Royal Australasian
College of Surgeons

Building Respect, Improving Patient Safety Action Plan

Phase 1 Evaluation
Final Report

June 2019

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Executive Summary

Background

Action Plan history

In 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG) to investigate the extent of discrimination, bullying and sexual harassment within the surgical profession. EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. This raised serious concerns for the wellbeing of individual surgeons and surgical trainees, of surgical teams and especially for the quality of care and safety of patients.

RACS responded to these issues by developing an Action Plan, *Building Respect, Improving Patient Safety* (Action Plan) (Attachment 1), which outlines how RACS intends to counter and drive out unacceptable behaviours from surgical practice and surgical training.

Goals

The Action Plan describes the actions needed to address each of the EAG recommendations. It contains eight goals, arranged under the three key action areas identified by the EAG. These goals are supported by a comprehensive workplan, which has been prioritised and gradually implemented.

Context

Implementation of the Building Respect Action Plan is a highly complex challenge, involving negotiation of multiple partnerships and priorities across health jurisdictions in two countries. It has been accomplished in an environment with many contextual influences, including rapidly changing community attitudes and expectations regarding respectful behaviours, as exemplified in the #Metoo movement. Achieving the goals of the Action Plan will require significant cultural change, and some resistance is to be expected, with some groups taking longer to change their attitudes and behaviours than others.

The Phase 1 evaluation

This was the first evaluation of the Building Respect Action Plan. As such, it was primarily focussed on further development and implementation of the program, whilst also looking for very early indicators of progress towards outcomes. The scope for this evaluation covered:

- Measure whether program implementation, governance and oversight are proceeding as intended.
- Measure whether early outcomes (delivery of pathways for identifying and addressing concerns about behaviour; program reach; target audience perceptions of the Action Plan) are being achieved as intended.
- Identify program strengths, what is working well, barriers to progress.

- Make recommendations on areas for program adjustment or improvement, based on findings.

The evaluation was conducted by collecting evidence against two Key Evaluation Questions (KEQ) focussed on Action Plan implementation and governance. A number of evidence sources were used, including documents, reports, presentations, a survey of College members, and in-depth interviews with selected Fellows, Trainees and International Medical Graduates (IMGs) to explore emerging issues. The findings and draft recommendations were validated with the Project Reference Group (PRG) before being finalised in this report.

Findings

The Key Evaluation Questions (KEQ) are shown below, together with their related findings.

KEQ 1: Has the Action Plan been implemented as intended to date?

Key points

- A significant amount of work has been delivered.
- Almost all of the program elements have been delivered according to plan.
- Visible commitment by College and Council is a strength.
- Building Respect elements are reaching target audiences.
- Deep permeation of the key messages.
- Some pockets of resistance to cultural change remain.
- RACS' complaints process, like other complaints processes, is not perceived as safe.
- Trainees do not appear to be very engaged with the College.
- Very strong support for the Action Plan amongst RACS membership.
- Challenge for RACS is that respectful behaviour is a whole of healthcare issue.
- Implementation of the Action Plan is in line with societal change.

Summary

The College's swift action in response to the recommendations of the EAG, its allocation of significant resources to the Building Respect Action Plan, and its appointment of a senior position to lead the implementation have been seen by the majority of interviewees and survey respondents as a strong commitment to the Action Plan. Almost all of the Action Plan has been delivered as planned, a significant achievement, given the size of the task. Overall the Action Plan has been positively received and is very strongly supported by Fellows, Trainees and IMGs.

The College is now seen to be in step with public opinion and broader societal shifts. More than this, the College is now seen as leading the way as an institution that has acknowledged these problems and made a serious commitment to addressing them.

The right audiences are receiving Action Plan communications via multiple sources, contributing to the high level of awareness of the key messages and the majority of actions that the College has taken. Survey respondents declared that they had a strong understanding of the issue around respectful behaviours and the need to take action. The visibility of the issue has brought it out in the open, with many people describing a new and growing dialogue within the workplace, with the reach of awareness extending beyond surgery to encompass other medical disciplines.

The survey highlighted a remarkably high level of support for the College's commitment to addressing discrimination, bullying and sexual harassment in surgery, with 95% of 1346 Fellows, 96% of 244 Trainees and 93% of 62 IMGs supporting the College's commitment. Early outcomes such as perceived cultural change in the workplace and representation of women in surgical training, are making good progress. RACS is leading the way in developing a model for introduction of respectful behaviours, with other Colleges and organisations turning to the College for policy advice and education programs.

A significant and visible element of the Action Plan was the education program, including the mandatory online e-module, which has now been completed by over 98% of Fellows, Trainees and IMGs; the face to face Operating With Respect course (OWR) mandated for surgical supervisors and RACS major Committee Members; and the Foundation Skills for Surgical Educators course (FSSE), with only 3% of the mandated cohort being followed up as this report was being prepared.

Despite this success, there remains a significant cohort of members that are resistant to change and unable to adjust their communication style. Interviewees reported scepticism amongst some of their colleagues regarding the Action Plan and pockets of resistance from others who describe the Action Plan as "*political correctness gone mad*." An incidental finding was that Trainees do not seem to be well engaged with the College, possibly through time limitations or fear of negative consequences for those highlighting unacceptable behaviours.

The major area for improvement is the College's complaints process, which, despite an increase in the number of complaints relating to respectful behaviours, is, like other complaints processes, not perceived as safe by more than half of Trainees.

Strengths

Implementation of the Action Plan has been successful and well delivered. One of the key strengths of the Action Plan has been highlighting the evidence linking behaviour to patient safety in its messaging and call to action. This is evidenced by the strong awareness of this message, shown in the survey responses. Another strength of the Action Plan has been the communications function. There has been strong

branding, development of a professional logo and strapline and very effective messaging targeted at the key audiences.

The huge and visible level of commitment and enthusiasm from College and Council have been observed by interviewees and survey respondents alike. This commitment has also been displayed in the prioritisation of resources to the Action Plan implementation, another strength of the College's approach to addressing this issue.

Opportunities for improvement

The RACS complaints process, like other complaints processes, is not perceived as safe by more than half of Trainees, and a substantial proportion of IMGs and females. The major reason for this is a lack of confidence that it will lead to positive outcomes, and fear that it could result in severe negative career consequences. The College has already recognised that the complaints system needs improvement, and it is currently being revised.

