessments (e.g. multi-source feedback) have specific enough criteria to enable the College and the Specialty Training Boards to use these in progression decisions.

3.3 Continuum of training, education and practice

The accreditation standards are as follows:

- There is evidence of purposeful curriculum design which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice, including continuing professional development.

- The specialist medical program allows for recognition of prior learning and appropriate credit towards completion of the program.

3.3.1 Continuum of the training, education and practice in 2017

A significant change since the last AMC assessment has been the development of the JDocs Framework. The JDocs Framework provides those interested in careers in procedural medicine with an opportunity to identify, develop and record the skills they require to enter specialty training. JDocs provides a comprehensive curriculum outline, and access to educational resources and self-assessment tools.

'Vertical' integration of the curriculum begins with JDocs, which aligns with the nine RACS competencies and uses key clinical tasks to articulate surgical skills early in trainees' careers and within the context of clinical practice. The need to support new surgical trainees by providing them with guidance on how to gain knowledge and skills that would readily integrate into surgical training was a significant driver in the development of JDocs.

The RACS continuing professional development program also uses this framework of competencies and outcomes. This means it is possible to map the curriculum from junior doctor to experienced independent consultant and throughout a surgical career.

The SET program was developed to encourage trainees to enroll directly in their preferred specialty, but within surgical training it is possible to move 'horizontally' from one specialty program to another, via the selection process. This does have drawbacks as transferring results in lost opportunity for the specialty who has trained the trainee for one to three years, and for doctors who were not selected during that period due to the number of posts available. It also may result in less than optimal numbers of surgeons graduating from the original specialty. The 2014 Review of the RACS SET Program noted that 90% of movement between specialties were from general surgery to other specialties. In 2015, approximately 42% of trainees who applied for another specialty were successful in transferring.

Specialty training programs have processes to acknowledge prior learning in another surgical specialty. A small number of fellows undertake training in a second specialty.

Recognition of Prior Learning

The College recognises that trainees entering SET may have gained prior medical training or experience comparable to components of the RACS SET program in terms of learning outcomes, competency outcomes and standards. The Recognition of Prior Learning (RPL) policy is available on the College's website. The policy is used in conjunction with the relevant specialty SET Program regulations. The outcome of assessment of RPL by training program is provided in the table below.

Training Program	***Year***	***No. of applicants***	***No. accepted***	***No. rejected***
Cardiothoracic	*2013*	*2*	*0*	*2*
	2014	*3*	*1*	*2*
	2015	*1*	*0*	*1*
General Surgery	*2013*	*49*	*40*	*9*
	2014	*59*	*46*	*13*
	2015	*87*	*78*	*9*
Neurosurgery	*2014*	*1*	*1*	*0*
	2015	*8*	*8*	*0*
	2016	*12*	*11*	*1*
Otolaryngology Head and Neck Surgery	*2014*	*2*	*1*	*1*
	2015	*0*	*0*	*0*
	2016	*1*	*1*	*0*
Orthopaedic Surgery Australia	*2013-15*	*4*	*0*	*4*

Training Program	*Year*	*No. of applicants*	*No. accepted*	*No. rejected*
Orthopaedic Surgery New Zealand	*2013-15*	*1*	*0*	*1*
Paediatric Surgery	*2013*	*0*	*0*	*0*
	2014	*5*	*5*	*0*
	2015	*0*	*0*	*0*
Plastic and Reconstructive Surgery (Australia)	*2014*	*0*	*0*	*0*
	2015	*1*	*0*	*1*
	2016	*1*	*0*	*1*
Plastic and Reconstructive Surgery (New Zealand)	*2014-16*	*0*	*0*	*0*
Urology	*2014*	*1*	*1*	*0*
Vascular	*2014*	*2*	*2*	*0*
	2015	*1*	*1*	*0*
	2016	*0*	*0*	*0*

3.3.2 2017 team findings

The team found evidence of purposeful curriculum design which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice, including continuing professional development. The nine RACS competencies act as an integrating framework. For each specialty, training is clearly structured under years or stages of training. Trainees report the curriculum is clear to them.

There has been a recent and optional addition to prevocational training under the name of JDocs. This has been carefully designed to link with SET selection criteria and training. Thus JDocs provides structure and a framework for prevocational trainees wishing for a surgical career. RACS has been purposeful in leaving this as a voluntary and non-accredited program.

Some specialties require sign off on prevocational competencies (e.g. appendectomy in general surgery) and this is further discussed under standard 7. Some trainees and supervisors perceived that these prevocational requirements change at times with little warning.

However, as the team has indicated previously, horizontal integration between the technical and non-technical aspects of surgical training and between specialties is not yet sufficiently explicit. The Fellowship Examination could be enhanced as a horizontal integrating mechanism by inclusion of another column in the examination blueprint for non-technical aspects.

As noted under standard 2.3, the team heard that many trainees consider they are unprepared to work independently as a consultant surgeon and that a fellowship year is commonly sought. This highlights there may be difficulties in the articulation of SET and junior consultant practice. However, with the shortening of the length of training already implemented in a number of specialties, this sentiment of unpreparedness may worsen in coming years. The College plans to undertake a survey to evaluate preparedness for practice. It will be important for the College to identify whether the issue is one of trainee competence or confidence, and what supports might be put in place to aid the transition to independent practice. This could include preparation of trainees to recognise their own CPD needs.

3.4 Structure of the curriculum

The accreditation standards are as follows:

- The curriculum articulates what is expected of trainees at each stage of the specialist medical program.
- The duration of the specialist medical program relates to the optimal time required to achieve the program and graduate outcomes. The duration is able to be altered in a flexible manner according to the trainee's ability to achieve those outcomes.

- The specialist medical program allows for part-time, interrupted and other flexible forms of training.
- The specialist medical program provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes.

3.4.1 Structure of the curriculum in 2017

The specialty curricula identify markers that demonstrate competence in the range of activities undertaken by trainees. They also identify assessment and examination tasks. Regulations specify barrier assessments to ensure trainees demonstrate required knowledge and skills before progressing to the next stage of training. Some specialties (for example, Neurosurgery, Otolaryngology Head and Neck Surgery, and Orthopaedic Surgery) specify minimum and maximum durations for stages of training. For example, in Orthopaedic Surgery the current training program is five years in duration, with a minimum training time of four years with flexibility allowed for trainees who require additional support or who demonstrate exceptional performance. There are differences in the duration of the program between specialties. The duration of each training program is determined by the individual Specialty Training Boards taking account of the specialty skills required, and estimated time needed to achieve competence.

The College is progressing more flexible approaches to the issue of the duration of training and taking steps to improve assessment by investigating entrustable professional activities (EPAs). Recent developments in this area are the key clinical tasks introduced in the JDocs Framework and the procedural skills and professional capabilities assessments used in selection to the training program in General Surgery. General Surgery is piloting some EPAs in 2017.

Surgical education and training remains significantly time-based and training in less than the usual time is rare. However, should a trainee come from another specialty, or have done significant other postgraduate medical training, then the program is able to allow for prior learning, especially with excellent performance at work.

Deferral, Interruption and Part-Time Training

Decisions to grant applications for deferral, interruption or part-time training are made by the relevant Specialty Training Board in accordance with specialty regulations, taking into consideration the reasons for the request, the trainee's progress to date and logistical considerations. Trainees in part-time and interrupted training in 2014, 2015 and 2017 are provided in the following table. Figures were not provided for 2016.

Year	***Application***	***CAR***	***GEN***	***NEU***	***ORT***	***OTO***	***PAE***	***PLA***	***URO***	***VAS***	***Total***
2014	*Part-time*	*0*	*6*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	***6***
	Interrupted	*2*	*40*	*1*	*2*	*10*	*1*	*6*	*3*	*5*	***70***
2015	*Part-time*	*0*	*3*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	***3***
	Interrupted	*3*	*36*	*2*	*0*	*6*	*1*	*3*	*2*	*4*	***58***
2017	*Part-time*	*0*	*5*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	***5***
	Interrupted	*2*	*33*	*4*	*5*	*4*	*4*	*5*	*4*	*2*	***63***

3.4.2 2017 team findings

In most cases, the specialty curricula outline expectations by year or stage. Duration is outlined in 3.1. As has been stated, the technical competencies within each specialty are presented in detail, with less detail and much more variability between specialties in the non-technical competencies.

As discussed under standard 3.2, the team considers that the College must better define what it means by 'competency-based training' and how 'time in training' and 'procedure numbers' complement specific observations of satisfactory performance in determining 'competence'.

The College reports a low number of trainees undertaking part-time training or altered learning arrangements, with more being able to interrupt training. In its documentation to the team, the College reported only five trainees were currently in part-time training, all in General Surgery, but anecdotal reports suggest there are more. Of note, Paediatric Surgery advocates for improvement in training conditions for women surgeons. The team commends Paediatric Surgery for the flexible position about to be created at Gold Coast Hospital. The College has policies in place that permit such training, however trainees do not seem to be taking advantage of this option for a number of reasons. A number of reasons were presented to the team as to why there were so few part-time trainees. Among these were:

- *jurisdictional requirements*
- *service demands*
- *small numbers of trainees in some specialties*
- *trainees did not want it*
- *Specialty Training Boards did not facilitate it*
- *a lack of role models*
- *curriculum demands, including the need to develop and retain 'muscle memory'; and training already long.*

The team is of the view that trainees are aware they may request flexible or part-time training but are hesitant to make such a request, for one or more of the reasons listed.

The College in its 2016 Diversity and Inclusion Plan makes a commitment to 'increase the representation of women in the practice of surgery by removing barriers to participation and introducing flexible training models for any trainee or surgeon, irrespective of gender.' The team noted that flexible training is now a standing item on the Board of Surgical Education and Training agenda. Several other Specialty Training Boards have, or are considering, flexible training policies and models such as job-sharing or designating positions as part-time. The College's momentum to identify and remove overt and hidden barriers to flexible training must be maintained.

The New Zealand chair of the Board of Otolaryngology Head and Neck Surgery has developed a proposal to amend the current rules to make interruption more 'user-friendly'. The team considers this proposal should be shared with other surgical specialties.

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College addressed the following recommendation in AMC monitoring submissions.

Recommendations for quality improvement

FF Make available to all trainees the learning modules under the Building Respect, Improving Patient Safety (BRIPS) program, once most or all College fellows are trained. (Standard 3.2)

In 2018, mandatory training for supervisors, trainers and senior committee members neared full compliance, making the Foundation Skills for Surgical Educators (FSSE) available to trainees. The RACS Activities Report showed a high number of trainers and participants involved in the Operating with Respect module during 2018, an increase from 2017, and there were 120 participants in the Training in Professional Skills (TIPS) course.

B 2021 team findings

The follow-up visit considered progress towards the remaining conditions and whether the College had responded to the recommendations for quality improvement.

Conditions to satisfy accreditation standards

8 Enhance and align the non-technical competencies across all surgical specialties including a consideration of the broader patient context. (Standard 3.2)

To be met by 2021.

9 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)

To be met by 2021.

10 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)

To be met by 2021.

11 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)

To be met by 2021.

12 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)

To be met by 2020.

13 RACS has a policy that is applicable to all specialty training programs to remove the overt and hidden barriers to flexible forms of training. RACS must build on the existing policy and processes, and liaise with hospitals to implement flexible training. (Standard 3.4.3)

To be met by 2018.

Recommendations for improvement

EE 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 3.1)

The team found the College and the specialty training boards to be well organised and committed to providing high quality training opportunities for the next generation of surgeons. There are many examples of good practice in curriculum design and training that could be shared amongst the specialty training boards.

The specialty training boards are all aware of the requirements to update their curricula to incorporate non-technical competencies though many indicated they are waiting for the Professional Skills curriculum to be finalised by the College to undertake these revisions. Some specialty training boards have progressed the inclusion of nine existing technical and non-technical competencies in existing or new curriculum and intend to add the tenth competency on cultural competency and cultural safety once this is available. The specialty training boards have

variable timelines and approaches for incorporating the competencies and Professional Skills curriculum and would benefit from a deadline for implementation from the College's Education Board.

Progress is reported with inclusion of most non-technical competencies in:

- Cardiothoracic Surgery, Orthopaedics Australia (AOA21), OHNS curriculum in 2018 and 2019.
- Orthopaedics (New Zealand) is now adapting the AOA21 curriculum for Aotearoa New Zealand.
- General Surgery's new curriculum commencing in 2022 in both Australia and Aotearoa New Zealand.
- Vascular Surgery has included the tenth competency into their new curriculum.

The collaborative approach for the Professional Skills Curriculum Development Project is positively received, engaging all specialty training boards and built understanding of the Professional Skills curriculum.

Each specialty training board and program will have different opportunities to demonstrate application of non-technical competencies and these differences are reflected in each specialty training board's curricula format. However, clear mapping of how the competencies are being demonstrated, at which levels and in which phase of training would address inconsistences and provide confidence to the College that the specialty training boards are addressing this condition.

The Training in Professional Skills (TIPS) course is available as a learning resource for trainees and supervisors, and is mandatory for trainees to undertake. The College indicated reasons for the variability between training programs was deliberate as the RACS TIPS Committee had undertaken a stepped approach to the program being implemented across the specialty programs. Volunteer faculty facilitates this course and time was needed to increase course delivery to support increased trainee demand. The College's Education Board and the Board of Surgical Education and Training (BSET) should continue to take necessary steps to ensure trainees complete the TIPS course as part of their training programs and maintain content relevance of the TIPS course especially as more specialty training boards implement changes to their curricula.

The College has revised the Surgical Competence and Performance Guide to further emphasise the need for a surgeon to contribute to the effectiveness of the healthcare system. In particular, Competency 5, Health Advocacy, in the Surgical Competence and Performance Guide clearly articulates the expected behaviour and ability of all surgeons to identify and respond to the health needs of patients, family, carers as well as the wider community.

While demonstration of this competency is part of the Professional Skills curriculum implementation, there continues to be a need to monitor Condition 9 separately. The College and a number of specialty training boards are still to determine how best to both teach and assess this competency in a manner that influences clinical decisions and judgement. When complete, the Professional Skills curriculum will assist the College and specialty training boards to better understand the breadth of learning opportunities for this competency. Evaluation of the new curricula, such as General Surgery and AOA21, may inform the curricula of other specialty training boards.

The specialty training boards indicate that their curricula documents the management of peri-operative medical conditions and complications. Existing curricula would benefit from clearly articulating explicit learning outcomes for the management of peri-operative medical conditions. The team heard from trainees and supervisors often citing pre-operative meetings and ward rounds as examples of peri-operative training. The College should support the development of learning outcomes by specialty training boards by providing clear direction on expectations for

its surgeons in peri-operative management. Again, sharing of good practice between specialty training boards as part of the current reviews will assist with wider inclusion.

CCrISP® is recognised by trainees and fellows as an excellent program for developing skills in the management of the deteriorating patient.

The College is demonstrating a commitment to the health needs of Aboriginal and Torres Strait Islanders and Māori by introducing a tenth competency as part of its Professional Skills curriculum. The development of the tenth competency, Cultural Competence and Cultural Safety, and the leadership shown to growing the number of Aboriginal, Torres Strait Islander and Māori surgical trainees and fellows is commendable.

The development of eLearning resources to support trainees with the behavioural markers for cultural competence and cultural safety will also assist with teaching of this competency. The modules planned will relate to promoting the status of Aboriginal and Torres Strait Islander peoples in Australia, developing cultural safety and incorporating into patient care, and promoting cultural competency and cultural safety in healthcare. The RACS Maori Health Advisory Group is working with the University of Otago to develop online and face to face cultural safety training as referenced in Standard 8.

The team heard that awareness of the introduction of the tenth competency amongst supervisors and trainees was not widespread. Clear communication by the College and specialty training boards to supervisors, trainees and applicants to the SET program is required to emphasise the importance of this competency upon implementation.

The College reported there has been agreement among the specialty training boards on a hybrid approach of competency-based and time-based surgical training. There is wide support and expertise for the hybrid model of competency-based and time-based training with specialty training programs at variable stages of development and implementation. However, the development of a shared definition does not appear to have been progressed, and may result in unnecessary work especially by some specialty training boards independently developing their understanding of competency-based training and associated experiential learning approaches. Progress on defining a standard definition for the hybrid competency-based and time-based approach is critical to ensuring consistent development and implementation across specialty training programs. Sharing of information amongst specialty training boards will also support cohesive content development and implementation processes. The College should also consider feedback from specialty training boards and programs that may struggle in their understanding of this model and how to practically implement within their programs and provide the adequate support. This will help to ensure quality educational outcomes are achieved for all specialty training programs.

The College has made significant progress to address overt and hidden barriers to flexible training. The overarching Trainee Registration and Variation Regulation that facilitates trainees undertaking flexible training posts is endorsed by all specialty training boards. There is evidence trainees were well supported by the College in their applications for flexible and part time training and the specialty training boards were clear in their commitment in supporting flexible training. The College is also promoting and raising awareness about flexible training options amongst trainees through a Trainee Engagement Working Group.

The team heard that while there are increasing opportunities for part-time training positions, a number of these positions were subsequently not being taken up. The survey report, *Breaking barriers; developing drivers for female surgeons* points to the barriers and opportunities to further improve entry and training for female trainees, and others who seek more training flexibility. Training periods of less than six months were available in some specialty training programs though the minimum percentage of training is 50% and all training requirements at full-time load are expected. This could also be a barrier for trainees applying and accessing flexible training.

New fellows and trainees did point to competency-based training as a possible solution to enable flexible training to become more accessible. However, this will require the hybrid time-based and

competency-based programs as well as the education policies to support flexibility in a competency-based structure.

The implementation of the Diversity and Inclusion Plan will further strengthen the candidate base for surgical training. The rapid expansion of online training sessions and eLearning resources in response to COVID-19 restrictions is seen by trainees as a positive move and they would like this to continue to enable equity access to training.

The College has made progress on recommendation EE and indicated continued action will be taken in response. Work has been undertaken by the College to ensure flexible training is accessible for trainees and challenges were recognised in creating part-time posts due to variability in the location and experience of trainees making these requests. Definition of particular circumstances that too narrowly define eligibility may also reduce access to flexible training. As noted in the commentary above, there is variability among the specialty training programs on the duration of flexible training though there is a College policy of a minimum of 50% full time training for assessment of competence.

The College has also made provision on its website indicating details on qualifications for recognition of prior learning. These include a list of skills courses equivalent to ASSET, CCrISP®, EMST and CLEAR for which recognition of prior learning will automatically be granted. Specialty training boards also publish regulations to inform recognition of prior learning for clinical, research and other application skills courses and examinations administered, and forms part of the SET training program.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

F The progress that has been made with the Surgical Education and Training (SET) program since its introduction in 2007.

G The formal surgical competency framework in the form of the nine RACS competencies for use across all surgical specialties.

H Ongoing desire for improvement as indicated by a number of surgical specialties undertaking curriculum review, as well as the move by the College and some surgical specialties to introduce curricula based on competencies expected at each stage of training.

2017 Conditions to satisfy accreditation standards

8 Enhance and align the non-technical competencies across all surgical specialties including a consideration of the broader patient context. (Standard 3.2)

9 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)

10 Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs. (Standards 3.2.3, 3.2.4 and 3.2.6)

11 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)

12 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)

13 RACS has a policy that is applicable to all specialty training programs to remove the overt and hidden barriers to flexible forms of training. RACS must build on the existing policy and processes and liaise with hospitals to implement flexible training. (Standard 3.4.3)

2017 Recommendations for improvement

EE 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 3.1)

FF Make available to all trainees the learning modules under the Building Respect, Improving Patient Safety (BRIPS) program, once most or all College fellows are trained. (Standard 3.2)

2021 Accreditation Commendations, Conditions and Recommendations

In 2019, the College addressed recommendation FF in their monitoring submissions to the AMC.

In the 2021 follow-up assessment, the team considers condition 8, 9, 10, and 11 to be progressing, condition 12 to be not progressing and condition 13 to be satisfied. Recommendation EE is progressing in its activities. The remaining conditions and recommendation for improvement under Standard 3 from the 2017 reaccreditation are replaced with condition 5, 6 ,7 ,8 and 9 and recommendation CC in 2021.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

5 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)

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

7 Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs. (Standards 3.2.3, 3.2.4 and 3.2.6)

8 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)

9 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)

2021 Recommendations for improvement

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. (Standards 3.3 and 3.4.2)

4 Teaching and learning

4.1 Teaching and learning approach

The accreditation standard is as follows:

- The specialist medical program employs a range of teaching and learning approaches, mapped to the curriculum content to meet the program and graduate outcomes.

4.1.1 Teaching and learning approach in 2017

The College delivers surgical training through public and private hospitals in Australia and public hospitals in New Zealand. Clinical training in hospitals is structured at hospital, rotational, regional, national and/or bi-national levels.

A wide range of teaching and learning approaches is used across the surgical training programs. Work-based experiential learning and formal sessions in the clinical context are supplemented by online and printed/scheduled materials. Clinically-based learning is supervised by surgical specialists, cognisant of curriculum requirements, and in accordance with the College's hospital and training post accreditation requirements. In addition to independent self-directed learning, there are group activities and mandatory courses, workshops, simulation, eLearning, peer-to-peer learning, journal clubs, and study groups. There is an increasing use of web-based technology and simulation as a training tool. Each specialty training program follows a curriculum and recommends reference books and supplementary resources relevant to the specialty. Trainees also have access to the extensive RACS library.

The College supports the use of simulation in the training program. Several specialties have introduced simulation into their requirements as relevant to specialty practice. As part of the urology curriculum review, the Board of Urology is currently reviewing how simulation may be better incorporated into the curriculum. The College's head office has a well-equipped skills laboratory, as do other states/territories and New Zealand.

Some learning activities are compulsory for all trainees, for example, the Care of the Critically Ill Surgical Patient (CCrISP®) and Early Management of Severe Trauma (EMST) skills courses. The CCrISP® course equips trainees to recognise a deteriorating patient, to implement a structured management plan, and includes practising 'calling in' the consultant and 'handover' to intensive care staff. The EMST course teaches trainees how to approach the care of a trauma patient in the first one to two hours following injury. This course has been adapted from the Advanced Trauma Life Support© (ATLS™) program developed by the American College of Surgeons.

The Australia and New Zealand Surgical Skills Education and Training (ASSET) course is aimed at SET trainees and medical graduates who are postgraduate year (PGY) 2 or above. It is a mandatory requirement of training for all specialties except Neurosurgery.

Some activities are compulsory for particular specialties, for example: General Surgery Surgical Education and Assessment Modules (SEAM); Orthopaedic Surgery Bone School; Paediatric Surgery Critical Appraisal Tasks (CATS) and Directed Online Group Studies (DOGS); and some are optional, for example, SET Ready and Self-Assessment eLearning resources. The Specialty Training Boards conduct specialty-specific educational activities, including tutorials, trainee days, clinical workshops and courses, and practice fellowship examinations.

Some College courses relate more to non-technical skills. Examples are the Critical Literature Evaluation and Research (CLEAR) course taken by trainees in Neurosurgery, General Surgery, Orthopaedic Surgery, Paediatric Surgery and Urology. This course is designed to provide the trainee with tools to undertake critical appraisal of surgical literature and to assist in the conduct of clinical trials, which is further enhanced with the formation of the Clinical Trials Network of Australia and New Zealand, meant to allow for trainee-led trials. Another course is Training in Professional Skills (TIPS). The learning outcomes for this course relate to: effective patient-doctor communication in surgical practice; effective teamwork and collegial communication in surgical practice; personal

strengths and areas for improvement with respect to skills relevant to the above domains; and appropriate professional behaviours in the workplace.

Since 2013, all applicants for surgical training have completed the Hand Hygiene Australia eLearning module. From 2016, applicants must complete the Operating with Respect eLearning module. Operating with Respect is online evidence-based training module addressing discrimination, bullying and sexual harassment and is mandatory for trainees, fellows and specialist international medical graduates.

The College accredits courses and activities from external education providers, which meet its educational standards and criteria. The College accredits activities such as tertiary courses, short courses, workshops, and online courses. In order to be accredited, the educational activities must be aligned to, and address, one or more of the nine RACS competencies. Since 2013, more than 30 courses have been accredited. The standards and criteria for the accreditation of educational courses and activities are available on the College's website.

The College partners with the University of Melbourne to deliver a Master of Surgical Education program. This program was developed in 2011 and allows surgeons to gain formal skills in teaching and educational scholarship.

4.1.2 2017 team findings

The SET program employs a range of teaching and learning approaches. Most of the formal teaching and learning activities relate to knowledge or technical skills which are well articulated in most curricula.

On the other hand, there appear to be few formal learning activities targeted at non-technical (professional) skills (also discussed under standard 3). Among these courses are CLEAR, TIPS and the Operating with Respect eLearning module. CLEAR is only mandated for five surgical programs. Although the Operating with Respect module is mandatory for trainees, supervisors, and specialist international medical graduates, it does not feature in any of the specialty training regulations. Likewise, Orthopaedic Surgery is the only specialty in which TIPS is incorporated into the training regulations.

The team noted that several specialties are currently undergoing curriculum review. As part of the review process, curriculum maps should be developed to show the alignment of learning activities, and outcomes at each stage of training, including graduate outcomes. This includes outcomes for non-technical (professional) skills. The team also recommends that compulsory RACS courses should be reflected in curricula, regulations and other training documents to aid mapping efforts.

4.2 Teaching and learning methods

The accreditation standards are as follows:

- The training is practice-based, involving the trainees' personal participation in appropriate aspects of health service, including supervised direct patient care, where relevant.
- The specialist medical program includes appropriate adjuncts to learning in a clinical setting.
- The specialist medical program encourages trainee learning through a range of teaching and learning methods including, but not limited to: self-directed learning; peer-to-peer learning; role modelling; and working with interdisciplinary and interprofessional teams.
- The training and education process facilitates trainees' development of an increasing degree of independent responsibility as skills, knowledge and experience grow.

4.2.1 Teaching and learning methods in 2017

Clinical experience is fundamental to the SET program. Clinical rotations provide trainees with the breadth of experiences in specialty-specific contexts. Specialty Training Boards allocate trainees to rotations in surgical units that have been accredited as training posts. Allocation is based on each

trainee's stage of training, their learning needs and, where possible, on their preferences regarding case mix and geographic location. Supervisors and trainers are responsible for ensuring that each trainee receives the training and clinical experience that enable them to develop the necessary knowledge and skills to fulfil training requirements across the competencies. Specialty Training Boards monitor each trainee's logbook to ensure they are accessing a sufficient caseload and an appropriate case-mix. Complementing hospital-based learning is a variety of teaching and learning methods as mentioned under standard 4.1.

During each rotation, clinical experiences include:

- *participation in ward rounds, handovers, multidisciplinary team meetings and outpatient clinics. The exception is NSW, which does not have traditional outpatient clinics*
- *participation in operating sessions where trainees develop technical skills and other competencies, such as teamwork and communication*
- *on-call duties to assess and manage patients with acute surgical problems*
- *participation in clinical audit and morbidity and mortality meeting review processes.*

Supervisors assess trainees' performance against standards expected for each stage of training; as trainees' knowledge, skills and experience grow they are expected to manage increasingly complex clinical situations. At later stages of training, trainees are expected to take a greater proportion of cases as primary operator with less direct input from consultant supervisors, and to perform more complex procedures, usually with the supervising surgeon as assistant, providing supervision as required.

For example, the Board in General Surgery requires all trainees to complete 100 upper gastrointestinal endoscopies and 50 colonoscopies before applying to sit the Fellowship Examination. The Australian and New Zealand Conjoint Committees for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) set the minimum training standards required prior to granting recognition of training in Upper Gastrointestinal Endoscopy, Colonoscopy and Endoscopic Retrograde Cholangio-Pancreatography (ERCP).

4.2.2 2017 team findings

For each surgical specialty, training is largely based in clinical practice, with responsibility for patient care graded by stage of training. Despite increasing clinical demands on trainees and supervisors, the College has managed to maintain apprenticeship-style learning which is closely overseen by trainers, supervisors and Specialty Training Boards. Each training post is accredited for patient case-mix, supervision, staffing levels, and working requirements for trainees and resources. Trainees must work within teams and with other health professional groups.

While clinically-based learning is largely opportunistic, the College provides several core courses and activities as outlined under standard 4.1.

Role modelling is an important teaching method. Trainees and members of some jurisdictions reported to the team that, while the Building Respect, Improving Patient Safety (BRIPS) program is leading to improvements, good role modelling is by no means universal. Furthermore, the relative lack of diversity in the senior surgical workforce as described under standard 1 means that trainees may not work with a diverse range of role models.

The team heard several concerns regarding the opportunities for trainees to obtain sufficient experience, not only to achieve basic competence, but to appreciate the natural history of a diverse range of cases. Some reasons for this were:

- *reduced working hours for trainees (refer to standard 2.3)*
- *lack of outpatient services (NSW)*
- *lack of opportunity for endoscopy training in the general surgery program and aesthetic surgery in the plastic and reconstructive surgery program.*

The College and Specialty Training Boards are using a range of methods to offset these deficiencies, predominantly through simulations and skills courses. Yet, the competence gained needs to match with performance in practice. The team recommends that the College find ways to enable general surgery trainees in New Zealand to meet their endoscopy requirements, for plastic and reconstructive surgery trainees to meet their aesthetic surgery requirement, and for all trainees in NSW to see patients at follow-up after surgery to learn about surgical outcomes.

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College had not addressed any conditions or recommendations in AMC monitoring submissions.

B 2021 team findings

The follow-up visit considered progress towards the remaining condition and whether the College had responded to the recommendation for quality improvement.

Conditions to satisfy accreditation standards

14 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)

To be met by 2021.

Recommendations for improvement

GG Consider options to mitigate the lack of training in some parts of Australia and New Zealand such as in outpatient settings, endoscopy and aesthetic surgery. (Standard 4.2.1)

Teaching across specialty training programs is recognised as being of a high standard and the updating of the curriculum will further improve trainee experience. Competency-based training will enable gaps in training to be identified and rectified, and further supports flexible training.

The enhancement of online access to teaching and virtual learning environments supporting trainee learning has been regarded by trainees as a positive development from COVID-19 restrictions. Trainees from regional and rural areas have appreciated this move and it is recommended the College and specialty training programs continue to support access to virtual learning environments. Examples of this support include:

- The online Bone School, under the AOA, was highlighted as a positive development for all trainees, regional/rural as well as metro, as it increased access for all.
- General Surgery Australia provided online access to five educational programs in each region and exam preparation courses.
- Plastic and Reconstructive Surgery Australia enabled weekly regional teaching sessions to be accessed online, and received positive feedback.

There is evidence of early alignment of learning activities with curricula outcomes for some specialty training boards at each stage of training, though inclusion of graduate outcomes is variable. The limited understanding of graduate outcomes has resulted in the process of mapping of learning activities being interpreted as the Professional Skills Curriculum. Mapping of the curriculum illustrates how learning activities and compulsory requirements meet the outcomes at each stage of training, covering both clinical as well as professional skills.

Mapping of learning activities and compulsory requirements have not progressed as the development of graduate outcomes has not occurred for the majority of the training programs. Some specialty training boards have expressed uncertainty about how to undertake the mapping and would benefit from more direction from the College. BSET acknowledged that this mapping work has not progressed with COVID-19 impacts being one of the reasons for delays.

The Professional Skills curriculum will be mapped to learning activities aligned to the graduate outcomes for each of the professional skills competencies. A review of curricula by most specialty training boards will progress after the Professional Skills curriculum is finalised.

The College indicates specialty training boards are addressing the lack of training in some parts of Australia and Aotearoa New Zealand such as new regulations for general surgery that hospitals seeking new posts must include an outpatient clinic and most specialty training boards are implementing outpatient clinics as part of hospital site accreditation. The College acknowledges there are challenges with access to endoscopy training in hospitals and General Surgery New Zealand is working to develop connections with the gastroenterology community to enable access for trainees to do endoscopy training in New Zealand. COVID-19 has further challenged opportunities for learning in elective surgical settings. The specialty training boards are encouraged to review lack of training and consider how trainees can continue to be supported through these training challenges, particularly through the COVID-19 pandemic.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

I All specialty training programs are based firmly in relevant clinical practice with trainees experiencing a wide range of acute and elective cases.

J The growing array of courses and resources with an increasing number of these available online, as well as the development of an appropriate suite of basic courses, such as Early Management of Severe Trauma (EMST), Care of the Critically Ill Surgical Patient (CCrISP), and Critical Literature Evaluation and Research (CLEAR).

K The College's support for the increasing use of simulation in surgical training.

2017 Conditions to satisfy accreditation standards

14 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)

2017 Recommendations for improvement

GG Consider options to mitigate the lack of training in some parts of Australia and New Zealand such as in outpatient settings, endoscopy and aesthetic surgery. (Standard 4.2.1)

2021 Accreditation Commendations, Conditions and Recommendations

In 2018 and 2019, the College had not addressed any conditions or recommendations in their monitoring submissions to the AMC.

In the 2021 follow-up assessment, the team considers condition 14 to be progressing and recommendation GG to continue in its activities. The remaining condition and recommendation for improvement under Standard 4 from the 2017 reaccreditation are replaced with condition 10 and recommendation DD in 2021.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

10 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)

2021 Recommendations for improvement

DD Consider mechanisms to support better access to training identified as lacking in parts of Australia and New Zealand (Standard 4.2.1)

5 Assessment of learning

5.1 Assessment approach

The accreditation standards are as follows:

- The education provider has a program of assessment aligned to the outcomes and curriculum of the specialist medical program which enables progressive judgements to be made about trainees' preparedness for specialist practice.
- The education provider clearly documents its assessment and completion requirements. All documents explaining these requirements are accessible to all staff, supervisors and trainees.
- The education provider has policies relating to special consideration in assessment.

Standard 5.1 requires that the College has a comprehensive and clearly documented program of assessment, which accommodates trainees requiring special consideration.

5.1.1 Assessment approach in 2017

The Surgical Education and Training (SET) program has a program of formative and summative assessments that includes workplace-based assessments, examination of technical and scientific knowledge from an early to mid-stage of training, and a final certification (fellowship) examination.

As discussed under the previous standards, the Becoming a Competent and Proficient Surgeon document outlines the expectations of trainees across the nine RACS competencies from prevocational through to novice, to intermediate, then to competent and to proficient.

Workplace-based assessments are the responsibility of each ***Specialty Training Board****. The College has two key committees with oversight responsibility for the examinations. The* ***Surgical Science and Clinical Examinations Committee*** *is responsible for the General Surgical Science Examination (GSSE), the Clinical Examination (CE) and the written component of four Specialty-specific Surgical Science Examinations (SSSEs). The* ***Court of Examiners*** *has oversight of all Fellowship Examinations and viva components of four SSSEs.*

A range of assessment-related policies and committees' terms of reference documents are publicly available on the College's website.

In accordance with the Assessment of Clinical Training policy, each surgical specialty uses assessments to guide learning and assess trainee performance to ensure it meets the designated standards at each stage of training. The regulations of each Specialty Training Board and the Guide to SET outline the number, type and frequency of assessments.

Over the past four years, the College has completed several reviews of its assessment program. In particular, in May 2016, RACS commissioned Cassandra Wannan to undertake a comprehensive review of all College assessments. This resulted in an extensive report, producing a total of 16 recommendations. These recommendations included seven recommendations relating to examination processes and nine recommendations regarding workplace-based assessments.

The College has a policy for special consideration in relation to the sitting of an examination. Trainees may apply for special consideration in cases where illness, bereavement or other serious matters beyond their control, have the potential to affect their examination results. The College's policy on reasonable adjustments for disability outlines the criteria and processes for accommodating the needs of a candidate where a disability may affect their ability to participate in the examination. The College also has a policy for the consideration of religious observance.

The committee chair or senior examiner of the relevant specialty Court of Examiners will review and determine adjustment to assessment protocols. Applications for special consideration are assessed by the relevant committee or specialty Court of Examiners. Applications for religious observance are considered by the College Board, committee or other body that administers the assessment activity.

5.1.2 2017 team findings

The team commends the College on its comprehensive suite of assessments administered by dedicated fellows supported by both the Specialty Training Boards and the College's Education Staff. Information regarding the College's assessments is comprehensive and readily accessible.

As discussed under standard 3, the training document Becoming a Competent and Proficient Surgeon clearly outlines the increasing expectations of trainees as they progress though training.

5.2 Assessment methods

The accreditation standards are as follows:

- The assessment program contains a range of methods that are fit for purpose and include assessment of trainee performance in the workplace.
- The education provider has a blueprint to guide assessment through each stage of the specialist medical program.
- The education provider uses valid methods of standard setting for determining passing scores.

Standard 5.2 requires the College to use a range of assessment methods that are blueprinted to the training curriculum. The College must determine the pass standard for each assessment, based on the concept of how a borderline candidate will perform. The College must then construct assessments that reliably and consistently distinguish between borderline pass and borderline fail candidates.

5.2.1 Assessment methods in 2017

Surgical trainees are assessed throughout the training program by a combination of examinations and workplace-based assessments.

Examinations

Examinations comprise both written and practical 'clinical' formats, and the topics examined are either generic to all surgical trainees or specialty-specific. All nine specialties have a suite of examinations with much commonality but also some significant differences as listed in the table below.

Generic Surgical Science Examination (GSSE)	*Compulsory for all prevocational applicants for surgical training.*
Clinical Examination (CE)	*Compulsory for all surgical specialties except Orthopaedic Surgery (Australia) and Neurosurgery.*
Specialty Specific Surgical Science Examination (SSE)	*Neurosurgery SSE replaced with a neuroanatomy examination which must be passed prior to entry to surgical training.* *General Surgery SSE replaced by a summative on-line module assessment.* *The other seven specialties undertake an SSE.*
Fellowship Examination	*Similar format undertaken by all nine specialties.*

Generic Surgical Science Examination

The Generic Surgical Science Examination (GSSE) assesses the candidate's knowledge, understanding and application of anatomy, physiology and pathology in health and disease. Trainees previously completed the examination within the first two years of training. From 2014,

this examination was made available to prevocational doctors – a major change since the inception of the SET program in 2007. From 2016, the GSSE is compulsory for all prevocational applicants for surgical training and must be passed prior to being eligible for selection into the program. The examination pass rate is variable: 85% in 2011; 60% in 2015. The examination results are not used quantitatively in selection.

Clinical Examination

The Clinical Examination (CE) is a practical examination, testing candidates' clinical application of the basic sciences early in surgical training. The examination is an objective structured clinical examination comprising 16 five-minute stations. Candidates are assessed as they undertake four questions or activities for each of the four station types: physical examination; communication; history taking; and procedure. The examination must be passed within the first two years of training. Trainees are permitted a maximum of four attempts. The examination pass rate is high but there is conflicting evidence regarding correlation with the outcomes of other assessments.