Despite the strong awareness of the key Action Plan messages, there is still a range of attitudes and entrenched beliefs about what is acceptable behaviour in the surgical workplace. Although it is expected that change will happen at a different pace for different cohorts, and there are likely to be people for whom the changes will take longer, there is an opportunity to consider ways to influence these "pockets of resistance" or whether the cultural change should be allowed to more gradually permeate.

Trainees are not as engaged with the College as other groups. Trainees and IMGs are not as aware of the key messages as Fellows. This could become an issue for future Fellows who may not have absorbed the messages early in their careers. Therefore, there is an opportunity to target messages specifically to these cohorts.

KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?

Key points

- The Action Plan has been resource-intensive.
- Action Plan outputs and activities are being closely monitored.
- Program outcomes are being evaluated as they develop.
- Emerging evidence and lessons learned inform practice.
- RACS is addressing identified strategic challenges for further implementation.
- RACS reports transparently to stakeholders about progress towards building a culture of respect.

Summary

The Building Respect Action Plan is extensively and effectively monitored. At this early stage of program implementation, the focus is on Action Plan outputs and activities,

with regular reporting through senior management and the CEO, to Council, Board of Council and the Building Respect Implementation Group. External evaluation and review have been built in to provide outcomes reporting at the appropriate stage of program development and to inform the continuous improvement approach. There is evidence to indicate that adjustments are being made to the Action Plan as new evidence or practical barriers emerge. Importantly, RACS management and Council have identified the key strategic challenges for further implementation and already have plans to address them.

Strengths

Dedicated senior position

One of the major strengths of the Action Plan has been the establishment of a dedicated senior position to drive program implementation. This has achieved a focal point for advocacy, coordination and progress monitoring, which has contributed to the strong achievements to date.

Culture of continuous improvement

Another strength is the culture of continuous improvement, evident through the close monitoring of actions and outputs against plans, and the openness to receive recommendations from external reviewers and examine the evidence for emerging trends and ideas. This underpins the Action Plan's adaptability, agility and responsiveness.

Transparent reporting

Transparency is also a key strength of the Action Plan. There has been extensive reporting both within and externally to the College about progress towards a culture of respect and this has strengthened the College's position as a leader in this significant undertaking, and validated the importance of this work to its members.

Opportunities for improvement

Addressing the cost of the Action Plan

Action Plan implementation has been resource-intensive, particularly the mandatory education, which has been funded by diverting resources from other priorities. There is no comprehensive cost recovery plan which could support sustainability of the Action Plan in the longer term.

Incorporating Building Respect principles into Business as Usual

Although the Action Plan is nominally mentioned in the current RACS Strategic Plan, the Building Respect principles are not incorporated into the all the elements of the Plan.

Inform Council about the introduction of outcome reporting

Councillors spoke of their need to see outcomes reporting against the Action Plan, however, it is very early in the program implementation to be able to measure many of the outcomes with any certainty. It is important to inform the Council about the planned schedule for outcome reporting over the remaining two phases of the evaluation.

Recommendations

1. Maintain momentum through visible high-level support for the Action Plan.

1.1 Maintain focus and drive through the Executive Leadership Team.
Maintain the momentum for implementation by continuing to focus on Action Plan outcomes at senior level.

1.2 Maintain the high visibility of Council support through external reporting and presentations.
Continue with the President's presentations, other presentations at conferences and both internal and external annual reporting to demonstrate the commitment of the Council and other office bearers, including at the STANZ level, to building a culture of respect.

1.3 Maintain high visibility of the Action Plan through a strong communications function.
Continue to fund and support the communications function, to review and update the messages and to refocus the communications on changing priority areas as the Action Plan is implemented.

1.4 Ensure Business as Usual integration by incorporating the Action Plan principles throughout the RACS Strategic Plan and annual workplans.
Demonstrate Council's commitment to the Action Plan goals by visibly integrating the principles into Business as Usual and make it central to how all College activities are delivered. Strengthen its place in the Strategic Plan and annual workplans to underpin all activities and values.

2. Review the complaints process to increase confidence that problems will be dealt with proportionately

2.1 Clarify and articulate RACS's role in the complaints process
Establish and agree the appropriate role for the College in the overall complaints system, including its legal and moral obligations to ensure a safe training environment, and to support cultural change in the practice of surgery. Once agreed, this should be clearly communicated to members.

2.2 Review the complaints process to ensure alignment with best practice
Ensure incorporation of best practice complaints handling, as outlined in the EAG recommendations, with the current review of the RACS complaints system. This includes a system which is clearly communicated to members, is transparent, timely and procedurally fair. As far as practical, align the RACS complaints process with hospital and regulatory systems.

2.3 Continue with regular external reviews of the complaints process
Maintain the practice of regular review and revision of the complaints process to ensure alignment with best practice principles and maintain a continuous improvement approach.

2.4 Increase the capacity of the mediation and advice/support process
Create positions within the College or in workplaces, to act as a source of informal advice and support as an alternative to making a formal complaint. Ensure these positions cover a diverse range of age, gender and geographical distribution.

2.5 Build expectations and rebuild confidence
Manage expectations around the potential outcomes of complaints and the proportionate responses for each level of inappropriate behaviour. Continue to publish the statistics from the complaints process, to highlight actions taken in response to complaints.

2.6 Monitor data, analyse trends and act to prevent further issues
Gather and regularly analyse complaints and other related data so that repeat offenders or hotspots can be identified. Continue to monitor workplaces where complaints have been unsubstantiated. Build a stronger partnership with RACSTA to facilitate Trainee engagement. Take action through training post accreditation.

3. Leverage the strengths of the existing Building Respect communications approach.

3.1 Maintain high visibility of the Action Plan through a strong communications function.
Continue to fund and support the communications function. Continue to build understanding of issues underlying discrimination, bullying and sexual harassment, to inform review and update of the messages. Refocus the communications on emerging priority areas as the Action Plan is implemented, to keep these issues at top of mind across the profession.

3.2 Use local champions to amplify the message
Establish a diverse group of local champions, for peer to peer communication and amplification of the key messages. Continue with work on development of the Surgical Directors groups and development of Key Opinion Leaders in each craft group.

3.3 Target communications to Trainees and IMGs
Develop specific messages and communication mechanisms for Trainees and IMGs to improve their awareness of key messages, the complaint system and the available support services.

4. Embed Action Plan into College planning and governance.

4.1 Align Action Plan reviews with RACS strategic planning
Align periodic reviews of the Action Plan with the Action Plan evaluation schedule and RACS strategic and annual planning to ensure consistency and embed building respect principles into the College's planning process. Align contextual reviews so that emerging priority action areas such as safe working hours, rotation of training impact on leave or the status of unaccredited trainees can be incorporated into Action Plan

activities, where relevant. Reviews should consider updating of measurable targets and timelines for the implementation so progress can be readily measured.

5. Investigate cost recovery options for Building Respect courses.

5.1 Integrate the Building Respect principles into RACS core curriculum.
Identification of opportunities to incorporate the Building Respect principles into the core RACS curriculum is in progress. This will avoid the need for separate and expensive courses.

5.2 Investigate other cost recovery models for delivering professional skills training.
Consider other options for delivery of the Building Respect messages, including through partnerships with hospitals and other colleges.

6. Improve understanding of the issues faced by Trainees.

6.1 Conduct an extensive consultation with Trainees.
Develop and deliver a comprehensive, staged and targeted consultation process to engage with surgical Trainees and gain understanding and insights into their issues, views and challenges in relation to the culture of surgical education and other related matters. This could be achieved through a combination of existing mechanisms such as the RACSTA survey and through internally or externally facilitated surveys, interviews and focus groups. Use findings to incorporate into the review of the Action Plan and adapt the Action Plan accordingly.

Structure of this report

This report documents the Phase 1 evaluation of the Building Respect, Improving Patient Safety Action Plan, covering the period 2015-2018.

Section 1, the *Introduction,* provides the background and context to the Action Plan and the scope and purpose of this evaluation.

Section 2 presents the detailed *Methodology* for the conduct of the evaluation.

Section 3 presents the *Findings* from all data sources, presented under each of the two KEQs. The KEQs were the research questions for this evaluation, forming the backbone of the evaluation. The KEQs are supported by sub-questions. The purpose of the sub-questions was to structure data gathering, to ensure collection of appropriate information to answer each KEQ in detail.

Section 4 presents the overall *Conclusions* followed by the *Recommendations.*

Section 5 presents the *Attachments* to this report:

Attachment 1: Building Respect, Improving Patient Safety Action Plan

Attachment 2: Building Respect Program Evaluation Framework

Attachment 3: Building Respect Program Logic Model

Attachment 4: Stakeholder Engagement Plan

Attachment 5: Survey Questions

Attachment 6: Semi-structured Interview Questions

Attachment 7: Definitions and common terminology

1. Introduction

1.1 Background

Action Plan history

In 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG) to investigate the extent of discrimination, bullying and sexual harassment within the surgical profession. EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. This raised serious concerns for the wellbeing of individual surgeons and surgical trainees, of surgical teams and especially for the quality of care and safety of patients. The EAG report was unequivocal in emphasising the need for cultural change:

> "…*there must be a profound shift in the culture of surgery and an unwavering commitment to achieving this… Discrimination, bullying and sexual harassment must become problems of the past…*" (EAG report 2015)

RACS responded to these issues by apologising to all people affected by unacceptable behaviours, accepting all of the EAG's recommendations and developing an Action Plan, *Building Respect, Improving Patient Safety* (Action Plan) (Attachment 1), which outlines how RACS intends to counter and drive out unacceptable behaviours from surgical practice and surgical training.

Vision

The Action Plan's vision is to *build a culture of respect in surgical practice and education*, which will contribute towards:

- Improved patient safety.
- Surgical workplaces that are safe and free from unacceptable behaviours.
- A surgical profession that is more representative of the cultural and gender diversity across the community.

Goals

The Action Plan aims to bring significant, but necessary changes to the culture of health workplaces and surgical training. It has been developed to reflect the principles of the Vanderbilt Model1.

The Action Plan outlines how RACS Council intends to achieve the vision and demonstrate the values. It provides details on the actions needed to address each of the EAG recommendations. The Action Plan addresses eight goals, arranged under the three key action areas identified by the EAG. These goals are supported by a comprehensive workplan, which has been prioritised and gradually implemented.

[1] Hickson GB, Pichert J, WEBB LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. Acad. Med. 2007 Nov;82(11):1040-8

Action area 1: Cultural Change and Leadership

Goal 1: Build a culture of respect and collaboration in surgical practice and education.

Goal 2: Respecting the rich history of the surgical profession, advance the culture of surgical practice so there is no place for discrimination, bullying and sexual harassment (DBSH).

Goal 3: Build and foster relationships of trust, confidence and cooperation on DBSH issues with employers, governments and their agencies in all jurisdictions.

Goal 4: Embrace diversity and foster gender equity.

Goal 5: Increase transparency, independent scrutiny and external accountability in College activities.

Action area 2: Surgical Education

Goal 6: Improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency and professionalism.

Goal 7: Train all Fellows, Trainees and International Medical Graduates (IMGs) to build and consolidate professionalism including:

- Fostering respect and good behaviour;
- Understanding DBSH: legal obligations and liabilities;
- 'Calling it out'/not walking past bad behaviour;
- Resilience in maintaining professional behaviour.

Action area 3: Complaints Management

Goal 8: Revise and strengthen RACS complaints management process, increasing external scrutiny and demonstrating best practice complaints management that is transparent, robust and fair.

1.2 Context

Implementation of the Building Respect Action Plan has taken place in an environment with many contextual influences, some of which are described below.

Community attitudes have changed

One significant enabling contextual change over the last three years has been the change in community attitudes and expectations around respectful behaviours. Campaigns such as #Metoo and public shaming of celebrity offenders have brought these issues to the forefront and have helped to amplify, normalise and reinforce the Action Plan messages.

Implementation is complex

Implementation of the Action Plan has taken place over a relatively short time (3 years to date), working through partners such as hospitals and across different health jurisdictions in two countries. The Action Plan elements have been delivered via different areas of the College, with central coordination. This has required negotiation

of partnerships, coordination of priorities and building of relationships across a broad range of organisations with conflicting priorities.