Specialty Specific Surgical Science Examination

Seven of the specialties currently have a specialty-specific examination to assess trainees' knowledge of surgical sciences and principles specific to their specialty. The Specialty Specific Surgical Science Examination (SSE) must be completed in accordance with the specialty requirements:

- *Orthopaedic Surgery - Orthopaedic Principles and Basic Science Examination (OPBS)*
- *Plastic and Reconstructive Surgery - Plastic and Reconstructive Surgical Sciences and Principles Examination (PRSSP)*
- *Paediatric Surgery – Paediatric Anatomy & Embryology (PAE) Examination and the Paediatric Pathophysiology (PPP) Examination*
- *Otolaryngology Head and Neck Surgery, Urology and Vascular Surgery – Surgical Science Specialty Specific (SSE) Examination.*

Neurosurgery and General Surgery have a variation as noted in the above table.

Fellowship Examination

The Fellowship Examination assesses the candidate's knowledge, clinical skills, judgment and decision making and professional competencies, in order to ensure that they are safe and competent to practise as surgeons. For all specialties except Vascular Surgery, the Fellowship Examination comprises two written components and five clinical/viva components. Vascular Surgery has one written and six clinical components.

The Fellowship Examination is very much the flagship of RACS' assessment program. The information session for new examiners is conducted in a very professional manner by dedicated leaders from the Court of Examiners. New examiners must observe before examining and examiner performance is assessed. This is also discussed under standard 8.1.

Material is selected for inclusion in the examination at an annual workshop, in February, and involves blueprinting against the curriculum.

The Fellowship Examination is comprehensive with seven separate examinations which might include written assessments, imaging, pathology and structured oral examinations. The "expanded closed marking system (ECMS)" appears fit for purpose and provides the Court of Examiners with the necessary information to make a determination on borderline candidates. For each examination, candidates are scored between 1 and 4 where 4 is excellent, 3 is a pass, 2 borderline and 1 a clear fail. The passing score for the Fellowship Examination is 21 – that is an average of 3 across all seven examinations. The team observed that it was very difficult to score 4 and in fact was mostly discouraged by the leading examiners. For each of the seven examinations there are two examiners scoring independently with a consensus mark reached at the end. For some sections of the

examination there will be an observer (usually a first-time examiner) scoring as well. Those scoring 19 or 20 are further discussed by the full Court of Examiners but generally the advice of the chair of the relevant specialty Court is followed.

The Fellowship Examination exhibits good reliability. The pass rate is approximately 70-80% across all specialties. The eventual pass rate (within 5 years) is 97%.

Standard Setting

The College's procedures for standard setting for the CE and the GSSE and specialty SSE, as well as reports and presentations are available on the RACS website. The College collaborates with the Australian Centre for Educational Research (ACER) in the development of standard setting. The standard setting methods for each of the GSSE, CE and Fellowship Examination appear to be appropriate with a sound evidence base. The specialty-specific SSE is variable with three disciplines using the much respected modified Angoff method but some others using a fixed cut-off mark based on historical precedent – which would not allow for examinations that vary in difficulty. A detailed explanation of the standard setting for the Orthopaedic Principles and Basic Science Examination is provided on the RACS website in a document authored by the Orthopaedic Surgery Senior Examiners in both Australia and New Zealand. The methods of standard setting are detailed in the table below as provided in the College's accreditation submission.

Generic Surgical Science Examination	*Rasch model scaling*
Clinical Examination	*Borderline regression*
Specialty Specific Surgical Science Examination (Urology, Otolaryngology Head and Neck Surgery, Vascular Surgery)	*Modified Angoff*
Cardiothoracic Surgical Sciences and Principles Examination	*Predetermined 75 per cent cut score*
SEAM module multiple-choice questions	*Predetermined 80 per cent cut score*
Neurosurgery Neuroanatomy Examination	*Predetermined 70 per cent cut score*
Orthopaedic Principles and Basic Science Examination	*Predetermined 70 per cent cut score*
Paediatric Anatomy & Embryology Examination	*Specialty experts. The anatomy component is assessed by two examiners, similar to the Fellowship Exam.*
Paediatric Pathophysiology Examination	*Predetermined 65 per cent cut score*
Plastic and Reconstructive Surgical Science and Principles Examination	*Predetermined 75 per cent cut score*
Fellowship Examination	*Expanded close marking system; consensus scoring. Specialty experts and predetermined pass mark outlined in marking policy clause 3.16 of Conduct of the Fellowship Examination policy.*

Workplace based Assessments

Workplace based assessments (WBAs) include mid-term and end-of-term assessments, Direct Observation of Procedural Skills (DOPS) reports, Mini-Clinical Examinations (Mini-CEX) reports and logbooks. These are largely at the discretion of each of the Specialty Training Boards (the

requirements for Orthopaedic Surgery in Australia and New Zealand differ). The table below is adapted from the College's accreditation submission and demonstrates some variation in the extent to which WBAs have been adopted across the surgical specialties.

Assessment type	***Surgical Specialty***
In-training Assessments (ITA) (mid-term and end-of-term assessments)	*All surgical specialties*
Direct Observation of Procedural Skills (DOPS)	*Cardiothoracic Surgery, General Surgery, Orthopaedic Surgery New Zealand, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology, Vascular Surgery*
Mini-Clinical Evaluation Exercise (Mini-CEX)	*General Surgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology, Vascular Surgery*
Multi-Source feedback (MSF)	*Paediatric Surgery (On request: Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Plastic and Reconstructive Surgery, Vascular Surgery, Urology)*
Entrustable Professional Activities (EPAs)	*General Surgery (piloting in 2017)*

In-training Assessments (ITAs)

During training, trainees will complete In-training Assessments (ITAs), also known as mid-term assessments and end-of-term assessments. ITAs are used both formatively and summatively by all specialties. Mid-term ITAs provide opportunities to guide learning activities and for early identification and support of trainees in difficulty. End-of-term assessments provide opportunities to review a trainee's performance over an entire rotation and to identify goals for subsequent rotations. End-of-term assessments also have summative functions, as failure to meet identified standards can result in trainees being placed on structured remediation programs, such as a performance management plan or on probation. Ongoing poor performance may lead to dismissal from the training program.

The Surgical Supervisor and the Specialty Training Board are responsible for the in-training evaluation of trainees. There is some variation between specialties in the forms used for the in-training assessment.

Surgical DOPS and Mini-CEX

Surgical Direct Observation of Procedural Skills (DOPS) is a method of assessing the trainee's competence in performing diagnostic and interventional procedures during surgical practice. The assessment involves an assessor observing the trainee perform an operative procedure within the workplace.

The Mini-Clinical Evaluation Exercise (Mini-CEX) assesses competencies essential to the provision of good clinical care. The assessment involves an assessor observing the trainee interact with a patient in an unrehearsed clinical encounter in the workplace.

There is considerable variation in the use of these forms. Forms used vary between the specialties. Orthopaedic Surgery (Australia) uses forms with AOA branding.

Multi-source feedback (MSF)

Multi-Source Feedback (MSF) is a questionnaire-based assessment that includes self-evaluation and feedback on observable behaviours from colleagues (peers and referring physicians), co-workers (nurses, pharmacists, psychologists etc.) and patients. The MSF is a mandatory assessment component only for Paediatric Surgery but is an option for four other specialties in the event of under-performance as detailed in the above table.

Logbooks

All trainees are required to complete logbooks. Logbooks are used to record each procedure undertaken by the trainee and their level of involvement in the procedure (for example, primary operator, assistant, etc.). The Surgical Supervisor and Specialty Training Board review logbooks at regular intervals. The College has developed an online Morbidity and Audit Logbook Tool (MALT) which will be available to fellows, trainees, and international medical graduates, and for prevocational doctors as a component of JDocs registration.

Entrustable Professional Activities (EPA)

Entrustable Professional Activities (EPAs) are a relatively new innovation for the College. Recent developments include the key clinical tasks introduced in the JDocs Framework and the procedural skills and professional capabilities assessments used in selection to General Surgery training. General Surgery is piloting some EPAs in 2017.

5.2.2 2017 team findings

The team commends the College on the careful moderation and blueprinting of the Fellowship Examination which serves to integrate standards across specialties and satisfy external stakeholders of the adequacy of surgical training. As discussed under standard 3, the Fellowship Examination could be enhanced as a horizontal integrating mechanism by inclusion of another column in the examination blueprint for non-technical aspects.

The team commends the College on the commissioning of the 2016 'Review of Assessments' by Cassandra Wannan. However, the team was unable to find an overall College-wide approach to the findings of the review report. In meetings with the chairs of the Specialty Training Board, there did not appear to be an awareness of the recommendations or even the existence of the report. A College response (negative or positive) to each of the report's recommendations is required.

The team supports the move of the GSSE from early in the SET program to being a prerequisite for entry into the SET program from 2017. This allows trainees to begin training with the necessary scientific background and concentrate on their specialty rather than being distracted by generalities in their early training years. However, only approximately 25% of applicants are successful in gaining entry to the program. Although some of the 75% of unsuccessful applicants may achieve entry subsequently, for most of these doctors, the GSSE is unlikely to significantly assist them in their ultimate career path. The College should look at strategies to reduce the time and financial burden for those candidates who are not selected for entry into surgical training. For example, the College may explore implementation of an 'early short-listing' so that only those with a reasonable probability of entry into training based on their CV and references are subject to the GSSE.

The CE did not receive widespread support from the trainees that were interviewed by the team. Many felt this was a 'leftover' from the previous training program structure where all specialties began their training in General Surgery. If it is to be retained, many trainees thought it should be more specific for their specialty.

Although considerable effort has been expended by the College and the Specialty Training Boards in undertaking standard setting of the GSSE, Clinical and Fellowship Examinations, the report of the 2016 Review of Assessments is notably critical of the standard setting process of those SSEs that continue to use 'cut-off' scores. Specific criticism of the Orthopaedic Principles and Basic Science

Examination standard setting is noted in the review report. The rigor of standard setting applied to other College examinations (and several of the SSEs) needs to be applied to all SSEs.

The College has begun the electronic delivery of examinations rather than paper-based. As experienced by other specialist medical colleges in the same transition, this demands the highest level of reliability of the IT platform given the high-stakes nature of the examinations and the unsolvable difficulties in the event of a technological failure. The AMC will be interested in updates from the College on progress in this area.

The team also recommends that behaviour-related reporting (i.e. descriptive of the key features) rather than simple scoring should be adopted by all specialties in their various DOPS and Mini-CEX as recommended in the 2016 Review of Assessments Report.

The team commends the College's progress with the implementation of EPAs and the plans to pilot with General Surgery. This is likely to fill a need at the level of service delivery as well as complementing work-based assessments. The team recommends that the College undertakes early evaluation of EPAs to allow any implementation difficulties to be rectified in a timely manner.

5.3 Performance feedback

The accreditation standards are as follows:

- The education provider facilitates regular and timely feedback to trainees on performance to guide learning.
- The education provider informs its supervisors of the assessment performance of the trainees for whom they are responsible.
- The education provider has processes for early identification of trainees who are not meeting the outcomes of the specialist medical program and implements appropriate measures in response.
- The education provider has procedures to inform employers and, where appropriate, the regulators, where patient safety concerns arise in assessment.

Standard 5.3 requires that the College provides sufficient feedback to trainees and supervisors to ensure that the objectives of the training program are met, trainees who are failing to progress are identified early and patient safety is protected.

5.3.1 Performance feedback in 2017

Feedback

In addition to the feedback supervisors and trainers give to trainees in clinical settings, feedback on examination performance is provided within the timeframes stipulated in the conduct of the examination policies.

The College has policies regarding feedback to unsuccessful candidates with opportunities for remediation. For the examinations taken early in training and the specialty-specific examinations, written feedback is provided to all unsuccessful candidates by the RACS Examinations Department. This is used as a basis for discussion with their supervisor.

Unsuccessful performance in the Fellowship Examination is defined separately and a suitable process specified. The senior examiner's feedback report is provided to the candidate following an unsuccessful attempt. This feedback is used as a basis for discussion between trainees and their supervisors to assist with the review and planning of training and/or examination preparation for a subsequent attempt.

If a candidate has been identified as a poor performer, defined by a total score of 14 or less (that is, more than six below the pass standard of 21), he or she will be interviewed by the relevant Specialty Training Board to address concerns and implement a remedial plan.

Patient safety

There is also a documented process for managing concerns regarding patient safety that become apparent in the course of an assessment. If the candidate is considered a risk to patient safety (not related to a defined score), the Specialty Training Board will be notified within two days. The Board will then consult with the candidate's supervisor, and may seek information from the hospital. If the Board agrees there are concerns for patient safety, it will recommend to the chair of the Board of Surgical Education and Training that the candidate be reported to the Australian Health Practitioner Regulation Agency (APHRA) or the Medical Council of New Zealand.

Trainee in difficulty and early identification of the under-performing trainee

The Specialty Training Boards have policies and processes to identify and support trainees who experience difficulties during their training. In-training assessments provide an opportunity to identify trainees whose performance is not satisfactory for their level of training. Such trainees may be placed on a performance management plan (description varies between specialties), or they may be placed on probation (typically for six months). During this time, trainee performance is reviewed regularly, with constructive feedback and support provided by surgical supervisors.

The College has developed the Keeping Trainees on Track (KTOT) course to assist supervisors and trainers with the early detection of trainees in difficulty. The course is available face-to-face or as an eLearning module. An online resource, Trainees in Difficulty, provides further useful information for supervisors.

Probation

Each Specialty Training Board has provision for periods of probation to assist trainees who are under-performing. During the probationary period, surgical supervisors regularly review trainees' performance and trainees are provided with feedback and support. Supervisors complete the required probationary forms, which trainees submit to their Specialty Training Board.

Dismissal from surgical training

The Dismissal from Surgical Training policy outlines the process, criteria and responsibilities for dismissal from the training program. Among the reasons for dismissal are: exceeding the maximum number of attempts at examinations (usually four); not completing examinations within the specified time-frame; or three unsatisfactory In-training Assessments (ITAs).

5.3.2 2017 team findings

The trainees who were interviewed by the team indicated that performance feedback to trainees appears is generally constructive and useful.

The KTOT program, which assists supervisors and trainers in the early detection of trainees in difficulty, is commendable, as are policies around remediation and probation of under-performing trainees.

The absence of routine MSF as a component of the ITAs was of concern to the team. Only Paediatric Surgery currently accomplishes this for all trainees. While some Specialty Training Board chairs were concerned regarding the organisational load that routine MSF would entail, there appears to be general agreement that this would be a valuable formative and summative assessment for trainees. This is particularly of relevance to the College given the Building Respect, Improving Patient Safety (BRIPS) action plan. In the opinion of the team, feedback from colleagues, co-workers and patients would appear to be of critical relevance to BRIPS for the trainee. The increased workload for supervisors of training is an issue but structures could be put in place to manage this. For example, were the College to stipulate a maximum number of trainees per supervisor of training (therefore multiple supervisors at large sites), as is the case at some colleges, each supervisor would therefore not have an excessive workload were MSFs to be introduced. The team recommends that

the Specialty Training Boards continue to explore the use of MSF for all trainees at set points throughout training.

5.4 Assessment quality

The accreditation standards are as follows:

- The education provider regularly reviews the quality, consistency and fairness of assessment methods, their educational impact and their feasibility. The provider introduces new methods where required.
- The education provider maintains comparability in the scope and application of the assessment practices and standards across its training sites.

Standard 5.4 requires that the College implements a cycle of quality improvement for its assessment program. This activity is a sub-set of the overarching monitoring and evaluation program that the College should implement for all of its programs.

5.4.1 Assessment quality in 2017

Training of assessors and examiners

The College has developed several resources for supervisors and trainers to ensure consistency in work-based and clinical assessments. These include the Supervisors and Trainers for SET (SATSET), Keeping Trainees on Track and the mandatory Foundation Skills for Surgical Educators courses which cover methods, tools and skills to facilitate supervision, training and assessment in the training program. This is discussed in further detail under standard 8.1.

The College goes to significant lengths to prepare examiners for the examinations with the objective of maintaining assessment standards and consistency. Mandatory training for new examiners for the Fellowship Examination is directed at the concepts of standards, standard setting, reliability and validity, as well as specific processes within the examination.

Monitoring examination pass rates

The RACS Activities Report provides comprehensive detail of examination pass rates including breakdowns by year, discipline, gender, region, number of attempts and trainee versus specialist international medical graduate. The RACS Examination Department monitors functions and reports to the Board of Surgical Education and Training. Explanation is sought for unexpected variation.

Monitoring examiner performance

Examiner performance is closely scrutinised with the use of 'heat maps' in the Fellowship Examination in an attempt to identify anomalies in scoring. Scoring by observers (examiners from different specialties) also assists in assessment of inter-rater reliability. Observers provide structured feedback on the validity of examination content, alignment to the syllabus, examiner performance and the taxonomy level employed.

Monitoring question performance

Questions in the GSSE are assessed (with the assistance of the Australian Council for Educational Research) with respect to reliability. The specialty Courts of Examiners meet annually to 'blueprint' forthcoming Fellowship Examinations by determining the allocation of examination content with regard to the specialty training curriculum, the RACS competencies and the taxonomy. This process is based on the consensus of experts, knowledge of clinical settings and work-based requirements and is supported by the collective knowledge, experience, expertise and qualifications (including educational qualifications) of the fellowship.

Quality control between assessments

The 2016 Review of Assessment Report provides cross correlations between the various assessments. Reliability was generally high with the possible exception of the Clinical Examination.

5.4.2 2017team findings

As discussed under standard 5.1, the commissioning of the 2016 Review of Assessments by Cassandra Wannan was commendable. Much of the report is very positive, particularly in reference to the Fellowship Examination. The report also identifies many areas identified for possible improvement. There is considerable valuable information in the body of the report and a total of 16 recommendations (seven pertaining to examinations and nine to work-based assessments). While the College must decide whether it would be appropriate to adopt all recommendations, each merits either a plan for implementation (if not implemented already), an alternative strategy to address the issue, or a rationale for rejection.

The team notes that the review report considers that essay-type examinations are widely-regarded as poorly performing in terms of reliability. Where essay-type questions are still being used, it is the view of the team that the College should consider whether they could be replaced with short-answer type questions (rather than MCQs as suggested in the report).

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College addressed the following condition and recommendations in AMC monitoring submissions.

Conditions to satisfy accreditation standards

15 Respond to the 2016 Review of Assessments Report by Cassandra Wannan by noting whether recommendations have already been implemented, require implementation or are rejected, including a rationale for the latter. (Standards 5.2 and 5.4)

Recommendations for quality improvement

HH Review the compulsory General Surgical Science Examination requirement in terms of usefulness, preparation time and financial burden for those who are not selected for entry into surgical training. (Standard 5.2.1)

II Review whether the Clinical Examination remains an essential assessment task, given that the 2016 Review of Assessment Report notes its poor reliability and trainee feedback questions its validity. (Standard 5.2.1)

In 2019, the College reported their response to each the recommendations to the 2016 Review of Assessments report by Cassandra Wannan, accepting all but one recommendation surrounding the use of entrustability scales for workplace based assessments (WBAs). It was also reported that a program of work was undertaken to support high quality feedback by supervisors to trainees following the Fellowship Examination and WBAs. A College wide review of standard-setting procedures was also completed and implemented.

In 2019, the College reported that the Generic Surgical Science Examination was believed to be an effective means of ensuring those entering surgical training achieve a satisfactory standard of surgical knowledge. The examination was cited as a motivating factor to assuming this knowledge and provides a benchmark for entering SET training. The Clinical Examination, however, was no longer an essential assessment task and removed as a prerequisite for selection into training for six surgical specialties.

B 2021 team findings

The follow-up visit considered progress towards the remaining condition and whether the College had responded to the recommendations for quality improvement.

Conditions to satisfy accreditation standards

16 Implement appropriate standard setting methods for all specialty-specific examinations (The AMC recognises that at least three specialties are already compliant in this respect). (Standard 5.2.3)

To be met by 2019.

Recommendations for improvement

JJ 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)

KK Explore the use of multi-source feedback for all surgical training programs at set points throughout training. (Standard 5.3.1)

LL Review whether the term 'essay-type' is appropriately used in all its current contexts. Where essay-type questions are used, consideration should be given as to whether they could be replaced with short-answer type questions. (Standard 5.4.1)

The Generic Surgical Sciences Examination (GSSE) has moved to the prevocational requirement for entry to training. The team heard from trainees who felt this did not place an excessive burden on those considering a career in surgery although they ultimately may be unsuccessful in their application to a surgical training program. The number of prevocational doctors presenting for the GSSE increased from 981 in 2018 to 1037 in 2019. The cumulative pass rate for the prevocational doctor cohort decreased from 60.3% in 2018 to 52.5% in 2019. The fall in pass rate could be partly explained by the increased number of prevocational doctors sitting the GSSE and may not have been successful in being selected for surgical training.

The Clinical Examination (CE) is an Objective Structured Clinical Examination (OSCE) consisting of 16 five minute stations. For trainees commencing from 2016, the Board of Neurosurgery removed the Clinical Examination as a requirement. For trainees commencing from 2018, General Surgery, Orthopaedic Surgery (Australia) and Otolaryngology Head & Neck Surgery removed the Clinical Examination as a requirement. For trainees commencing training from 2019, Orthopaedic Surgery in New Zealand removed the Clinical Examination as a requirement. The pass rate for the Clinical Examination in 2019 was 61.7%.

The Specialty Specific Examinations (SSE) are sat early in surgical training. The pass rate in the SSE increased from 77% in 2018 to 80.5% in 2019. The team were informed that seven of the nine disciplines use the Angoff method for standard setting for their specialty-specific examinations. Although General Surgery has replaced their SSE with online modules, the assessment component of these modules is also standard set using the Angoff method. Orthopaedic Surgery use the Bookmark method which is an internationally recognised alternative method of standard setting with some advantages and disadvantages relative to Angoff. The remaining exception is the Neurosurgery specialty-specific examination which uses a historically-developed method of standard setting based on the degree of difficulty of each question. Given the low number of candidates in the neurosurgical examinations and the difficulties of standard setting for low number examinations, it is probably reasonable for the current method to continue providing passing rates continue to be acceptable.

The Fellowship Examination (FE) is a highly developed exit examination with strong participation by fellows. It is an extensive process of setting questions to a prescribed standard in which seven stations are marked 1-4, equating to unsatisfactory, borderline, pass and excellent. A mark of 21 across the seven stations is a pass in the FE, equating to an average mark of three across the

examination. Candidates with marks of 19 or 20 are considered in detail by the Specialty Court and then by the Full Court as to whether they should be elevated to a pass. This appears to be a fair and transparent method of handling what is effectively a "borderline range" in the passing standard. However, the team considered the FE pass rate to be generally on the low side and the College should consider exploring the reasons behind this as a part of consistent review of assessment quality.

Those associated with the various examinations at the College are to be commended for the efforts made to continue assessment during the challenges of COVID-19. However, the team heard that, unfortunately, not all candidates were able to be accommodated at the examination time of their choice, though this appears to have been rectified in later runs of the examination and the College is encouraged to continue to support trainees to sit the examinations by providing clear communication and consideration.

The movement of many specialties to a "competency-based curriculum" has led to an expansion in common tools employed such as Entrustable Professional Activities (EPAs), Direct Observation of Procedural Skills (DOPS) and mini-Clinical Evaluation Exercise (mini-CEX). These are mostly early in their implementation. For example, a new OHNS competency-based curriculum began in 2019, with General Surgery commencing in 2022, and Urology more recently. The College and specialty training boards should monitor the utility of these assessment tools, particularly in the early years of implementation.

Most specialties have made good progress in the development of behavioural descriptors for WBAs, often in the context of the introduction of a competency-based curricula. The revised RACS Surgical Competence and Performance Guide provides a framework for development of professional skills with ten competencies, including the newly included Cultural Competence and Cultural Safety. The College is asked to provide an update on recommendation JJ at the time of the next report to the AMC on the development of any behavioural descriptors to include the tenth competency. In the interest of a common approach, the team recommends WBAs in all disciplines would have moved to behavioural descriptors rather than a simple scoring scale or pass-fail.

Multi-source feedback (MSF) is used variably by the different specialty training programs – ranging from general use for all trainees (e.g. vascular surgery, urology) to limited use for trainees on probation (e.g. general surgery). The team heard some specialties speak of additional administrative burden in administering MSFs and also of "MSF fatigue" by trainees and participants. A more common approach to bridge the current wide variation in utilisation of MSFs for trainee assessment across the 13 specialty training programs is desirable.

Some specialty training programs (e.g. paediatric surgery) continue with essay-type questions in the written section (e.g. two of seven stations) of the FE. The rationale provided refers to an opportunity to demonstrate high-level cognitive thinking at this level.

The College reported an assessment commission is in progress that will incorporate examination design and question format, indicating there will be a consultation process with a report due in 2022. However, while the Assessment Commission Steering Group has met several times, the Education Board has agreed to suspend the Commission until further notice. The team were informed that "Programmatic Assessment" would be a focus of that report and a particular focus would be on how the published descriptions of programmatic assessment might be adapted in the context of postgraduate surgical training.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

L The overall conduct of the Fellowship Examination including its careful moderation and blueprinting which serves to integrate standards across surgical specialties and satisfy external stakeholders of the adequacy of surgical training.

M The commissioning of the 2016 Review of Assessments by Cassandra Wannan.

N The Keeping Trainees on Track program which assists supervisors and trainers in the early detection of trainees in difficulty.

2017 Conditions to satisfy accreditation standards

15 Respond to the 2016 Review of Assessments Report by Cassandra Wannan by noting whether recommendations have already been implemented, require implementation or are rejected, including a rationale for the latter. (Standard 5.2 and 5.4)

16 Implement appropriate standard setting methods for all specialty-specific examinations (The AMC recognises that at least three specialties are already compliant in this respect). (Standard 5.2.3)

2017 Recommendations for improvement

HH Review the compulsory General Surgical Science Examination requirement in terms of usefulness, preparation time and financial burden for those who are not selected for entry into surgical training. (Standard 5.2.1)

II Review whether the Clinical Examination remains an essential assessment task, given that the 2016 Review of Assessment Report notes its poor reliability and trainee feedback questions its validity. (Standard 5.2.1)

JJ 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)

KK Explore the use of multi-source feedback for all surgical training programs at set points throughout training. (Standard 5.3.1)

LL Review whether the term 'essay-type' is appropriately used in all its current contexts. Where essay-type questions are used, consideration should be given as to whether they could be replaced with short-answer type questions. (Standard 5.4.1)

2021 Accreditation Commendations, Conditions and Recommendations

In 2019, the College addressed condition 15 and recommendations HH and II in their monitoring submissions to the AMC.

In the 2021 follow-up assessment, the team considers condition 16 to be satisfied. Recommendation JJ is progressing in its activities and recommendation KK and LL to be addressed. The remaining recommendation for improvement, recommendation JJ, under Standard 5 from the 2017 reaccreditation is replaced with recommendation EE in 2021.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

Nil

2021 Recommendations for improvement

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)

6 Monitoring and evaluation

6.1 Monitoring

The accreditation standards are as follows:

- The education provider regularly reviews its training and education programs. Its review processes address curriculum content, teaching and learning, supervision, assessment and trainee progress.
- Supervisors contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses supervisor feedback in the monitoring process.
- Trainees contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses their confidential feedback on the quality of supervision, training and clinical experience in the monitoring process. Trainee feedback is specifically sought on proposed changes to the specialist medical program to ensure that existing trainees are not unfairly disadvantaged by such changes.

Standard 6.1 requires two important activities: monitoring the delivery of the College's training and education programs, and obtaining input to the development or redevelopment of those programs.

6.1.1 Monitoring in 2017

Both the College and the Specialty Training Boards use a variety of methods for monitoring the surgical training programs. The College collects and publishes a significant amount of data about its activities, including the Annual Activities Report which is a comprehensive and valuable summary. There is regular monitoring of all of the key aspects of the training programs, including course delivery, examinations, professionalism, attrition and fellow and trainee satisfaction.

The College has several formal means of monitoring its programs and the satisfaction of key stakeholders with regard to surgical education and training. These include:

- *six-monthly end of rotation Royal Australasian College of Surgeons Trainees' Association (RACSTA) survey, which is now being compiled as five-yearly data to protect trainee anonymity and encourage a higher response rate and more robust feedback*
- *six-monthly Specialist Training Program (STP)-funded training posts end-of-rotation survey*
- *two-yearly Fellows' survey*
- *curriculum review through the Specialty Training Boards.*

Supervisors contribute to monitoring and program development through the Specialty Training Boards. In some of the larger specialties this input occurs through regional subcommittees. Curriculum review is an ongoing activity for the College which is discussed in further detail under standard 3.

There is also regular consideration and review of aspects of the selection process and selection tools. Additionally, all courses delivered by the College are evaluated, with evaluation reports reviewed for potential improvements. The Specialty Training Boards regularly monitor the progress of trainees and the quality of trainee supervision through a variety of mechanisms.

In 2015, the College showed courage and leadership by forming the independent Expert Advisory Group (EAG) to undertake the substantial review of concerns relating to discrimination, bullying and sexual harassment. This involved a substantial commitment of resources and openness to a very public critique of the College's inner workings and culture. The College supported the EAG by providing a background paper, briefing paper, surveys of hundreds of fellows, trainees, specialist international medical graduates and over 300 hospitals, as well as facilitation of online discussions. This was clearly a mammoth effort by the College. As previously discussed, the work of the EAG resulted in the Building Respect, Improving Patient Safety (BRIPS) Action Plan.

6.1.2 2017 team findings

The College has a commendable approach to monitoring, with significant systems in place for both the collection of data and monitoring of programs from internal stakeholders. The team found a strong commitment to not only the collection of data but its use in the ongoing assessment of many aspects of the SET program. The Annual Activities Report published by the College highlights the breadth and depth of monitoring that occurs and covers its work in education and assessment, as well as providing details on the surgical workforce. The team commends the College for the ongoing publication of this report which is a useful way of providing feedback to a range of internal and external stakeholders.

Given the amount of data tracked across the College programs, the team considers this could be better used to inform and support any major changes to the SET program. An overall plan with a commitment to cycle through all aspects of the program and review and renew it in that timeframe would assist in managing such a large and complex system. The team considers the College would benefit from, and should develop, an overarching framework for monitoring and evaluation.

The team found considerable optimism, particularly amongst fellows, about the early impact of BRIPS on surgical culture, as well as the potential for improving the community view of surgeons and the College following on from the negative publicity in 2015. The team also found enthusiasm and support amongst trainees for BRIPS, though they reported a more mixed view about whether the entrenched culture of bullying and sexism was changing as quickly as the College believes. Trainees expressed the view that bad behaviour is recognised by many within the profession, but that trainees feel the onus is still on them to speak up and call it out. Many trainees still view taking this step highly risky to their career prospects. The team found a large gap between what senior surgeons (and College staff) believe about the risks to a trainee's career from speaking up and trainees' assessment of that risk.

Across the board, there is a view that BRIPS has put the key issues on the table, enabling discussion of good and bad behaviour and raising expectations. However, the team found a strong view that the College must assiduously continue to implement the action plan if it hopes to achieve the necessary and ongoing culture change.

The College currently relies on the Specialty Training Boards to capture the views of supervisors, through representatives who are board members. While this is useful, the development of a more direct, first-hand means of collecting input would be beneficial for both the College and supervisors. The team considers the College needs to establish methods to seek confidential feedback from supervisors of training, taking better advantage of their in-depth knowledge to better contribute to the monitoring and development of the training program.

In terms of trainee feedback, the College is conscious of the importance of hearing from trainees, but is also aware of the challenge of doing this effectively. The RACSTA survey now has a higher response rate than in past years, though it is still below 50%. STP-funded training posts have less than a 20% response rate on end-of-rotation surveys. Additionally, many trainees the team spoke with admitted that they do not give full and frank responses out of fear that their demographic data (particularly for those in smaller specialty training programs) would identify them. The team heard repeatedly that it is too risky to give honest feedback about the quality of supervision after a particular rotation. Trainees provided the team with specific examples of when trainees had been identified based on their feedback. There is also a lack of confidence that the feedback given via methods such as the centralised complaints hotline run through RACSTA will be used to initiate change. The team recommends that the College, in conjunction with the Specialty Training Boards, develop a policy to manage the situation whereby a trainee has been inadvertently identified as a result of providing feedback.

Though challenging, the College will need to work closely with trainees and RACSTA to identify and understand the barriers to giving robust feedback and to develop approaches to improving this key issue. The team considers the College must make a clear and public commitment to developing and

implementing completely confidential and safe processes for obtaining—and acting on—regular, systematic feedback from trainees on the quality of supervision, training and clinical experience.

6.2 Evaluation

The accreditation standards are as follows:

- The education provider develops standards against which its program and graduate outcomes are evaluated. These program and graduate outcomes incorporate the needs of both graduates and stakeholders and reflect community needs, and medical and health practice.
- The education provider collects, maintains and analyses both qualitative and quantitative data on its program and graduate outcomes.
- Stakeholders contribute to evaluation of program and graduate outcomes.

Standard 6.2 requires that the College has a framework for evaluating its training and education program. This framework might include:

- systematically evaluating participation in the program
- the satisfaction of trainees and supervisors with the program and its individual components
- the impact of the program on learning and behaviour
- the outputs of the program in terms of number and characteristics of graduates
- and/or the outcomes of the program in terms of improving the eye health of the community.

Such a framework might include goals for participation, satisfaction, impact, outputs and outcomes. These goals might be the standards against which the training program is evaluated, and might be the impetus for new and revised programs to improve program performance. The evaluation program might also have goals for its own improvement, such as moving from evaluating only the number of graduates to evaluating the impact of those graduates on eye health.

6.2.1 Evaluation in 2017

The nine RACS competencies describe the key characteristics of practice required for surgeons. Together with the recently revised RACS Code of Conduct, which defines the professional standards for all fellows, these form the standards against which the College's program and graduate outcomes are evaluated.

There is a variety of tools which enable trainees to understand and assess themselves against the expected standards, including The Surgical Competence and Performance Guide, Becoming a Competent and Proficient Surgeon and the JDocs Framework which identifies performance standards for prevocational doctors.

The College undertakes a wide variety of evaluation activities of its training and education programs. The range of evaluation reports and reviews undertaken in the past five years, include:

- *Annual Scientific Congress evaluation report (2016)*
- *Fellowship Examination written hurdle requirements (2015)*
- *Leaving surgical training (2016)*
- *Predictive utility of selection tools (2016)*
- *Review of Assessments (2016)*
- *Selection diversity: gender bias in SET applicant outcomes (2016)*
- *SET evaluation – quantitative (2013)*

- *SET evaluation – mixed methods (2013).*

The 2016 Leaving Surgical Training study was initiated due to what was felt to be an unacceptably high rate of trainees failing to complete the SET program; women were disproportionately represented in this group. The themes emerging from this study include inflexible training, discrimination, bullying and sexual harassment, as well as the complexity of work or the sense of it being the 'wrong' career choice. The issue of the inflexibility of training related not only to timing (inability to train less than full-time) but importantly it reflected the need for trainees to move, often interstate, for training and sometimes several times during the program.

The College was frank in its accreditation submission to the AMC in acknowledging the very limited exposure it has to hearing the views and perspectives of external stakeholders. The College noted the lack of regular, formal stakeholder evaluation from external groups, such as patients or hospital and surgical directors. This gap has made it particularly challenging for the College to adequately understand or integrate the views of the broader medical and non-medical communities.

6.2.2 2017 team findings

The College should be commended for its resources which aim to define the professional standards and competence of surgeons and trainees. Working across nine surgical specialties with their associated Specialty Training Boards makes it potentially a significant challenge to clarify and codify the program and graduate outcomes for all surgeons. When speaking with trainees and supervisors, most indicated that upon completion of the training—plus a fellowship year—the surgical training program produces surgeons who are able to practise independently. However, as discussed under standard 2, because there are not clear program and graduate outcomes for each specialty it is difficult for the College to accurately measure program or graduate outcomes. This is a key task for the College to set its mind to in the near future.

As discussed under standard 3, the College plans to undertake a survey of new fellows to evaluate their preparedness for practice. The team commends this initiative and recommends that the College consider what supports might be put in place to aid their transition to independent practice.

The evaluation activities undertaken in recent years have been largely independent studies and surveys, looking at discrete areas of the curriculum or the program. While each piece contributes to a broader understanding of the strengths and weaknesses of the College's activities, there is currently no overarching framework or approach to evaluation. The team commends the intent but considers there is a need for a more systematic and coordinated approach which will produce more useful information.

The team commends the College for its plans to introduce an annual survey in 2017 of those trainees who leave surgery without completing the program. Based on the results of the initial survey, the team believes there will be potentially very valuable insights gained from this. Developing concrete actions in response to the survey data and themes will be important for change and for building confidence amongst trainees that the College listens to and responds proactively to criticism.

The initial survey was commissioned by RACS in 2015 to better understand why some trainees left the program, as part of the work of the RACS EAG into bullying, discrimination and sexual harassment. The study was conducted by independent researchers in the same year the EAG was established. It surveyed and interviewed trainees who had withdrawn from surgical training between 2008 and 2015. The research found inflexibility in the specialty training programs, surgery being the wrong career choice (including for lifestyle reasons), and poor supervision were also significant factors in trainees' decision to leave, as well as concerns about the culture of surgical training. Lack of academic success was ruled out as a factor, with about 80% of research participants continuing to work or train in medicine, almost all in other medical specialties.

The College is currently disadvantaged in its ability to ensure that program and graduate outcomes reflect broader community needs and priorities by its largely inward focus. Stakeholder representation is still almost exclusively internally based, that is, surgeons or trainees with only very limited external input. There is minimal crossover or attempts to elicit feedback from non-surgical

medical or nursing professionals, hospitals, state health departments, health administrators, or health consumer groups. Also, there is little to no input from the community to help build the picture of what today's surgeon should look like from a broader, non-surgical perspective.

The team commends the College on its placement of a small number of external representatives on some of its major committees and applauds its commitment to requiring an external member on all boards from 2017. This needs to be seen as only one element of inviting the consumer and community perspective into the work of the College.

The team considers that the College would benefit from several changes. The first would be to increase the external representation on boards and committees, viewing this as a valuable opportunity to benefit from ongoing interdisciplinary and cross-sector perspectives and input into College decisions as detailed under Standard 2.1. This representation would ideally include both non-surgical health experts as well as those with a strong track record of representing the consumer or community perspective. The second change is to establish a routine and systematic approach to external stakeholder consultations.