Achieving the goals requires significant cultural change

A major cultural change program such as the Building Respect Action Plan brings issues around change management and bedding down of processes and systems across a bi-national program. Uncertainty caused by change can manifest in negative or unproductive attitudes and behaviours, for example through resistance to change by not following standards, procedures or policies. These are common reactions to change and it can be anticipated that some groups will take longer to change their attitudes and behaviours than others.

1.3 Phase 1 Evaluation

Focus

The purpose of this first evaluation of the Building Respect Action Plan was to evaluate the Action Plan implementation and very early outcomes.

The focus was to:

- Measure whether program implementation, governance and oversight are proceeding as intended.
- Measure whether early outcomes (delivery of pathways for identifying and addressing concerns about behaviour; program reach; target audience perceptions of the Action Plan) are being achieved as intended.
- Identify program strengths, what is working well, barriers to progress.
- Make recommendations on areas for program adjustment or improvement, based on findings.

Evaluation audience

The findings of this evaluation will be reported to the following:

- RACS Council and major committees;
- Building Respect Implementation Group;
- Building Respect Expert Advisory Group; and
- RACS Fellowship/ Trainees/(IMGs).

Scope

This evaluation is a process evaluation, covering the Action Plan implementation and governance. One sub-question has been included for an indication of very early progress towards the short-term outcomes.

The Key Evaluation Questions (KEQ) and sub-questions are shown below.

KEQ 1: Has the Action Plan been implemented as intended to date?

1.1 Have the program elements been delivered according to the plan to date?

1.2 Are the program elements reaching the intended audiences?

1.3 What are the reactions of the program's target audiences to the program activities?

1.4 What are the barriers/enablers for program implementation?

1.5 Have there been any unintended consequences, positive or negative, of program activity?

1.6 To what extent is data showing early progress towards short term outcomes?

KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?

2.1 Is the program sufficiently resourced?

2.2 Is program progress being monitored?

2.3 Are program outcomes being monitored/evaluated?

2.4 Are adjustments being made to the program in light of emerging data trends and/or practical barriers?

2.5 Is there adequate oversight of and accountability for program delivery?

2.6 Is RACS reporting transparently about progress towards building a culture of respect?

Structure of this report

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Section 3 presents the *Findings* from all data sources, presented under each of the two KEQs. The KEQs were the research questions for this evaluation, forming the backbone of the evaluation. The KEQs are supported by sub-questions. The purpose of the sub-questions was to structure data gathering, to ensure collection of appropriate information to answer each KEQ in detail.

Section 4 presents the overall *Conclusions* followed by the *Recommendations.* The high-level themes were developed after analysis, validation and integration of the findings. The relationship of each theme to the relevant KEQs is indicated.

Section 5 presents the *Attachments* to this report:

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Attachment 4: Stakeholder Engagement Plan

Attachment 5: Survey Questions

Attachment 6: Semi-structured Interview Questions

Attachment 7: Definitions and common terminology

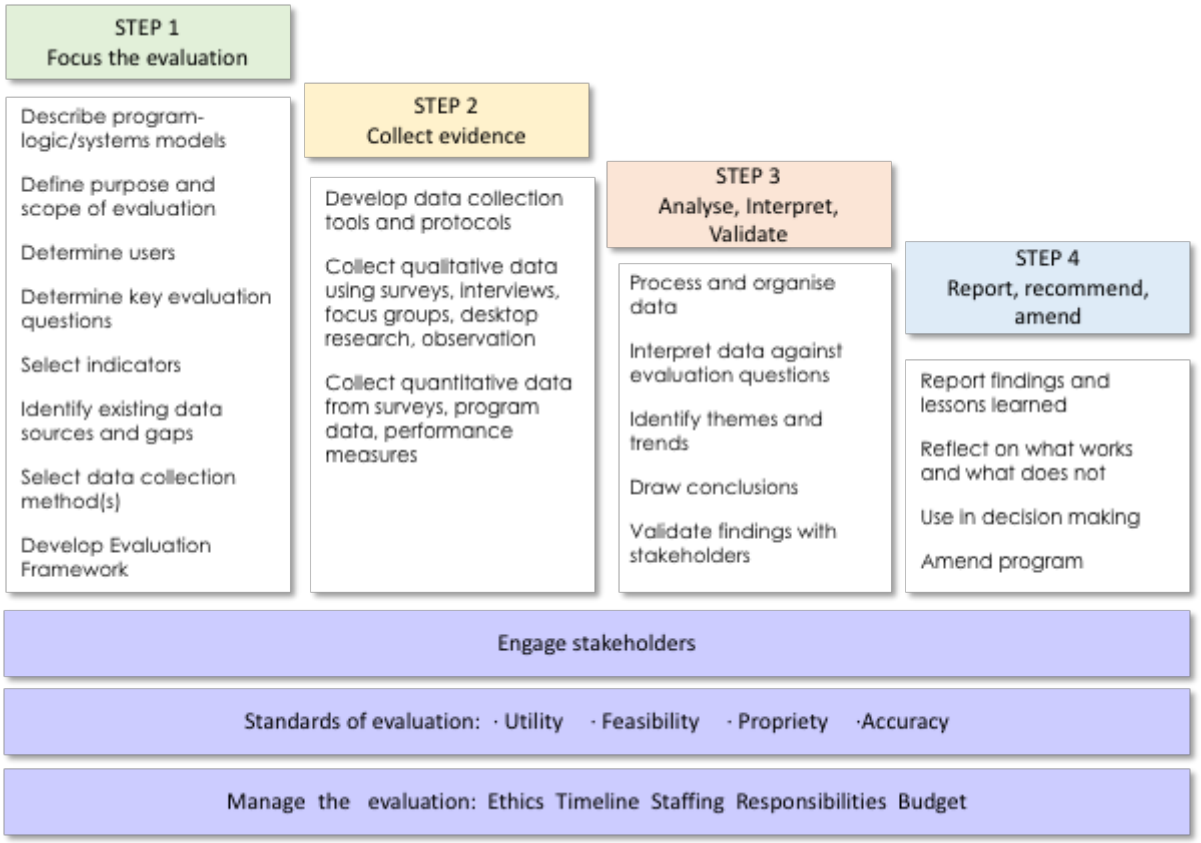
2. Methodology

2.1 Overall evaluation approach

Evidence based model for Program evaluation

The evaluation model used for this evaluation was a four-step, evidence-based modification of the University of Wisconsin evaluation model as shown in the figure below. This approach also complies with the NSW Government Program Evaluation Guidelines (2016), widely used for evaluations of government agencies across Australia. The evaluation was structured around the Building Respect Program Evaluation Framework (developed in 2018 and following the elements of Step 1 below) (Attachment 2) and conducted in an iterative way, with each step building upon the outputs of the previous step and consultation throughout the process.

Figure 2.1 Evidence-Based Evaluation Model



Adapted from Taylor-Powell and Henert, University of Wisconsin, 2008

Use of best practice principles

The evaluation approach was guided by the following, evidence-based principles, sourced from the model above and from government program evaluation guidelines widely used in Australia.2.

Principle	How it was expressed
1. Build evaluation into Program design	A detailed program logic model was developed during the evaluation design stage (Attachment 3). This logic model informed the development of the key evaluation questions. The resulting Evaluation Framework (Attachment 2) guides this and future evaluations.
2. Base evaluation on sound methodology	The Evaluation Framework was developed using methodology adapted from the recognised University of Wisconsin model (Step 1 in Figure 2.1 above). The design of this evaluation follows the Evaluation Framework, the NSW Government Program Evaluation Guidelines (2016) and the evidence-based principles of utilization focussed evaluation[3].
3. Include resources and time to evaluate	The Building Respect Action Plan includes resources and timing for evaluations. The Evaluation Framework includes a schedule of evaluations. This evaluation was conducted with an approved work plan, timeline and budget which allocated appropriate resources to conduct the evaluation to the required standard.
4. Use the right mix of expertise and independence	The evaluation was conducted by Ruth Friedman from The Thread Consulting (TTC), a professional independent evaluator. She employed a methodology based on significant stakeholder engagement to ensure the findings represent a range of viewpoints and experiences and to ensure contextual understanding in interpretation of findings and development of recommendations.
5. Ensure proper governance and oversight	The project governance framework for this evaluation included a work plan agreed at the beginning of the evaluation, regular written progress reports and regular progress meetings with the Building Respect Executive Lead. Development of the Evaluation Framework was guided by a Project Reference Group including Deputy CEO (later CEO) John Biviano; Executive Project Lead, Building Respect Improving Patient Safety, Judy Finn; Dean of Education, Associate Professor Stephen Tobin; Communications Consultant, Nicole Newton. The Phase 1 evaluation was guided by a Project Reference Group comprised of the Deputy CEO (later CEO) John Biviano; Executive Project Lead, Building Respect Improving Patient Safety, Judy Finn; Acting EGM Education, Rob di Leva; Communications Consultant, Nicole Newton; Academy of Surgical Educators Program Coordinator, Grace Chan. This group reviewed and approved each deliverable during the evaluation.
6. Be ethical in design and conduct	Ethical considerations were incorporated into the evaluation design to ensure access for stakeholders and confidentiality of interview and survey information. All evidence and findings have been presented in de-identified form. TTC consultants are members of the Australasian Evaluation Society and abide by its *Code of Conduct for Ethical Evaluations*.
7. Be informed and guided by relevant stakeholders	Data collection was conducted via individual interviews, a survey and examination of documents, to ensure a broad range of input to the findings. In addition, PRG workshops, circulation of drafts, and extensive consultation with the PRG and the Executive Project Lead was conducted to provide oversight and input into each deliverable, to ensure the validity of interpretations and to incorporate contextual factors into the analysis and recommendations.
8. Consider and use evaluation data meaningfully	Evaluation data were organised against the KEQs and analysed for emerging themes, trends and meaning, within the context of the practical realities of the program. Findings and interpretations were validated by the PRG, after which recommendations for improvement were developed.
9. Be transparent and open to scrutiny	An agreed work plan with timelines, responsibilities and deliverables was used to ensure transparency and support good project management throughout the evaluation.

[2] NSW Government Program Evaluation Guidelines. Department of Premier and Cabinet [Internet]. 2016 [cited 2017 Aug 17]. Available from: https://arp.nsw.gov.au/sites/default/files/NSW%20Government%20Program%20Evaluation%20Guideline%20January%202016_1.pdf
Government Program Evaluation Guidelines (2016)

[3] Patton MQ. Essentials of utilization-focused evaluation. Thousand Oaks, California: Sage; 2012

Stakeholder consultation

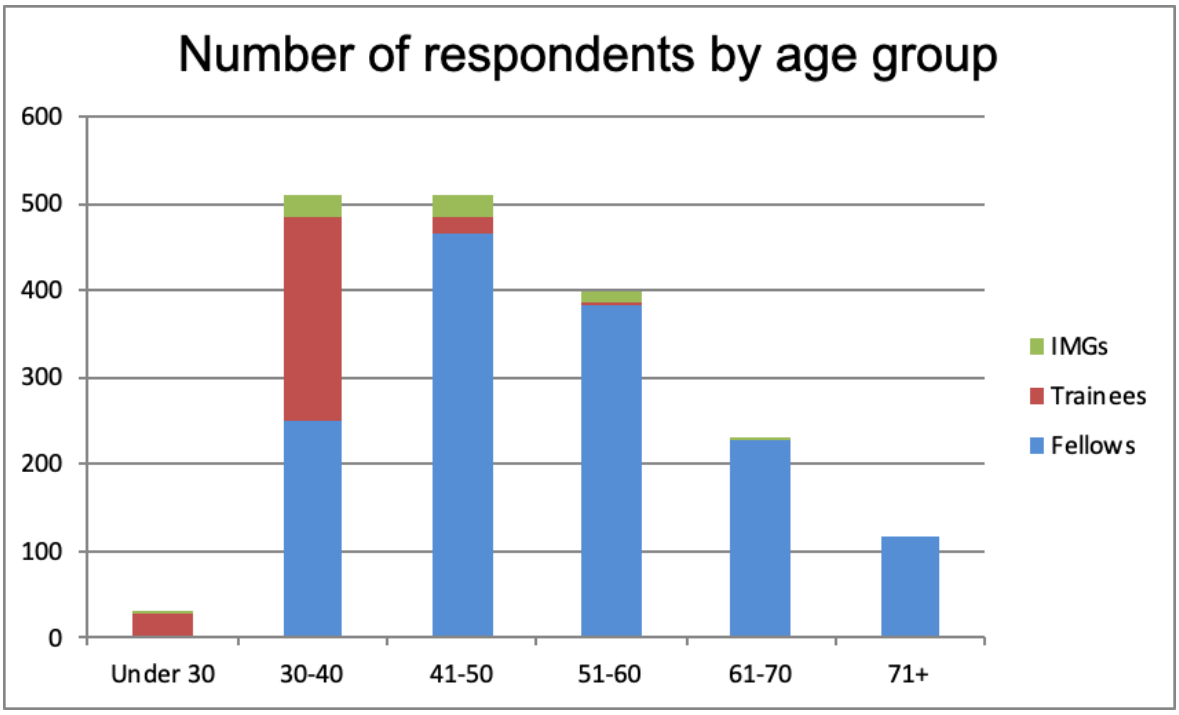
Internal stakeholder consultation was built into every step of the evaluation, to ensure broad input into the evidence, validation of the findings and interpretations, and support for the evaluation approach from the people who have the most detailed knowledge of the Action Plan. The consultation methods included a variety of access points to ensure stakeholders had an opportunity to provide input to the evaluation:

- Three interactive workshops with the PRG to confirm the evaluation methodology, validate findings and discuss the practical application of draft recommendations.
- Circulation of draft surveys and interview guides to the PRG for comment and input.
- Semi-structured and open-ended Interviews (in-depth telephone interviews) with 10 Fellows, 6 Trainees, 5 IMGs and 3 Councillors.
- A survey sent to 7,765 Fellows, Trainees and IMGs with a 23% response rate.
- Meetings with the Executive Project Lead to confirm the approach, validate findings and ensure input of contextual information.
- Presentations to the RACS Board and the Building Respect Implementation Working Group to report on progress.
- Circulation of the draft report to the PRG for comment.

Some interviewees (Fellows) were selected by random, stratified sampling to provide representation across geographic regions, specialties and gender. The intention had been to select Trainees and IMGs in the same way, however, this proved difficult as these two cohorts were not as willing to participate in interview. Therefore, snowball sampling was implemented, using the contacts of known people to gain as random and broad a sample of willing participants as possible, whilst ensuring geographical and gender diversity.

Analysis of survey respondents indicated there were 1446 Fellows (1158 males: 80%; 283 females: 19.6% and 5 intersex/indeterminate: 0.34%). There were 280 Trainees (158 males: 56%; and 122 females: 44%) and 72 IMGs (57 males: 79%; and 15 females: 21%). (Figure 2.2).

Figure 2.2: Analysis of survey respondents



58% of Fellows responding to the survey were mainly employed in the Public sector, with 42% mainly in the Private sector. Almost all Trainees were employed in the public sector. IMGs were split with 85% in the Public sector and 15% in the Private sector. There were no significant differences in responses to the survey questions between people mainly employed in the private sector and those in the public sector. There was no significant difference in the responses of people working mainly in rural locations compared with those in metropolitan locations.

Differences in response between Fellows, IMGs, Trainees, males and females have been noted where they occurred.

Project governance

The project was delivered according to an agreed work plan with timelines, budgets and an approved stakeholder list. Regular progress reports were provided to the Executive Project Lead against the agreed work plan. All project deliverables were approved by the PRG before being finalised.

2.2 Focussing the evaluation

Confirmation of the Evaluation Framework and evaluation approach

The Building Respect Evaluation Framework was developed in 2018 to guide each of the three phases of the evaluation of the Building Respect Action Plan, scheduled for 2019, 2020-2021 and 2026. The Evaluation Framework is a comprehensive document which contains a listing of each KEQ and sub-question, how it will be answered (indicators) and the data source for each question. It provides the 'road map' for each evaluation.

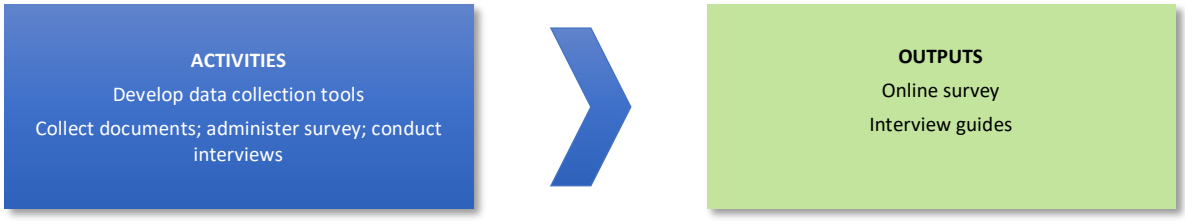
However, the Building Respect Action Plan is complex, delivered through multiple streams of activity across Australia and New Zealand. Implementation of the Action Plan is occurring in a dynamic and complex environment, meaning that the Evaluation Framework, developed in 2018, may need some updating and adjustment before commencement of each scheduled evaluation.

Therefore, this evaluation began with an in-depth discussion with the PRG about the current context, the planned evaluation approach and stakeholders to be consulted. The purpose of this discussion was to identify the potential challenges, risks and practical issues that could arise during the evaluation, in particular during the data collection phase. The relevance of the Evaluation Framework and the KEQs were confirmed with minor changes, and an evaluation approach taking into consideration the current context was agreed.

The following deliverables were produced:

- Evaluation Work Plan.
- Stakeholder Engagement Plan (Attachment 4).

2.3 Collection of evidence



Ensuring validity of data

One of the central issues in evaluation is ensuring that findings and recommendations are based on valid data. Quantitative data are quoted in numerical terms and tested for statistical significance. Qualitative data are tested for their substantive significance through presentation of findings, patterns and themes. In mixed methods evaluations, both types of data are used to establish and confirm the validity of the findings.

The validity of findings can be demonstrated by ensuring:

- Confidence that data highlight what is really happening in the program.
- An agreed approach for dealing with outliers.
- Minimisation of bias.
- Confidence in the inferences drawn from the data.