The team commends the Board of Paediatric Surgery for its leadership in being the first Specialty Training Board to invite a community representative to become a member. Both the community representative and the Board spoke very highly of this initiative. Members of the College noted the difficulty of finding adequately skilled consumer and community members to take up places within its governance structure. However, the team considers that with an appropriately supported and resourced approach to the recruitment, selection and support of these members, this challenge could be addressed.

There has been little external community consultation, despite good opportunities, such as through the recent revision of the RACS Code of Conduct. This may have been achieved through consumer organisations such as the Heart Foundation, Cancer Australia, etc. The team received feedback about the College's lack of formal consultation processes, particularly when considering major changes to the SET program. Several different groups mentioned not only the lack of consultation but also the lack of warning to those affected. The team strongly encourages the College to consider opportunities for seeking broad community and external stakeholder input. The team is confident that a commitment to this kind of consultation and contribution by external stakeholders will enhance and increase the speed of cultural change that the College is hoping to see across the SET program.

6.3 Feedback, reporting and action

The accreditation standards are as follows:

- The education provider reports the results of monitoring and evaluation through its governance and administrative structures.
- The education provider makes evaluation results available to stakeholders with an interest in program and graduate outcomes, and considers their views in continuous renewal of its program(s).
- The education provider manages concerns about, or risks to, the quality of any aspect of its training and education programs effectively and in a timely manner.

Standard 6.3 requires the College to 'close the loop' on the monitoring and evaluation process by reporting back to internal and external stakeholders:

1 how their feedback and data were used in the evaluation

2 what new or revised programs resulted from this evaluation, and

3 whether this evaluation, and any new or revised programs that ensued, improved the performance of the training program as a whole.

6.3.1 Feedback, reporting and action in 2017

The majority of the College's reporting of monitoring and evaluation activities, and changes and proposed actions, occur through its governance structures as described under standard 1. Monitoring and evaluation reports are usually submitted to the initiating board or committee and also may be submitted to committees responsible for the activities under review, where these differ from the initiation committee. The College's approach to disseminating evaluation information varies, depending on the activities being reported. Major research findings are often presented at national and international conferences or shared among other medical education groups. The EAG findings were published widely, including in the media, on social media and in journals.

The College records strategic and key operational risks to its training and education programs in the RACS Risk Register. The College addresses concerns about the quality of its training programs through its governance and administrative structures. Actions and resources are identified and prioritised while project management plans are put into place.

6.3.2 2017 team findings

The team commends the College on its worthy goal (#3) from the BRIPS Action Plan to 'increase transparency, independent scrutiny and external accountability' in College activities. To achieve this will require a commitment to cultural change and leadership in addressing issues of discrimination, bullying and sexual harassment. But it will also demand an organised approach to inviting consultation, feedback and collaboration to improve the surgical training program. One important element of this is the development of a broad reporting structure which shares relevant information and increases the transparency of decision-making processes.

The College notes that its cyclical review and renewal of programs is informed by stakeholder representation on boards and committees (Standard 6.3.2). The team would see this as but one way to hear and report back to stakeholders. As previously noted, one of the limitations of this is that currently the College's governance structure is almost completely comprised of internal stakeholders and while they can provide a very in-depth and detailed knowledge, this is not the only input/output required.

The team did not find it clear as to how the data collected from the ongoing monitoring and evaluation is systematically fed back into the decision-making mechanisms of the College. This is particularly important when addressing concerns about, or risks to, the quality of any aspect of the College's training. While the team applauds the College's actions in undertaking the EAG review, the feedback from trainees and RACSTA suggests that the College was receiving reports of widespread bullying, discrimination and, to a lesser extent, sexual harassment for years before action was taken. If the College's commitment to cultural change is to be believed—by trainees and the wider community—there is an urgent need for it to show an unambiguous link between its monitoring, evaluation and action.

If the College intends to develop a broader, more consultative approach to monitoring and evaluation, it will be critical that it simultaneously builds a transparent and broad reporting structure to match. The team considers that the College must 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.

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College addressed the following conditions and recommendation in AMC monitoring submissions.

Conditions to satisfy accreditation standards

18 In conjunction with the Specialty Training Boards, develop a policy to manage the situation whereby a trainee has been inadvertently identified as a result of providing feedback. (Standard 6.1.3)

23 Develop and implement an action plan in response to the 2016 Leaving Surgical Training study. (Standard 6.2)

Recommendations for quality improvement

NN Implement the planned New Fellows' Survey to evaluate their preparedness to practice and the annual survey of trainees who leave surgery without completing the program. (Standard 6.2.2)

In 2018, the College reported considerable work was undertaken to improve confidence in the process of reporting complaints. Following an external review, the College developed a disclosure statement on victimisation and the importance of trainee confidentiality in complaints processes. Seven principles for responding to and supporting trainees providing feedback or lodging a complaint were further developed and accepted by the Board of Surgical Education and Training in June 2018. These principles were circulated to trainees and specialty training boards and the College was to publish on their website.

In 2019, the College developed an action plan to address core issues identified in the 2016 Leaving Surgical Training study. These included inflexibility in the training program, unacceptable learning culture, and surgery being deemed as a career with an unattractive lifestyle choice.

The College continued to commission research into barriers to women selecting surgery as a career, with some specialties reporting a percentage of 50% female trainees.

In March 2018, the College distributed the Younger Fellows survey to all fellows in their first ten years of practice. A presentation on the preparedness for practice and alignment for workforce was delivered at the College's 2018 Annual Scientific Conference.

B 2021 team findings

The follow-up visit considered progress towards the remaining conditions and the College's response to the recommendation for quality improvement.

Conditions to satisfy accreditation standards

17 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)

To be met by 2019.

19 Establish methods to seek confidential feedback from supervisors of training, across the surgical specialties, to contribute to the monitoring and development of the training program. (Standard 6.1.2)

To be met by 2019.

20	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) *To be met by 2019*.
21	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) *To be met by 2020*.
22	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) *To be met by 2020*.
Recommendations for improvement	
MM	Explore with trainees how response rates to surveys on training posts could be improved. (Standard 6.1.3)

The College indicated a draft Monitoring and Evaluation (M&E) framework is in development in conjunction with the specialty training boards. It is planned that the M&E framework will enhance the quality of SET practices, with the SET program design central to the framework with the Results Logic Model used to measure progress. The monitoring plan outlines data sources including both trainee and supervisor feedback and the evaluation component will include both process and summative evaluations. Process evaluations will assess the way the SET program is being implemented and summative evaluations will assess the achievement of graduate and program outcomes identified in the M&E framework.

Consultation on the M&E framework has commenced beginning with a limited stakeholder group as part of a consultation process. The team considers there is an opportunity for the draft M&E framework to undergo consultation with a more diverse group of stakeholders to ensure an informed approach to monitoring and evaluation. The consultation period should also serve to inform an exploration of the capacity of specialties to engage with, and implement monitoring and evaluation requirements. A subsequent plan to support this implementation across all specialties would be of benefit to the overall approach. Furthermore, the M&E framework must result in evidence of the quality of all aspects of training. Therefore, the team recommends the College consider amending a purpose of the M&E framework from "developed to comply with AMC Conditions" to "developed to ensure all specialty training programs comply with AMC standards".

The team recognises the College's progress in the development of the draft M&E framework with implementation due in the second half of 2022. The College needs to consider project timeframes to ensure timely implementation and considered alignment to the requirements.

The team found the College surveyed supervisors in collaboration with the specialty training boards about the supervisor framework and challenges faced in implementing the training program. A number of methods are used by specialty training boards to seek feedback from supervisors including through email, training post evaluations, surveys and face to face meetings. The team did not find evidence of a coordinated approach by the College to receive confidential feedback from supervisors. It was unclear how the specialty training boards regularly provided this feedback to the College or if supervisors may approach the College directly with confidential feedback.

The draft M&E framework provides the opportunity for a greater depth of understanding in relation to seeking confidential feedback from supervisors of training, across the surgical specialties, in the future and with appropriate consultation, ensure innovative approaches and

contemporary practice. This has the opportunity to contribute to the strength of monitoring and development as it relates to the training program.

Processes to ensure confidentiality in relation to feedback provided are essential to effective participation, and supervisors must be sufficiently encouraged as to the benefits of participation to ensure feedback is robust. Standardisation of the approach would ensure improvement could be achieved, supported and resourced in an effective way.

A streamlined, coordinated approach by the College and its specialty training boards with confidentiality for supervisors in mind, and with clear links to the goals of contributing to training program development is required for the College to meet Condition 19. The alignment of processes across all specialty training boards would be of benefit and provide an opportunity to scale up examples of feedback collection that have already been identified and explored in each area of specialty.

The College indicated a single system of feedback is being developed integrating existing mechanisms including the RACSTA survey, specialty training board surveys and the Medical Board of Australia's Medical Training Survey (MTS), though the College notes the MTS exclusively surveys trainees in Australia and not in New Zealand.

The RACSTA survey is conducted biennially for all SET trainees in Australia and New Zealand, and publicly reports in a five year aggregate to support trainee confidentiality. The College's Hospital Training Post Accreditation Working Group has produced a revised draft of Accreditation Standards for stakeholder feedback and the process is expected to be completed in 2021. The revised standards will inform the revision of trainee surveys to align more closely with the accreditation criteria. The specialty training boards have various methods of collecting feedback from trainees that is coordinated at training board level, including post training evaluations.

The team did hear from trainees that feedback is mostly provided through hospital post accreditations. The team also heard that trainees in smaller specialties or training locations face greater difficulty in providing confidential feedback and this situation is similarly acknowledged by the College. The College has achieved measures of success through BRIPS and a change in culture has been observed throughout the College and by its fellows and trainees. However, there remains a need for trainees who consider bullying, harassment or discrimination to be occurring at a training site, or at specialty level to have access to confidential outlets to provide feedback to the College and receive the appropriate support. The College should consider how the availability of these mechanisms are communicated to trainees regularly as well as the involvement of other confidential feedback mechanisms to support trainees including the use of a third party to collect and review the feedback

With the consultation process for the M&E framework underway, there is an opportunity to clearly articulate the requirements and processes to achieve confidential and safe feedback by trainees. The College should consider consulting trainees in the development of specific processes to inform the approach of obtaining confidential feedback from trainees within the M&E framework. Trainee representatives can be partners in the development of the minimum standards applied to the development of the framework and implementation plans to ensure pathways to confidential and safe participation.

The College has developed a stakeholder engagement matrix and communication template as part of its planned M&E framework to identify and engage with key stakeholders in Australia and New Zealand. Formal consultation methods are also being developed at specialty training board level. A number of specialty training boards currently include community representatives or external non-surgical and health professionals in the consultation process.

The current consultation for the M&E framework should seek to clearly articulate the requirements and processes to achieve regular collection of feedback on the surgical training program from non-surgical health professionals, healthcare administrators, and consumer and community representatives.

Consumers and community representatives currently participating in committees and Boards indicated they were willing to participate in this collection of feedback. A more diverse representative group of consumer, community members and allied professionals will be required to ensure the relevance, effectiveness and validity of the feedback collected.

Similarly, consumers and community representatives require support, training and resources to ensure they are prepared to participate in these processes. Consideration should also be afforded to strengthen the process of formal collection of qualitative data (narratives and observations) that can inform improvement. This will also include improving the capacity to translate lived experience and thematic considerations into opportunities for enhancement.

Progress towards Condition 22 can only be assessed once the M&E framework has been developed further as it will outline the process for reporting monitoring data through College governance, administrative structures and its members. The specialty training boards themselves conduct a range of monitoring and evaluation activities currently reported through BSET. It is planned for the One College Transformation Project to further facilitate reporting of the controlled data dissemination to key stakeholders and allow for increased automation of data evaluation.

The development of a robust data management system will also inform the capacity for improvement and functionality of collection of information. To meet this standard, it is contingent on the College and specialty training boards to fully consider the recommendations, planning and applying effective implementation strategies associated with the M&E framework.

The College should ensure that consideration is given to the different capacities and resources of the different specialty training boards to undertake the processes of engagement, data collection and thematic interpretation required to ensure the success of the monitoring and evaluation process. The M&E framework is a high level guide that could benefit from greater exposition of detail to ensure standardisation of approach and implementation action plan guides to support collection and use of information collected.

The team notes that although work on these conditions has commenced, the College should consider a review of timeframes to ensure a timely implementation to ensure these conditions are satisfied in time.

The College has made progress on recommendation MM and indicated continued action will be taken in response. A survey review has been undertaken by the College to compare and identify overlaps between the RACSTA survey, specialty training board questions and the Medical Training Survey. It is hoped that this process would help to streamline questions in the RACSTA survey to help reduce survey fatigue and support improvement in response by trainees. Specialty training boards similarly have reviewed strategies to improve response rates, including working to ensure trainees they are not at risk of identification by participating.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

O The significant systems in place for the collection of data from internal stakeholders to monitor programs.

P As a result of the findings from the 2016 Leaving Surgical Training study, the College's plans to introduce an annual survey in 2017 of those trainees who leave the training program prior to completion.

2017 Conditions to satisfy accreditation standards

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

18 In conjunction with the Specialty Training Boards, develop a policy to manage the situation whereby a trainee has been inadvertently identified as a result of providing feedback. (Standard 6.1.3)

19 Establish methods to seek confidential feedback from supervisors of training, across the surgical specialties, to contribute to the monitoring and development of the training program. (Standard 6.1.2)

20 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. (Standards 6.1.3 and 8.1.3)

21 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)

22 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)

23 Develop and implement an action plan in response to the 2016 Leaving Surgical Training study. (Standard 6.2)

2017 Recommendations for improvement

MM Explore with trainees how response rates to surveys on training posts could be improved. (Standard 6.1.3)

NN Implement the planned New Fellows' Survey to evaluate their preparedness to practice and the annual survey of trainees who leave surgery without completing the program. (Standard 6.2.2)

2021 Accreditation Commendations, Conditions and Recommendations

In 2018 and 2019, the College addressed condition 18 and 23 and recommendation NN in their monitoring submissions to the AMC.

In the 2021 follow-up assessment, the team considers conditions 17, 19, 20 and 21 to be progressing and condition 22 as not progressing. Recommendation MM is considered to be addressed. The conditions under Standard 6 from the 2017 reaccreditation are replaced with conditions 11, 12, 13, 14 and 15 in 2021. Recommendation FF is new in 2021.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

11 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)

12	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)
13	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. (Standards 6.1.3 and 8.1.3)
14	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)
15	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)
2021 Recommendations for improvement	
FF	Consider amending a purpose of the monitoring and evaluation framework to ensure it is developed with the intention for all specialty training programs to comply with AMC standards (Standard 6.1.1)

7 Trainees

7.1 Admission policy and selection

The accreditation standards are as follows:

- The education provider has clear, documented selection policies and principles that can be implemented and sustained in practice. The policies and principles support merit-based selection, can be consistently applied and prevent discrimination and bias.
- The processes for selection into the specialist medical program:
  - use the published criteria and weightings (if relevant) based on the education provider's selection principles
  - are evaluated with respect to validity, reliability and feasibility
  - are transparent, rigorous and fair
  - are capable of standing up to external scrutiny
  - include a process for formal review of decisions in relation to selection which is outlined to candidates prior to the selection process.
- The education provider supports increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees.
- The education provider publishes the mandatory requirements of the specialist medical program, such as periods of rural training, and/or for rotation through a range of training sites so that trainees are aware of these requirements prior to selection. The criteria and process for seeking exemption from such requirements are made clear.
- The education provider monitors the consistent application of selection policies across training sites and/or regions.

7.1.1 Admission policy and selection in 2017

Trainees are selected into one of nine surgical specialties by 13 different selection processes. There are 13 processes given that General Surgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, and Plastic and Reconstructive Surgery have separate selection processes for each of Australia and New Zealand. The administration of selection may be through the College (five programs) or through the relevant specialty society and association (eight programs).

Although eligible for selection after the intern year, applicants are on average at PGY4 to PGY6 before they enter the SET program, therefore, the period of prevocational training now averages approximately 5.5 years: that is, the intern year and another 4.5 years before surgical training commences. Most of the 4.5 years is usually spent in 'non-accredited' service surgical resident then registrar positions. During the prevocational years, the JDocs Framework is available to the aspiring surgeon but as yet is not a pre-requisite for entry into surgical training. However, as of 2017, the Generic Surgical Science Examination (GSSE) has become a pre-requisite for selection to any of the nine specialties, in addition to completion of the Hand Hygiene and Let's Operate with Respect modules.

Each Specialty Training Board has responsibility for developing its own regulations for selection. These must be within the guiding principles set by the College and as outlined in the policy document, 2014 Selection to Surgical Education and Training, which gives consideration to the relevant AMC and MCNZ accreditation standards and the Brennan report. There is a strong emphasis on fairness and transparency.

Curriculum vitae (CV), applicant-nominated structured referee reports and multi-station interviews are used by all disciplines, but the details and weighting of the individual elements differ. Varying detail of CV scoring is provided for each of the specialties but for most specialties each section of the

CV is assessed subjectively rather than providing a points rating for a given achievement. There are some specialties (e.g. Cardiothoracic Surgery) that provide specific detail as to how many points are awarded for each specific achievement.

All applicants are made aware of the appeals mechanism as described under standard 1.3 should they consider that there has been an error in the selection process.

The number of trainees selected into the programs relates directly to the number of training positions available to each of the 13 selecting panels. Employing hospitals are not involved in the selection process. Successful applicants are recommended to hospitals but there is no obligation for that hospital to employ them. If the hospital declines to accept a recommended trainee, this does not affect accreditation of that hospital's training post.

The number of trainees by specialty who entered the SET program in Australia and New Zealand (2013–15), as detailed in the College's accreditation submission, is provided below.

		CAR	***GEN***	***NEU***	***ORT***	***OHN***	***PAE***	***PLA***	***URO***	***VAS***	***Total***
AUS	*2013*	*5*	*105*	*6*	*35*	*19*	*6*	*12*	*16*	*13*	***217***
	2014	*7*	*60*	*9*	*58*	*13*	*4*	*12*	*0*	*8*	***171***
	2015	*7*	*83*	*11*	*51*	*9*	*5*	*17*	*24*	*8*	***215***
NZ	*2013*	*1*	*13*	*1*	*9*	*2*	*0*	*3*	*3*	*1*	***33***
	2014	*0*	*9*	*1*	*9*	*5*	*2*	*4*	*0*	*0*	***30***
	2015	*1*	*11*	*0*	*9*	*2*	*2*	*4*	*5*	*2*	***36***

The number of both applicants and trainees selected for the SET program are published in the annual RACS Activities Report. Inspection of the 2015 data reveals that there were 1003 applicants for the program of which only 281 (28%) were female. The greatest discrepancy was in Orthopaedic Surgery where only 13% of applicants were female. In total, 25% of applicants succeeded in gaining entry to the program with similar proportions of male and female applicants being successful. Neurosurgery had the lowest application success rate (19%) and Orthopaedic Surgery the highest (32%).

The College's Education, Development and Research Department monitors and reviews the selection process at the end of each selection round. The Department reviews the processes and tools used as well as the reports on selection outcomes by specialty. Recommendations will be made to the surgical specialty to address any concerns. Each specialty also reviews its selection processes and tools. Some have a designated committee and/or staff member to undertake detailed analyses of selection tools; some use external experts to review selection tools and processes.

Otolaryngology Head and Neck Surgery has a specific policy of reserving the greater of 10% of posts or one post for an Aboriginal and Torres Strait Islander trainee who meets the 'minimum standard for appointment as defined by the Board'. Cardiothoracic Training Board approved a similar policy in February 2017. Such a policy is not in use by the other seven surgical specialties in Australia. In New Zealand, the RACS Māori Health Advisory Group has advised that it does not seek affirmative action in the selection of Māori candidates.

Information about compulsory rotations is said to be readily available to trainees but not easily found in the selection area of the College's website. The specifics of the rotations are not made available to trainees such that it would not be possible to apply specifically for a set of hospitals in the same state (in those specialties having interstate or international rotations). The College reports that applicants apply knowing that the program is a national one.

7.1.2 2017 team findings

As in all specialist medical colleges, there is considerable interest in the selection process from all those involved, as well as a desire to select the most suitable applicants whilst maintaining transparency and fairness. It was not clear to the team whether the object of the selection process is to select the most suitable trainee for year 1 of the training program, or the future consultant surgeon. This difference is important as greater prevocational experience will impact more on the former than the latter. Similarly, it was not clearly defined as to whether the selection objective was selecting the best surgical trainee or selecting the surgical workforce that could best meet the surgical needs of Australia and New Zealand. Again, there are important differences in these two objectives. Rurality, Indigenous status and diversity are all attributes that make essential contributions to the surgical workforce but might be overlooked in selecting the best 'surgeon'. It is recommended that the objectives of the selection process are both clear and consistent for each of the 13 selection processes.

Given that SET programs are mostly five to seven years in length, and applicants are currently at an average of PGY4 to PGY6 before they enter the program, the new fellow will be on average 10 years postgraduate. With the addition of research leave, parental leave, part-time training and an (often expected) overseas fellowship, it is quite plausible for a new fellow to be 15-20 years postgraduate before entering specialist practice. This seemingly long process may discourage many with an interest in surgery from applying for surgical training and is inefficient. An extended time in prevocational surgery may allow the SET 1 trainee to perform more procedures independently and therefore be attractive to selection committees but is unlikely to have a significant impact on the final product of surgical training. The College should consider setting an upper limit on the number of years of prevocational experience that can advantage an applicant in selection. This will become increasingly important as the prevocational space becomes more crowded with a higher number of medical graduates looking to pursue a specialist career.

There is considerable variation across the specialties regarding the extent to which details are publicised regarding how many selection points are awarded for specific achievements on the curriculum vitae. Most specialties are clear as to broad category point allocation and also as to what within those categories is deserving of recognition, but few are specific as to how many points would be awarded for each defined achievement e.g. a peer-reviewed first author paper. Such detail would assist applicants and improve the consistency and transparency of the selection process. It is of course appropriate that the allocation of points varies among specialties however this allocation information should be publicly available.

The team also heard at site visits that the selection criteria often changes without sufficient notification or consultation with trainees, and in some cases resulting in entire degrees no longer being scored in the CV, where they are no longer considered relevant to that specialty. Subsequent changes to selection criteria should first undergo evaluation and consultation with all stakeholders with an appropriate amount of lead time prior to implementation. The rationale for all proposed changes should also be clearly communicated at the time they are declared. This requires ongoing attention by the College and the Specialty Training Boards.

Assessing the prevocational performance of applicants as part of the selection process was of concern to almost all fellows involved with trainees. Considerable variation exists not only in technical ability but also in professional qualities – the latter being particularly relevant in a specialty challenged by accusations of workplace bullying and harassment. There is a general agreement that the current process of referee reports does not function well. As with referee reports across all the specialist medical colleges, the referee perceives an expectation that the applicant must be awarded maximum scores (or close to) on all categories. This seems to occur regardless of the number or nature of the questions being asked and almost regardless of how many referees are used. As these references are the only means by which prevocational performance is applied to selection, lack of appropriate discrimination is a problem. For the smaller selection panels, this is less of a problem with all applicants being reasonably 'known' to the panels but this in itself may lack fairness and transparency. At least one specialty selection panel uses telephone references

which is an acceptable form of reference but must be done in an open and transparent manner. Some training boards are using Entrustable Professional Activities (EPA) style assessments of prevocational skills acquisition.

College members interviewed by the team were of the view that the Brennan report prevented anything other than individual referee reports being used to assess prevocational performance and were essentially at a loss as to how the 'true' prevocational performance could be applied to selection in a fair and transparent manner. One fellow suggested that surgeons, senior trainees and senior nurses might provide a collective appraisal of the prevocational applicant via a 'multi-source' process. For the larger programs, the multi-source panel could 'rank' applicants, thereby providing the discrimination needed to reliably influence the selection outcome. This suggestion seems worthy of exploration given the widespread dissatisfaction with the current process.

Critical in the selection process for a surgical training program is the inherent ability of the applicant to perform technical procedures which require some aptitude in surgical dexterity. The team heard from many fellows who are frustrated at the lack of surgical ability in some of the trainees selected. Information on surgical ability could influence selection by more effective prevocational referencing and/or measures of inherent technical dexterity. The latter has been explored in North America and may have a future role in selection for surgical training programs in Australia and New Zealand.

Given the relatively uniformly high-scoring referee reports, discrimination relies on other elements of the selection process including academic record, research achievements and interview. The team heard from almost all fellows that, although some research participation is desirable, it should probably not be a key discriminator for selection to surgical training programs.

As discussed under standard 1.6, an issue that was raised on a number of occasions was that the College undertakes a selection process into training which is separate to that of recruitment into employment. The College advises hospitals of the trainees who have been 'allocated' to their hospital but does not share referee reports.

The team was disappointed to learn that only two specialties (Otolaryngology Head and Neck Surgery and Cardiothoracic Surgery) has a process to assist in the recruitment of Aboriginal and Torres Strait Islander trainees. With increasing numbers of Indigenous medical graduates, it is essential that specialist medical training programs have processes to assist in the selection, training and ongoing support of Aboriginal and Torres Strait Islander doctors. It was disappointing to hear from a number of Specialty Training Board representatives that selection should be based solely on a concept of "merit" which appears to be purely clinical/technical. There was a lack of agreement that there could also be merit in selecting an applicant who would better meet critical community needs. Similarly, there do not appear to be any strategies to increase intake of surgical trainees from a rural background, even though this is known to be the single strategy most likely to address the maldistribution of the medical workforce.

In the description of the process for supporting the selection of an Aboriginal and Torres Strait Islander trainee, Otolaryngology Head and Neck Surgery refers to 'reaching the minimum standard for selection'. This standard needs to be accurately and publicly defined for all nine specialties such that it is not the subjective impression of the selection panel but a prospectively defined clear standard for entry into surgical training.

The minimum application criteria are mostly clearly specified. As discussed under standard 5, the team supports the moving of the GSSE to the prevocational space and therefore becoming an essential application criterion. Trainees interviewed thought that study and preparation for the examination was valuable but became a distraction from their specialty once training had commenced. The problem created by moving this examination is that only 25% of applicants for surgical training are successful, meaning that 75% of those making a considerable professional, emotional and financial investment in the GSSE do so with little long-term benefit for most alternative careers. The College is therefore encouraged to devise strategies to reduce the burden on applicants not selected into surgical training.

It is clear from the College's Annual Activities Report that there is a relative lack of female applicants to surgical training. Women constitute on average 25% of applicants but the number is much lower for Orthopaedic Surgery (15%) and higher for Paediatric Surgery (40%). Fellows interviewed by the team largely ascribed the overall lack of female applicants to perceived gender differences in 'medical interests'. Few had considered the possibility that structures within the surgical training programs (e.g. a perceived lack of part-time training opportunities) might disincentivise female applicants. The team was pleased to read in the Diversity and Inclusion Plan of the intention to explore both the real and perceived impediments to diversity of applicants for the training programs. The planned survey of final year medical students, and PGY1 and PGY2 doctors may be key to learning why current applicants are predominantly male. The team recommends that the College promote and monitor its Diversity and Inclusion Plan through the College and all Specialty Training Boards to ensure there are no structural impediments to a diversity of applicants for the training programs, and applicants selected into each program, as well as participation in the practice of surgery.

7.2 Trainee participation in education provider governance

The accreditation standards are as follows:

The education provider has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

7.2.1 Trainee participation in education provider governance in 2017

The RACS Trainees' Association (RACSTA) was established in 2007 and advocates for trainees within the College. The chair of RACSTA is a voting member of RACS Council. RACSTA has representation from each training region and each of the nine specialties. The RACSTA Board reports directly to the College Education Board.

As described in their terms of reference, 'RACSTA was established to provide leadership and strategic direction for the Trainees' Association and to facilitate its goals and objectives.' Core among their main roles are advocacy for trainee issues to the College, as well as acting as the liaison between the College and trainees. They have a board that is comprised of 13 specialty representatives, including 8 regional representatives, College council representatives nominated by Council, and a number of co-opted members. All registered trainees of RACS are eligible to vote and stand for election to RACSTA, including those who are on interrupted training, with the exception of those who are suspended, on probation or under review by their Specialty Training Board. RACSTA board members are elected by the trainee body via the regional networks and Specialty Trainee Groups.

The chair of RACSTA is elected by secret ballot at a board meeting, and all board members have an equal vote. The chair remains in the role for one year with the option for re-election for an additional year, while terms for other board positions are similarly between one to two years depending on the specific role. Succession planning is in-built into the structure, which ensures that the immediate past chair continues to serve on the executive for an additional year to facilitate the transition.

The RACSTA Board engages in meetings, teleconferences, and workshops as required, but holds at least two face-to-face meetings per year, and all proceedings are recorded in minutes and reported to the RACS Council and to the Trainees' Association.

Trainee representatives are also members of each Specialty Training Board and many key RACS committees also include trainee members. In addition, some of the surgical specialties have their own trainee associations.

In 2015, a RACSTA executive officer was appointed to provide additional support to the RACSTA Board. The College provides funding for RACSTA's staff support and activities, including the significant undertaking of the development of the Morbidity Audit and Logbook Tool (MALT) Offline app, which has been largely a trainee-driven initiative.

As discussed under standard 6, RACSTA, in 2011, introduced an end-of-term survey to seek confidential feedback from trainees. De-identified survey results are reported to the Board of Surgical Education and Training and the Specialty Training Boards.

Trainees can also report their concerns or seek assistance via the RACSTA generic email address. A RACSTA board member will contact the trainee by phone, particularly if an issue requires action or intervention. RACSTA filters trainees' concerns and opinions through to RACS and the training boards via reporting mechanisms and representation at relevant meetings.

7.2.2 2017 team findings

RACSTA is an effective organisation, well supported by the College fellows and staff. Trainee involvement with RACSTA is commendable as all have extensive clinical and training commitments alongside their involvement in this important body which advocates effectively on behalf of trainees.

RACSTA is to be commended for its commitment to the rolling five-year analysis of the bi-annual trainee survey. It will be important that this survey is conducted in a manner that allows trainees to comment freely without fear of subsequent retribution by a consultant surgeon, a supervisor of training or training board.

RACSTA is to be commended for its contribution to the Building Respect, Improving Patient Safety (BRIPS) program – in its design, the validation of its delivery, and ongoing monitoring and quality improvement efforts.

Although there is trainee representation on Council, the team considers that a single trainee among 28 or so fellows may lack effectiveness. Although there is a trainee on each of the Specialty Training Boards, this trainee may feel compromised in raising training difficulties – particularly in the smaller disciplines.

Many trainees feel that they are somewhat restricted in any criticism of training or trainers for fear of ramifications on workplace-based assessments or future training. While the team sees no ready solution to this problem, it does highlight the importance of effecting change through RACSTA representation. Not all trainees seemed to be aware of this avenue for addressing their concerns in a less direct manner.

The team heard that some of the regional training committees do not include trainee representation. As this is a forum in which many significant discussions take place regarding rostering and movement between rotations, trainees consider it is important that there is adequate representation and input into these discussions. This is an area for further consideration by the specialties. The otolaryngology head and neck surgery training board reports that regional trainee representation is inappropriate as discussions include commentary on peers' and colleagues' performance.

7.3 Communication with trainees

The accreditation standards are as follows:

The education provider has mechanisms to inform trainees in a timely manner about the activities of its decision-making structures, in addition to communication from the trainee organisation or trainee representatives.

The education provider provides clear and easily accessible information about the specialist medical program(s), costs and requirements, and any proposed changes.

The education provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

7.3.1 Communication with trainees in 2017

Responsibility for what, when and how information is communicated is stipulated in RACS policy and specialty regulations. Most communication to trainees is delivered by the Specialty Training Boards and general information is provided on the RACS or Specialty Society/Association website.

Increasing use is made of social media including Facebook and Twitter. There is a weekly e-newsletter (Fax Mentis) and a monthly publication (Surgical News). RACSTA also has an increasing noticeable presence in being the liaison between the College and trainees, with regular newsletters and independent social networking accounts.

RACS is responsible for providing information to trainees on the overall surgical education and training program and policies, including selection, examinations, information on skills courses, and program costs. The Specialty Training Boards inform trainees about their status in and progression through the program, the requirements of the program, and any program changes or issues affecting training.

7.3.2 2017 team findings

In feedback to the team, trainees generally felt communication to be at a satisfactory level through the various publications and personal email. The website provides a resource for both trainees and prospective applicants to the training program. Emphasising the presence and role of RACSTA as a liaison body would also assist in bolstering communication pathways.

During the site visits, trainees and specialist international medical graduates consistently reported concerns with the high costs of training and assessment fees. The team recommends that the College and the Specialty Societies/Associations ensure transparency in setting and reviewing fees for training, assessments and training courses, while also seeking to contain the costs of training.

7.4 Trainee wellbeing

The accreditation standards are as follows:

The education provider promotes strategies to enable a supportive learning environment.

The education provider collaborates with other stakeholders, especially employers, to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training. It publishes information on the services available.

7.4.1 Trainee wellbeing in 2017

Over recent years, issues of discrimination, bullying and sexual harassment affecting RACS trainees have been well publicised in the media. As previously reported, the College responded with the establishment of the EAG which reported in 2015. Recommendations from the EAG Report via the BRIPS Action Plan have either been implemented or are in the process of implementation. A key element of the action plan is cultural change in the workplace, and this will be an ongoing process.

RACS has engaged Converge International to establish a 'Surgeons Support Service' for trainees experiencing personal, emotional or workplace difficulties. Converge International report twice yearly to the College regarding the service and it appears to be well received by trainees.

The guidelines for the accreditation of training posts address trainee welfare issues as well as training. This is discussed under standard 8.2.

Supervisors play a key role in identifying trainees who are experiencing personal or professional difficulties. Contact with RACSTA, via an executive member, is also an option for a trainee with personal and/or professional difficulties. RACSTA may assist directly, but also may direct the trainee to appropriate support, whether this is the Surgeons Support Service, hospital, supervisor, GP, or training board.

7.4.2 2017 team findings

Most trainees were very pleased to be undertaking surgical training and very conscious of the intense commitment needed to attain their career objectives in surgery. The team heard from trainees that they were well aware before application of the expectations of the surgical training

program. The trainees informed the team that had they not been prepared or able to make the necessary personal commitment, they would have pursued a different medical career.

Most trainees are accepting of rotations within their region including rural rotations. However interstate and international rotations can cause particular hardship. This is more particularly so for trainees with partners who have reduced mobility or children dependent on relatives for child-minding. It is the view of the team that interstate and international rotations should only occur if they are an absolute necessity for breadth of training. This should never be the case in the larger regions but may be necessary for the small specialties in the smaller regions where there may be only one training site. In that latter event, the program for interstate and/or international rotations should be clearly specified on commencement of training. The College must adhere to mandatory minimum notice periods for any rotations (including rural rotations within a region) that require a change in domicile. This is also discussed under standard 8.2.

As discussed under previous standards, trainees reported to the team that, while BRIPS program is leading to improvements, the culture of bullying, harassment and sexual harassment may not be changing quickly. It is important that the College continue to maintain its momentum with the BRIPS program.

7.5 Resolution of training problems and disputes

The accreditation standards are as follows:

The education provider supports trainees in addressing problems with training supervision and requirements, and other professional issues. The education provider's processes are transparent and timely, and safe and confidential for trainees.

The education provider has clear impartial pathways for timely resolution of professional and/or training-related disputes between trainees and supervisors or trainees and the education provider.

7.5.1 Resolution of training problems and disputes in 2017

The College manages complaints about bullying and harassment. Issues raised by trainees in relation to training supervision and requirements are generally managed in the first instance by Specialty Training Boards. The regulations stipulate how each of the boards conducts the process, and there are RACS guidelines to assist boards in meeting natural justice requirements, Natural Justice – Guidelines for Decision Makers.

If the issue is not resolved by the Specialty Training Board, the matter is referred to the Censor-in-Chief Review Committee, comprising the censor-in-chief and two members of the Education Board Executive. This committee can ask the Specialty Training Board to reconsider the original decision but does not appear to have the power to overrule a Specialty Training Board decision. If the trainee remains dissatisfied with the decision, a formal Appeals Committee is convened to manage the decision.

7.5.2 2017 team findings

It is obviously critically important that trainees can provide constructive criticism of their training program in order that this valuable feedback contributes to ongoing development of the educational programs. It is also absolutely critical that any negative comments from a trainee do not negatively affect their progress in the training program. Even a perception that this could happen is likely to curtail important constructive feedback. Other than possibly in General Surgery, it is extremely difficult for a trainee not to be readily identified by virtue of the comment made – particularly if in reference to deficiencies of a training post. It will be important for the College and the Specialty Training Boards to work together to ensure there are processes in place that enable trainees to raise issues and resolve disputes during training without jeopardising their ongoing participation in the training program. The RACSTA five-year rolling survey and the training post accreditation process give some opportunity for some de-identification but further progress is essential.

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College addressed the following conditions in AMC monitoring submissions.

Conditions to satisfy accreditation standards

25 Clearly document and make publicly available the standard of entry into each surgical training program. (Standard 7.1)

26 Develop a policy that leads to the increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees in each surgical training program. (Standard 7.1.3)

29 Address trainee concerns about being able to raise issues and resolve disputes during training by ensuring there are mechanisms for trainees to do so without jeopardising their ongoing participation in the training program. (Standard 7.5)

In 2018, the College reported and provided details demonstrating the selection regulation regarding standard of entry for each surgical specialty. The standard of entry is publicly available.

In 2018, the College reported that all specialty training boards endorsed the RACS Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative Policy and in 2019, made progress with several other initiatives to increase recruitment, including collaborations with the Māori Health Advisory Group and awards to Aboriginal and Torres Strait Islander and Māori recipients. The College reported two Aboriginal and seven Māori applicants were selected into SET training in 2018.

In 2019, the College reported all trainee concerns were considered through a weekly triage process by a multi-agency group involving educational, legal and surgical, directed by the Deputy CEO. Complaints related to specific fellows were either referred to appropriate jurisdiction or used interventions based on the Vanderbilt principles. Trainees could receive support through a third-party counselling service. A new *Reconsideration, Review and Appeals regulation*, was approved by the Board and covered College decisions that might be challenged. The policy, available on the College website, aimed to support and guide RACS trainees through a fair and transparent process to resolve disputes during training.

B 2021 team findings

The follow-up visit considered progress towards the remaining conditions and whether the College had responded to the recommendations for quality improvement.

Conditions to satisfy accreditation standards

24 Further develop the selection policies for each surgical training program, particularly with regard to the provision of transparent scoring of each element in the curriculum vitae and the standardisation in the structure of referee reports. (Standard 7.1)

To be met by 2020.

27 Promote and monitor 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)

To be met by 2019.

28 Increase transparency in setting and reviewing fees for training, assessments and training courses, while also seeking to contain the costs of training for trainees and specialist international medical graduates. (Standard 7.3.2 and 10.4.1)

To be met by 2019.

Recommendations for improvement

OO In relation to selection into the surgical training programs:

(i) Evaluate the objectives of the selection process to ensure they are both clear and consistent across all surgical training programs.

(ii) Develop a process to ensure that updates and changes to entry prerequisites undergo a consultation process, and provide appropriate lead time for prospective applicants to meet them.

(iii) Explore the means by which prevocational work performance and technical ability may be more appropriately assessed as part of the selection process.

(iv) Examine the key discriminators (e.g. academic record, research, experience, interview performance) in the current selection process and whether these are the most relevant for predicting performance both as a trainee and as specialist. (Standard 7.1.1)

PP Implement a program to increase awareness of the presence and role of the RACS Trainees' Association (RACSTA). (Standards 7.2 and 7.3)

The specialty training programs are aligned in their commitment to a fair and effective selection process with considerable investment by the College and specialty training boards noted by the team. All programs employ an evidenced points-based structured curriculum vitae (CV) and referee reports with transparent scoring. The programs continue to differ in the scoring of CVs and the content and structure of the referee reports. The CV scoring matrices are transparent internally, however, while most are available online to prospective applicants, not all are yet available online. The team encourages the College and specialty training boards to explore ways the format, transparency and availability of CV scoring matrices can be consistently applied.

Overall, trainees considered that the CV review process was fair and transparent and the lead-time for communicating changes was generally fair. Some trainees expressed concerns that the combination of the global move to 'open access' journals and the points awarded for research publications on the evidenced CVs was incentivising trainees to spend large sums of money securing publications in open access journals.

The points-based CV has been utilised by some programs as an opportunity to promote diversity and inclusion:

- Vascular Surgery awards points for those living or working in a rural environment or for time spent in a representative role advocating for the health of First Nations' people.
- Orthopaedic Surgery New Zealand, Plastic and Reconstructive Surgery New Zealand and General Surgery New Zealand award points for cultural and language fluency in Te Reo Māori and Te Ao Māori.
- The Urological Society of Australia and New Zealand (USANZ) and General Surgery Australia award points for time spent training in rural areas.

Most specialty training programs employ their own independent referee process. The structure and content of the referee reports vary greatly, with some programs using the RACS template, and many others using a modified version of the template. The specialty training boards and the trainees alike shared concerns that the referee form was a 'poor discriminator'. This was

particularly the case when the RACS referee template was used, with concerns raised that a large proportion of applicants progressing to interviews achieved 100% of marks available.

Some specialty training boards (e.g. General Surgery New Zealand) have had success in requiring referees to qualitatively justify maximum scores. Several Boards use a phone-based referee process which has been identified as very effective. The administrative burden of such a process has been identified by the larger training programs as being too onerous to implement. The number of referees used in selection also varies between specialty training boards. Most require 6-8 referees. AOA collects one departmental Referee Report from each site at which the applicant has worked in the previous two years, intending to represent the consensus opinion of the surgical team. The AOA process incorporates non-surgical colleagues, as does OHNS and Plastic and Reconstructive Surgery in both Australia and New Zealand.

The team considers the College to have satisfied its development of selection policies through transparent CV scoring under condition 24. The benefits of the varied approaches towards differing reference reports are apparent for specialties of different sizes. As such, the team considers that a single approach in the standardisation in the referee report structure may no longer be of benefit and encourages good practice be shared across the College and specialty training boards.

Specialty training boards acknowledge that prolonging the experience of the unsuccessful applicant is undesirable. The trainees did not feel that this experience was common, but did express reservations regarding the ease at which an individual may be able to change vocational pathways after multiple years in the role of an unaccredited specialty surgical registrar. The challenge identified by the specialty training boards is that this cohort of applicants often have more time to accumulate points on the CV and attain relevant clinical experience. The AOA, for example, has introduced a CV point threshold required to progress to interview but does not contribute to the final selection score. The New Zealand Board of Plastic and Reconstructive Surgery have indicated a similar approach. Paediatric Surgery identified that their competency-based curriculum enabled them to assess applicants' competency at the level of a junior registrar, with competency beyond this level not necessarily benefiting the applicant in the application process, but was able to be recognised as prior learning if they were accepted into training.

Some specialty training boards have implemented policies to limit the number of times an applicant may apply to the training program. OHNS employs a model associated with a limited number of attempts and a 6-year time limit while others use a 'three strike' approach. The team observes there are various approaches employed by some specialty training boards, and there may be an opportunity for the College to identify and share good practice across specialties to adopt as well as to investigate approaches to mitigate time spent by unsuccessful trainees, and to potentially advise or create alternative pathways.

The Diversity and Inclusion Plan was very well received by trainees, supervisors of training and specialty training boards alike and all seemed very supportive and proud of the initiatives that have been implemented. The College and specialty training boards are commended for their focus on diversity in selection, particularly for the increasing numbers of trainees identifying as Māori, Aboriginal, or Torres Strait Islander.

There are also a number of excellent initiatives across the College to promote diversity and inclusion through the selection process and mitigate gender and ethnic disparity. For example:

- Orthopaedics in Australia and New Zealand aim to have one female surgeon on each of their three person selection panels.
- Australian Board of Plastic and Reconstructive Surgery has a process of reference checks performed by interstate fellows to mitigate potential for bias. Selection panels are blinded.
- New Zealand Board of Plastic and Reconstructive Surgery engages a cultural advisor to support its selection process.

- USANZ use blinded CV scoring, where assessors are blinded to name and ethnicity. The logistical challenges and administrative burden of this has been acknowledged as a barrier to others.
- Vascular Surgery has moved to a 'semi-blinded' interview process with applicants disclosing first-name only.
- In New Zealand, 45% of trainees in each of Plastic and General Surgery are female trainees.
- AOA assessors for selection are asked to undertake an unconscious bias assessment through Harvard.
- AOA selection process includes a set of minimum-interviews with six stations and each station has deliberate scenario based questions around diversity and cultural inclusion.
- The sequestered selection position initiative (e.g. in OHNS, USANZ and Vascular) appears well received by trainees, although uptake of positions continues to be a challenge for some programs.
- The pilot Indigenous Surgical Specialist Pathway program provides surgical pre-SET training and mentoring opportunities for Aboriginal and Torres Strait Islander doctors, working with surgeons in Darwin and Flinders University.

The team heard that an obstacle to Diversity and Inclusion initiatives in the selection process is an inability to access the background data of applicants due to the data being held centrally by the College and it would seem that the sharing of de-identified data by the College with specialty training boards would be helpful in overcoming this obstacle. The team also noted the Diversity and Inclusion initiatives were significantly variable across specialty training boards and the College might consider adopting an evidence-based 'best practice' tool to monitor and support the specialty training boards in the process of adopting these initiatives.

In addition, the significant cost of training and preparation for selection in some specialty training programs may be a barrier to accessing training for individuals from minority or lower socioeconomic backgrounds or due to family circumstances, such as single parents with dependents. The evaluation of selection further shows a limited increase in the number of female trainees entering training in some specialty training programs with no female Aboriginal and Torres Strait Islander trainees. The *Breaking Barriers* report and feedback received indicate structural barriers continue to exist for female trainees within training programs. Monitoring and reporting on applicant demographics as well as considering further approaches to enable greater accessibility to training for various groups would enhance selection outcomes for the College's Diversity and Inclusion initiatives.

The team notes the College and all specialty training boards are considerably invested in ongoing critique and analysis of their respective structured CVs, particularly as to which key discriminators best predict performance. Many specialty training boards have identified that research may not be the best predictor of performance and have decreased the yield of research. Furthermore, awarding points to applicants with rural experience, and with Aboriginal and Torres Strait Islander or Māori background has been recognised as an opportunity to promote diversity and inclusion.

The College has made available on its website a list of the fees charged by RACS in relation to training. This shows the College SET fee and the Specialty SET fee in Australia and New Zealand (where relevant). The team heard concerns from trainees about the significant disparities in fees between surgical and non-surgical training, and among different surgical training programs, which may reflect the varied structures and components of the specialty training programs. Achieving fee transparency depends on the complete findings of the KPMG audit of fees and the clarity of the College's service agreements with the specialty training programs. Fee transparency may be helpful in justifying the fee disparity to trainees and in the pursuit of benchmarking between specialty training programs. In an attempt to contain fees, multiple specialty training

boards have expressed their intention to mitigate year-on-year fee increases by only increasing by CPI. The predictability of this fee structure was appreciated by trainees.

The Trainee Engagement Working Group formulated a communications plan and related actions to increased trainee engagement and awareness of the role of RACSTA. The objectives of RACSTA and its activities was planned to be embedded in all communication from RACS to surgical trainees. Key performance indicators included increased induction conference attendance and tri-annual RACSTA newsletter click rate. Actions taken as a result of issues identified through the RACSTA survey is also part of the overall communication strategy to trainees and other stakeholders. The College might consider developing a social media presence to further increase RACSTA's profile among trainees.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

Q The commitment of the RACS Trainees' Association (RACSTA) in implementing a rolling five-year survey of the trainee experience, and by advocating on behalf of trainees.

R The College's clear commitment to trainee participation in governance by dedicating both human and financial resources to ensure the RACS Trainees' Association (RACSTA) is well supported.

S The specialties of Otolaryngology Head and Neck Surgery and Cardiothoracic Surgery that reserve a place for an Aboriginal and Torres Strait Islander applicant who reaches the minimum standard for selection.

2017 Conditions to satisfy accreditation standards

24 Further develop the selection policies for each surgical training program, particularly with regard to the provision of transparent scoring of each element in the curriculum vitae and the standardisation in the structure of referee reports. (Standard 7.1)

25 Clearly document and make publicly available the standard of entry into each surgical training program. (Standard 7.1)

26 Develop a policy that leads to the increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees in each surgical training program. (Standard 7.1.3)

27 Promote and monitor 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)

28 Increase transparency in setting and reviewing fees for training, assessments and training courses, while also seeking to contain the costs of training for trainees and specialist international medical graduates. (Standards 7.3.2 and 10.4.1)

29 Address trainee concerns about being able to raise issues and resolve disputes during training by ensuring there are mechanisms for trainees to do so without jeopardising their ongoing participation in the training program. (Standard 7.5)

2017 Recommendations for improvement

OO In relation to selection into the surgical training programs:

(i) Evaluate the objectives of the selection process to ensure they are both clear and consistent across all surgical training programs.

(ii) Develop a process to ensure that updates and changes to entry prerequisites undergo a consultation process, and provide appropriate lead time for prospective applicants to meet them.

(iii) Explore the means by which prevocational work performance and technical ability may be more appropriately assessed as part of the selection process.

(iv) Examine the key discriminators (e.g. academic record, research, experience, interview performance) in the current selection process and whether these are the most relevant for predicting performance both as a trainee and as specialist. (Standard 7.1.1)

PP Implement a program to increase awareness of the presence and role of the RACS Trainees' Association (RACSTA). (Standards 7.2 and 7.3)

2021 Accreditation Commendations, Conditions and Recommendations

In 2018 and 2019, the College addressed conditions 25, 26 and 29 in their monitoring submissions to the AMC.

In the 2021 follow-up assessment, the team considers conditions 27 and 28 to be progressing and condition 24 to be satisfied. Recommendations OO and PP are considered to be addressed. The remaining conditions under Standard 7 from the 2017 reaccreditation are replaced with conditions 16 and 17 in 2021.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

16 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. (Standards 7.1 and 6.1 and 6.2)

17 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. (Standards 7.3.2 and 10.4.1)

2021 Recommendations for improvement

Nil

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

8.1 Supervisory and educational roles

The accreditation standards are as follows:

- The education provider ensures that there is an effective system of clinical supervision to support trainees to achieve the program and graduate outcomes.
- The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the specialist medical program and the responsibilities of the education provider to these practitioners. It communicates its program and graduate outcomes to these practitioners.
- The education provider selects supervisors who have demonstrated appropriate capability for this role. It facilitates the training, support and professional development of supervisors.
- The education provider routinely evaluates supervisor effectiveness including feedback from trainees.
- The education provider selects assessors in written, oral and performance-based assessments who have demonstrated appropriate capabilities for this role. It provides training, support and professional development opportunities relevant to this educational role.
- The education provider routinely evaluates the effectiveness of its assessors including feedback from trainees.

8.1.1 Supervisory and educational roles in 2017

Supervisor of training role

The College has well-defined principles of supervision, including the eligibility criteria for, and the duties to be performed by, a supervisor. Each Specialty Training Board provides further specification of a supervisor's duties through its training regulations. Some specialties have developed position descriptions and supervisor handbooks. The College does not set supervisor to trainee ratios but assesses whether an institution can support the number of training posts.

Supervisors are responsible for: coordinating the management, education, and training of trainees; conducting performance assessments; monitoring operative experience and reviewing operative logbook summaries; and managing issues of unsatisfactory trainee performance. Supervisors are the liaison between trainees and hospital authorities on matters related to training. Supervisors also liaise with the Specialty Training Boards regarding trainee and training matters.

Appointment and tenure

Supervisors must be fellows of RACS and meet the criteria set down in the Surgical Supervisors Policy. Some Specialty Training Boards also require membership of the specialty society or association. Each Specialty Training Board determines the appointment process and term of appointment for their specialty. The term of appointment is usually three years, with supervisors eligible for reappointment. The maximum period that a Specialty Training Board can allow a supervisor to serve is nine years. In extraordinary circumstances, the College censor-in-chief may approve an extension for a supervisor.

The Surgical Supervisors Policy documents the mandatory and recommended training required of all supervisors and trainers. As a minimum, supervisors and trainers are required to complete the Supervisors and Trainers for SET (SAT-SET) and Keeping Trainees on Track (KTOT) courses. Supervisors and surgeons who teach and train SET trainees are now required to complete the Foundations Skills for Surgical Educators (FSSE) or equivalent, and undertake advanced training in

discrimination, bullying and sexual harassment. The College has scheduled eighty FSSE courses for 2017.

Supervisors are required to undertake professional development activities relevant to the role. The College's website contains a number of resources for those involved in education and training. A number of the surgical specialties also conduct workshops and training days specifically for supervisors.

As discussed, the College's Academy of Surgical Educators (ASE) has more than 700 members and promotes formal training of fellows involved in the education and training of trainees.

Feedback on supervisor performance

The College collects feedback from trainees on supervisor performance via a number of means including the RACS Trainees' Association (RACSTA), surveys conducted by the Specialty Training Boards, and the post reaccreditation process. Feedback is also gathered via the complaints hotline which specifically addresses discrimination, bullying and sexual harassment and breaches of the RACS Code of Conduct. The College does not collect specific named feedback attributed to a trainee about a supervisor within a post. The College reports that trainees remain reluctant to be named.

The College is in the process of developing supervision standards which will provide a baseline against which supervision will be assessed and remediation plans can be developed. This initiative is a key focus for the College in 2017 and stems from the Building Respect, Improving Patient Safety (BRIPS) Action Plan. A process for review of supervisor performance will be implemented in 2018.

Assessors

Membership of the Court of Examiners is by application, seconded by a RACS fellow. New fellowship examiners are selected in consultation with members of the court. Members must be a RACS fellow and compliant with a College-approved continuing professional development program. In selecting new examiners, the specialty court considers the geographical and teaching hospital representation and subspecialty mix to ensure diversity and broad representation. Examiners usually serve for nine years, and their appointment is reviewed every second year.

The College has a mandatory one-day training course for fellowship examiners. The training covers the concepts of examination standards, standard setting, reliability and validity. Once appointed, all new examiners must attend a College Fellowship Examination to observe examiner performance and the examination process. This was also discussed under standard 5.

There is no application process for clinical examiners. Prior to each examination, an expression of interest is circulated to identify interested fellows. The College has developed a clinical examiner training course which was made available to examiners in June 2017.

Evaluation of assessors and feedback from trainees

The College conducts a voluntary post-examination survey of the candidates which includes feedback on examiner performance. The College uses a range of other methods to evaluate examiner performance and these are described under standard 5.

Mentors

Following an unsuccessful trial of a facilitated mentoring program, the College has developed a mentoring webpage which provides a guide, tools and templates to develop and support an effective mentoring relationship.

8.1.2 2017 team findings

The College has a dedicated paid and pro-bono workforce providing high-quality surgical training. The team generally found that supervisors and trainers feel well supported by the College.

Some supervisors reported to the team that the requirements of the supervisor role are becoming more onerous each year, making pro-bono work increasing difficult. The College acknowledges that balancing training and development commitments in a volunteer workforce is a major challenge for supervision. The College reports that a constant constraint of the SET program is the provision of adequate paid and protected time to allow supervisors to fulfil their educational role. When competing with service provision, the lack of time devoted to training impacts on the supervisor's ability to provide high-quality assessment and feedback, particularly for trainees experiencing difficulties.

Training requirements, including the roles for supervisors and trainers, are clearly articulated and easy to access. The College provides clear direction about mandatory training requirements for supervisors. The newly developed College courses, KTOT, Operating with Respect (OWR) and FSSE, have a high uptake by supervisors. Supervisors reported to the team that these courses are of high quality and relevant. The assessment team was also given the opportunity to observe the FSSE course. The introduction of mandatory training for clinical examiners is noted as a positive step for the College.

The College does not currently mandate cultural safety training for supervisors, trainers and assessors, with the assumption made that this occurs within the hospital setting. The team recommends that the College mandate training and include this requirement as part of accreditation standards for training posts.

The team found that there is a range of data collected from trainees regarding training posts. However, unless specific concerns are raised, none of these methods provide feedback in relation to a specific supervisor or trainer. The College acknowledges that further work is required to improve the quality of supervision, and identify and remediate underperforming supervisors. Data quality in relation to trainee feedback about supervisors was consistently raised as an issue. Trainees are reluctant to provide feedback, and reported concerns regarding de-identification processes. The College will need to continue to work towards providing an environment where trainees are able to provide feedback without fear of consequences.

The team commends the work of the College in developing supervision standards and a process for reviewing supervisor performance. The team recommends that the College in conjunction with the Specialty Training Boards finalise the supervision standards and process for reviewing performance and implement across all specialty training programs.

8.2 Training sites and posts

The accreditation standards are as follows:

- The education provider has a clear process and criteria to assess, accredit and monitor facilities and posts as training sites. The education provider:
    - applies its published accreditation criteria when assessing, accrediting and monitoring training sites
    - makes publicly available the accreditation criteria and the accreditation procedures
    - is transparent and consistent in applying the accreditation process.
- The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and:
    - promote the health, welfare and interests of trainees
    - ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner
    - support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which

provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand

- ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment.

- The education provider works with jurisdictions, as well as the private health system, to effectively use the capacity of the health care system for work based training, and to give trainees experience of the breadth of the discipline.
- The education provider actively engages with other education providers to support common accreditation approaches and sharing of relevant information.

8.2.1 Training sites and posts in 2017

The College has clearly defined standards for the accreditation of hospital posts entitled Accreditation of Hospitals and Posts for Surgical Education and Training. The College accredits individual posts within hospitals, and not the hospital as a whole.

In 2016, the College reviewed its accreditation standards to incorporate the BRIPS Action Plan. The College introduced a requirement for hospitals to demonstrate that they 'build and maintain a culture of respect for patients and staff.' The College is engaging with hospitals, hospital networks and jurisdictions to ensure this standard will be met. As discussed under standard 1, a number of formal agreements and memoranda of understanding have been signed.

The accreditation criteria are based around eight core educational, clinical and governance standards. The accreditation standards cover: building and maintaining a culture of respect for patients and staff; education facilities and systems required; quality of education and learning; surgical supervisors and staff; support services and flexibility for trainees; clinical load and theatre sessions; equipment and clinical support services; clinical governance, quality and safety.

Each Specialty Training Board has a published process for accrediting a training post in that specialty, which is compliant with the RACS Training Post Accreditation and Administration Policy. The accreditation team (sometimes referred to as an inspection team which is effectively a subcommittee of the Specialty Training Board) will make a recommendation on the suitability of the post for training purposes.

The accreditation team usually comprises two to three fellows of the relevant specialty who are involved in training. Usually team members will be from outside the jurisdiction in which the post under review is located. The Board in General Surgery also includes a trainee representative in the accreditation process.

The accreditation team reviews the hospital's accreditation submission, meets with hospital administration, members of the unit and current trainees. The team considers whether the post provides the experience necessary for a trainee, based on likely operative experience, the breadth of procedures undertaken in the unit, the equipment available to ensure the unit can perform the procedures indicated in its submission, the infrastructure available to support a trainee (library, study facilities, access to examination leave, etc.) and the level of supervision a trainee would receive.

The draft report prepared by the accreditation team is made available to the hospital prior to finalisation. The accreditation recommendation is presented to the Specialty Training Board for approval. The Specialty Training Board decides on the accreditation period, and whether there should be any further inspections during the accreditation period. While five years is the usual accreditation period, a board may accredit a post for a shorter period.

The Specialty Training Board may re-inspect posts where it identifies – through complaints, trainee surveys, trainee underperformance, etc. – that there may be a diminution of standards. Issues that may result in a post review include significant change in staff, proven complaints of discrimination,

bullying and sexual harassment, changes of accreditation by another organisation, and change of service provision by the hospital.

The College acknowledges the benefits of training in the private sector, including exposure of trainees to procedures predominantly conducted in that sector. The College accredits 73 Australian Department of Health Specialist Training Program (STP) posts. Posts are predominantly in the public sector, however the College is encouraging private sector hospitals to seek accreditation. This initiative has had limited success, which the College considers is due to the different expectations of private patients. It is also essential that trainees receive experience as the primary operator with appropriate supervision. Such opportunities can be limited in private hospitals.

Accrediting posts in rural areas depends somewhat on the organisation of specialist services by health jurisdictions: suitable units exist in medium-sized cities, but trainees rotating in from a metropolitan-based program usually fill the training positions. The College reports that because there are more trainees in General Surgery and Orthopaedic Surgery, these programs are organised on a regional basis, and this enables the operation of training posts in rural areas. It is possible within these programs to have more non-metropolitan training, however, other specialties are city-based due to the need for highly specialised equipment (for example, Neurosurgery).

The College reports that all trainees gain experience in the provision of health care to Aboriginal and Torres Strait Islander patients in the major teaching hospitals. Some Specialty Training Boards have introduced initiatives that address Indigenous health in rural communities. For example, members of the Board of Otolaryngology Head and Neck Surgery, and its supervisors and trainees, undertake regular outreach clinics to remote Indigenous communities.

The College has included jurisdictional representatives on accreditation teams with the full rights and duties exercised by surgeon-members of the team. Jurisdictional representatives have also been invited to be members of the Specialty Training Boards, the Board of Surgical Education and Training, and the Education Board.

The Australian and New Zealand College of Anaesthetists (ANZCA) and RACS provide representation on each other's councils to facilitate communication on high-level issues of education, and this includes strategic discussion on accreditation. The College has participated in workshops organised by the Council of Presidents of Medical Colleges and the Health Workforce Principal Committee regarding collaboration on accreditation. Currently, the College does not share information from its accreditation process with other colleges, and does not collaborate with them on joint accreditations, nor share findings about common criteria.

8.2.2 2017 team findings

The team considers that the College accreditation standards and processes are fit for purpose and are driving positive changes within workplaces. The accreditation process is rigorous, transparent and clearly defined. Information regarding the accreditation process is easily accessible.

The College has eight accreditation standards, the first of which concerns respectful and safe working and educational environments. Hospital executives at various sites visited by the team commented on the efforts of the College in operating with respect. They reported that this has translated to conversations with medical staff about appropriate behaviour within the workplace. Trainees have reported feeling that consultants are taking more interest in their psychological health. The team recommends that each Specialty Training Board, with the support of the College, must maintain momentum with the BRIPS action plan, by promoting the program and the positive participation of all fellows and trainees, including supporting all surgeons to "call out" bad behaviour in work and training.

As discussed under standard 2, the team heard reports during site visits that trainees are working hours additional to those recorded formally in order to bypass safe working hours requirements. The team also heard that some trainees are often expected to work a one in two on-call roster, with fatigue a potential issue. The team recommends that the College and Specialty Training Boards continue to closely monitor working hours through the accreditation process.

Cultural competency training is inconsistent across specialties and between Australia and New Zealand as covered under standard 3.2. The College's Australian and New Zealand cultural competency training frameworks have been developed independently. Cultural safety and Indigenous health is not currently specified within training curricula, and is not assessed. The efforts of the Indigenous Health Committee to ensure that meaningful cultural competence training is rolled out across the College is commended. The team recommends that the College include in their accreditation standards a requirement that training sites demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence.

The Board of Otolaryngology Head and Neck Surgery fully supports training and education opportunities in diverse settings aligned to the curriculum requirements, including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand. Trainees in Otolaryngology Head and Neck Surgery undertake outreach visits to sites that provide health care to Aboriginal and Torres Strait Islander peoples. These outreach clinics include: Deadly Ears Program – Queensland; Kimberley Region Outreach Clinics – Western Australia; Yatala Outreach Clinic – South Australia. The team commends this program of visits as an area of strength which it recommends other specialty training programs may also wish to consider.

The team considers that the lack of access to flexible training has a significant impact on the welfare of trainees. While the team noted that College policies and the College executive are supportive of part-time and flexible training, there is a disconnect in terms of trainees accessing this training. Flexible training is not currently role modelled by the College, and is reported by some trainees and supervisors to be perceived as substandard training. This issue is further discussed under standard 3.4.

The team heard considerable feedback in relation to the impact of interstate and international rotations on trainee welfare. Such rotations are disruptive to the usual support networks and to caring roles. Trainees reported loss of benefits such as sick leave and other accrued leave when transferring between jurisdictions. Trainees also reported inadequate notification periods ahead of interstate and international rotations. The team recommends that the College develop a policy that is adhered to by all Specialty Training Boards that minimises the number of interstate/international rotations and stipulates a minimum advanced notice period prior to commencement of rotations. The team encourages the College to develop a practice whereby trainees are given a plan for their rotations at the commencement of their training program. The College is also encouraged to work with the jurisdictions to assist in preventing the loss of employment benefits when trainees transfer between jurisdictions.

The great majority of trainees have limited exposure to rural and regional training locations. The team recommends that the College further explore how it can expand the training programs in rural and regional locations.

The team considers further collaboration amongst the Specialty Training Boards to support common accreditation processes and share relevant information is required. The team notes the College's contribution to the Health Workforce Principal Committee's Accreditation of Specialist Medical Training Sites Project. As detailed under the notes to the accreditation standards, the AMC endorses the work on developing tools to support consistent approaches to accreditation. The College is encouraged to map the RACS accreditation standards against the accreditation domains outlined in the Accreditation of Specialist Medical Training Sites Project Final Report.

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College addressed the following condition in AMC monitoring submissions.

Conditions to satisfy accreditation standards

32 Promote the Building Respect, Improving Patient Safety (BRIPS) program and encourage the positive participation of all fellows and trainees, including supporting all surgeons to "call out" bad behaviour in work and training. (Standard 8.2.2)

In 2018, the College reported 95% compliance with the Operating With Respect (OWR) module of the Building Respect, Improving Patient Safety (BRIPS) program as of 30 June 2018, with specialty training boards affirming ongoing support for the program through active participation.

B 2021 team findings

The follow-up visit considered progress towards the remaining conditions and whether the College had responded to the recommendations for quality improvement.

Conditions to satisfy accreditation standards

30 Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standard 8.1.3, 8.1.5 and 8.2.2)

To be met by 2020.

31 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)

To be met by 2021.

33 In the hospital and training post accreditation standards for all surgical training programs include a requirement that sites demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence. (Standard 8.2.2)

To be met by 2019.

Recommendations for improvement

QQ Develop a policy that is adhered to by all Specialty Training Boards which stipulates the minimum advanced notice required prior to requiring commencement of new rotations and which also minimises the number of interstate /international rotations. (Standard 8.2.2)

RR Work with the jurisdictions to assist in preventing the loss of employment benefits when trainees transfer between jurisdictions. (Standard 8.2.3)

SS Consider how to expand the surgical training programs in rural and regional locations. (Standards 8.2.2 and 8.2.3)

TT Support collaboration amongst the Specialty Training Boards to develop common accreditation processes and share relevant information. (Standard 8.2.4)

The College has developed two new courses, Difficult Conversations with Underperforming Trainees and Promoting Advanced Surgical Education (PrASE), and the Foundation Skills for Surgical Educations (FSSE), the team consider these to be excellent developments to support supervisor training. The College reported the Supervisors and Trainers for SET (SATSET) course was revised and a new course, Induction for Surgical Supervisors and Trainers (ISST) was

developed and piloted in November 2020 and March 2021. Keeping Trainees on Track (KTOT) is also under review and an online delivery is planned in 2021.

As a first step to mandating cultural safety training for all supervisors, clinical trainers and assessors, RACS has identified separate cultural safety training courses for Australia and New Zealand. The College is developing the Australian course as four online modules; modules one and two are developed and available, modules three and four remain in development. In New Zealand, the College has identified an Otago University course, "*MIHI 501 HEALTH PROFESSIONALS COURSE: Application of the Hui Process / Meihana Model to Clinical Practice*" comprising online learning modules and one on-site training seminar. It is now available, beginning in 2021 with the first on-site component in October 2021. The numbers able to attend are limited by the on-site course capacity of 50 attendees. A number of New Zealand surgeons have committed to undertaking the course in October 2021

The team considers both of these courses will provide suitable cultural safety training, and early feedback received was positive and the content considered to be thorough. The College is yet to make participation in cultural safety courses mandatory for all supervisors, clinical trainers and assessors, and some specialty training boards and the New Zealand Board reported it is their intention to do so in the future, given that the courses have only commenced delivery this year.

The team found that knowledge of and support for the courses in Australia was very variable. While there was support in principle for undertaking cultural safety training, there was some reluctance to make it immediately compulsory, centred on the perception that this might lead to an increase in cost and time commitment for those undertaking these courses in addition to their other existing requirements, particularly for on-site practical courses.

While there is an intention by the College to mandate cultural safety training for supervisors in future, the timeline for implementation was not obvious and should be made clear. The College indicated an intent to utilise hospital accreditation and continuing professional development processes to encourage full compliance.

The College's published *Standards for Supervision* are set out in the supervision framework, which sets out the core competencies expected of supervisors. The supervision standards have been finalised and implemented. Nearly all supervisors and trainers have undertaken the FSSE course with a rate of completion undertaking from 94% to 97% for SET supervisors, SET trainers, SIMG supervisors and SIMG trainers.

The College has implemented a self-assessment tool for supervisors, based on the supervision framework, rather than an external process for reviewing supervisor performance, as asked for in condition 31. The specialty training boards do not have a process for formal and consistent feedback for supervisors on their performance. The reasons cited for a feedback process not yet being formalised include that supervisors are working pro bono, already having demands on their time such as the OWR and FSSE courses, and the perception that prior to putting in place regular, formal assessments, supervisors needed to have adequate training and adequate resources to undertake the training and work. Many supervisors rely on notification of specific problems, or use the hospital accreditation system for any supervision problems to be highlighted. Culture change may be required to work through any perceived resistance to receiving feedback.

The implementation of the College's *Standards for Supervision* and supervision framework needs an effective review and feedback process to ensure its efficacy.

The revised *Hospital training post accreditation standard*, approved and published on the College website, recently incorporated *Principle 2: Cultural competency and safety*. Its aim is to "*ensure that hospitals can demonstrate a commitment to promoting Aboriginal and Torres Strait Islander and/or Māori cultural competence, and can provide a culturally safe training environment for Trainees and patients"*. This is achieved through Standard 5 in the *Hospital training post accreditation standard* that training sites need to demonstrate "*There is a hospital wide*

commitment to provide culturally safe care". The criteria under this standard clearly delineate how this standard will be assessed at the training sites.

The College plans to pilot the revised training post accreditation standards with a select group of accredited posts at the beginning of 2022, before a full roll-out later in 2023. This is part of a larger College hospital training post project, to encourage consistent approach and processes across specialties and improve information sharing across specialties and training sites. The College intends this rollout in alignment with the Rural Health Equity Strategy in a strategic and sustainable manner, considering accreditation timelines, in order to manage the burden on hospital administration. Training sites will be provided time to review the standards approved in June 2021. The outcomes of the project include plans for the College to be responsible for accrediting training site processes according to core accreditation standards while specialty training boards will accredit specialty-specific hospital training posts. The College is asked to provide the timeline of implementation of the revised hospital training post accreditation standards and processes in its next report to the AMC. The way the College monitors changes in surgical culture, gender diversity and cultural safety in training sites and posts will also be of interest.

The College considered recommendation QQ and consulted with specialty training boards to discuss feedback and proposed changes. The College will work to embed policy recommendations in existing SET regulations and the team noted there were varied notification periods for allocations from three to nine months currently in place for different specialties. Although the College has elected not to continue with recommendation QQ, it is encouraged to consider identifying a minimally acceptable rotation notice period across specialty training programs to better support trainees.

Based on recommendation RR, the College reported work with the RACSTA Committee on the portability of trainee leave entitlements across Australian states and territories, and New Zealand and engaging with jurisdiction to establish reciprocal agreements. Evidence of progress include specific entitlement ensuring no parental leave disadvantage for trainees returning to their home jurisdiction because of medical college requirements in all Australian states and territories except the ACT.

RACS commissioned a strategy paper "Equitable distribution of the surgical workforce" responding to the National Medical Workforce Strategy. A further paper was presented to BSET by the RACS Rural Surgery Section (RSS) Committee to consider a review of selection into training, and each specialty was asked to consider rural selection initiatives and offer training to support a graduating rural surgeon to develop an appropriate scope of practice and skills. Both these papers contributed to longer term College strategies and commitment to rural health.

As part of the review of the RACS hospital accreditation criteria, a working party represented by each specialty training board was established to provide context of each specialty and the way the accreditation process would work in practice. Creating a process suitable for all specialties was considered with feedback from all specialty training boards.

The Rural Health Equity strategic plan will assist in identifying ways to expand the surgical training program in rural and regional locations, and the revised Hospital Training Post Accreditation Standard will help support collaboration amongst the specialty training boards to develop common accreditation processes and share relevant information.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

T The College's dedicated, high-quality, paid and pro-bono workforce that is committed to training.

U The large scale implementation of the Foundation Skills for Surgical Educators (FSSE) and Operating with Respect (OWR) courses as part of the Building Respect, Improving Patient Safety (BRIPS) program.

2017 Conditions to satisfy accreditation standards

30 Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standards 8.1.3, 8.1.5 and 8.2.2)

31 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)

32 Promote the Building Respect, Improving Patient Safety (BRIPS) program and encourage the positive participation of all fellows and trainees, including supporting all surgeons to "call out" bad behaviour in work and training. (Standard 8.2.2)

33 In the hospital and training post accreditation standards for all surgical training programs include a requirement that sites demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Maori cultural competence. (Standard 8.2.2)

2017 Recommendations for improvement

QQ Develop a policy that is adhered to by all Specialty Training Boards which stipulates the minimum advanced notice required prior to requiring commencement of new rotations and which also minimises the number of interstate /international rotations. (Standard 8.2.2)

RR Work with the jurisdictions to assist in preventing the loss of employment benefits when trainees transfer between jurisdictions. (Standard 8.2.3)

SS Consider how to expand the surgical training programs in rural and regional locations. (Standards 8.2.2 and 8.2.3)

TT Support collaboration amongst the Specialty Training Boards to develop common accreditation processes and share relevant information. (Standard 8.2.4)

2021 Accreditation Commendations, Conditions and Recommendations

In 2018, the College addressed condition 32 in their monitoring submissions to the AMC.

In the 2021 follow-up assessment, the team considers conditions 30 and 31 to be not progressing and condition 33 to be satisfied. Recommendations QQ, RR, SS and TT are considered to be addressed by the College. The remaining conditions and recommendations for improvement under Standard 8 from the 2017 reaccreditation are replaced with condition 18 and 19 in 2021.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

18 Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standards 8.1.3, 8.1.5 and 8.2.2)

19 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)

2021 Recommendations for improvement

Nil

9 Continuing professional development, further training and remediation

9.1 Continuing professional development

The accreditation standards are as follows:

- The education provider publishes its requirements for the continuing professional development (CPD) of specialists practising in its specialty(s).
- The education provider determines its requirements in consultation with stakeholders and designs its requirements to meet Medical Board of Australia and Medical Council of New Zealand requirements.
- The education provider's CPD requirements define the required participation in activities that maintain, develop, update and enhance the knowledge, skills and performance required for safe and appropriate contemporary practice in the relevant specialty(s), including for cultural competence, professionalism and ethics.
- The education provider requires participants to select CPD activities relevant to their learning needs, based on their current and intended scope of practice within the specialty(s). The education provider requires specialists to complete a cycle of planning and self-evaluation of learning goals and achievements.
- The education provider provides a CPD program(s) and a range of educational activities that are available to all specialists in the specialty(s).
- The education provider's criteria for assessing and crediting educational and scholarly activities for the purposes of its CPD program(s) are based on educational quality. The criteria for assessing and crediting practice-reflective elements are based on the governance, implementation and evaluation of these activities.
- The education provider provides a system for participants to document their CPD activity. It gives guidance to participants on the records to be retained and the retention period.
- The education provider monitors participation in its CPD program(s) and regularly audits CPD program participant records. It counsels participants who fail to meet CPD cycle requirements and takes appropriate action.

9.1.1 Continuing professional development in 2017

RACS established its continuing professional development (CPD) program in 1994. Its most recent iteration was published in 2016 for use from 2017.

The Professional Standards Board oversees the CPD program which is revised every three years. The program is published on the RACS website as well as being available in hard copy.

Participation in CPD is mandatory for all RACS fellows and there was 100% compliance by those participating in the CPD program in 2014. At the time of the accreditation submission, the College indicated that the 2015 CPD year was being finalised and is on track to again reach 100% compliance.

If a fellow does not participate, they are referred to the College's Professional Conduct Committee for review and possible sanction, including loss of fellowship. Since 2013, three fellows have had their fellowship removed for failing to meet CPD requirements, with RACS notifying the Australian Health Practitioner Regulation Agency (AHPRA) about these terminations.

Fellows are required to select a type of practice that best reflects their work. As it is important that fellows maintain the same standards of surgical care regardless of hours worked, the requirement is the same for fellows working in full- and part-time practice. Fellows must ensure that the majority of their CPD activities relate to their specific scope of practice.