A number of data collection and analysis strategies were used to address these issues:

- Multiple data sources were used, from a range of geographical and demographic perspectives, to ensure a range of views from which to draw conclusions. Gathering information from a range of sources serves to triangulate the findings, with each source confirming and extending understanding of the findings from the other sources, to increase confidence in the validity of the findings and reduce the impacts of bias. This evaluation included examination of a range of data sources (policy documents, progress reports, external reviews, statistics and business plans); 24 interviews (via telephone) with Fellows, Trainees, IMGs and Councillors; and an online survey sent to all Fellows, Trainees and IMGs.
- Quantitative data were collected, via the online survey. These data provided an answer to the question: What is happening? in relation to the KEQ.
- Quantitative information was supplemented with deep contextual information from qualitative data sources such as in-depth interviews. Additional qualitative data was included from the comments and major themes taken from the open-ended response section of the survey. The qualitative data was

not intended to provide statistical information, and is therefore not presented in a quantifiable manner. It was collected to explore issues "in-depth" and provide an increased understanding of Action Plan successes, strengths and weaknesses at a deeper level and within the realities of program delivery. The data enabled identification of the contextual situation which provided some explanation of the question: *Why is this happening?*

- Data were analysed and cross referenced to support triangulation of the data i.e. ensure a number of data sources as well as a number of data collection methods to support and corroborate each finding and to identify outliers, views or inputs that significantly differ from the main findings. In this report, each finding has been reported from multiple data sources and methods, where available, to demonstrate validity and corroboration and increase confidence in the finding.

- Findings were further validated, whilst maintaining the independence of the external evaluator, firstly by discussion with the Executive Program Lead, and secondly by presenting them to the PRG (knowledgeable stakeholders) who provided practical knowledge to discuss, challenge or confirm the plausibility, relevance and utility of the findings, interpretations and proposed recommendations. This consensual validation of the findings, by three sources (consultant, Action Plan experts, and the Program Managers) is the standard for validating and reporting of qualitative data.

Data collection included quantitative and qualitative methods

A survey was used as the major data collection instrument and distributed to all RACS members (7765 people received the survey, 1798 (23%) responded). The survey distribution ensured access for all RACS members to express their views and to provide input to the evaluation. The survey was developed using a mixed methods approach to ensure it addressed issues and used language relevant to the target audiences. This was achieved by conducting eight exploratory open-ended interviews with purposively selected stakeholders representing a range of Fellows, Trainees and IMGs from different geographical locations and of different gender. Whilst the KEQs formed the basis for the survey, the themes and issues identified in the exploratory interviews provided the detail within each question (Attachment 5: Survey questions).

Semi-structured in-depth telephone interviews were conducted with 17 people. Consistency between interviews was supported by the use of an interview guide, developed from the KEQs, the initial, exploratory interviews and in consultation with the Executive Project Lead and PRG. Different aspects of the interview guides were used, depending on the interviewees, for example, the governance questions were not asked of people who did not have a role in the Action Plan governance. (Attachment 6: Semi structured interview questions).

Interviews provided important contextual information on unintended consequences, very early outcomes and the lived experience of Fellows, Trainees and IMGs. This

information supplemented the more quantitative data from the survey and provided stories and examples from which meaning and context could be better extracted.

Documents and reports included policy documents, progress reports, external reviews, statistics and business plans. Information from these documents was extracted and organised against the KEQs, to support other findings and provide more detailed understanding.

2.4 Analysing, interpreting and validating findings

Structured data analysis and interpretation

The KEQs, as taken from the Evaluation Framework, were the research questions for this evaluation, forming the backbone of the evaluation. The sub questions provided detail to help more specifically answer the KEQs by breaking down the information required. Findings were arranged against the KEQs to collect the evidence which formed the answer to each research question.

Raw quantitative and qualitative data were organised against the KEQs to reveal patterns and trends. Numerical responses and ratings from survey data were presented as graphs. Interviews, comments and open-ended questions from the survey were analysed to identify emerging issues, perceptions and strengths. Action Plan data was analysed for trends and evidence of effective implementation.

The relationships between the data were tested, and examined for corroboration of findings between data sources, until the most important findings emerged for each KEQ.

Quotes from respondents were identified to represent the emerging findings, with some quotes included to identify conflicting views, where present, to ensure a balanced reporting of those views against the rest of the findings. Where available the position of the respondent has been included.

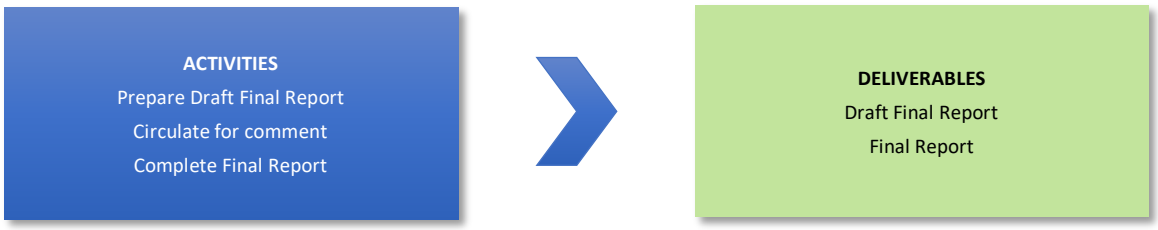
Themes and data trends were considered within the consultant's understanding of cultural and contextual factors, developed through the interviews and discussions with the Executive Project Lead and the PRG. This supported interpretation of the meaning and significance of the findings, highlighting strengths and opportunities for improvement.

Recommendations have been developed to leverage the Action Plan strengths and address areas identified for improvement. Recommendations have been kept to those priority recommendations which can most practically be implemented by the College.

Validation of findings

Findings and interpretations were presented firstly to the PRG and then to the Building Respect Implementation Group and RACS Board for discussion, contextual input and analysis, including testing of assumptions, conclusions and draft recommendations for practicality and feasibility.

2.5 Final Report



Preparation of Report

Feedback from the validation workshop was incorporated into a Draft Report and circulated for comment before completion.

3. Evaluation Findings

This section presents the evaluation findings organised under the two KEQs relevant to the scope of this evaluation, extracted from the Evaluation Framework. (Attachment 2). The KEQs form the backbone of the evaluation and provide a structure against which the findings are reported. The sub-questions that appear in the evaluation framework under each KEQ were used to structure data gathering to ensure appropriate information was collected to answer each KEQ in detail.

KEQ 1: Has the Action Plan been implemented as intended to date?

Overall assessment of findings for this KEQ

Almost all of the Action Plan has been delivered as planned, a significant achievement, given the size of the task. Overall the Action Plan has been positively received and is very strongly supported by Fellows, Trainees and IMGs but there are small pockets of resistance to the key messages.