The changes to 2017 CPD program are largely related to the implementation of recommendations of the EAG into discrimination, bullying and sexual harassment, and to ensure the program is aligned with the standards articulated by the Medical Board of Australia and the Medical Council of New Zealand. New features of the CPD program are that all active fellows must participate in one reflective practice activity annually, which for 2017 is the RACS Operating with Respect (OWR) eLearning module, and that fellows in non-operating (i.e. consulting-only) practice are required to undertake a peer review audit of their practice each year. The College advises that in the long term it is anticipated that participants will use multi-source feedback to inform their learning plan and subsequent educational activities.

The CPD program requirements are outlined in the 2017 handbook as follows:

Type of Practice	***Annual Requirement***
Operative practice in hospitals or day surgery units	• *Undertake a peer reviewed Surgical Audit and participate in Australian and New Zealand Audit of Surgical Mortality (ANZASM) where available* • *Accrue at least 10 points in Clinical Governance & Quality Improvement* • *Accrue at least 50 points in Maintenance of Knowledge & Skills* • *Participate in at least one activity in Reflective Practice*
Operative procedures in rooms only	• *Undertake a peer reviewed Surgical Audit and participate in ANZASM where available* • *Accrue at least 50 points in Maintenance of Knowledge & Skills* • *Participate in at least one activity in Reflective Practice*
Operative practice as a locum only	• *Undertake a peer reviewed Surgical Audit and participate in ANZASM where available* • *Note: If a peer reviewed audit is not available, maintain a logbook of surgical procedures in MALT and present this to the Locum Evaluation and Peer Review Committee* • *Accrue at least 50 points in Maintenance of Knowledge & Skills* • *Participate in at least one activity in Reflective Practice*
Clinical consulting practice only	• *Undertake a peer reviewed Audit of Practice* • *Accrue at least 50 points in Maintenance of Knowledge* • *& Skills* • *Participate in at least one activity in Reflective Practice*
Surgical assisting or other non-consulting practice	• *Accrue at least 30 points in Maintenance of Knowledge & Skills* • *Participate in at least one activity in Reflective Practice*

There are four CPD program categories as detailed below:

Category 1 - Surgical audit and peer review

All surgeons in operative or clinical consulting practice are required to participate in an audit each year and submit the audit for peer review. Fellows can participate in a range of audits including: focused audit; group audit (including clinical unit audit); selected audit from surgical practice; total/practice workload audit and peer review of reports (non-operative fellows). The College provides a surgical audit and peer review guide on its website.

Category 2 - Clinical governance and quality improvement

The clinical governance framework includes elements that take place in a continuous quality improvement environment such as clinical audit, clinical effectiveness, clinical risk management, organisational and staff development, patient and carer experience and information management.

Clinical governance activities generally attract 1 point per hour and can include: hospital or clinical meetings that focus on improvements in clinical care; activities related to organisation or review of

surgical services; completion of Australian and New Zealand Audit of Surgical Mortality (ANZASM) surgical case form; participation in annual individual and/or department performance review.

Category 3 - Maintenance of knowledge and skills

Surgeons must maintain their skills, knowledge and competence which includes developments in their area of practice, as well as advances in clinical and medical science. Fellows are required to attend activities that span the range of the College's nine competencies.

Attendance at meetings/seminars/workshops/courses attracts 1 point per hour and includes: scientific meetings; courses/workshops that focus on technical competencies and professional practice/non-technical competencies; and participation in a Masters/Diploma/Certificate course at tertiary institutions. Other activities in Category 3 that attract 1 point per hour include: general teaching activities to trainees, undergraduates, health professionals – including grand rounds, multi-disciplinary meetings and clinical teaching rounds; supervision of surgical trainees; and acting as an examiner for the College, AMC, universities or other recognised educational institutions.

Category 4 - Reflective practice

Fellows are required to participate in education that promotes self-reflection and champions respectful behaviour. This includes embracing diversity, fostering gender equity, increasing transparency and being open to independent scrutiny and external accountability. As described above, fellows must complete the OWR eLearning module before the end of 2017; and complete at least one activity from reflective practice each year, from 2018 onwards. Other Category 4 activities that focus on a review of professional practice across a range of College competencies include: development of a structured learning plan including self-reflection; participation in a structured mentoring program; and recipient of a structured practice visit by a peer with evaluation and action plan.

The College has also developed a range of resources to support fellows to meet the requirements of Category 4, including the online Learning Plan which is available through the RACS Portfolio. Fellows can also choose to develop their own learning plan.

The College offers a comprehensive program of professional development activities across the surgical competencies. These include generic, non-technical competencies of communication, collaboration and teamwork, judgment and decision making, professionalism, health advocacy, management and leadership, and scholarship and teaching. Programs are provided in a range of learning modes including workshops, forums, webinars, seminars, blended learning, residential workshops and online learning.

The College offers activities that address cultural competence, professionalism and ethics. The Network for Indigenous Cultural and Health Education (NICHE) portal is available to all Australian specialists. The College reports that work is continuing on developing a wide range of modules that aim to improve cultural understanding and awareness.

All activities offered by the College – and an increasing number delivered by external providers – are assessed for educational validity, appropriateness and relevance before they are 'CPD-approved'. The College approves approximately 350 activities each year, with attendance data automatically populated into a participant's CPD online record.

The number of participants in the CPD program by category and by region, as provided in the College's accreditation submission, are given in the tables below.

Participants by category	***Number of participants***
RACS CPD program	*5119*
Non Fellow RACS CPD program	*95*
External CPD programs:	*1271*
Australian Orthopaedic Association	*797*
New Zealand Orthopaedic Association	*228*
Royal Australian College of General Practitioners	*13*
Australasian College for Emergency Medicine	*2*
Royal Australian and New Zealand College of Ophthalmologists	*227*
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	*1*
Royal College of Physicians and Surgeons of Canada	*3*
Total number of participants	***6485***

Participants by region	***Number of participants***
RACS CPD participants based in Australia	*5283*
RACS CPD participants based in New Zealand	*860*
RACS CPD participants based overseas	*342*
Total number of participants	***6485***

As detailed above, approximately 1000 RACS fellows participate in alternative CPD programs which have been recognised and approved by the College with 80% of these participants undertaking the separate CPD program of either the Australian Orthopaedic Association (AOA) or the New Zealand Orthopaedic Association (NZOA). While compliance with the NZOA CPD program is reported to be 100% this is not the case for the AOA CPD program. The team was advised that 26 out of 1600 fellows are neither participating in the RACS nor the AOA programs and will therefore be reported to the RACS Professional Conduct Committee.

Each year 7% of RACS participants are randomly subject to a full audit of their CPD participation.

9.1.2 2017 team findings

The team found that there is near universal support for, and uptake of, the RACS CPD program. It noted the regular update of the program every three years and considers that the consultation process internally and with external bodies such as the Medical Council of New Zealand and the Medical Board of Australia is comprehensive.

The team commends the College for using the CPD program as the means by which mandatory training and greater awareness of discrimination, bullying and sexual harassment has been brought into the ongoing professional lives of all fellows.

Also well regarded by the team is the introduction of the self-reflection component through the Reflective Practice category which all surgeons regardless of their type of practice must undertake. It was noted that it is intended to enable reflection on topics such as diversity, gender equity, increasing transparency and openness to independent scrutiny, and external accountability. The team also recommends that this list, which it understood to be suggestions and not a limited list, should nevertheless be expanded to include cultural competence as an area of reflection.

The team was advised that the College has formed a CPD Audit Working Group, which it felt was a necessary step, especially with its particular focus on the breadth of the surgeon's individual practice and the inclusion of a more robust feedback loop. The AMC looks forward to updates on progress.

The team spent considerable time with representatives of the Australian and New Zealand Society for Vascular Surgery (ANZSVS) who have developed the Australian Vascular Audit. It is compulsory for surgeons who are members of the ANZSVS but is also available to non-members who practise vascular surgery. It covers four areas of vascular practice: carotid surgery; lower limb arterial bypass surgery; access surgery for renal dialysis; and aortic surgery. In discussion with the team, and in its accreditation submission to the AMC, the ANZSVS argued the College (and indeed the AMC) should mandate the ANZSVS audit for all vascular surgeons, not just those who are members of the Society.

This argument has not found favour with the College for several reasons and it is hoped that the recently formed RACS CPD Audit Working Group will, in its deliberations, enter into dialogue with the ANZSVS on this matter. In its feedback to the draft accreditation report, the College indicated that a meeting with ANZSVS will be arranged.

As detailed above, 26 Orthopaedic fellows are non-compliant in CPD and will be reported to the RACS Professional Conduct Committee. The team recommends that the College and the Australian Orthopaedic Association (AOA) continue to share data to ensure those surgeons enrolled in the AOA CPD program are compliant. The College reported to the team that it is committed to ensuring there is 100% compliance of Australian Orthopaedic surgeons in either the AOA or RACS CPD programs.

9.2 Further training of individual specialists

The accreditation standard is as follows:

- The education provider has processes to respond to requests for further training of individual specialists in its specialty(s).

9.2.1 Further training of individual specialists in 2017

The College has developed policy and processes to respond to further training of individual specialists on request from a variety of sources such as hospitals, specialty societies and individual surgeons. The focus is particularly on technical skill deficiencies of an individual but there is also a mechanism for reviewing clinical standards for both individuals and clinical units. The processes are outlined in the RACS Reskilling and Re-entry Program Guidelines and the RACS Clinical Standards Review policy available on the College's website.

For fellows returning to active practice, or an element of clinical practice, following a period of absence, the fellows must first contact the College's Executive Director of Surgical Affairs (EDSA). The EDSA in discussion with the relevant Specialty Society President reviews the reskilling and re-entry request to determine if a structured reskilling and re-entry program is required. Consideration is given to adverse events, complaints, or restrictions on practice imposed by regulators; length of time away from clinical practice; and results of a review of current practice, if this has been undertaken. If reskilling is considered appropriate, the EDSA appoints an appropriate supervisor to coordinate a clinical attachment.

A structured re-skilling and re-entry program will include the following elements: goals; achievement of expected competencies; clear competencies to be achieved; allocated time for regular feedback to the fellow; performance assessment based on the Specialty Training Board's training assessment reports.

The fellow undergoing retraining must maintain a logbook of surgical procedures using the appropriate data set recommended in the Surgical Audit and Peer Review Guide.

At the completion of the reskilling and re-entry program, the supervisor prepares a report for the EDSA on the program, including the extent to which the goals of the program have been achieved.

9.2.2 2017 team findings

The team is satisfied that the College has addressed this standard. The team considers that the College could further explore its own role in identifying the poorly performing fellow, for example through CPD returns, and offer further training to those so identified.

9.3 Remediation

The accreditation standards are as follows:

- The education provider has processes to respond to requests for remediation of specialists in its specialty(s) who have been identified as underperforming in a particular area.

9.3.1 Remediation in 2017

In contrast to standard 9.2 where the focus is on remedying a deficiency in technical skills, the College regards remediation as applying to situations where there is a departure from acceptable practice in non-technical skills and behaviours, and it has linked this standard to the College's complaints management processes.

The improvement of complaints handling is described as a major pillar of the Building Respect, Improving Patient Safety (BRIPS) Action Plan which has been referred to throughout the report.

9.3.2 2017 team findings

While, understandably, the focus on the College's accreditation submission for this standard has been on responding to complaints regarding discrimination, bullying and sexual harassment, the team has noted that formal processes exist to assist requests for further training or remediation of individual surgeons, whether self-referred or referred by others, which can address all or some of the nine key competencies of a surgeon. The team regarded this as a strength of the College's program.

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College addressed the following recommendation in AMC monitoring submissions.

Recommendations for quality improvement

VV As part of the reflective practice category, consider including cultural competence as an area of reflection. (Standard 9.1.3)

In 2018, participation in cultural competence activities was included in the RACS Continuing Professional Development (CPD) Program under Category 4 – Reflective Practice. The College reviewed its provision of cultural competency education and encouraging other education providers to have their activities approved within the RACS program.

B 2021 team findings

The follow-up visit considered whether the College had responded to the remaining recommendations for quality improvement.

Recommendations for improvement

UU Implement a mechanism for the newly established CPD Audit Working Group to provide more robust feedback to fellows with a particular focus on the breadth of surgeon's individual practice. (Standard 9.1.3)

WW Explore the College's role in identifying the poorly performing fellow. (Standard 9.2.1)

The RACS CPD program, Surgical Competence and Performance Framework, has undergone a review in recent years with key changes introduced on 1 July 2021. From this time, all participating fellows must develop a learning plan each year, tailored to their scope of practice. They will be required to conduct a self-audit, covering at least 50% of the breadth of their practice annually. They will also undertake a performance review of themselves and a performance review of another at least once annually as well as undertaking two or more educational activities, at a minimum of 40 hours per annum.

The revised framework includes the addition of the tenth RACS competency in Cultural Competence and Cultural Safety, with changes filtering through the CPD program in the development of scope of practice requirements. Fellows in Australia will be required to participate in an audit of surgical mortality each year.

The team noted that the participation rate in the CPD program from 2017-2019 in both Australia and New Zealand has been 98-100%. RACS has introduced a phone app to support fellows' participation in CPD and where fellows have participated in relevant College events, the app will be automatically populated with the relevant information. Verification of submitted CPD has been increased from 7% to 10% of participants.

In relation to the poorly performing fellow, the revamp of the Surgical Audit Guide, RACSTA feedback and College visits are seen as mechanisms for the College to identify such fellows. Other avenues include complaints to a hospital, a health authority and/or to a Medical Board. A review of the Code of Conduct has also been scheduled in 2021. The role of fellows in assisting healthcare institutions, Medical Boards and poorly performing surgeons is well recognised and acknowledged. The team has learnt that the Medical Council of New Zealand is satisfied with the RACS New Zealand branch's support with remediation of surgeons.

The team commends the College for its well-developed CPD program, one which undergoes regular review to ensure that it is contemporary and effective.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

V The CPD program is the means by which mandatory training and greater awareness of discrimination, bullying and sexual harassment has been brought into the ongoing professional lives of all fellows.

W The promotion of the importance of self-reflection through the addition of a Reflective Practice category with all participants required to undertake at least one such activity per year.

X Reducing the burden of reporting for fellows by organising for providers of RACS CPD activities to report attendances to the College which is updated directly onto each fellow's online CPD profile.

2017 Conditions to satisfy accreditation standards

Nil

2017 Recommendations for improvement

UU Implement a mechanism for the newly established CPD Audit Working Group to provide more robust feedback to fellows with a particular focus on the breadth of surgeon's individual practice. (Standard 9.1.3)

VV As part of the reflective practice category consider including cultural competence as an area of reflection. (Standard 9.1.3)

WW Explore the College's role in identifying the poorly performing fellow. (Standard 9.2.1)

2021 Accreditation Commendations, Conditions and Recommendations

In 2018, the College addressed recommendation VV in their monitoring submissions to the AMC.

In the 2021 follow-up assessment, the team considers the College to have addressed recommendations UU and WW. There are no commendations, conditions or recommendations for improvement in 2021.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

Nil

2021 Recommendations for improvement

Nil

10 Assessment of specialist international medical graduates

10.1 Assessment framework

The accreditation standards are as follows:

- The education provider's process for assessment of specialist international medical graduates is designed to satisfy the guidelines of the Medical Board of Australia and the Medical Council of New Zealand.
- The education provider bases its assessment of the comparability of specialist international medical graduates to an Australian- or New Zealand- trained specialist in the same field of practice on the specialist medical program outcomes.
- The education provider documents and publishes the requirements and procedures for all phases of the assessment process, such as paper-based assessment, interview, supervision, examination and appeals.

10.1.1 Assessment framework in 2017

The processes for assessment of specialist international medical graduate (SIMG) surgeons differ significantly between Australia and New Zealand, and will be treated separately within this section of the report.

In Australia, the College undertakes all specialist international medical graduate assessments and decision making, advising the MBA at the stage of eligibility for award of fellowship.[1]

Conversely, in New Zealand, the College assesses details of the specialist international medical graduate's qualifications, training and experience so that it can provide that information to the MCNZ, to enable the MCNZ to make the decision about vocational registration. The MCNZ specifies that fellowship is not necessary for vocational registration and cannot be required as a pre-requisite for vocational registration of specialist international medical graduates in New Zealand.

Australia

RACS' policy for assessment of SIMG surgeons in Australia is described in an overarching policy, Specialist Assessment of International Medical Graduates in Australia. The College has a comprehensive range of policies relating to its processes for the assessment of specialist international medical graduate surgeons in Australia. These are publicly available on the College website.

The SIMG assessment process assesses the comparability of specialist international medical graduates (by comparing their training and the examinations undertaken) with those of an Australian-/New Zealand-trained surgeon holding FRACS in that specialty.

Initial assessment, either as a preliminary assessment of the documentation supplied or by interview by a panel (after invitation to an interview), assesses the SIMG surgeon as either substantially comparable (SC), partially comparable (PC), or not comparable (NC) to a locally-trained surgeon in that branch of surgery. Those judged SC will be asked to undergo a period of level 4 supervised clinical assessment (MBA definition[1]), those judged PC will be asked to undergo an initial period of level 3 clinical assessment (followed by level 4) and pass the RACS fellowship examination.

The Australian interview panels have a representative(s) of the Specialty Training Board in the specialty in which the SIMG is being assessed, along with a representative of the RACS Board of Surgical Education and Training (BSET) and a jurisdictional representative. The recommendations of the panel are forwarded to BSET or its executive and there is a process described for those

---

[1] Medical Board of Australia, "Guidelines: Supervised practice for international medical graduates", January 2016

occasions when consensus cannot be reached. While there is a very well-defined process for assessing the comparability of the specialist surgical training and the exit examination of the SIMG, there is far less clarity in assessment of subsequent experience as outlined in the MBA guidelines. For example, if an SIMG's specialist training program is of lesser duration to the College program, the College must consider the training and any experience completed after training to determine comparability"[2].

Those SIMGs assessed as SC or PC then undertake assessments as requested, and the College has relevant policies. When all assessments are successfully completed, the MBA is notified accordingly.

Recent initiatives in College's SIMG assessment include the establishment of the International Medical Graduates Committee and expansion of the role of Clinical Director IMG Assessments and Support. The International Medical Graduates Committee met for the first time in 2017 and its duties include development and review of IMG assessment tools, oversight of the assessment process to ensure consistency, and providing recommendations to BSET for changes to the IMG assessment process. As noted under standard 1, membership of this committee includes representatives from all Specialty Training Boards, two international medical graduates who have completed the pathway, and a community representative. The role of the Clinical Director IMG Assessments and Support includes monitoring of progress and support of SIMGs.

These two recent initiatives have come about in part in response to feedback from the Expert Advisory Group (EAG) about negative perceptions of the IMG assessment pathway by applicants, and in part to achieve greater consistency in SIMG assessment across the College.

New Zealand

The College's process for the assessment of SIMGs' qualifications, training and experience so that it may provide advice to the MCNZ on eligibility for vocational registration is described in the policy, Vocational Assessment of International Medical Graduates in New Zealand. The memorandum of understanding between the College's New Zealand Board and the MCNZ describes the responsibilities and understanding of each party. The New Zealand Board delegates the assessment tasks to the New Zealand Censor's Committee. The assessments requested by the MCNZ consist of preliminary assessment on the documentation and final assessment at interview of the SIMG's qualifications, training and experience to inform the MCNZ's decision on vocational registration.

The interview panel consists of the New Zealand Censor, New Zealand chair or nominee of the relevant Specialty Training Committee/Board, one or more New Zealand chairs or nominees in another specialty and the RACS New Zealand manager or nominee. The various aspects of qualifications, training and experience are assessed as equivalent, as satisfactory, or neither "equivalent to" nor "as satisfactory as"[3]*, and overall the SIMG is assessed as suitable for recommendation for one of the following: the supervision pathway (similar to substantially comparable in Australia); the assessment pathway (similar to partially comparable in Australia); or not equivalent. The SIMG assessments are subject to approval by the New Zealand Board, but the final decision rests with the MCNZ.*

Those on the supervision pathway will provide supervision reports directly to the MCNZ. Those on the assessment pathway will have their assessment overseen by RACS, who will advise the MCNZ when it is successfully completed, according to RACS policy.

The College then assesses eligibility for fellowship for New Zealand SIMG surgeons as a completely separate process once vocational registration has been attained, and uses similar processes to that used for SIMG assessment in Australia. This means that for New Zealand SIMGs, there is a two-stage process and the same or similar information has to be provided twice, often years apart and

---

[2] *Medical Board of Australia, "Guidelines: Good practice guidelines for the specialist international medical graduate assessment process", 2 November 2015*

[3] *This wording reflects that of the governing Act of Parliament, (New Zealand) Health Practitioners Competence Assurance Act 2003*

significant extra cost is incurred. As fellowship is not essential for practice as a specialist surgeon in New Zealand, this has the potential unintended consequence of increasing the number of non-FRACS surgeons in New Zealand, currently approximately 13% of all vocationally registered (specialist) surgeons.

10.1.2 2017 team findings

RACS has a suite of policies covering all aspects of SIMG surgeon assessment in Australia and New Zealand.

Australia

The outcomes of assessment of SIMGs in Australia vary among the specialties, and for some specialties, it is rare for any SIMGs to be considered substantially comparable (SC), while for other specialties a significant proportion are considered SC. The full analysis of outcomes by specialty is detailed under standard 10.2. As all specialties follow the same overarching policies, the variation in outcomes of assessment by specialty is more likely to be a result of the application of the policy, rather than the policy per se. The most likely source of that variation is undue focus on the comparability of the training and examination process the SIMG has undertaken to the exclusion of the mitigating effect of subsequent experience. While the policies do place emphasis on the SIMG sitting a comparable examination, it states that one of the criteria for SC assessment is that the SIMGs do not need to pass an exit examination 'if the quantity, depth and scope of surgical practice in the specialty is of sufficiently high standard as to waive the need to sit the Fellowship Examination'.

For that reason, RACS could make its policies adhere to the MBA guidelines by making them more specific, changing the methods of assessing comparability, or ensuring more uniform and appropriate interpretation of the role of 'training and any experience completed after training' in SIMG assessments. This would help ensure that both training and post-training experience are appropriately considered in assessment of comparability, and not in any way suggest that vocational experience and examination completion should each be independently comparable (without considering the additional impact of post-training experience and further training in mitigating any deficiencies in initial training and examinations).

The published policies on all aspects of SIMG assessment compare the SIMG with a locally-trained surgeon and the RACS training program, and adhere to the MBA guidelines.

Discussion of the RACS appeals process is provided under standard 1.3 of this report. While there are many requests for reconsideration of SIMG assessment decisions, there are very few appeals. Despite this, there was significant negative feedback provided by SIMGs in AMC surveys and in meetings with the team. Common themes raised include: the focus of the assessment on initial training and which does not take into account post-training experience, such that almost all applicants in some subspecialties received a decision of '2 years' supervised practice and the examination no matter what their qualifications, training and experience; and a perceived a lack of clarity in the standards SIMGs were judged against;

The recent initiatives of the establishment of the International Medical Graduates Committee and the expanded role of Clinical Director IMG Assessments and Support should improve SIMG assessment by overseeing the process, recommending improvements, and ensuring more uniform application of the MBA guidelines. These initiatives also have the potential to improve support for SIMGs, especially those who are struggling with the process. The team recommends that the College proceed with its plans to provide greater support for SIMG surgeons working towards specialist/vocational registration particularly.

New Zealand

The RACS policies for assessment of SIMGs in New Zealand in order to provide advice to MCNZ meet the MCNZ guidelines.

The team heard during site visits that the separation of fellowship assessment from assessment for vocational registration has had the unintended consequence of an increasing the number of vocationally registered non-FRACS surgeons in New Zealand. This has a flow-on effect on the specialist surgical workforce available for supervision and other College activities in New Zealand that require fellowship, unless RACS takes steps to either make it more attractive for this group to seek fellowship, or to allow such surgeons to take a wider role in RACS activities in New Zealand. The College may consider how it could better support surgeons without a FRACS in New Zealand who are vocationally registered.

10.2 Assessment methods

The Accreditation standards are as follows:

- The methods of assessment of specialist international medical graduates are fit for purpose.
- The education provider has procedures to inform employers, and where appropriate the regulators, where patient safety concerns arise in assessment.

10.2.1 Assessment methods in 2017

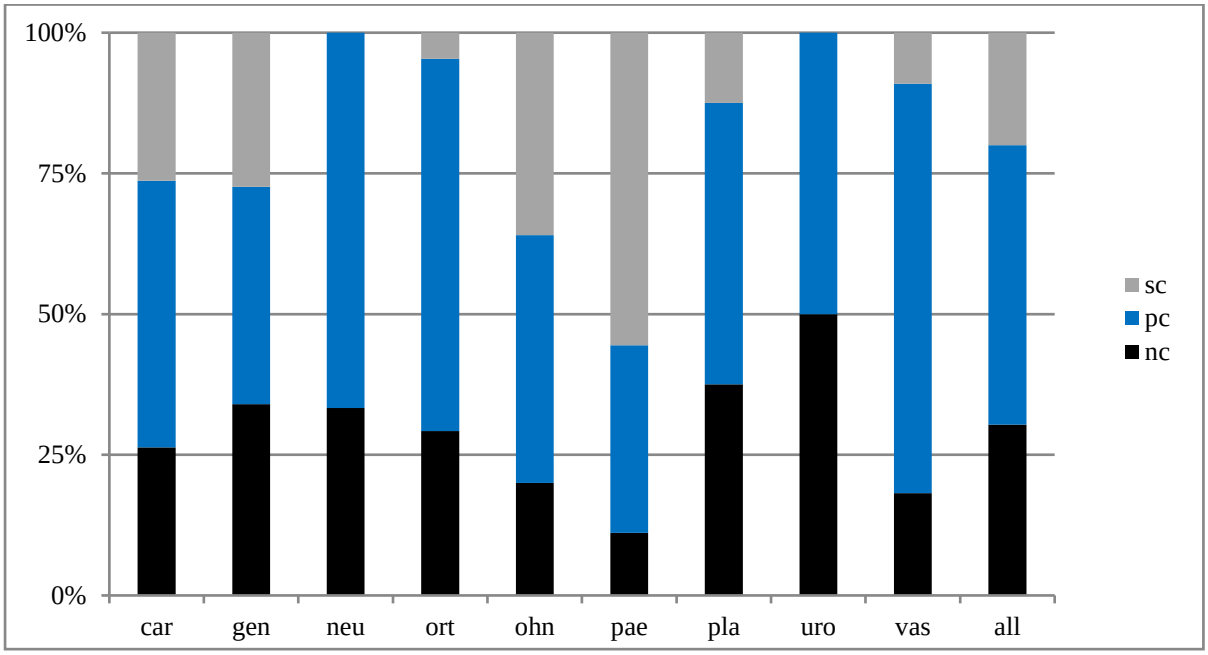
The assessment methods include assessment of comparability of the documentation supplied, followed by interview, and then clinical assessment, which may include participation in specified skills courses, activities including professional development activities and if partially comparable (PC), the fellowship examination in the relevant specialty. There is no non-examination assessment available for SIMGs assessed as PC.

Australia

The following table is a summary by specialty of the outcomes of 270 IMG applications (including the actual numbers and the percentage of SIMGs assessed in each specialty) from 2010-2015, as provided in the College's accreditation submission to AMC.

	CAR	***GEN***	***NEU***	***ORT***	***OHN***	***PAE***	***PLA***	***URO***	***VAS***	***Total***
NC	*5*	*36*	*3*	*19*	*5*	*1*	*6*	*5*	*2*	*82*
	26%	*34%*	*33%*	*29%*	*22%*	*10%*	*35%*	*42%*	*15%*	*30%*
PC	*9*	*41*	*6*	*43*	*11*	*3*	*8*	*5*	*8*	*134*
	47%	*39%*	*67%*	*66%*	*48%*	*30%*	*47%*	*42%*	*62%*	*50%*
SC	*5*	*29*	*0*	*3*	*9*	*5*	*2*	*0*	*1*	*54*
	26%	*27%*	*0*	*5%*	*39%*	*50%*	*12%*	*0*	*8%*	*20%*
	For those that don't add to 100%, there are still a few in progress									

The information presented in the table above is shown below in graphical format.



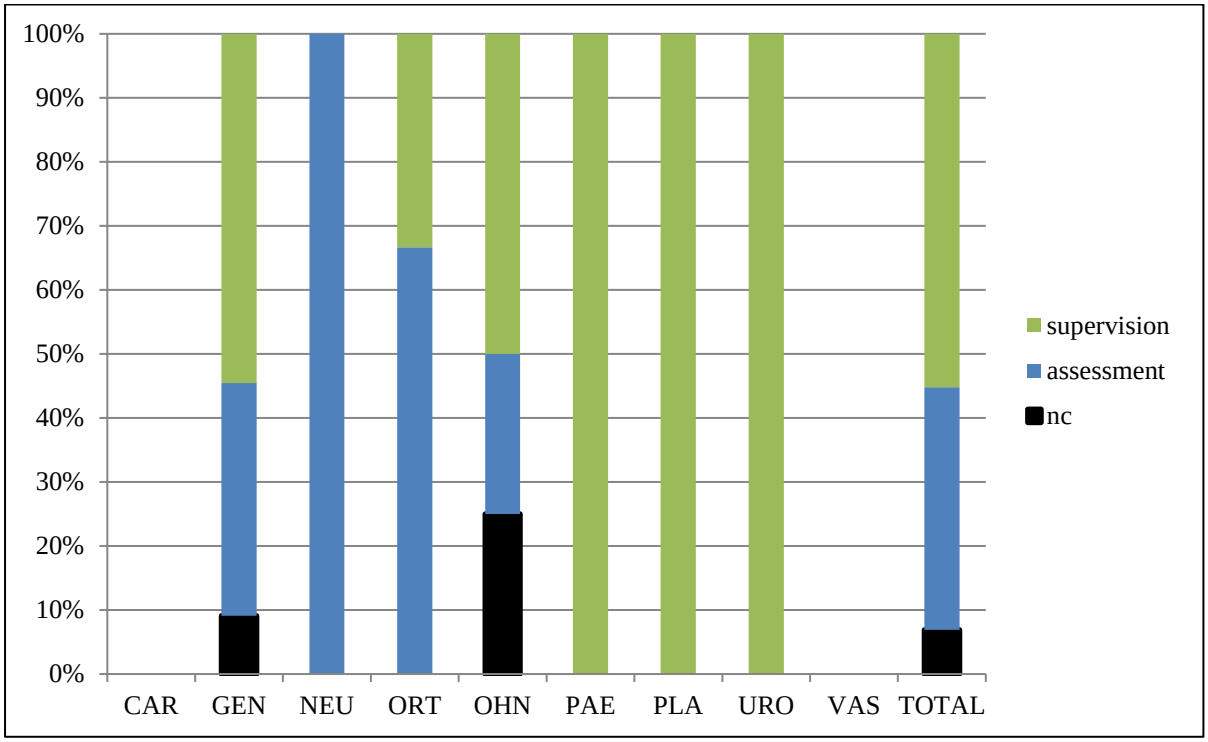
SIMG applicants in Australia come from 28 countries, although the top three countries (United Kingdom, India and South Africa) accounted for 52% of all applicants in 2016, as noted in the RACS Activities Report 2016. (In Australia in 2016, 70% of all applicants for specialist assessment by specialist medical colleges came from those three countries).

New Zealand

The following table is a summary by specialty of the outcomes of interviews of 29 IMG applicants (including the actual numbers and the percentage of SIMGs assessed in each specialty) for 2015 and 2016, as provided in the RACS Activities Reports 2015 and 2016. The 2015 and 2016 data have been combined by the AMC.

MCNZ	CAR	GEN	NEU	ORT	OHN	PAE	PLA	URO	VAS	Total
NC	0	1	0	0	1	0	0	0	0	2
	0	9%	0	0	25%	0	0	0	0	7%
Assess-ment (PC)	0	4	2	4	1	0	0	0	0	11
	0	36%	100%	67%	25%	0	0	0	0	38%
Super-vision (SC)	0	6	0	2	2	2	2	2	0	16
	0	55%	0	33%	50%	100%	100%	100%	0	55%

The information presented in the table above is shown below in graphical format.



The data provided in the activities table for the last two years indicate a significant number (55%) are assessed as supervision pathway (equivalent to substantially comparable in Australia), with 38% being assessed as assessment pathway (equivalent to partially comparable) and the balance (7%) not equivalent. The numbers are too small to make too much of a comparison between specialties, but there does appear to be less specialty-to-specialty variation than in Australia.

Australia and New Zealand

In the event that serious concerns are raised concerning SIMG misconduct or patient safety, the College has developed procedures to inform employers. These procedures are described in the Fellowship Examination Eligibility and Exam Performance Review and IMG Misconduct policies available on the College's website.

As part of the regular three-monthly performance review, the clinical supervisors and/or the Specialty Training Board are responsible for identifying any issues of underperformance or safety. Underperformance will result in a meeting between the international medical graduate and the supervisor/Specialty Training Board, leading to the development of a performance management plan. If a subsequent period of underperformance is identified a formal interview is held to reassess comparability.

10.2.2 2017 team findings

Australia

For the comparability assessment in Australia, there is considerable variation among specialties with some (Neurosurgery, Orthopaedic Surgery, Urology and Vascular Surgery) consistently finding fewer than 10% of applicants are substantially comparable to a locally-trained surgeon (detailed in the table above). While it is possible that this is affected by the inherent variability of small numbers applying in the specialties, not including the large specialty of Orthopaedic Surgery, the outcomes are consistent year by year and indicate variation in the process of comparability assessment, probably due to inadequate allowance for the mitigating effect of post-training experience, as noted above.

There is considerable reliance on the fellowship examination in the relevant specialty as the external assessment for SIMGs assessed as partially comparable, with no non-examination external assessment available. The team recommends that other assessments, such as externally provided workplace-based assessments, or the MCNZ vocational practice assessment should be developed to replace the Fellowship Examination for selected specialist international medical graduates.

The team heard negative feedback from SIMGs about the behaviour of a few of the fellows conducting the assessment interviews, with the SIMGs feeling that the interviewers were looking to 'fail' them, and were not treating them with the respect they felt they deserved as fellow specialists. The team also heard unverifiable statements from SIMGs of expressions of improper attitudes from fellows outside of the assessment process regarding the likelihood of individual SIMGs being accepted into the surgical fraternity. This behaviour would appear to be at odds with the RACS Building Respect, Improving Patient Safety (BRIPS), as detailed under standard 1.6.

New Zealand

There is less variation between specialties in assessment advice provided to the MCNZ indicating that the assessment methods for comparability are likely fit for purpose (although again there are issues with small numbers of applicants in the smaller specialties).

Australia and New Zealand

The IMG department described the processes for notifying employers, and where appropriate, the regulators, where patient safety concerns arise in assessment, which are appropriate.

10.3 Assessment decision

The Accreditation standards are as follows:

- The education provider makes an assessment decision in line with the requirements of the assessment pathway.
- The education provider grants exemption or credit to specialist international medical graduates towards completion of requirements based on the specialist medical program outcomes.
- The education provider clearly documents any additional requirements such as peer review, supervised practice, assessment or formal examination and timelines for completing them.
- The education provider communicates the assessment outcomes to the applicant and the registration authority in a timely manner.

10.3.1 Assessment decision in 2017

Australia

According to RACS policy, those assessed as substantially comparable are asked to undergo clinical assessment of up to 12 months duration, and to take part in professional development activities and specified skills course and activities. Those assessed as partially comparable are asked to undertake: clinical assessment for a period of up to 24 months; the fellowship examination; and professional development activities and specified skills course and activities. Those requirements are specified in communications with the SIMGs. It may be identified during clinical supervision that an international medical graduate is performing better than expected or an exceptional level. Supervisors can recommend a reduction in periods of supervision and/or waiving of other requirements, including the fellowship examination. The Specialty Training Board considers these recommendations.

New Zealand

The College's advice to MCNZ on vocational registration is completed on the agreed documentation (RGR5). The College must communicate its advice to MCNZ within three to four months of receipt of the application, if the SIMG is already in New Zealand. MCNZ then communicates its assessment decision directly to the SIMG.

10.3.2 2017 team findings

Australia

The policy covering assessment decisions for both pathways (substantially comparable (SC) and partially comparable (PC)) adhere to the MBA guidelines. The policies take into account the SIMG's specialist medical program outcomes, although some specialties do not take advantage of the fact that the Fellowship Examination requirements can be waived (see above).

As noted under 10.1.1, a number of SIMGs commented to the team on a lack of clarity in the basis for the assessment decision and that it did not appropriately take account of previous training and experience.

Although the additional requirements are documented in letters to the SIMGs, some reported to the team that the advice provided was not clear.

The College reports the agreed key performance indicators of the assessment processes to the MBA, which publishes them. In 2016, RACS was the only College that did not meet the requirements for the maximum duration of period of practice recommended for SC SIMGs: the standard is 12 months or less, and two RACS SIMGs assessed as SC (17% of total) were asked to undertake clinical practice of 18 months or longer. It took RACS greater than 28 days to notify five SIMGs (10% of those interviewed) of the interview outcome. These specific instances highlight times when RACS has not met the requirements of the pathway, or timeliness of notification of the SIMG of the outcome of the assessment

New Zealand

RACS advice to the MCNZ meets the requirements of the MCNZ, including that fellowship cannot be recommended as a requirement for gaining vocational registration.

10.4 Communication with specialist international medical graduate applicants

The accreditation standards are as follows:

- The education provider provides clear and easily accessible information about the assessment requirements and fees, and any proposed changes to them.
- The education provider provides timely and correct information to specialist international medical graduates about their progress through the assessment process.

10.4.1 Communication with specialist international medical graduate applicants in 2017

Australia and New Zealand

All of the policies relevant to IMG assessment are published on the RACS website, in a specific IMG site, along with information to assist SIMGs with the assessment process and links to appropriate documentation, information and resources.

10.4.2 2017 team findings

Australia

While information available on the website describes the processes by which the assessment judgements are made, some SIMGs find it difficult to use this information to gain some indication of

their likely outcomes, especially those who are less likely to be found substantially comparable (SC). The amount of information available on the website may also be confusing to those SIMGs. The team recommends that the College make information available to future applicants that may allow them to assess the likelihood of their application achieving SC or partially comparable status prior to them making a substantial financial payment that historical evidence might suggest is unlikely to succeed.

There was a significant amount of negative feedback from SIMGs assessed by RACS about the total fees they are charged for their assessment. The team recommends that the College consider this along with trainee fees as discussed under standard 7.3 of this report.

There was also a significant amount of negative feedback about the lack of access to resources, such as examination revision courses, to assist SIMGs to successfully complete the SIMG assessment process. The team recommends that the College provide access to educational resources for SIMGs in the SIMG assessment process, such as examination revision courses, and other resources that are accessible to trainees. This is particularly important for those practising in rural and regional areas. While it's not the College's responsibility to find a supervised post for the SIMG, difficulty in obtaining a supervised post was consistently noted as an issue by SIMGs in the AMC survey and meetings with the team.

In relation to supervision, the team heard feedback from some SIMGs regarding the expense incurred for the period of oversight, in addition to the sporadic and intermittent nature of the supervision provided, particularly for those working in areas of need. It is important that the College ensures that supervisors are fully aware of their role and prepared for it.

New Zealand

This is dealt with by MCNZ itself.

2021 Follow-up Assessment

A 2018-2019 Progress reported in AMC monitoring submissions

The College addressed the following condition and recommendations in AMC monitoring submissions.

Conditions to satisfy accreditation standards

34 All College and Specialty Training Board specialist international medical graduate assessment processes and associated documentation must reflect the Medical Board of Australia and Medical Council of New Zealand guidelines by ensuring that both training and post-training experience are appropriately considered in assessments of comparability. (Standard 10.1)

Recommendations for quality improvement

XX Provide greater support for specialist international medical graduate surgeons working towards specialist/vocational registration, and including access to educational resources, such as examination revision course, and other resources that are accessible to trainees. (Standard 10.2.1)

YY Make information available to future applicants that may allow them to assess the likelihood of their application achieving substantially or partially comparable status prior to them making a substantial financial payment that historical evidence might suggest is unlikely to succeed. (Standard 10.4.1)

In 2019, the College reported there was now a detailed, publicly available RACS policy, *Assessing an IMG's comparability to an Australian and New Zealand Trained Surgical Specialist,* with clear definitions for assessment of comparability. In addition to assessing recency of practice, training

program, and exit examination, the specialist international medical graduate (SIMG) is also assessed by postgraduate training and experience, depth and scope of practice, and non-technical skills.

Following the 2017 assessment, the College established an eLearning IMG Orientation Program. From March 2018, SIMGs who accept a specialist pathway are required to complete the relevant eLearning module prior to commencing clinical assessment. The College also developed a video resource regarding the clinical component of the Fellowship Examination. Both eLearning resources have been made available to all international medical graduates who have accepted a specialist pathway.

In 2018, the College undertook a five-year analysis of the outcomes of international medical graduate assessments in Australia and published the information on their website. In 2019, the College website was updated with detailed information for international medical graduates on the overview of the process, with a chance for self-assessment against each specialty's standards, policies, guidelines and forms.

B 2021 team findings

The follow-up visit considered progress towards the remaining condition.

Conditions to satisfy accreditation standards

35 Develop and adopt alternative external assessment processes such as workplace-based assessments to replace the Fellowship Examination for selected specialist international medical graduates. (Standard 10.2.1)

To be met by 2020.

There is work underway to address Condition 35 as the College is in the process of piloting the External Validation of Professional Performance (EVOPP) method as a workplace-based non-examination external assessment of SIMGs. The EVOPP pilot program has been interrupted by the COVID-19 pandemic with its restriction on movement as it requires interstate input for the assessments by trained College assessors. To date, four pilots have been conducted, two in 2018 and one each in 2019 and 2020. The finalisation of the pilot program and then the implementation timeline of EVOPP needs to be clarified. The team considered that the EVOPP when finalised should be an appropriate alternative external assessment to meet condition 35.

The team heard the College has yet to determine which SIMG category of assessment would be offered the EVOPP, however, the current recommendation is for all newly assessed SIMGs with a partially comparable assessment outcome to be included in the pilot. The intention of the pilots is to have involved SIMGs to undertake both the EVOPP and the Fellowship Examination, presumably to use performance in the Fellowship Examination as the standard for comparison. Specialty training boards will need such evidence to consider replacing the Fellowship Examination with an EVOPP.

The team is concerned about this comparison strategy, as one of the main reasons for its recommendation in the 2017 reaccreditation report was the view that, particularly for selected surgeons, performance in a Fellowship Examination was not an appropriate method of assessment of their training, qualifications, experience and performance in practice, especially for those in established practice, and had then recommended other methods of assessment. However, the team is also sympathetic to the view that those proposing it consider it the best way of convincing the sceptics of the value of EVOPP.

The team noted the College adapted to the use of virtual interviews to support assessment as a result of COVID-19 restrictions. This is considered to be an appropriate response and the continued use of virtual interviews in Australia and New Zealand is supported.

Australia

The team heard feedback on the SIMG assessment process from SIMGs and jurisdictional representatives that delays in each step of the process can be extensive and that the need for clearer communication and feedback to SIMGs is urgently needed. The College, for its part, has undertaken an external review of its own processes, which flagged problems with its processes and delays and is in the process of implementing the resultant recommendations, which have not been shared with the team.

There was also frustration expressed by both jurisdictional representatives and SIMGS that the processes employed by the surgical specialties were incongruent and could be considered opaque and unreasonable, particularly for SIMGs in rural and regional areas. Examples cited by SIMGs included that requirements for documentation were onerous, broad assessment timelines and long waiting times for interviews, slow and unclear communication about assessment outcomes, and inflexibility to consider prior work experience in Australia. The team also heard feedback that there was reluctance by SIMGs to appeal a decision as that would translate to time lost in training as time spent in a non-training position is not able to be recognised retrospectively. The team noted that the revised Medical Board of Australia standard, implemented at the beginning of 2021, does not allow retrospective recognition of time prior to the start of the SIMG process.

New Zealand

The team heard there were also significant delays in the process for New Zealand and similar concerns from SIMGs over transparency of the process. So far, no surgeons in New Zealand participating in the SIMG process have asked to have concurrent MCNZ and RACS processes (as recommended for in the 2017 AMC accreditation report). The College advised that they have developed a policy that would allow this, but it has only recently been introduced. All of those eligible to request this have gained their specialist qualification in surgery less than five years ago and would therefore automatically be required to sit the Fellowship Examination by the RACS policy.

It is important to note that, on the whole, the MCNZ was satisfied with the relationship it had with the College, and in its view, considered RACS provided good support and oversight to those undergoing assessment. The team heard that the advice provided to the MCNZ after assessment of SIMGs conforms to MCNZ requirements and supports the MCNZ as the decision-maker on entry into the vocational register for surgery. The RACS New Zealand branch cooperates with the MCNZ's vocational practice assessments by nominating appropriate surgeons for the assessment team. There was concern raised that the RACS New Zealand branch may not be sufficiently staffed for the proposed work and the roles it was undertaking.

Australia and New Zealand

The differences in processes between countries do stem from the very different roles RACS and the regulators have in Australia and New Zealand. The one agreed concern was the timeliness of assessment and the advice to the MCNZ, and as in Australia, there were significant delays in administrating the process identified.

While it would appear that there are still significant discrepancies in the percentage of applicants found to be non-comparable between Australia and New Zealand and between specialties as seen in analysis of the results of SIMG assessment from 2016 - 2020, the team was advised that the College has undertaken to address these discrepancies through deliberate attempts to standardise processes across specialties in recent years.

The College is asked to provide an update in subsequent reports to the AMC about the progress and implementation of the EVOPP under Condition 35. In addition, the team is also concerned about extended processing times and perceived lack of transparency in SIMG assessments within the College in both Australia and New Zealand. While there is no further condition imposed under this standard, the College and specialty training boards are strongly encouraged to consider how timelines and transparency in communicating assessment decisions may be improved and

whether the expectations by the College of SIMG candidates were reasonable to their assessment for comparability. For instance, the College may consider publishing the outcomes of applications (non-comparable, partially comparable and substantially comparable) by specialty and by country of specialist qualification in the interest of transparency. The College is asked to provide an additional report to the AMC on any further action taken to address the feedback provided on its SIMG assessment process and as a result of its own external review.

2017 Accreditation Commendations, Conditions and Recommendations

2017 Commendations

Y The recent formation of the College's International Medical Graduates Committee and the expanded role of the Clinical Director of IMG assessment along with the College's plans to increase support for specialist international medical graduate surgeons.

Z The quality of the advice provided to the Medical Council of New Zealand (MCNZ) on eligibility for vocational registration, which satisfies the MCNZ guidelines and embodies the principle that fellowship cannot be recommended as a pre-requisite for vocational registration by MCNZ.

2017 Conditions to satisfy accreditation standards

34 All College and Specialty Training Board specialist international medical graduate assessment processes and associated documentation must reflect the Medical Board of Australia and Medical Council of New Zealand guidelines by ensuring that both training and post-training experience are appropriately considered in assessments of comparability. (Standard 10.1)

35 Develop and adopt alternative external assessment processes such as workplace-based assessments to replace the Fellowship Examination for selected specialist international medical graduates. (Standard 10.2.1)

2017 Recommendations for improvement

XX Provide greater support for specialist international medical graduate surgeons working towards specialist/vocational registration, and including access to educational resources, such as examination revision course, and other resources that are accessible to trainees. (Standard 10.2.1)

YY Make information available to future applicants that may allow them to assess the likelihood of their application achieving substantially or partially comparable status prior to them making a substantial financial payment that historical evidence might suggest is unlikely to succeed. (Standard 10.4.1)

2021 Accreditation Commendations, Conditions and Recommendations

In 2018 and 2019, the College addressed condition 34 and recommendations XX and YY in their monitoring submissions to the AMC.

In the 2021 follow-up assessment, the team considers condition 35 under Standard 10 to be progressing and is replaced with condition 20. Recommendation GG is new in 2021.

2021 Commendations

Nil

2021 Conditions to satisfy accreditation standards

20 Develop and pilot alternative external assessment processes such as workplace-based assessments to replace the Fellowship Examination for selected specialist international medical graduates. (Standard 10.2.1)

2021 Recommendations for improvement

GG 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. (Standards 10.3 and 10.4)

Surgical Training Programs

Introduction

Given the complex nature of the RACS governance structure, with its nine specialties and 13 specialty training programs having diverse arrangements in Australia and New Zealand, each specialty training board/program provided comment on its own status in regard to the outstanding conditions over the course of the 2021 follow up assessment.

The team undertook to review each specialty training board's part in addressing the 25 outstanding conditions on accreditation the College was required to satisfy from the 2017 reaccreditation assessment. This section articulates team findings for each specialty in the 2021 follow up assessment.

Cardiothoracic Surgery in 2017

The Board of Cardiothoracic Surgery is responsible for the SET program in Cardiothoracic Surgery in Australia and New Zealand, reporting to the College's Board of Surgical Education and Training.

Cardiothoracic surgery is the medical specialty devoted to the surgical management of intrathoracic diseases and abnormalities. The cardiothoracic surgeon may perform surgical procedures that involve the lungs, heart, and/or the great vessels. The Cardiothoracic Surgery program provides trainees with clinical and operative experience, to enable them to manage both cardiac and thoracic conditions that relate to the specialty, including becoming familiar with the techniques related to the discipline.

As of 2016, there were 39 trainees (33 in Australia and 6 in New Zealand) in Cardiothoracic Surgery training.

The Cardiothoracic Surgery program is usually taken sequentially over a six-year period: SET 1 to SET 6 require satisfactory completion of six-month terms; and SET 2 to 6 require five years of satisfactory operative experience.

There is a minimum of 12 rotations and trainees may only stay in one institution for a maximum of two years. The specific program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

New Cardiothoracic Surgery SET program regulations came into effect at the beginning of the 2017 training year.

Team findings in 2017

The team acknowledges the tragic death of Dr Patrick Pritzwald-Stegmann FRACS, cardiothoracic surgeon, during the course of this accreditation review, and the significant impact his death has had on his family, patients, cardiothoracic surgery colleagues, the RACS community and the health sector.

Cardiothoracic surgery is one of the smaller specialties in surgery. There are a number of advantages and disadvantages associated with the small size from the perspective of the trainees and supervisors.

Some of the advantages include familiarity between fellows and trainees and a high level of support and encouragement provided to trainees as they progress through the program. Some of the disadvantages include: the impact of the smaller group when a trainee is not performing well or a placement is not progressing well; and the burden of the travel requirements in order to fulfil the 12 placements. This is evidenced by the low response rates to the AMC trainee survey and feedback to the team from trainees regarding difficulties in reporting issues with placements due to the genuine fear of being identified and of retribution. Refer to standards 6.1 and 7.4 for further discussion of this issue.

The Board of Cardiothoracic Surgery reports a positive, supportive and constructive relationship with the College. The Board enjoys its position within the College and the benefits this brings including educational advice from RACS and support for the secretariat. The Board does not see any need or benefit in a more separate arrangement, such as those in place for the larger specialties.

Trainees and supervisors reported to the team generally high satisfaction with Cardiothoracic Surgery training and education. Cardiothoracic Surgery fellows are considered well trained and competent.

The Board expressed support for the Building Respect, Improving Patient Safety (BRIPS) program and the need for culture change within surgery, including Cardiothoracic Surgery. The team received feedback from trainees and supervisors about the strong need for change to be balanced with training in providing and receiving constructive criticism to ensure that high training standards are met.

The team was particularly pleased to see some evidence of flexible training being supported by the Board of Cardiothoracic Surgery, noting that this is in the context of a lack of flexible training options with the RACS specialty training program across all specialties. The team strongly encourages the Board of Cardiothoracic Surgery to actively pursue flexible training options for its trainees. Refer to standard 3.4 for further discussion of this issue.

The Board of Cardiothoracic Surgery was able to evidence acceleration through the standard timing of the SET program under a competency-based assessment framework. While the team commends the Board of Cardiothoracic Surgery on progress is this area, the Board is encouraged to undertake further work to ensure a robust competency-based assessment framework is in place, along with associated monitoring and evaluation processes.

Cardiothoracic Surgery is one of only two surgical specialties (Otolaryngology Head and Neck Surgery being the second) that is actively recruiting Aboriginal and/or Torres Islander trainees. The Board of Cardiothoracic Surgery approved a policy for selection of Aboriginal and/or Torres Islander trainees in February 2017. The team was particularly impressed with the commitment of the Board of Cardiothoracic Surgery to actively increase the number of Aboriginal and/or Torres Strait Islander trainees.

The team noted feedback that Cardiothoracic Surgery training is over-subscribed and there is resistance from trainees about specialist international medical graduates entering Australia and New Zealand and competing for a small number of consultant posts.

There are several areas for improvement for Cardiothoracic Surgery that also apply more broadly to the College and surgical specialties, as articulated under the relevant accreditation standards. The issues raised by and with trainees, supervisors and the Board of Cardiothoracic Surgery relate to: difficulty in differentiating between candidates in the selection process; safe working hours, including the perceived need for more hours to gain experience and competence, versus the same or less hours for work-life balance and safe practice; lack of cultural competence in the curriculum; the need for new fellows to undertake a fellowship or be mentored by a senior consultant in their early post-fellowship years; loss of entitlements when rotating between jurisdictions or countries; the need to review the curriculum and fully articulate program and graduate outcomes; and the need to review that appropriate facilities and educational resources are available to trainees to support self-learning activities as well as structured educational programs.

Cardiothoracic Surgery in 2021

Cardiothoracic Surgery is the eighth largest specialty, with 237 fellows, 41 trainees and 5 SIMGs in Australia and New Zealand in 2020. The training delivers quality surgeons who are well regarded internationally. The current specialist training board has a relatively new membership, and reports a good relationship with the society. The service agreement between RACS and the speciality society is due for renewal within the next 12 months. The specialty training board will require significant and specific support from RACS to meet all outstanding AMC conditions on accreditation.

As a small specialty training board, Cardiothoracic Surgery adopt many RACS policies, and are aware of the review processes by RACS to ensure ongoing compliance with the broad range of College policies. The specialty training board has a new community representative, and has processes within accreditation visits to ensure broad stakeholder engagement. The specialty training board have considered diversity both at the board level and amongst trainees. The Board report good ethnic diversity amongst the fellows. There have been changes to how interviews are conducted, and to ensure that every interview panel has at least one female panel member. There are structured and informal pathways for mentorship of female trainees.

Having last been reviewed in 2006, the specialty training board are aware that there is need for curriculum review. There have been meetings between RACS and the training board in relation to the impending curriculum review, which is on hold due to the current COVID-19 pandemic. The 2006 curriculum is not publicly available, there is no publicly available graduate outcome or program outcome statement. The development of a new curriculum is anticipated to take at least 12-24 months. The specialty training board has committed to work alongside RACS in order to ensure that the tenth competency is included within its curriculum and specialty training programs.

The specialty training board have made efforts to ensure that non-technical skills are both taught and examined throughout training. This teaching is mapped to the previous nine competencies. There have been recent changes to the fellowship examinations to assess surgical complications as well as peri-operative assessment.

The specialty training board have clear, publicly available entry requirements. CV scoring sheets can be accessed online. The specialty training board report that they are supportive of the RACS flexible training policy. Notwithstanding this, they report that Cardiothoracic Surgery is not a particularly flexible long term lifestyle. Trainees, however, were able to articulate opportunities for flexible training.

Trainees raised concerns about their ability to provide anonymous feedback about teaching and supervision. The specialty training board acknowledged that the small number of trainees fosters these concerns and is considering learning how to manage safe processes for trainee feedback from other small specialty training boards. The small number of fellows creates similar difficulties with obtaining confidential feedback from supervisors. A number of strategies have been introduced including a supervisors' engagement day and utilisation of supervisors in selection processes. Additionally, the five year accreditation cycle visits are viewed as both collegial and standard setting activities.

General Surgery in 2017

The SET program in General Surgery operates in Australia and New Zealand and is administered in each country respectively by General Surgeons Australia (GSA) and by the New Zealand Association of General Surgeons (NZAGS). As per the service agreements between GSA and RACS and NZAGS and RACS, these Societies provide administrative support to the Board in General Surgery (BiGS) which is the overseer of the SET program in General Surgery, and reports directly to the Board of Surgical Education and Training and the RACS Council.

General Surgery is a specialty within the discipline of surgery. The general surgeon is a surgical specialist engaged in the comprehensive care of surgical patients involving the Breast and Endocrine Systems, Trauma, Hepatobiliary, Colorectal, Upper Gastrointestinal and Surgical Oncology.

As of 2016, there were 433 trainees (374 in Australia and 59 in New Zealand) in General Surgery training.

The SET program in General Surgery is structured over a four-year curriculum: SET 2-5 in which trainees are required to satisfactorily complete 8 six-month terms in posts accredited by the Board in General Surgery. Trainees who commenced training prior to 2016 were required to complete 10 rotations. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings in 2017

General Surgery is the largest of the surgical specialties and many of the strengths and areas for development are common to all specialties, however magnified due to the size of the discipline.

General Surgery has a dedicated pro-bono senior surgical workforce which is effectively managing a large number of trainees and this is a significant strength.

The team considers there appears to be a satisfactory working relationship between GSA and the College. However, GSA expressed concerns that there is unnecessary duplication of data between the Societies and the College, giving rise to some inaccuracies and incorrect reporting of data by the College, for example the trainee data in the Activities Report. Refer to standard 1.2 for further discussion of this issue.

There appear to be significant challenges in the communication and links between NZAGS and various Departments within the College in Australia. The team received feedback that there is limited communication from the College Departments to NZAGS and the specific issues raised include: the timeliness of communication; ability to provide feedback on policy changes; and an inability to contribute to decisions that directly affect the Societies. NZAGS is concerned that it is not able to access the information required to operate the training program, due to privacy concerns of RACS. NZAGS also has concerns about the possibility of legal challenge and is seeking indemnification by RACS for the training-related activities undertaken by NZAGS.

NZAGS states that its interaction with the RACS decision-making educational bodies is limited and that the College communicates directly with fellows, but not with the Association Executive or administrative staff. The team considers that this is an area for further development between the College and NZAGS.

In relation to the representation of specialties on the RACS Board of Surgical Education and Training (i.e. comprising the chair of each Specialty Training Board), the team heard from the BiGS that it considers this 'senate style' representation to be unrepresentative, with much smaller specialties having equal representation to the larger specialties.

In discussion with the team, General Surgery raised concerns about a lack of involvement in the development of College initiatives such as the one-day Bullying Discrimination and Sexual Harassment course, which it considered could be more effective. The BRIPS program is also a source of concern to General Surgery and these mandatory programs are considered to have significant workforce implications if all supervisors and trainers in General Surgery are required to participate. The team notes there are concerns about the lack of appropriate stakeholder engagement and buy-in in their development/implementation which is also impacting on the perceived effectiveness of these programs. The team considers there is action required by the College to improve local engagement and ownership of these programs. Refer to standard 1.2 for further discussion of this issue.

The General Surgery curriculum is regularly reviewed and contemporary. A major review of the curriculum occurs every three years. The review process includes elected surgeons considering the curriculum, reflecting on current practice and recent developments, and determining what is necessary for trainees. The team commends this regular review of the curriculum.

The BiGS was not able to provide clear graduate outcome statements, however it is in the process of defining program outcomes through entrustable professional activities and procedural-based assessments. The team considers this is an important initiative and the AMC will be interested to receive updates on the progress of this activity. Refer to standards 3.4 and 5.2 for further discussion of this issue.

The BiGS advised that there is no specific training program that meets the needs of surgeons working in rural areas. Regarding the development of a curriculum to specifically train rural general surgeons, it is noted that while the curriculum for General Surgery encompasses colorectal, hepatobiliary, upper GI and breast surgery, it does not cover those parts of other specialties (such as Otolaryngology, Head and Neck Surgery and Urology) that are considered appropriate, and often

essential, for a rural general surgeon given the urgency of the presentations and geographical limitations regarding alternative treatment options. Those who met with the team considered that the required skills would be learnt on the job. The team considers it might disincentivise rural practice if it is known that there are additional skills required of the rural general surgeon upon taking up such a role. The BiGS should consider the inclusion in the curriculum of all skills required of both a general and rural general surgeon.

The team commends the BiGS for the time, effort and consideration put into the examination processes. The team notes the significant work that has been undertaken to ensure that assessments are fair and align with the curriculum.

The efficiency in the delivery of the CPD program is considered a strength, and was commended by those fellows who met with the team.

Selection into the SET program in General Surgery is described as merit-based, and as such there is no quota system for Indigenous doctors or doctors with a rural background. As discussed under standard 7.1, this will require action.

As discussed under standard 7, it is recommended that the College develop a selection process that will enable the applicant's prevocational performance (such as surgical skills or behavioural issues) to be taken into consideration. For a large discipline such as General Surgery, there is currently a high level of dependence on the 'applicant-nominated' referees which is considered to be problematic in terms of identifying possible professional or behavioural issues. The BiGS considers that a method such as 360 degree (multi-source) feedback would not be a practical alternative with too many trainees for a single supervisor to coordinate this feedback. The team notes that multi-source feedback has been found to be a valuable tool by other specialist medical colleges.

The team considers that gender equity in General Surgery would be improved by a training structure that makes it easier for a parent with significant family responsibility to participate. The team heard varied reports on the rotation experience of trainees. In general, the trainees in larger jurisdictions reported to have sufficient training posts to enable them to rotate within a hub in the state, whereas smaller jurisdictions require more significant movement of trainees to experience the full training experience. In contrast to the smaller disciplines, the team considers that rotations to distant locations might not always be required to achieve sufficient diversity in training in General Surgery.

The team heard that the regional committees try to meet individual trainee needs (for example family) in relation to their training rotations. Specific direction from the College in the form of principle-based policy from which General Surgery regulations can be developed, is likely to encourage those with a family contemplating General Surgery but currently uncertain about the manageability of distant rotations. The team considers that training credit for periods less than six months on a pro-rata basis is needed for those taking parental leave during a training period. Part-time training should be readily achievable in General Surgery, particularly given the larger numbers of trainees than other disciplines. The team considers that this issue requires attention. This discriminates against a parent with significant family responsibilities contemplating general surgical training. Refer to standard 3.4 for further discussion of this issue.

The team heard that some general surgeons (for example, those with an interest in breast surgery) are not participating in general surgery after-hours rosters. It is a key workforce requirement that a sufficient quantity of general surgeons fulfil the general surgery after-hours roster requirements of a typical hospital in Australia or New Zealand. Many general surgeons focus on specific areas of practice, such as breast surgery, which makes them unsuitable for general surgery on-call rosters. The team notes that this is something that likely needs consideration by hospital administration in terms of ensuring general surgeons maintain their general skills.

General Surgery in 2021

General surgery is the largest specialty, with separate Boards of General Surgery in Australia and New Zealand with 2294 fellows, 480 trainees and 19 SIMGs in 2020. The team noted both Boards indicated communication challenges with the College that could be improved. For example,

College deadlines for responses from the General Surgery Board did not consider that specialty societies are smaller organisations and often have a limited number of staff managing the work of the Board. The team heard the General Surgery Board in New Zealand's request for approval of the inclusion of the tenth competency in the training program had a waiting time of 18 months. The College and Boards are encouraged to look into improving mutual communication so as to facilitate more appropriate and efficacious outcomes.

The General Surgery training program does not yet have publicly available graduate outcomes. The Australian Board in General Surgery is seeking advice about making the graduate outcomes (and curriculum) publicly available. The General Surgery specialty training boards in Australia and New Zealand have joined together to develop the new general surgery curriculum, which is expected to be competency based, and implemented in 2022. The General Surgery specialty training boards are in discussion with the College about the RACS professional skills curriculum, to harmonise the two professionalism frameworks. The tenth competency was not yet included, as they were awaiting the final version of the RACS tenth competency to be developed by the College. Peri-operative medicine is covered well in the curriculum and is also considered to be well-taught.

Some General Surgery trainees expressed a lack of confidence about becoming consultants at the end of their training. In response to this feedback, the fifth year of training intended to be following the completion of the fellowship exam in the fourth year has been added to the new program commencing in 2022. Access to adequate exposure to endoscopy was still an issue in New Zealand and the specialty training board should consider concrete ways of supporting trainees in this area.

In Australia, there were no Aboriginal or Torres Strait Islander applicants to the General Surgery training program even though there are quarantined posts available. Given the needs in rural health and distribution of surgeons, the specialty training board should look into the reasons behind this and encourage application and selection. This is especially important as this is the largest surgical specialty within the College.

The General Surgery Board in New Zealand distributes its own feedback form at the end of the year, as trainees move sites, to aid confidentiality and transparency of feedback. Within Australia, feedback is requested at the end of each rotation (six months) and is collated from the last four rotations to improve anonymity. The team heard that it is not common for regular feedback to be given to supervisors though this should evolve with College-led initiatives. Feedback is utilised and reviewed and where appropriate issues are raised through the various channels including supervisors and through out of cycle inspections.

While not specifically commented on, there are Māori and Pacific Island trainees in New Zealand, and there are senior and respected Māori surgeons who can act as role models. The General Surgery Board in New Zealand and a number of supervisors indicated they will be attending the cultural safety course (MIHI 501) in 2021.

The team noted improved gender diversity in selection with female trainees well represented in training posts in Australia (38%) and in New Zealand (46%).In New Zealand, there are diverse members on the selection panel with cultural input into the process to ensure cultural safety. The General Surgery Board in New Zealand has reduced the weighting of the CV and research in selection and added points for cultural inclusivity. In Australia, added points are awarded for rural experience in selection.

Neurosurgery in 2017

The administration and management of the SET program in Neurosurgery is delegated to the Neurosurgical Society of Australasia (NSA) in accordance with the Service Agreement. The SET program in Neurosurgery operates in Australia, New Zealand and Singapore. The Board of Neurosurgery has dual reporting roles and represents both the College and the NSA on all matters relating to the training program.

Neurosurgery provides for the operative and non-operative management of disorders that affect the central, peripheral and autonomic nervous system, including their supportive structures and vascular supply. This includes prevention, diagnosis, evaluation, treatment, critical care and rehabilitation as well as the operative and non-operative management of pain. Neurosurgery encompasses disorders of the brain, meninges, skull and their blood supply including the extracranial carotid and vertebral arteries, disorders of the pituitary gland, disorders of the spinal cord, meninges and spine, including cranial and peripheral nerves.

As of 2016, there were 46 trainees (41 in Australia and 5 in New Zealand) in Neurosurgery training.

The Neurosurgery training program is structured on a three-level sequential curriculum over a minimum of five years and a maximum of nine years: Basic Neurosurgical Training (1-2 years); Intermediate Neurosurgical Training (3-4 years); and Advanced Neurosurgical Training (1-3 years).

Trainees must rotate through a minimum of four training units during their SET program. This will often include two different jurisdictions. The specific program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings in 2017

The team is of the view that Neurosurgery is a well-organised specialty with a clear sense of direction.

The Board of Neurosurgery has clearly paid considerable attention to its curriculum and the structure of training, in particular the three-level sequential aspect of the curriculum. The team considers that the Board of Neurosurgery is further advanced in outlining its program and graduate outcomes than many of the other surgical specialties. The team commends the Board for its progress while noting that this important work must be finalised.

The selection process in Neurosurgery includes performance in the Generic Surgical Sciences Examination and the Anatomy Examination, and assessment of the CV as well as referee reports. From these inputs up to 24 applicants are selected annually for interview. Trainees responding to the AMC survey agreed that criteria for selection into the program are clear and that the selection process follows the published criteria.

The practice undertaken by Neurosurgery to interview all referees for applicants for training, rather than depend on the written referee report, was highly commended by the team, especially given the issues identified in review of written reports for other specialties.

The Board indicated that the paucity of applicants from Queensland, South Australia, Northern Territory and New Zealand is of concern, particularly since trainees tend to stay or return to their state of origin. The team was advised that the Board of Neurosurgery is examining why applicants are not applying from the above regions. It also intends to approach the Australian Indigenous Doctors' Association regarding the barriers for Aboriginal and/or Torres Strait Islanders in applying for Neurosurgery training. The team encourages the Board to progress this work as discussed under standard 7.1.

The issue of diversity of trainees and flexibility of training was a recurrent theme across all specialties. In the additional information from the College provided to the team, the team noted that there were no Neurosurgery trainees undertaking part-time training and only four on interrupted training. Trainees reported in the AMC survey that given the demanding requirements for training in Neurosurgery, flexible training is not an option. The Board of Neurosurgery needs to reconsider these issues in depth and in light of the team's overall assessment regarding selection, diversity and flexibility of training.

There is a minimum of four rotations required of trainees in Neurosurgery, compared to eight rotations in a number of other specialties. To gain the required breadth of experience, a number of trainees may have to spend up to 12 months outside their region. The team was advised that trainees know by June or July their rotations for the following year, a relatively good standard of practice, although the team encourages the College to develop a practice whereby trainees are given a plan

for their rotations at the commencement of their training program. Refer to standard 8.2 for further discussion of this issue.

According to the AMC survey, both trainees and supervisors are satisfied with the process of supervision.

The Board of Neurosurgery advised the team that no specialist international medical graduate has been recognised in Australia as substantially comparable to an Australasian neurosurgeon, although one of the respondents to the AMC's survey of specialist international medical graduates identified themselves as such. This contrasts with other specialties where up to one third have been assessed as substantially comparable.

Comments made by the six Neurosurgery respondents to the AMC specialist international medical graduate survey were varied. Even though their experiences of the assessment process varied, the issues mirrored the experiences of specialist international medical graduates across the College. The discussion under standard 10 regarding the need to consider experience of both training and post-training experience in the assessment of comparability has particular relevance for Neurosurgery.

Neurosurgery in 2021

Neurosurgery is the six largest speciality with 310 fellows, 54 trainees and 2 SIMGs in Australia and New Zealand in 2020. In the 2017 AMC reaccreditation assessment of RACS, the assessment team found that "Neurosurgery is a well-organised specialty with a clear sense of direction" and the team's perception was unchanged in the 2021 follow-up assessment of the College. The speciality training board provided comment to the outstanding conditions as relevant to the Neurosurgery training program and current status.

The team heard representatives describe a productive relationship with the College and its process in adopting RACS policies and standards, including BRIPS, the Innovate Reconciliation Action Plan and the Diversity and Inclusion Plan. Progress was made by the specialty training board on the following:

- Neurosurgery Board's relationship with the College.
- The implementation of the Building Respect, Improving Patient Safety (BRIPS) Action Plan, the Reconciliation Action Plan (RAP) and the Diversity Inclusion Plan (DIP).
- Alignment of training programs to graduate outcomes.
- Standard setting methods for its examinations.
- Methods of monitoring and evaluation of its training and education processes, and inclusion of other health professionals and broader community in providing feedback on the training program.
- Cultural safety training for its supervisors.
- Approach to replacing the Fellowship Examination for SIMGs.

The team considered that a number of these matters had been satisfactorily addressed by the specialty training board and in the overall College response.

The team considers the Neurosurgery training program to be well organised with good policies to include diversity in trainee cohorts. There is a publicly available graduate outcome statement and robust and fair trainee selection processes are considered to be employed. The Neurosurgery Board provided comprehensive documentation about its selection regulations, training regulations, and its statement of competence about graduate outcomes of education and training in neurosurgery. The statement on graduate outcomes is published on its website and publicly available for anyone who seeks it.

The Board of Neurosurgery's policy is to select at least one Aboriginal and Torres Strait Islander trainee and one Māori trainee into training per year as long as they meet the minimum standard.

This initiative remains to be supported by the RACS Indigenous Health Committee. The Board is also looking at ways to increase female representation in the specialty. One mechanism to support this initiative is to propose a 40% selection of female trainees into training, providing minimum criteria for selection are met. This initiative was proposed by the Board and approved by the College in July 2021, and changes include preferencing the selection of woman with two points will be incorporated into the 2022 selection regulations.

The Board of Neurosurgery indicated it was currently undertaking a review of its curriculum which has been delayed in 2020 due to COVID-19 disruptions and is now due for completion in 2021. As such, the Board was unable to provide further comment on the outstanding conditions pertaining to specialty curriculum and training programs at the point of the assessment

The team recognised that the issue of trainee feedback, particularly if it is to be unidentifiable, can be difficult in a specialty with a small cohort of trainees. Confidential feedback is collected six-monthly for ten years and is used to support accreditation and reviews of training sites where serious concerns are raised. Senior members of the Board make themselves available for trainees to confidentially express their concerns. The problem inherent with small trainee and SIMG numbers in a specialty is reinforced by surveys conducted by the AMC for this review process, with notably lower returns for smaller specialties, though it is noted the response rate for Board-initiated surveys was greater than 90% over a ten year period.

In regard to SIMGs, the team's own analysis of the data available to it for the 2016-2020 period showed only a small percentage of applications were assessed as substantially comparable. In 2017, the Board of Neurosurgery advised that no SIMGs had been recognised in Australia as substantially comparable. The issues regarding RACS SIMG assessment processes are more broadly addressed under Standard 10.

Orthopaedic Surgery in 2017

RACS has devolved the delivery, administration and management of the SET program in Orthopaedic Surgery in Australia and New Zealand to the Australian Orthopaedic Association (AOA) and the New Zealand Orthopaedic Association (NZOA) respectively.

Orthopaedic Surgery is defined as the medical specialty that focuses on the diagnosis, care and treatment of patients with disorders of the bones, joints, muscles, ligaments, tendons, nerves and skin. These elements make up the musculoskeletal system. The surgeons who specialise in this area are called Orthopaedic Surgeons. Orthopaedic Surgeons are involved in all aspects of health care pertaining to the musculoskeletal system. They use medical, physical and rehabilitative methods as well as surgery.

As of 2016, there were 280 trainees (234 in Australia and 46 in New Zealand) in Orthopaedic Surgery training.

In Australia and New Zealand, the current program in Orthopaedic Surgery is structured over a five-year period. In certain circumstances, training may be completed in four years. Trainees must complete a minimum of eight rotations. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations in New Zealand and AOA policies and Progression Requirements in Australia, according to the delegations of the AOA/RACS Service Agreement. AOA has spent several years developing a new AOA 21 curriculum for introduction in 2018.

Team findings in 2017

The College has devolved autonomy for the program in Orthopaedic Surgery to AOA through a service agreement, whereas NZOA has a partnering agreement, and is more closely aligned to the College. The NZOA Annual Report shows evidence of this close relationship with the College and how RACS initiatives are melded with those of NZOA. The AOA and NZOA Presidents report they meet regularly.

A regular interaction between AOA and the College occurs at the Board of Surgical Education and Training. AOA seeks more involvement in College governance. The team heard from stakeholders that the interface issues between AOA and the College have a negative impact, in particular relating to the lines of accountability for training not being sufficiently clear. The team considers the governance arrangements between the College and AOA are unwieldy and could be better harmonised. The discord between the AOA and the College was clearly expressed to the team by the AOA and is also evident to trainees, as commented by some of them in the AMC survey. Such disharmony does not reflect well on either the AOA or the College.

The team commends the AOA on its Reconsideration, Review and Appeals Policy which could serve as a well set-out example for the College. Refer to standard 1.3 for further discussion of this issue.

The team commends the new curriculum, AOA 21, which has been developed with external consultation, including an educational expert. It has a strong underlying pedagogy. AOA 21 was launched in 2017 for introduction in 2018. Instead of five one-year stages, AOA 21 will have three key phases of training comprising: Introduction to Orthopaedics (approximately 12-18 months); Core Orthopaedics (approximately 36 months); and Transition to Consultant Practice (approximately 12 months). The first phase will focus on foundation (non-technical) and trauma competencies. There will be barrier assessments at the end of each phase where progression decisions will be made based on a programmatic assessment framework. In the third phase, there will be a stronger focus than previously on preparedness for practice.

The curriculum for AOA 21 has not been approved by the College nor does AOA intend to seek approval as it considers its Service Agreement with the College provides it with autonomy to make such decision about the program. In relation to the New Zealand program, beginning at the commencement of the strategic education review in 2012 leading up to the design of AOA 21 and continuing until present, AOA made offers to the NZOA to join AOA 21, but cost has been an issue for NZOA. The NZOA is utilising AOA's previous curriculum, which was developed before 2011 and is watching progress before committing. In feedback on the draft accreditation report, it was reported that NZOA has advised that it would like to adopt AOA 21 Curriculum and other aspects of AOA 21 and planning is now underway.

The current Orthopaedic Surgery curriculum outlines outcomes across the nine RACS competencies and these have been mapped to both assessment and stages of training. Trainees in Australia and New Zealand report expectations are very clear.

There are no specific cultural competence learning outcomes or assessments in the previous AOA curriculum, this has been addressed in the AOA 21 Curriculum, which includes Cultural Awareness and Sensitivity in the Advocacy section. Further, it is suggested that addressing the health needs of Indigenous peoples could feature more explicitly in the purpose statements of both AOA and NZOA.

There are several differences between the Australian and New Zealand programs. As noted above, from 2018, the curricula will be different as AOA rolls out AOA 21, and the selection processes are slightly different. The team does not view this as an issue as long as there is alignment of selection criteria, the graduate learning outcomes, and the expectations of the College. The Fellowship Examination remains common at present and New Zealand has a very high pass rate in the examination.

The team commends both AOA and NZOA for mentioning community and patients in their mission statement. 'The AOA is the peak professional body in Australia for advancing excellence of orthopaedic practice in the interests of patients and the community, and in the training of surgeons to world-class standards'. The NZOA has on its website 'Promoting excellence in patient care and advocating for the needs of patients with orthopaedic conditions.'

The ratio of trainees to supervisors is low in Orthopaedic Surgery, often 1:1, and no more than 2:1 in Australia and 6:1 in New Zealand. This is considered a strength of the training program.

Once a trainee has completed their training, it is intended that they will be able to work unsupervised as an Orthopaedic Surgeon. Stakeholders uniformly praised the level of technical expertise of newly

qualified Orthopaedic Surgeons. That said, Orthopaedic Surgery trainees met by the team indicated that they would graduate with major gaps in their training, almost all of whom included procedural skills as one such gap.

Other observations made by some trainees relate to the fees they are required to pay to the College, the value and benefit of which is not apparent to them, in particular given that the AOA delivers the training program. Under standard 7.3 of this report, the need for transparency of the fee-setting process is recommended which applies equally to Orthopaedic Surgery.

While diversity and equal opportunity are mentioned by AOA in policy, there is little evidence of this in the trainee complement. Likewise, the NZOA website might mention more on diversity and inclusion.

Very few trainees have worked part-time, with a few more having interrupted their training. This remains an issue for the College in general but the accreditation process of training posts by the specialties, including Orthopaedic Surgery, does provide an opportunity for dialogue between the specialty and the hospital system for the benefit of trainees. The team considers that the Training Committee/Board must do more with jurisdictions to promote flexible training.

While the rules state that if a trainee has more than six weeks off in a six-month rotation that rotation is not counted as valid, the team heard this could be discretionary, and that decision making around this is not transparent. The AOA and NZOA are encouraged to consider this issue in the broader context of addressing the barriers to flexible training.

The AMC trainee survey indicated that some Orthopaedic Surgery trainees have real issues to raise about their training and supervision experiences, and the specialty should consider how it improves support for such trainees. Refer to standard 7.5 for further discussion of this issue. The team was reassured that the specialty is taking seriously the RACS BRIPS program and this is to be commended and must be sustained.

The issues concerning specialist international medical graduate assessment for eligibility for specialist registration in Australia and entry to fellowship are covered in detail under standard 10. Of particular relevance to Orthopaedic Surgery is the emphasis on judging an experienced specialist international medical graduate by an examination rather than by observed experience and patient outcome (with only 5% recommended as substantially comparable). The survey of Orthopaedic Surgery specialist international medical graduates provided much negative comment and dissatisfaction about the process they were undertaking. There were allegations (not uniformly expressed) that the process was unclear, unfair, costly, and that the emphasis on judging an experienced specialist international medical graduate by an examination rather than solely by observed experience and patient outcome was misplaced. The team was informed by the chair of the AOA Federal Training Committee that the Committee is of the view that the UK orthopaedic examination is not to the same standard as the Australasian examination Both the College and the AOA should heed the conditions and recommendations detailed under standard 10.

However, it should be noted that the New Zealand Board of Orthopaedic Surgery's recommendations to MCNZ on eligibility for vocational registration in Orthopaedic Surgery are more consistent with the need to take into account the mitigating effect of post-training experience (with 33% being recommended for supervision pathway).

Orthopaedic Surgery in 2021

Orthopaedic Surgery is the second largest specialty in the College after General Surgery, with 1739 fellows, 291 trainees and 20 SIMGs in Australia and New Zealand in 2020. The team commends the Australian Orthopaedic Association (AOA) and the New Zealand Board of Orthopaedic Surgery (NZOA) for their commitment to and delivery of quality training.

The College has an updated service agreement for training in Australia with the AOA. The Federal Training Committee (FTC) of the AOA is responsible for management and delivery of the training program with the College responsible for the Fellowship Examination. This arrangement is

reported by both parties to be working well. A partnering agreement is yet to be signed with the NZOA.

The AOA21 curriculum launched in 2017 is now well-embedded. Trainees who commenced in 2018 with Introduction to Orthopaedics, have now progressed into Core Orthopaedics. The first trainees are expected to be able to progress into Transition to Practice (the third and final stage of the AOA21 Training Program) from mid-2021. The training committee plans to review the curriculum in 2022. The AOA21 curriculum has been shared with NZOA, with this being adapted for the local context.

The AOA21 curriculum has clear graduate outcomes including foundation competencies which align with the College's competencies, however these are not publicly available. A mapping exercise between the AOA21 competencies and the College's competencies has been undertaken. The tenth RACS Competency is yet to be incorporated formally into the AOA21 curriculum, but is mentioned in the New Zealand training regulations. It was recently mandated that trainees must complete the RACS Aboriginal and Torres Strait Islander Health and Cultural Safety Curriculum Modules as they become available. For the past two years in New Zealand, trainees have been assessed on their cultural safety.

The AOA is represented on the College's professional skills curriculum development project and has indicated willingness to share curricular design with other surgical specialties.

AOA21 training and assessment is supported by a web-based Trainee Information Management System (TIMS) accessed through a phone app. This captures significant quantities of data on Trainee eLogs and WBAs. The data may be helpful in identifying the approximate caseload required for a trainee to achieve competence. The NZOA also uses a Trainee Information Management System (TIMS) and mobile app for surgical supervisors and consultants to support trainee assessment. This includes workplace-based assessments, a Quarterly Run Assessment (QRA) and feedback entries focusing on RACS competencies.

The curriculum uses competency-based, programmatic assessment with progression decisions made by a regional panel using all available evidence through the preceding phase. The competency-based approach allows some flexibility if trainees cannot meet case numbers. While no recognition is given for prior experience, this may allow trainees to progress through their workplace-based assessments more quickly. Trainees have nine years to complete SET. In New Zealand, there may be a hybrid time- and competency-based approach. The FTC has revised its Reconsideration, Review and Appeal of Training Decisions, which has now been separated from the broader organisation-wide policy.

Trainees indicated there had been 'teething problems' with AOA21, but overall felt they would be well-prepared for practice by the new program. Supervisors felt well supported by the training committees. The AOA training committee conducted a Supervisor Survey in 2020. The responses indicated a need for enhanced induction of supervisor, as well as education in training policy and use of technology

Selection practices are being refined to increase diversity of surgical trainees. Three-person selection panels include one female orthopaedic surgeon and one non-surgeon. In Australia, candidates who meet the entry threshold have a six-station multiple mini interview, including cultural competency. In New Zealand, cultural competency questions have been included in the last two years. Given the negative correlation between the CV score and performance in training, the AOA no longer considers the CV score as contributing towards ranking for interview. The CV is now used only as a minimum threshold. Multiple referees are selected by applicant's local Director of Training, not the applicant themselves, and may be from non-surgical staff. The referee reports map to the AOA21 foundation competencies, including all technical and non-technical competencies.

The AOA continues to apply the Aboriginal and Torres Strait Islander Selection Initiative and now has three current trainees who identify as Indigenous and who are reported to be well-supported. There were no new Indigenous trainees in Australia selected in 2021 but two new Māori trainees

in New Zealand. Over 10% of New Zealand trainees are Māori. Further work is needed to enhance pathways to selection for Aboriginal and Torres Strait Islander doctors in this specialty. NZOA has appointed a kaumatua (Māori elder) and is setting up a Diversity Committee as well as an advisory group of Māori SMOs and trainees, Ngā Rata Kōiwi. Ngā Rata Kōiwi is a group of Māori Orthopaedic surgeons and trainees who are dedicated to improving Orthopaedic outcomes for all Orthopaedic patients. A Cultural Inclusion Working Group has been established by the AOA.

The number and proportion of female trainees is rising slowly. The FTC aspires to have 30% female trainees, with the proportion currently 16%. In New Zealand, 20% of those selected for 2021 were female.

The AOA FTC has launched new accreditation standards for training in 2019. Of note, any training site with three or more posts must have a plan in place to facilitate a part-time training post. Commitment to cultural safety and competence is now included in its Hospital Accreditation Standards.

The AOA runs its own CPD program aligned with that of the College. NZOA also runs its own CPD program, which was reported to be more onerous than the RACS CPD program.

Otolaryngology Head and Neck Surgery in 2017

The SET program in Otolaryngology Head and Neck Surgery is administered in Australia conjointly by the College and the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), and in New Zealand conjointly by the New Zealand Society of Otolaryngology Head and Neck Surgery (NZSOHNS) and the New Zealand office of the College.

Otolaryngology head and neck surgeons investigate and treat conditions of the ear, nose, throat, and head and neck, such as nasal and sinus conditions, snoring and breathing problems, tonsillitis, cancers of the head and neck including thyroid surgery, voice problems, plastic surgery of the nose and face, hearing difficulties and deafness, and tumours of the head, neck and ears.

As of 2016, there were 88 trainees (72 in Australia and 16 in New Zealand) in Otolaryngology Head and Neck Surgery training.

The program in Otolaryngology Head and Neck Surgery is conducted over a minimum of five years. All training terms are six months in duration. Trainees are required to satisfactorily complete a minimum of 10 six-month accredited clinical rotations, unless the Board of Otolaryngology Head and Neck Surgery approves recognition of prior learning or early completion of training. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings in 2017

The Board is 18 months into a review of its curriculum, considering its effectiveness in meeting training program outcomes. As part of this review, the Board is planning to transition to a competency-based curriculum. Several specialties now outline expected standards of performance at particular stages, a move away from time-based training. Otolaryngology Head and Neck Surgery is introducing minimum and maximum periods of time in which competencies at each level must be achieved. The ability to alter the program in a flexible manner according to the trainee's ability is considered an important initiative.

The Board is developing nine key skills as part of the curriculum, including cultural competency. The Board of Otolaryngology Head and Neck Surgery is developing a specific Aboriginal and Torres Strait Islander and Māori curriculum module to ensure the health needs of these groups are being addressed. A copy of the draft module was provided to the team. The team commends the Board for the inclusion of cultural competency as a core part of the curriculum.

There are currently no defined graduate outcome statements, and this is an area that is being considered in the curriculum review. It is planned that the new curriculum will be used to measure teaching and assessment outcomes.

The expected implementation date for the new curriculum is February 2018. The team commends the Board for embarking on this review. The development of graduate outcome statements and the implementation and evaluation of the curriculum will be areas of interest to the AMC in future reporting. Refer to standards 2.3 and 3 for further discussion of these issues.

The Board indicates that most rotations are 12 months, with some being six months. There are also interstate rotations. The training experience of each of the rotations is quite different as each hospital has a particular subspecialty, although some hospitals have a general spread of patients. New South Wales has the biggest spread in terms of rotations. The Board reported that while it tries to accommodate and relocate trainees in their home state, there was some question regarding whether this is advantageous in terms of training continuity.

While the Board is commended for the planned innovative approaches in providing a more flexible program for trainees, the current lack of flexibility within the program requires further attention. The AMC survey indicated that most trainees strongly disagree that part-time posts are available within their training site. Trainees expressed concerns that part-time training is difficult to access, and felt that it may reflect badly in their assessments.

The survey of trainees also indicated there seems to be no flexibility in the rules around the length of time that can be missed from a rotation. The College's policies on interrupted training state that this can only occur in six-month blocks that align with the prescribed College 'terms'. This means that if a trainee requires interruption outside of these periods, they are required to take longer time off training than requested, i.e. 12 months instead of six months. The team has heard that this is hugely disruptive for both training and overall mental health and wellbeing. This is an area that requires further attention from the College and the Board. Refer to standard 3 for further discussion of this issue.

The team was informed of a proposal by the New Zealand chair of the Board of Otolaryngology Head and Neck Surgery to amend the current rules to make the interruption rule more 'user-friendly'. The team considers this proposal should be shared with other surgical specialties.

The team notes that the Board is considering an increase in procedural-based assessment and assessment by direct observation. This may increase the workload of supervisors, the impact of which will need continued monitoring to ensure the assessment is being implemented as expected, and not placing an unrealistic burden on supervisors.

The team notes that Otolaryngology Head and Neck Surgery is the only surgical specialty to date that has implemented changes to support entry of Aboriginal and Torres Strait Islander doctors to surgical training. In 2017, a training position will be prioritised for Indigenous doctors who meet the minimum standards for interview. Otolaryngology Head and Neck Surgery is commended for this initiative and it is hoped other boards will follow this lead in future selection rounds. Refer to standard 7.1 for further discussion of this issue.

As discussed under standard 8.2, the Board also supports training and education opportunities in diverse settings aligned to the curriculum requirements, including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand. This is a significant strength of the specialty.

Trainees undertake outreach visits which provide experience of the provision of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand. These outreach clinics include: Deadly Ears Program – Queensland; Kimberley Region Outreach Clinics – Western Australia; Yatala Outreach Clinic – South Australia. The team commends this program and recommends other specialty training programs may also wish to consider implementing a similar program.

The team heard that there are currently no trainee representatives on some of the regional Otolaryngology Head and Neck Surgery training committees. As this is a forum in which many significant discussions take place regarding rostering and movement between rotations, trainees

consider it is important that there is adequate representation and input into these discussions. This is an area for further consideration by the specialty. Trainee engagement and input into discussions regarding the flexibility of the training program is required.

Otolaryngology Head and Neck Surgery in 2021

The Board of Otolaryngology, Head and Neck Surgery (OHNS Board) has oversight of the Otolaryngology Head and Neck Surgery SET Program. The College collaborates with the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) to manage the SET training program in Australia while the New Zealand Society of Otolaryngology, Head and Neck Surgery (NZOHNS) administers the training program in New Zealand. OHNS is the third largest specialty in the College with 614 fellows, 88 trainees and 12 SIMGs in Australia and New Zealand in 2020.

The OHNS SET training program is designed to provide trainees with clinical and operative experience in order to learn special methods of investigation and become competent in techniques related to the discipline. At the conclusion of training, it is expected that trainees will be able to perform as independent practitioners, meeting the requirements of all identified RACS competencies.

The 2019 curriculum has defined areas on culturally responsible health care. The team were pleased to see the inclusion of cultural safety and competency as a core part of the curriculum. The team were informed that the cultural safety competency Australia module was not yet mandated for trainees in Australia. The team considers this needs to be mandatory in light of the tenth RACS professional competency in Cultural Safety and Cultural Competence and initiatives for the Reconciliation Action Plan, Diversity and Inclusion and Rural Health Equity.

Although there is a broad definition of graduate outcomes in the curriculum, the OHNS Board needs to synthesise this into a clear statement of graduate outcomes that is publicly visible to meet a condition by the AMC in the 2017 reaccreditation.

The OHNS Board introduced a competency-based curriculum in 2019, following a period of extensive development. The move away from time-based training in a flexible manner according to the trainee's ability is an important initiative. There is still a requirement to complete 500 type A and 500 type B procedures through training.

The SET program has a maximum of 14 terms with no prescribed minimum. The trainee progresses from Novice (maximum 4 terms) through Intermediate (maximum 6 terms) to Competent (maximum 4 terms). Failure to progress within the time-frame or not reaching satisfactory performance at the End of Term Assessment (EOTA), results in a performance management plan and the trainee placed on probation. Failure to meet the requirements of the performance management plan may lead to expulsion from training.

The new curriculum incorporates a number of comprehensive workplace-based assessments (WBAs) including Mini Clinical Examination (MiniCEX), Direct Observation of Procedural Skills (DOPS), Procedural Based Assessment (PBA), Case-Based Discussion (CBD) / Outreach Based Discussion (OBD) and Mid-Term and End-of-Term assessments. Multi-Source Feedback (MSF) is currently only used for trainees on probation. Each assessment tool has detailed assessment templates with behavioural descriptors that relate to relevant RACS competencies. The PBAs are categorised into one of the five OHNS disciplined-specific modules and by their technical level – Novice, Intermediate or Competent. Trainees need to complete all mandatory PBAs for their current level before progressing to the next level and must perform 5 in each term. Professional skills are included in the 2019 curriculum. The RACS Professional Skills Curriculum will be assessed to determine whether the professional skills component of the OHNS curriculum should be modified.

The Board reported that in 16 out of 19 trainees passed the SSE (84.2%) and 12 out of 15 trainees passed the Fellowship Exam (80%) with 3 out of 9 (33%) specialist international medical graduates passing.

Only Paediatric Surgery and Cardiothoracic Surgery had lower pass rates in the Fellowship Examination in 2019 however, both had much lower number of candidates sitting than OHNS.

There is not currently an adequate monitoring and evaluation framework that provides regular stakeholder input to the curriculum. This is particularly important with the introduction of the new competency-based curriculum in 2019.

In 2020, the Board engaged ASOHNS & NZSOHNS members, OHNS trainees, trainers and supervisors to provide input to formulate a five-year Training Strategic Plan. Approximately 1500 responses were workshopped into a Strategic Plan. The Strategic Plan will be presented to the Board for ratification in 2021. Following are the current feedback processes

1 Trainee Supervisors meet biannually with the Board Regional Chairs to discuss training. The Board Regional Chair reports to the Board.

2 Trainee Supervisors meet annually with the Board Chair to provide insight and feedback in relation to training.

3 The Board Hospital Inspectors interview the hospital Medical Director, Head of Unit, Supervisor and trainees at a minimum every 5 years and report to the Board.

Relevant stakeholders such as training supervisors, hospital administrators and other relevant health professionals should be given an opportunity to feedback on a regular basis and that feedback should be fed into a process that ensures any relevant initiatives can be made and re-assessed.

Similarly, there is not currently a regular process for New Fellows (e.g. within the first 5 years of training) to reflect back on the strengths and weaknesses in their training and whether it prepared them for appropriately for consultant practice in OHNS.

Selection for training in OHNS has a number of innovations to address common issues of concern. In order to better validate referee reports, all referees are spoken to verbally by selection panels. The verbal references become a more valid tool in selection and show greater discrimination between applicants. The selection points awarded for a PhD qualification are being reduced and applications are being limited to four applications to be accepted into training over a course of six years (excluding maternity leave) as a means of avoiding prolonged prevocational training that does not lead to a specialist training in OHNS.

There is a dedicated position in Australia for an applicant of Aboriginal & Torres Strait Islander origin. Extra selection points are given for Māori-focussed research in New Zealand. Points are awarded for rurality in Australia and points for rurally-focussed research in New Zealand.

In 2019, 28% of all applicants for OHNS were female applicants, which is close to the overall RACS surgical training application average of 29.7% female. Of the 85 OHNS trainees in 2019, 31.8% were female which was above the overall RACS trainee average of 29.6%. The OHNS Board initiated a special measure in 2020 to achieve substantive gender equality.

Trainee feedback on training sites is assessed longitudinally and delivered by the two trainee representatives on the SET Board. This may serve as an example as to how to preserve trainee anonymity and therefore be more confident that feedback is accurate.

ASOHNS launched a Learning Management System at the commencement of 2020. As part of this system trainees cannot progress through the levels unless they complete an anonymous feedback questionnaire regarding their training experience at each rotation. The Board will use this information over time to build up a profile for each training post.

The RACS Trainees' Association (RACSTA) Survey is conducted at the end of each training term and all trainees in accredited training posts for the designated period are invited to participate. The results are shared with the Board for discussion at their meetings.

The team were informed that flexible training is included in the hospital accreditation standards and there were three trainees currently undertaking flexible training. The requirement to

develop a return to work plan for trainees returning from extended leave is not yet part of the hospital accreditation standards.

The Board has a clearly defined, regulated process for trainees returning to work from extended leave. This is a Board responsibility and is facilitated by the supervisor and trainers within the Hospital Training Unit. The Board does not view this as part of the Hospital Accreditation scope.

Paediatric Surgery in 2017

The Board of Paediatric Surgery is responsible for the delivery of the SET program in Paediatric Surgery in Australia and New Zealand, reporting to Board of Surgical Education and Training.

Paediatric Surgery is defined as the specialty that includes surgeons who have specialist training in the management of children (usually up to the age of about 16 years) who have conditions that may require surgery. Specialist paediatric surgeons normally deal with non-cardiac thoracic surgery, general paediatric surgery and paediatric urology. Their responsibilities include involvement in the antenatal management of congenital structural abnormalities, neonatal surgery and oncological surgery for children.

As of 2016, there were 31 trainees (28 in Australia and 3 in New Zealand) in Paediatric Surgery training.

The Paediatric Surgery program is structured over a seven-year sequential curriculum in four phases: SET 1 (12 months), Early SET (24 months), Mid SET and Senior SET (8 six-month rotations). The specific program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings in 2017

As a small specialty, Paediatric Surgery takes advantage of its size to keep closely in tune with its trainees. Trainees appear to be comfortable approaching the chair of the Specialty Training Board when issues or concerns arise. The Board of Paediatric Surgery has actively engaged with its trainees individually and through its trainee representative who is a full and respected member of the Board. The annual Registrar Training Seminar, which is compulsory for all active trainees, is an excellent opportunity to bring the Board into contact with all trainees and to stay abreast of their current issues.

A small specialty can have advantages, but also potentially makes it more difficult for trainees to safely and confidentially report bullying or poor behaviour within such a small network of trainees and supervisors. The Board should consider, in conjunction with the College's complaints process, developing a safe and completely confidential process for identifying and addressing poor behaviour within the specialty, ideally at an early stage. The Board must be cognisant of the fact that there is still significant fear and stigma attached to raising concerns about the behaviour of other surgeons (particularly senior surgeons and supervisors) or acknowledging personal difficulties that may be perceived as weaknesses. Refer to standards 6.1 and 7.4 for further discussion of this issue.

SET 1 trainees are closely supervised and assessed within the Paediatric Surgery program throughout the first year (fixed assessment program). This is a relatively recent change which allows for the early identification of possible weaknesses or potential unsuitability of trainees. If problems are identified, there is an opportunity to establish a performance management plan to address concerns in a timely way. The quarterly review of trainee assessments by the Board also enables it to keep a close eye on trainee progress.

Trainees are encouraged by the Board to complete the same RACS training courses as the Paediatric Surgery supervisors (for example, the Keeping Trainees on Track (KTOT)), Foundation Skills and Supervisors and Trainers in Surgical Education and Training (SATSET) courses). The Board Chair even became a trainer for one of the training modules in order to give his trainees access to this course at low cost and quickly. This has helped trainees understand and take a more mature role in seeking and accepting feedback. The Board also considers it will help trainees to be proactive in

addressing concerns with their supervisor or other colleagues before they reach the level of a complaint. The Board would like to see access for trainees to attend the fellows training courses which it considers will enable trainees to become both better students and teachers.

Paediatric Surgery currently relies on training posts and hospitals to provide training in cultural competence rather than mandating or providing any training or support of their own. The Board should highlight the essential nature of these skills by mandating that each trainee receives cultural competency training during the program. Refer to standard 3.2 for further discussion of this issue.

Paediatric Surgery is heavily invested in the BRIPS program and its outcomes which is commended by the team. The specialty advocates for improvement in training conditions for women surgeons. The team commends the innovative proposals to address the issue of parental leave inequities or loss due to mandatory interstate training moves in mid and senior SET. This issue of parental leave loss is an example of the kind of concerns the College will need to tackle if it is fully committed to addressing and eliminating the barriers for women entering and staying in surgery.

The team considers that the Board needs to address the barriers to flexible training at the hospital-level, by considering the imposition of conditions on training posts, rather than expecting the trainee to negotiate individually. Given there are more training posts than trainees, it would seem to be an opportunity to push harder for this much-needed change. The team commends Paediatric Surgery for the flexible position about to be created at Gold Coast Hospital. The Board should continue to actively show its support for the creation of flexible training posts and for seeing flexible training become a more common reality, keeping in mind that there is still a high-level of fear associated with asking for or pursuing this option. It might be helpful for the Board to consider easing the strict requirement that applications for flexible training must be made no less than six months prior to the commencement of the rotation; it can be challenging to forward plan pregnancies and other unexpected personal issues that might impact on full-time training.

The Board is committed to a move towards competency-based training, a process which is nearly complete. The team encourages the Board to finalise the paediatric surgical assessment form which will include the full list of competencies required and when trainees are expected to achieve them. This transparency and outlining of clear expectations is essential for competency-based training and will allow those who achieve the competencies to finish training more quickly. Competency-based training will also provide greater possibilities for flexible training posts by allowing trainees to take family or other leave, outside of the currently very rigid six-month scheduled blocks, without losing credit for training time. Refer to standard 3 for further discussion of issues relating to the structure of the curriculum including flexible training.

As discussed previously, Paediatric Surgery was the first of all Specialty Training Boards to invite a community representative on to its Board. This has been very positive, providing a unique and useful external perspective for discussion and decision making for the Board. The Board is commended for its commitment to the ongoing presence of a community member on the Board. To build on this success, and leadership within the broader College, the Board is encouraged to develop a more formal process for selection and ongoing support and training for this role. Ideally, this will be done in conjunction with the College who should be developing College-wide resources and support for representation by consumers and community. While individual consumer representation is very useful, the Board is also encouraged to consider structured mechanisms for collecting feedback from a broader group of external stakeholders. The Board's initial outreach to the Cystic Fibrosis and Pull-Thru Network organisations is a commendable start and should be continued and expanded to include other health consumer groups, in order to gain a better understanding of community views and expectations of the Paediatric Surgery training program. Refer to standards 2 and 6 for further discussion of this issue.

Paediatric Surgery in 2021

The Paediatric Surgery SET program is administered in collaboration with the Australian and New Zealand Association of Paediatric Surgeons. The Board of Paediatric Surgery has oversight of the SET program, reporting to the Board of Surgical Education and Training within the College.

Paediatric Surgery is the ninth largest speciality in the College with 127 fellows, 30 trainees and 3 SIMGs in 2020.

The relationship between the College and the Board of Paediatric Surgery is close due to the small size of the specialty training program. The internal regulations governing the training program are written in line with the College processes, and therefore act as an extension of their work.

A trainee successfully completing the SET program in Paediatric Surgery will have demonstrated proficiency in the surgical competencies outlined by RACS. The SET Program in Paediatric Surgery is designed to provide trainees with clinical and operative experience to enable them to manage children with conditions that relate to the specialty, including becoming familiar with the techniques related to the discipline.

At the conclusion of the SET Program, it is expected that trainees will have a detailed knowledge of surgery of those conditions recognised as belonging to the specialty of Paediatric Surgery and a less detailed knowledge of the surgery of those conditions recognised as belonging to super-specialist areas within Paediatric Surgery. This should include knowledge of the embryology, anatomy, physiology and pathology related to the discipline of these conditions. Due to the often independent nature of the work, it is necessary that the trainees exhibit a high standard of competence at the end of their training and are equipped for independent practice.

Paediatric surgery does not yet have a clear graduate outcomes statement, but would likely be able to develop one quite easily from their detailed competency-based curriculum. The Board is encouraged to make these graduate outcomes publicly available in line with the AMC condition on accreditation.

The RACS Board of Paediatric Surgery has a competency-based curriculum. The curriculum is split into three stages; Early SET, Mid SET and Senior SET. The duration of training is expected to be a minimum of 6 years and a maximum of 11 years. Although the Board does not accept applications for recognition of prior learning, it was the impression of the team that trainees who had completed multiple unaccredited years did tend to progress more quickly through the earlier stages of training.

There are four examinations to be completed during training; including the SET Clinical Examination, the Paediatric Anatomy & Embryology Examination, the Paediatric Pathophysiology Examination and the Paediatric Fellowship Examination. The SET Clinical Examination is required to be completed by the end of the first two years of SET training, the Paediatric Anatomy & Embryology Examination is to be completed any time in Early SET, the Paediatric Pathophysiology Examination must be completed no later than the second year of Mid SET. The decision to move the Anatomy & Embryology and Pathophysiology examinations earlier in training appears well received. The experience of trainees was that splitting the exams meant that important knowledge was established earlier in their training, allowing them the opportunity to apply the knowledge clinically, whilst also better spreading the total examination workload over the course of training.

A variety of workplace-based and non-workplace based assessments are also completed as part of training, these include: Measure of Understanding and Surgical Expertise (MOUSE), Mini Clinical Evaluation (Mini-CEX), mandatory presentations, Critical Appraisal Tasks (CATs), Directed Online Group Studies (DOGS and two 360 Degree Evaluation Surveys in Early SET and as directed by the Board.

In terms of unsatisfactory performance, Early SET One Trainees who have two unsatisfactory rotations will be dismissed from the program. In all other SET levels, the trainee will be considered for dismissal if their performance is rated as unsatisfactory in two or more rotations.

The process of selection incorporates a points-based CV, referee reports and an interview panel. Across the College, candidates uniformly score well on the referee reports. A method currently being used by the Board of Paediatric Surgery is to use a more detailed form which aims to better distinguish applicants. The interview process involves four panels; each panel generates a score

for the attributes being assessed, as well as a communication score. The communication scores of each panel are averaged to provide a fifth component that contributes to the overall assessment score.

Confidential feedback is an ongoing challenge for Paediatric Surgery due to the small number of training posts resulting in feedback being generally identifiable. The Board also recognises that the small number of consultants makes it common for a clinical supervisor to also be involved in exam assessment. This situation may give rise to the perception by trainees that their training or career may be adversely affected by providing negative feedback, despite assurance from the Board that this would not be the case. The RACSTA rolling anonymous survey is therefore important in overcoming this obstacle.

Plastic and Reconstructive Surgery in 2017

The SET program in Plastic and Reconstructive Surgery is administered and overseen in Australia by the Australian Society of Plastic Surgeons Inc. (ASPS) and in New Zealand by the New Zealand Association of Plastic Surgeons (NZAPS). As per the service agreements between the ASPS and RACS and NZAPS and RACS, the Societies respectively provide administrative support to the RACS Australian Board of Plastic and Reconstructive Surgery and the RACS New Zealand Board of Plastic and Reconstructive Surgery. Both specialty boards report to the Board of Surgical Education and Training.

Plastic and Reconstructive Surgery is defined as a wide-ranging specialty involving manipulation, repair and reconstruction of the skin, soft tissue and bone. Plastic Surgery is a specialty not restricted to one organ or tissue type. The main emphasis is on maintaining or restoring form and function, often working in a team approach with other specialties.

As of 2016, there were 96 trainees (80 in Australia, 15 in New Zealand, and one from overseas) in Plastic and Reconstructive Surgery training.

Plastic and Reconstructive Surgery trainees who begin training at SET 1 are expected to complete five years of training. Each year of training is divided into two surgical terms. Trainees must complete a minimum of ten rotations (each of six months full-time equivalent clinical training time). Trainees are rotated through a minimum of four training units during the program. This will often include two different jurisdictions in Australia and in New Zealand and always involves at least two cities. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings in 2017

The Australian Board of Plastic and Reconstructive Surgery and New Zealand Board of Plastic and Reconstructive Surgery Boards each report a good relationship with the College. The relationship between the Australian and New Zealand Boards is very collegial. The New Zealand Board notes that since there has been a separation between them, small irritants have been removed from the relationship.

The two Boards have the same curriculum and examinations. The Boards are in the midst of a significant curriculum review, with a proposed change to a competency-based curriculum in 2019. The examples of the new competency-based curriculum, provided to the team in draft form for facial and breast surgery, set out the expectations of trainees by SET phase (early, mid and late) to guide trainees in their learning. The revised curriculum will incorporate entrustable professional activities to foster trainees' development of an increasing degree of independence in relation to learning. Consultation on all modules will take place in 2018. The team considers it would be appropriate to review the curriculum once it is finalised (with a target set for 2019).

The current curriculum has little on cultural competence; while there are plans to incorporate content on cultural competence into the new curriculum, the team was left with the impression that this would link mainly to the communication competency rather than to all RACS competencies.

Refer to standard 3.2 for further discussion of the inclusion of cultural competence content in the curriculum.

There is currently a deficit in the experience available to trainees with regard to aesthetic surgery which is a significant part of plastic and reconstructive surgery practice, but not often available in public hospitals. Currently the training sites have difficulty providing aesthetic surgery experience for their trainees, and so those graduating from the training program will have a gap in this area of practice. This is discussed in further detail under standard 4.

The presence of post-fellowship fellows within the hospital can decrease clinical experience of other trainees. The team heard this varies from hospital to hospital.

Although the training program is five years in duration, trainees can spend many years trying to enter the program, which results in the effective lengthening of the training program. The introduction of competency-based training will help by allowing those who achieve the competencies to finish training more quickly.

The team noted that trainees have very limited opportunities for flexible training. There is no part-time training available and there is a limited number of trainees in interrupted training, with restrictive rules for interrupted training similar to the other specialties. The team notes that while the Boards are working to remove some of the barriers to flexible training, further work is needed. Refer to standard 3 for further discussion of issues relating to the structure of the curriculum including flexible training.

The Australian and New Zealand Boards are enthusiastic about the BRIPS program, and consider it has made a difference, especially in regional areas. The Boards consider that the cultural change is occurring, but needs to continue, as not all fellows have insight into their behaviour. The team heard that accreditation of training posts has been withdrawn due to issues of bullying and harassment, which is to be commended. The team noted the need for protection for 'whistle-blowers'. Refer to standard 7.5 for further discussion.

The team heard that trainees often work a one in two on-call roster, with fatigue a potential issue. The Boards reported that while rest periods are organised, they may be somewhat ad-hoc and are usually employer driven. Refer to standard 8.2 for further discussion.

Plastic and Reconstructive Surgery in 2021

Plastic and Reconstructive Surgery is the fourth largest specialty in the College and is managed by two Boards – the Australian Board of Plastic and Reconstructive Surgery and the New Zealand Board of Plastic and Reconstructive Surgery. There are 555 fellows, 105 trainees and 13 SIMGs in Australia and New Zealand in 2020. Plastic and Reconstructive Surgery is regarded as a well organised specialty with a clear sense of direction and clearly identified capacity to adapt to the needs of trainees, supervisors and stakeholders, and is to be commended. There is a strong level of community engagement demonstrated and a willingness to further enhance this partnership for the benefit of all stakeholders.

Both the Australian Board of Plastic and Reconstructive Surgery and the New Zealand Board of Plastic and Reconstructive Surgery reports regular interaction with the College and being consulted on College matters, including providing feedback on the monitoring and evaluation framework. There is a community representative on the Australian Board of Plastic and Reconstructive Surgery in Australia and trainee representatives are an essential partner for the Board to provide a valuable pathway to ensuring matters arising and opportunities for improvement are escalated and explored in an appropriate way. Report back mechanisms are also strong and reflective of trainee expectations.

The development of a new competency-based curriculum is well underway by the Australian Board of Plastic and Reconstructive Surgery reflects the commitment of the specialty training board towards continuous improvement. The tenth RACS competency, Cultural Safety and Cultural Competence, is planned to be included as part of the review. Program and graduate

outcomes are to be clearly defined and aligned to the ten competencies with graduate outcomes made available publicly and easily identified as such. The Board has indicated the aesthetic component in the curriculum has been clarified and specific work was undertaken to improve reporting of aesthetic training where there was a perceived to be a lack. Actions undertaken include surveying exposure to aesthetic procedures during rotations, having aesthetic topics in meetings and conferences and continuing to assess aesthetic topics.

The new curriculum will commence in 2022 in Australia with existing trainees migrating over to this program in 2023. The old curriculum will cease to be utilised in the training program. This process is clearly defined and understood by stakeholders. An electronic tool to enhance approaches to training and will also utilise e-portfolio to ensure consistency for trainees is being developed.

The New Zealand Board of Plastic and Reconstructive Surgery ratified their new curriculum in 2019 with expected program and graduate outcomes and related required competencies to be attained.

Flexible training options have been offered for many years now and the specialty training board continues to support efforts to reduce barriers to applying or completing the training program. The opportunity to request a flexible post is highly regarded by trainees, though no trainees in New Zealand were reported to have undertaken flexible training. This specialty has a low rate of attrition during training and the trainee feedback was positive in relation to all elements of the program.

During COVID-19 restrictions, the team heard the Boards actively supported trainees with challenges in relation to completing program requirements out of their control. In particular, the Australian Board of Plastic and Reconstructive Surgery supported trainees in both general plastic surgery and in aesthetic surgery during the pandemic by considering extensions to training time for trainees who perceived there was a lack of training opportunities. Individual posts were created, especially when there was a need to move elective cases into the private sector. One trainee was actively supported to transition to a new provider, who was subsequently accredited, to ensure all avenues of assistance were provided. All other trainees were able to meet program requirements during this time.

Trainees were assessed through various methods including workplace-based assessments and mandatory courses for completion. Trainees felt that the Fellowship exam was fair and that the selection process and communication mechanisms in place throughout their initial engagement and participation was clear and transparent.

The work to support Aboriginal and Torres Strait Islander applicants has been in place for approximately three years. Although there have not been any applications to this program, the College retains the option to directly select Aboriginal and Torres Strait Islander applicants into the training program. This has also informed an approach to engaging directly with potential applicants early in training with the view to supporting selection in the specialty.

In Australia, there is a strong commitment to attracting and retaining rural trainees and this is reflected in selection practices. There is an understanding of the needs of rural and regional trainees and their communities, which informs an authentic and sustainable approach to workforce development.

As with all surgical specialty training programs and raised by the team in Standard 7, there is an opportunity for the consideration of fees in relation to other Colleges and specialty training programs.

There is a robust process in place to encourage confidential and safe feedback. Due to the limited size of the cohort, this can be challenging but the specialty training board maintains a flexible approach to gathering information in innovative ways. This has been well received by trainees and supervisors.

Opportunities for further improvement may arise from the development of the draft RACS Monitoring and Evaluation (M&E) Framework, however, it is noted that the specialty training board has systems in place that would see them well prepared for any changes.

Urology in 2017

The new Surgical Education and Training (nSET) program in Urology is administered by the Urological Society of Australia and New Zealand (USANZ). The College collaborates with the USANZ, as an agent of RACS, to administer the program. The Board of Urology has oversight for the conduct of the training program in Australia and New Zealand, reporting to the Board of Surgical Education and Training.

Urology is defined as the medical specialty dedicated to the treatment of men, women and children with problems involving the kidney, bladder, prostate and male reproductive organs. These conditions include cancer, stones, infection, incontinence, sexual dysfunction and pelvic floor problems. Urologists prescribe and administer medications and perform surgical procedures in the treatment of disease or injury.

As of 2016, there were 104 trainees (92 in Australia and 12 in New Zealand) in Urology training.

The nSET program in Urology commenced in 2016 replacing the previous six-year program. The nSET program is structured over a five-year sequential curriculum. The five stages are as follows: nSET 1 (core surgery general skills), nSET 2 (first year advanced clinical urology training); nSET 3 (second year advanced training); nSET 4 (third year advanced training); nSET 5 (senior registrar level). Trainees must complete five 12-month rotations. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings in 2017

Urology has very capable leadership and has produced comprehensive documentation as part of this AMC accreditation. The Board of Urology appears to be acutely aware of possible directions for improvement and strives to select the best trainees and deliver a high-quality training program. The Board successfully interacts with other surgical specialties and notably has flagged the Orthopaeadic Surgery curriculum as a framework on which to further develop its own curriculum.

The Board acknowledges the need for curriculum development and, in particular, the need to better define program and graduate outcomes. As in all specialties, the former is more difficult because of varying rotations of the trainees: that is, one trainee may be exposed to a strong cancer centre in SET 2 and another might not get that rotation until later in training. However, urgently required is a more detailed and accurate definition of the scope of practice of an urologist on the day he/she is awarded fellowship. This will not only be of assistance to hospital credentialing bodies but will also more precisely guiding both training and assessments. A timetable for this curriculum development is required as it appears to be currently somewhat 'open-ended'.

The Board of Urology is very aware of the critical importance of trainee selection and the inappropriateness of research being a key discriminator. The Board appears keen to explore avenues to ensure those trainees that are selected have all the necessary aptitudes for a career in Urology – both technical and professional.

There is wide recognition within the specialty that selection of trainees with the necessary attributes is critical to delivering the best urological care to the community. All disciplines within the College and all specialist medical colleges struggle to translate performance in the workplace prior to selection into the selection process. The difficulty can largely be attributed to non-discriminating referee reports – almost always scored to a high level and seemingly regardless of what wording is used in the assessments. The Board is encouraged to look at collective referee reports from the place of work, coordinated by the local urologists as a collective but considering feedback from multiple sources including other junior colleagues and non-medical staff. Imperative in such a 'global assessment' would be an appraisal of inherent technical ability. Refer to standard 7.1 for further discussion of this issue.

The team considers that there is a need to increase the 'efficiency' of training so that the current high standard of the graduating surgeon can be accomplished within safe working hours. This must occur without prolonging either training or prevocational training. Feedback from Urology training supervisors highlighted the conflict that often arises between clinical service demands and training. The Board of Urology should look at strategies to ensure that training is achieving the correct priority in the workplace and that supervisors are not conflicted such that clinical service delivery receives an emphasis that compromises training. Refer to standard 3 for further discussion of this issue.

Urology currently uses multi-source feedback (MSF) only for the trainee in difficulty. There is a perception that wider use would produce an excessive load on the training supervisors. As there is mostly only 1-3 trainees for each training supervisor, the team considers that MSF assessment is logistically plausible as a regular routine training assessment (e.g. annually) and would provide valuable early feedback to the trainee regarding their broader 'professional qualities' and how they are perceived by both colleagues and other health professionals with whom they interact. Refer to standard 5.3 for further discussion of this issue.

The assessment processes are particularly well developed, again with strong leadership from the Chair of Examiners and a dedicated pool of Urology examiners for the Specialty Surgical Sciences Examination and Fellowship Examination. Parts of the Fellowship Examination were observed by the team and were conducted to a very high standard.

The structure of the program appears inherently fair to trainees with respect to being able to train mostly within a single region and rotations are general 12-monthly within that region. Handover takes place between supervisors of training within each region as trainees rotate across the training sites.

Urology in 2021

The College collaborates with The Urological Society of Australia and New Zealand (USANZ) to administer the Surgical Education and Training (SET) program. Urology is the fifth largest specialty in the College with 552 fellows, 103 trainees and 3 SIMGs in Australia and New Zealand in 2020. The Board of Urology has oversight for the conduct of the SET training program in Urology.

The Urology specialty training boards, as part of the curriculum development process, undertook a broad consultation process including external review by community organisations, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Royal Australian and New Zealand College of Radiologists (RANZCR) and the College of Intensive Care Medicine of Australia and New Zealand (CICM). The consultation has identified useful opportunities to engage with other organisations to deliver reciprocal teaching and learning. The specialty training boards in Urology also circulated the curriculum to supervisors for confidential feedback this year and has plans to undertake annual confidential surveys (augmented by face-to-face discussions) to be distributed at the end of the clinical training year.

Trainee feedback on training sites is mediated via the trainee representatives on Regional Training Boards and assessed over two years to improve anonymity. This is a worthwhile attempt to preserve anonymity in giving this important feedback. There is not currently a process for New Fellows (e.g. within the first 5 years of training) to reflect back on the strengths and weaknesses in their training and whether it prepared them for appropriately for consultant practice in Urology.

Urology introduced a revised competency-based curriculum in 2020. The revised curriculum has clearly defined learning outcomes linked to three stages of training. A teaching and learning strategy is under development and will be mapped to the sections of the curriculum. The specialty training board in Urology has established provisions for recognition of prior learning that determine the trainees' level of training at entry.

The SET program in Urology is designed to provide trainees with clinical and operative experience in order to learn special methods of investigation and become competent in techniques related to the discipline. At the conclusion of the SET program it is expected that trainees will be able to perform as independent practitioners, meeting the requirements of all identified RACS competencies. A publicly-available graduate outcome statement is required and would be relatively easily generated from the competency-based curriculum.

The Urology curriculum has embedded the RACS tenth competency - Cultural Safety and Cultural Competence. The team was informed that the RACS cultural competency (Australia) module was not yet mandated for trainees. The team considers this to be mandatory in light of the tenth RACS professional competency.

Flexible training is supported. Three trainees undertook training in less than full-time capacities in 2019 and two trainees are undertaking flexible training in 2020 by job-sharing one training post for the duration of the year.

The specialty training boards in Urology planned to trial new WBAs in the second half of 2020, with delays occurring due to COVID-19. The board expects to further refine and implement the WBA as a component of entrustable professional activities (EPAs). It also plans to incorporate routine use of multi-sourced feedback (MSF) for EPAs, which will occur at different stages of the training programs. The Specialty Specific Surgical Sciences Examination was sat by 27 trainees of which 25 (93%) passed. In 2019, 30 urology trainees sat the Fellowship Examination, of which 21 (70%) passed.

The reference requirement for selection into Urology training require the referee to select from an array of descriptors, rather than simple scoring. This has reduced the incidence of "all 100%" referee reports and increases the validity of this component of selection. The specialty training boards in Urology do not currently award selection points for indices of rurality. There is a sound evidence base from other disciplines as to what factors make future practice in a rural centre more likely and this evidence should inform future selection strategy in this area.

The team heard attempts have been made to encourage Aboriginal and Torres Islander & Māori trainees into training posts, however, the process was unclear and appeared to be largely unsuccessful. In 2019, there were exactly 100 urology trainees, of which 20 were female. There were 66 applicants to the training program (up from 63 in 2018) of which 19 (28.8%) were female.

There has not been sufficient research in the prevocational and final year medical student space to determine why there is a preponderance of male applicants for training in urology. Blinding of CVs and ensuring that there is female representation on selection panels are both commendable but the low applicant proportion of females requires further exploration.

Vascular Surgery in 2017

The College collaborates with the Australian and New Zealand Society for Vascular Surgery (ANZSVS), as an agent of RACS, to administer the SET program in Vascular Surgery. The Board of Vascular Surgery has oversight for the conduct of the training program in Vascular Surgery, reporting to the Board of Surgical Education and Training.

Vascular Surgery is defined as a specialty of surgery in which diseases of the vascular system, or arteries and veins, are managed by medical therapy, minimally-invasive catheter procedures and surgical intervention and reconstruction.

As of 2016, there were 46 trainees (41 in Australia and 5 in New Zealand) in Vascular Surgery training.

The program in Vascular Surgery is structured over a five-year sequential curriculum in posts accredited by the Board of Vascular Surgery. Trainees must complete 10 six-month rotations at different accredited training posts. Trainees are allocated to a single training post for two concurrent six-month rotations, and may not be placed at the same training post during SET 2-5.

The training program is bi-national and trainees are expected to spend at least one year in an interstate or overseas post. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings in 2017

The Board of Vascular Surgery reported to the team that it has a close working relationship with the College through structured information processes and the existence of appropriate supporting committees. However, an area of concern to the Board is the lead time given to implement decisions made by College and the Education Board. As discussed under standard 1, greater time to enact the changes was requested by the Board of Vascular Surgery.

The Board of Vascular Surgery conducted a review of the program in 2015, and the revised regulations included: management of underperforming trainees; role of the Board in rating of assessments; role of supervisors; and review of required rotations of each trainee. The Board reported that the regulations are now reviewed annually.

Trainees reported satisfaction and pride in being in the Vascular Surgery training program.

The current curriculum sets out the expectation of trainees by SET year and is in sufficient detail to guide training. Assessments seem appropriate with examinations and workplace-based assessments (WBAs) spaced at regular intervals. If underperformance of a trainee is identified, the frequency of WBAs is increased. Non-technical skills assessments are included in the WBA. There are a number of vascular-specific online modules available and used by trainees. There is an acknowledgement that some are in need of updating and this process has commenced.

The Board of Vascular Surgery reviews trainees regularly to ensure that exposure and experience matches the expected outcomes. Learning plans may be altered to ensure achievement of required competencies. There has been progress on moving towards a competency-based model of education and assessment.

The teaching of cultural competence is considered appropriate in New Zealand however there is a need for greater emphasis in Australia. As discussed under standard 3, the Board must appropriately address cultural competence in the curriculum.

The Board takes the BRIPS initiative seriously and supports the RACS process. The Board expressed some concerns about the lack of follow-up when issues of discrimination, bullying and sexual harassment are passed on to the College according to process. Information from the College to the Board was felt to be slow and incomplete. It is unclear if this is related to confidentiality issues and further clarity on the role of the Board versus the College would be appreciated. Of note, Vascular Surgery has removed accreditation from a training site/position where there were complaints of bullying indicating they take the issues seriously and this is commended by the team.

In relation to training sites and posts, the team was informed that, at some sites, trainees are required to be on-call one week in two, and it is therefore considered that fatigue is an issue in some locations. The team recommends that the Board monitor this issue through its accreditation processes. Refer to standard 8.2 for further discussion.

As discussed under standard 9, the disagreement between the ANZSVS and the College on the Society's proposal to mandate its audit tool as the only acceptable practice assessment system was reported to the team. Although the College identifies the Society's tool as excellent, its position is that there are other acceptable tools. This has been discussed repeatedly between parties and has yet to be resolved. This should be addressed as it is a significant point of discord in an otherwise well-functioning specialty. Refer to standard 9.1 for further discussion of this issue.

There is a mechanism for assessing and evaluating specialist international medical graduates which can successfully lead to fellowship. The processes were cited as time consuming but reaching an appropriate conclusion. The Board reported that it is supportive of the recent improvements in the College's International Medical Graduate department. Refer to standard 10 for further discussion.

Vascular Surgery in 2021

Vascular Surgery is the seventh largest speciality in the College with 239 fellows, 48 trainees and 6 SIMGs in Australia and New Zealand in 2020. The Board of Vascular Surgery reports a positive relationship with the College and has a stable membership. There are two female members on the Board of Vascular Surgery, and a community representative has recently been appointed. The specialty training board has a specific SIMG position and indicated that fellows who are female, SIMGs and young fellows are being encouraged to join as members of the Board.

In 2020, the specialty training board undertook a curriculum review. The pending implementation of a curriculum, mapped to the ten RACS surgical competencies and clear articulation of expected competencies for each stage of training is to be commended. The specialty training board is confident that the renewed curriculum will facilitate training to ensure non-technical skills and to develop a workforce to meet the needs of the entire community. Flexible training is supported with one flexible training post accredited for the specialty. New fellows rate the quality of training highly and feel well prepared for independent practice.

The specialty training board have considered the urgent needs to improve rural vascular care and anticipates further changes to the curriculum to embed the RACS professional skills curriculum once it is finalised. The specialty training board plans to make a graduate outcome statement publicly available.

Trainees participate in fortnightly online training which specifically addresses the non-technical competencies including the tenth competency. Cultural safety and cultural competency will be an integral aspect of the revised curriculum and is included as part of professional behaviours in the current curriculum. The finalisation and implementation of the revised curriculum should be aligned to relevant assessment for both clinical and non-technical skills.

The Board of Vascular Surgery interviews every trainee at the annual skills course to seek confidential feedback on all aspects of their surgical training. This process involves a 15 minute conversation with the chair of the Board and an additional Board member.

The Board of Vascular Surgery publishes the CV scoring guide prior to application to provide guidance on scoring. CVs are not able to be blinded in the scoring process, as each section of the CV required candidates to verify information which would include their identity (e.g. publications, presentations, certificates of attendance). The speciality training board has had equal gender representation on the interview board for the last five years.

Selection processes give points for previous cultural competency training, rural origin, rural work and work within Indigenous communities. The selection process includes a minimum entry pathway for Aboriginal and Torres Strait Islander trainees with a similar pathway being considered for Māori Trainees. Approximately 20-25% of each years' trainee intake is female.

The specialty training board has demonstrated commitment to gender representation on the Board, interview panels, and trainee selection, along with other diversity and inclusion initiatives.

Appendix One Membership of the 2017 AMC Assessment Team

Professor Chris Baggoley AO (Chair) BVSc (Hons), BMBS, B Soc Admin, FACEM, FRACMA
Professorial Fellow, School of Medicine, Faculty of Health Sciences, Flinders University. Adjunct Professor, Department of Medicine, University of Adelaide

Professor Phillippa Poole (Deputy Chair) BSc, MBChB, MD, FRACP
Head, Department of Medicine, Faculty of Medical and Health Sciences, University of Auckland

Ms Susan Biggar BA, MA
National Engagement Adviser, Health Practitioner Regulation Agency

Dr Kenneth Harris MD, FRCSC
Deputy CEO, Executive Director, Office of Specialty Education, Royal College of Physicians and Surgeons of Canada (via teleconference from Ottawa)

Dr Tammy Kimpton BMed, FRACGP.
General Practitioner, Scone Medical Practice. Former President, Australian Indigenous Doctors' Association

Adjunct Professor Linda Mellors PhD (Med), BA, BSc (Hons), GradCert (HlthSrvMgt), GAICD, WCLP
Chief Executive, Health Services, Mercy Health

Professor Michael Permezel MBBS, MRCP, MRACOG, MRCOG, FRACOG, MD, FRCOG
Professor, Department of Obstetrics and Gynaecology, Mercy Hospital for Women, Austin and Repatriation Medical Centre, University of Melbourne

Dr Jonathan Sen MBBS, BHSc (Hons)
General Medical Registrar, Austin Health and Northern Health

Dr Leona Wilson ONZM BMedSc, MB ChB, MPH, FRCA, FANZCA, FAICD
Specialist Anaesthetist, Wellington Hospital

Ms Jane Porter
Manager, Specialist Training and Program Assessment, Australian Medical Council

Appendix Two Membership of the 2021 AMC Assessment Team

Professor Phillippa Poole (Chair) BSc, MBChB, MD, FRACP, FANZAHPE
Head, School of Medicine, Faculty of Medical and Health Sciences, University of Auckland and General Physician, Auckland City Hospital

Professor Chris Baggoley AO BVSc (Hons), BMBS, B Soc Admin, DUniv, FACEM, FIFEM, FRACMA, FAAHMS
Medical Practitioner, Professorial Fellow, School of Medicine, Faculty of Health Sciences, Flinders University & Adjunct Professor, Department of Medicine, University of Adelaide Qualifications and Former Chief Medical Officer, Australian Government Department of Health.

Ms Robyn Burley BA, MA (Education and Psychology)
Executive General Manager, Education, Learning and Assessment, Royal Australasian College of Physicians

Dr Jessica Dean MBBS (Hons), BMedSci (Hons), LLB
ICU Registrar, St Vincent's Hospital Melbourne and Director, Beyond Blue

Dr Tammy Kimpton BMed, FRACGP, MAVMED
General Practitioner, Scone Medical Practice

Ms Kellie O'Callaghan BA, GDipMtlHlthSc, GAICD
Principal Consultant, O'Callaghan + Co

Emeritus Professor Michael Permezel AO MBBS, MRCP, MRACOG, MRCOG, FRACOG, MD, FRCOG
Dean of Education, Royal Australian and New Zealand College Obstetricians and Gynaecologists

Dr Leona Wilson ONZM BMedSc, MB ChB, MPH, FRCA, FANZCA, FAICD
Specialist Anaesthetist, Wellington Hospital and Executive Director of Professional Affairs, Australian and New Zealand College of Anaesthetists

Ms Juliana Simon
Manager, Specialist Medical Program Assessment, Australian Medical Council

Appendix Three List of Submissions on the Programs of RACS in 2017 and 2021

2017

Australian and New Zealand College of Anaesthetists
Australian and New Zealand Gastric and Oesophageal Surgery Association
Australian and New Zealand Society for Vascular Surgery
Australian Commission on Safety and Quality in Health Care
Australian Medical Association
Australian Orthopaedic Association
Australian Private Hospitals Association
Australian Society of Plastic Surgeons
Department of Health, Western Australia
General Surgeons Australia
Health Complaints Commissioner, TAS
Health Consumers Alliance of SA
Health Quality & Safety Commission New Zealand
Health Workforce Principal Committee
Healthcare Consumers Association of the ACT
Leaders in Indigenous Medical Educators (LIME)
Ministry of Health and Health Workforce New Zealand
New Zealand Association of General Surgeons
New Zealand Association of Plastic Surgeons
New Zealand Medical Association
New Zealand Orthopaedic Association
New Zealand Private Surgical Hospitals Association
NSW Ministry of Health
Office of the Health Ombudsman, QLD
Queensland Health
Royal Australasian College of Physicians
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian and New Zealand College of Psychiatrists
Royal College of Pathologists of Australasia
South Australia Health
South Australian Medical Education & Training
The University of New South Wales, Faculty of Medicine
The University of Newcastle / University of New England, Joint Medical Program
The University of Queensland, School of Medicine
The University of Western Australia, Faculty of Medicine, Dentistry and Health Sciences
University of Notre Dame Australia, School of Medicine Fremantle
University of Otago, Faculty of Medicine
University of Wollongong, Graduate School of Medicine
Urological Society of Australia and New Zealand

2021

ACT Health Directorate
Australian and New Zealand Society for Vascular Surgery
Australian Medical Association
Australian Orthopaedic Association
Australian Salaried Medical Officers' Federation
Australian Society of Otolaryngology Head and Neck Surgery
Australian Society of Plastic Surgeons
Bond University
Department of Health Victoria
General Surgeons Australia
Health Issues Centre
Health Quality and Safety Commission New Zealand
Leaders in Indigenous Medical Education Network
Postgraduate Medical Council of Western Australia
Queensland Department of Health
The Royal Australian College of General Practitioners
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal New Zealand College of Urgent Care
SA Health
The Royal Australian and New Zealand College of Psychiatrists
The University of Queensland
The University of Sydney
University of Adelaide
Urological Society of Australia and New Zealand
WA Department of Health

Appendix Four Summary of the 2017AMC Team's Accreditation Program

Location	Meeting
SYDNEY, NEW SOUTH WALES	
Monday, 27 March 2017 – Dr Tammy Kimpton, Ms Susan Biggar, Ms Juliana Simon (AMC Staff)	
NSW Ministry of Health	Health Department Representatives
Royal North Shore Hospital	Senior hospital executives
	Trainees
	Members of Surgical Team
RACS NSW Regional Office via teleconference	Trainees from John Hunter Hospital
	Supervisors from John Hunter Hospital
	NSW State Committee
Tuesday, 28 March 2017 – Dr Tammy Kimpton, Ms Susan Biggar	
Liverpool Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Representatives of Related Health Disciplines
Bankstown-Lidcombe Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
BRISBANE, QUEENSLAND	
Tuesday, 28 March 2017 – Adjunct Professor Linda Mellors, Dr Kenneth Harris, Associate Professor David Hewett, Ms Karen Rocca (AMC Staff)	
Queensland Regional Office	Health Department Representatives
Queensland Health	Health Department Representatives
Princess Alexandra Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Members of Surgical Team
Wednesday, 29 March 2017 – Adjunct Professor Linda Mellors, Dr Kenneth Harris, Associate Professor David Hewett	
Queensland Regional Office via teleconference	Trainees from Gold Coast Hospital
	Supervisors from Gold Coast University Hospital
Greenslopes Private Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees

Location	Meeting
AUCKLAND, NEW ZEALAND	
Wednesday, 29 March 2017 – Professor Phillippa Poole, Dr Leona Wilson, Mr Philip Pigou (MCNZ CEO)	
Middlemore Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Members of Surgical Team
	Representatives of Related Health Disciplines
	New Zealand National Board
	Teleconference with International Medical Graduates, New Zealand
Thursday, 30 March 2017 – Professor Phillippa Poole, Dr Leona Wilson, Mr Philip Pigou (MCNZ CEO)	
Middlemore Hospital via teleconference	Ministry of Health and Health Workforce New Zealand
	Trainees from Dunedin Hospital
	Supervisors from Dunedin Hospital
	GS and OHNS Training Board New Zealand Subcommittee Chairs
	Trainees from Christchurch Hospital
	Supervisors from Christchurch Hospital
MELBOURNE, VICTORIA	
Thursday, 30 March 2017 – Professor Michael Permezel, Dr Kenneth Harris, Ms Jane Porter (AMC Staff)	
St Vincent's Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Members of Surgical Team
Royal Children's Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
Friday, 31 March 2017 – Professor Michael Permezel, Dr Kenneth Harris	
RACS Victorian Regional Office	Victorian Regional Committee
Department of Health, Victoria	Health Department Representatives
Frankston Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Representatives of Related Health Disciplines

Location	Meeting
ADELAIDE, SOUTH AUSTRALIA	
Monday, 8 May 2017 – Professor Chris Baggoley, Dr Jonathan Sen, Dr Kenneth Harris	
South Australia Health Department	Health Department Representatives
Royal Adelaide Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Representatives of Related Health Disciplines
	Members of Surgical Team
	Teleconference with Alice Springs Hospital Trainees
Tuesday, 9 May 2017 – Professor Chris Baggoley, Dr Jonathan Sen	
RACS South Australian Regional Office via teleconference	Specialist International Medical Graduates, Australia
	Trainees from Bunbury Regional Hospital, Alice Springs Hospital, Calvary Hospital, Royal Hobart Hospital
	Supervisors from Bunbury Regional Hospital, Alice Springs Hospital, Calvary Hospital, Royal Hobart Hospital
RACS Annual Scientific Congress, Adelaide Convention	South Australia Regional Committee
	Australian and New Zealand Society for Vascular Surgery

Team meetings with Royal Australasian College of Surgeon's Committees and Staff

Monday, 3 April – Wednesday, 5 April 2017

Professor Chris Baggoley AO, Professor Phillippa Poole, Ms Susan Biggar, Dr Kenneth Harris, Dr Tammy Kimpton, Adjunct Professor Linda Mellors, Professor Michael Permezel, Dr Jonathan Sen, Dr Leona Wilson, Ms Jane Porter (AMC staff), Ms Juliana Simon (AMC Staff)

Meeting	Attendees
Monday, 3 April 2017	
Standard 1: Context of training and education Standard 2: Outcomes of specialist training and education	President Chair Professional Development Standards Board Treasurer Vice President Chair, Expert Advisory Group Censor-in-chief/ Chair, Education Board NZ Censor Chair, BSET Member, BSET Acting CEO Director, Education Development and Assessment Director, Education and Training Administration

Meeting	Attendees
	Dean of Education Manager, Complaints Resolution Director, Relationships & Advocacy
Standard 3: The specialist medical training and education framework (curriculum) Standard 5: Assessment of learning	Censor-in-chief/ Chair, Education Board Chair, BSET Chair, Board of Paediatric Surgery Chair, Board of General Surgery Chair, Australian Board of Plastic and Reconstructive Surgery Chair, Board of Urology Chair, Board of Vascular Surgery Chair, AOAFTC Dean of Education Director, Education Development and Assessment Director, Education and Training Administration Manager, Education Development and Research
Tuesday, 4 April 2017	
Board of Paediatric Surgery	Chair, Board of Paediatric Surgery Members
Board of General Surgery	Chair, Board of General Surgery Members Director, Education and Training, GSA
AUS and NZ Boards of Plastic and Reconstructive Surgery	Chair, Australian Board of Plastic and Reconstructive Surgery New Zealand Chair, Board of Plastic and Reconstructive Surgery Members Education and Training Manager, ASPS Training and Membership Service Coordinator, NZAPS
Board of Cardiothoracic Surgery	Chair, Board of Cardiothoracic Surgery Members
Board of Neurosurgery	Chair, SET Board of Neurosurgery Members, SET Board of Neurosurgery (one member via teleconference) Trainee Representative, SET Board of Neurosurgery Chief Executive Officer, NSA
Board of Urology	Chair, Board of Urology Training Manager, USANZ
AOA Federal Training Committee and NZ Board of Orthopaedic Surgery	Chair, AOA Federal Training Committee Member, AOAFTC Members, NZOA National Education Manager, Australia National Education Manager, New Zealand

Meeting	Attendees
Board of Otolaryngology Head and Neck Surgery	Chair, Board of Otolaryngology Head and Neck Surgery Member SET Administrator, ASOHNS
Board of Vascular Surgery	Chair, Board of Vascular Surgery Members General Manager, ANZSVS Executive Officer, ANZSVS
Standard 10: Assessment of specialist international medical graduates	Censor-in-chief/ Chair, Education Board Member, NZOA Chair, BSET Deputy Treasurer/ Deputy Chair, BSET (IMG) Chair, Board of Paediatric Surgery Chair, AOAFTC Chair, Board of Vascular Surgery Director, Education and Training Administration Manager, International Medical Graduates Clinical Director IMG Assessment
Standard 9: Continuing Professional Development	Chair, Professional Development & Standards Board Chair, Professional Development Chair, Professional Standards Post Fellowship Education and Training Committee Executive Director of Surgical Affairs (Australia) Executive Director of Surgical Affairs (New Zealand) Dean of Education Acting CEO Manager, Professional Standards
Wednesday, 5 April 2017	
Standard 5: Assessment of Training, including WBA	Chair, Court of Examiners Senior Examiner, General Surgery Specialty Representative, Cardiothoracic Exam Committee Chair, SSE and CE Committee Examiner, General Surgery Court of Examiners Senior Examiner, Urology Court of Examiners Dean of Education Director, Education Development and Assessment Manager, Examinations Department Manager, Education Development and Research
Community Representatives	Council Member (AUS) Council Member (NZ) Community Representative Expert Community Advisor

Meeting	Attendees
Standard 7: Trainees	Censor-in-chief/ Chair, Education Board Chair, Court of Examiners Post Fellowship Education and Training Committee Chair, Surgical Science and Skill Examination Committee Chair, BSET SSE and CE Committee Member Deputy Treasurer/ Deputy Chair BSET (IMG) Chair, PDSB Clinical Director, IMG Assessment Dean of Education Director, Education and Training Administration Director, Education Development and Assessment
Women in Surgery	Chair, Women in Surgery Members
Indigenous Health Committee	Chair, Indigenous Health Committee Deputy Chair, Indigenous Health Committee Indigenous Health Committee member/past-chair Manager, Fellowship Services Policy Support Officer
Standard 8.1: Supervisory and educational roles	Chair, PDSB Censor-in-chief/ Chair, Education Board Chair, Court of Examiners Post Fellowship Education and Training Committee Chair, Surgical Science and Skill Examination Committee SSE and CE Committee Member Dean of Education Director, Education and Training Administration
Younger Fellows	Younger Fellows Committee Member / Observer on Council SA, NT, NSW, QLD Representatives Deputy Chair, New Zealand
Royal Australasian College of Surgeons Trainees' Association (RACSTA)	Chair, RACSTA Training Portfolio, RACSTA Executive Support and Advocacy Portfolio, RACSTA Executive
Standard 8.2: Training sites and posts	Chair, Court of Examiners Post Fellowship Education and Training Committee Member Chair, BSET Deputy Treasurer/ Deputy Chair BSET (IMG) SSE and CE Committee Member Director, Education and Training Administration
Standard 6: Monitoring and evaluation	President Chair, PDSB

Meeting	Attendees
	Censor-in-chief/ Chair, Education Board Chair Surgical Science and Skill Examination Committee Dean of Education Director, Education Development and Assessment Manager, Education Development and Research

Team meetings with Royal Australasian College of Surgeon's Committees and Staff

Wednesday, 28 June – Thursday, 29 June 2017

Professor Chris Baggoley AO, Professor Phillippa Poole, Ms Susan Biggar, Dr Kenneth Harris (via video), Dr Tammy Kimpton, Adjunct Professor Linda Mellors, Professor Michael Permezel, Dr Jonathan Sen, Dr Leona Wilson, Ms Jane Porter (AMC staff), Ms Juliana Simon (AMC Staff)

Meeting	Attendees
Wednesday, 28 June 2017	
Meeting with New Council	President Vice President Censor-in-Chief Treasurer Chair, Professional Development and Standards Board Acting CEO Dean of Education Director, Education Development and Assessment Director, Education and Training Administration Acting Director, Fellowship and Standards Manager, Surgical Training Manager, Education Development and Research
Standard 4: Teaching and learning	Manager, Prevocational and Online Education Manager, Education Development and Research
Standard 1.5: Education Staff	Acting CEO Dean of Education Director, Education Development and Assessment Director, Education and Training Administration Acting Director, Fellowship and Standards Manager, Surgical Training
Thursday, 29 June 2017	
AMC Team prepares preliminary statement of findings	AMC Team
Team presents preliminary statement of findings	AMC Team RACS Council Senior Staff Senior Education Staff Principal Advisors to Council

Appendix Five Summary of the 2021 AMC Team's Accreditation Program

Location	Meeting
ACT, NT, SA, TAS and WA	
Tuesday 8 June 2021 – Professor Phillippa Poole, Dr Tammy Kimpton, Ms Juliana Simon (AMC Staff)	
Various training sites in ACT, NT, SA, TAS and WA (Virtual)	Directors of surgery and/or supervisors from Canberra Hospital, Royal Darwin Hospital, Royal Adelaide Hospital, Launceston General Hospital and Sir Charles Gardiner Hospital
	Surgical trainees from Canberra Hospital, Royal Darwin Hospital, Royal Adelaide Hospital, Launceston General Hospital and Sir Charles Gardiner Hospital
South Australia Regional Office (Virtual)	South Australia Regional Committee
QUEENSLAND	
Thursday, 10 June 2021 – Ms Kellie O'Callaghan, Professor Michael Permezel AO, Ms Georgie Cornelius (AMC Staff)	
Queensland State Office (Virtual)	Queensland State Committee
Various training sites in Queensland (Virtual)	Directors of surgery and/or supervisors of Gold Coast Hospital, Greenslopes Private Hospital and Townsville Hospital and Health Service
	Surgical trainees of Gold Coast Hospital, Greenslopes Private Hospital and Townsville Hospital Health Service
NEW ZEALAND	
Friday 11 June 2021 – Professor Phillippa Poole, Dr Leona Wilson ONZM	
Auckland City Hospital	Senior hospital executives of Auckland City Hospital
	Directors of surgery and/or supervisors of Auckland City Hospital
	Surgical trainees of Auckland City Hospital
	Members of surgical team/related health disciplines of Auckland City Hospital
Various training sites in New Zealand (Virtual)	Directors of surgery and/or supervisors of Dunedin Hospital, Hutt Hospital, Waikato Hospital and Wellington Regional Hospital
	Surgical trainees of Dunedin Hospital, Hutt Hospital, Waikato Hospital and Wellington Regional Hospital
NEW SOUTH WALES	
Wednesday, 16 June 2021– Ms Robyn Burley, Dr Tammy Kimpton, Ms Georgie Cornelius (AMC Staff), Ms Tahlia Christoferson (AMC Staff)	
Royal North Shore Hospital	Senior hospital executives of Royal North Shore Hospital
	Directors of surgery and/or supervisors of Royal North Shore Hospital
	Surgical trainees of Royal North Shore Hospital

New South Wales Regional Office (Virtual)	New South Wales State Committee
Various training sites in New South Wales (Virtual)	Directors of surgery and/or supervisors of John Hunter Hospital, Westmead Children's Hospital and Port Macquarie (RA2)
	Surgical trainees of John Hunter Hospital, Westmead Children's Hospital and Port Macquarie Base Hospital (RA2)
NEW ZEALAND	
Wednesday 16 June 2021 – Professor Phillippa Poole, Dr Leona Wilson ONZM	
New Zealand Office (Virtual)	New Zealand National Board
HEALTH DEPARTMENTS, CONSUMER GROUPS, SIMGs & RURAL TRAINING SITES IN AUSTRALIA	
Thursday 17 June 2021 – Professor Chris Baggoley AO, Ms Robyn Burley, Dr Jessica Dean, Ms Kellie O'Callaghan, Ms Juliana Simon (AMC Staff)	
Meeting with Health Departments in Australia (Virtual)	Health Departments in Australia
Meeting with SIMGs in Australia (Virtual)	SIMGs in Australia
Meeting with Consumer Groups in Australia (Virtual)	Consumer Groups in Australia
Rural Training Sites (Virtual)	Directors of surgery and/or supervisors from rural sites
	Surgical trainees from rural sites
MINISTRY OF HEALTH NEW ZEALAND AND SIMGs IN NEW ZEALAND	
Thursday, 17 June 2021 – Professor Phillippa Poole, Dr Leona Wilson ONZM, Ms Georgie Cornelius (AMC Staff)	
Meeting with SIMGs in New Zealand (Virtual)	Meeting with SIMGs in New Zealand
Meeting with Ministry of Health New Zealand (Virtual)	Ministry of Health New Zealand (including the Health Workforce directorate)
VICTORIA	
Friday, 18 June 2021 – Dr Jessica Dean, Professor Michael Permezel AO, Ms Juliana Simon (AMC staff), Ms Georgie Cornelius (AMC Staff)	
Austin Hospital (Virtual)	Senior hospital executives of Austin Hospital
	Directors of surgery and/or supervisors of Austin Hospital
	Surgical trainees of Austin Hospital

The Royal Children's Hospital (virtual)	Senior hospital executives of The Royal Children's Hospital
	Directors of surgery and/or supervisors of The Royal Children's Hospital
	Surgical trainees of The Royal Children's Hospital
Victoria Regional Office (virtual)	Victoria Regional Committee

Meeting with the Royal Australasian College of Surgeons Committees and College Staff

Monday, 21 June – Thursday, 24 June 2021

Professor Phillippa Poole (Chair), Professor Chris Baggoley AO, Ms Robyn Burley, Dr Jessica Dean, Dr Tammy Kimpton, Ms Kellie O'Callaghan, Emeritus Professor Michael Permezel AO, Dr Leona Wilson ONZM, Ms Juliana Simon, Ms Georgie Cornelius

Meeting	**Attendees**
Monday, 21 June 2021	
Standard 1: The context of training and education Standard 6: Monitoring and Evaluation Standard 7: Trainees	President Vice President Censor in Chief Chair, BSET SIMG Committee Chair CEO EAG Chair EGM Education EGM Fellowship Engagement
Standard 2: Outcomes of Specialist Training and Education Standard 4: Teaching and Learning Standard 6: Monitoring and Evaluation	President Vice President Censor in Chief Chair, BSET CEO EGM Education
Tuesday, 22 June 2021	
Standard 3: Specialist Medical Training and Education Framework (Curriculum) Standard 8.2: Training Sites and Posts	President Censor in Chief Chair, BSET Chair Court of Examiners CEO EGM Education
Standard 5: Assessment of Learning Standard 10: Assessment of SIMGS	Censor in Chief Chair, BSET SIMG Committee Chair Chair Court of Examiners EGM Education

Meeting	Attendees
	CEO Clinical Director SIMG Assessment & Support
Standard 6: Monitoring and Evaluation	President Vice President Chair, PSAC COO/Deputy CEO Head, Training Services
Standard 7: Trainees Standard 8: 1 Supervisory and Education Roles	President Censor in Chief Chair, BSET CEO EGM Education
Standard 9: Continuing Professional Development	Chair, PSAC Chair, Professional Standards Chair, Post Fellowship Education and Training Accreditation Panel EGM Fellowship Engagement Manager Professional Standards
Demonstration and of the functionality Eportfolio/Online Learning tools/Portal (Covers multiple standards)	Manager Online learning and Innovation) Senior Business Analyst Head Digital Services
Standard 7: Trainees (RACSTA)	Chair Deputy/Education Portfolio Training Portfolio Support and Advocacy
Indigenous Health Committee	Chair Deputy Chair Member Trainee Representative President EGM Fellowship Engagement Manager Fellowship Services Senior Project Officer
Discussion with College staff responsible for education and post/site network accreditation functions on plans, resources and challenges (Covers multiple standards)	Head Training Services Project Lead – Surgical Education and Training SET Manager Head, Training Services EGM Education
Community Representatives	Community Representatives
Women in Surgery/Diversity	Section Chair WIS PSEC

Meeting	Attendees
	Councilor Member Trainee Representative Executive Project Lead, Building Respect Chair
Younger Fellows	Chair Member Manager Fellowship Services
Wednesday, 23 June 2021	
Board of Paediatric Surgery	Chair Deputy Chair President, ANZAPS Executive Officer
Australian Board of General Surgery	Chair Deputy Chair Incoming Deputy Chair President, GSA Director – Education and Training Manager – Education and Training
New Zealand Board of General Surgery	Chair Chair, Training Committee President, NZAGS Training Manager
Board of Cardiothoracic Surgery	Chair Deputy Chair President, ANZSCTS Executive Officer
Australian Board of Plastic and Reconstructive Surgery	Chair Member SA and NT Regional Chair President, ASPS Training Manager
New Zealand Board of Plastic and Reconstructive Surgery	Chair Member President, NZAPS Training Manager Supervisor of Training Waikato Hospital
Board of Neurosurgery	Chair New Zealand Member President, NSA CEO, NSA

Meeting	Attendees
Board of Urology	Chair Chair, New Zealand Regional Training Committee President, USANZ Past President, USANZ Training Manager
AOA Federal Training Committee	Chair President Chair, Orthopaedic Women's Link CEO Training Manager
New Zealand Board of Orthopaedic Surgery	Chair CEO Training Manager
Board of Otolaryngology Head and Neck Surgery incl. New Zealand Subcommittee	Chair Chair, New Zealand Subcommittee President, ASOHNS President, NZSOHNS Training Manager
Board of Vascular Surgery	Chair Member Training Manager
Thursday, 24 June 2021	
Preparation of Preliminary Statement of Findings	AMC Team
Delivery of Preliminary Statement of Findings	CEO RACS Councillors