The right audiences are receiving Action Plan communications via multiple sources, contributing to the high level of awareness of the key messages and the majority of actions that the College has taken. Early outcomes such as perceived cultural change in the workplace and representation of women in surgical training, are making good progress. RACS is leading the way in developing a model for introduction of respectful behaviours, with other Colleges and organisations turning to the College for policy advice and education programs.

The major area for improvement is the College's complaints process, which, despite an increase in the number of complaints relating to respectful behaviours, is, like other complaints processes, not perceived as safe by more than half of Trainees.

Strengths

Implementation of the Action Plan has been successful and well delivered. One of the key strengths of the Action Plan has been highlighting the evidence linking behaviour to patient safety in its messaging and call to action. This is evidenced by the strong awareness of this message, shown in the survey responses. Another strength of the Action Plan has been the communications function. There has been strong branding, development of a professional logo and strapline and very effective messaging targeted at the key audiences.

The huge and visible level of commitment and enthusiasm from College and Council have been observed by interviewees and survey respondents alike. This commitment has also been displayed in the prioritisation of resources to the Action Plan implementation, another strength of the College's approach to addressing this issue.

Opportunities for improvement

The RACS complaints process, like other complaints processes, is not perceived as safe by more than half of Trainees, and a substantial proportion of IMGs and females. The major reason for this is a lack of confidence that it will lead to positive outcomes, and

fear that it could result in severe negative career consequences. The College has already recognised that the complaints system needs improvement, and it is currently being revised.

Despite the strong awareness of the key Action Plan messages, there is still a range of attitudes and entrenched beliefs about what is acceptable behaviour in the surgical workplace. Although it is expected that change will happen at a different pace for different cohorts, and there are likely to be people for whom the changes will take longer, there is an opportunity to determine whether communication should be targeted towards these "pockets of resistance" or whether the cultural change should be allowed to more gradually permeate.

Trainees are not as engaged with the College as other groups. Trainees and IMGs are not as aware of the key messages as Fellows. This could become an issue for future Fellows who may not have absorbed the messages early in their careers. Therefore, there is an opportunity to target messages specifically to these cohorts.

Detailed findings

A significant amount of work has been delivered.

A significant amount of work, covering a broad range of activities under the banner of the Building Respect Action Plan, has been completed and delivered. The Progress Update reports (2016, 2017, 2018) show that almost all actions have been delivered as planned, which is a major achievement.

The most visible area of activity has been the Let's Operate With Respect campaign, which includes videos, social media, posters and merchandise such as branded surgical caps. This was the first digital campaign for the College, and it has been widely shared across social media, with extensive use of the hashtag #operatewithrespect.

The other significant and visible element of the Action Plan was the education program, including the mandatory online e-module, which has now been completed by over 98% of Fellows, Trainees and IMGs; the face to face Operating With Respect course (OWR) mandated for surgical supervisors and RACS major Committee Members; and the Foundation Skills for Surgical Educators course (FSSE), with only 3% of the mandated cohort being followed up as this report was being prepared. Although there was some resistance to completing the training, especially due to time constraints, interviewees reported examples of people experiencing change during the face to face courses, others reported learning more about themselves and several acknowledged the excellent access to courses, with multiple courses delivered at numerous locations.

Important work has been completed to underpin cultural change, including development of the Diversity and Inclusion Plan, with targets for gender diversity in surgical training and on RACS committees; development or updating of policies, standards, procedures, fact sheets and guides. Thirty-five partnership agreements have been established with hospitals or health networks across Australia and New

Zealand, health jurisdictions, medical colleges and universities. These have evolved into collaborations on communication of campaign messages, education and training programs, consideration of models to facilitate flexible training and establishment of pilots for innovative programs being tested before upscaling. A complaints process has been established, with a policy, user guide, manual and other information available on the RACS website.

Almost all of the program elements have been delivered according to plan.

Although there have been delays to some areas of the Action Plan, such as Multi Source Feedback, discussions with the Executive Project Lead and the Building Respect Implementation Group revealed that a significant amount of work has actually been done on MSF, including establishment of a model for IMGs, however work continues, to overcome issues associated with the sustainability of the model being trialled. Similarly, work is progressing regarding establishment of protocols for sharing of hospital complaints information with the College, with St Vincent's Health Australia.

Visible commitment by College and Council.

The College's swift action in response to the recommendations of the EAG, its allocation of significant resources to the Building Respect Action Plan, and its appointment of a senior position to lead the implementation have been seen by the majority of interviewees and survey respondents as a strong commitment to the Action Plan. This has been complemented by a range of highly visible activities such as the presentations to surgeons and to external groups, by College Presidents and Office bearers, development of partnerships across Australia and New Zealand and a significant level of external reporting on progress and goals.

> "*Willingness to do what it takes*." (Councillor)
>
> "*Impressed more and more with how things are being rolled out.*" (Fellow)
>
> "*Patchy*." (Fellow, referring to the implementation of the Action Plan)
>
> "*Tsunami-like change*." (Fellow referring to implementation of the Vanderbilt model nationally, including the private sector, in such a short time frame)

Barriers for implementation.

Some pockets of resistance to cultural change

The program logic model for the Building Respect Action Plan acknowledges that cultural change takes time, often taking many years before behaviour change can be seen. This presents a major, but expected, challenge for Action Plan implementation. Interviewees reported some degree of scepticism amongst some of their colleagues regarding the Action Plan and pockets of resistance from others who describe the Action Plan as "*political correctness gone mad*." Others described surgeons in their workplace who do not seem to be able to adjust their communication style to be more respectful. They feel entitled to speak harshly in theatre because of a situation which they see as relating to patient safety. These people represent the group most resistant to change that will require particular communication and may take the longest to impact.

Respectful behaviour is a whole of healthcare issue

As a leader in making cultural change, the College faces a number of challenges. The College faces the challenge of working with multiple partners, across many jurisdictions, in two countries, in order to achieve its goals for cultural change. There are the challenges of following up on the multiple partnership agreements and in working closely with other medical disciplines where training on respectful behaviours has not taken place. These challenges have been anticipated and planned for, however, they do impact on the speed at which change can be achieved.

Implementation of the Action Plan is in line with societal change.

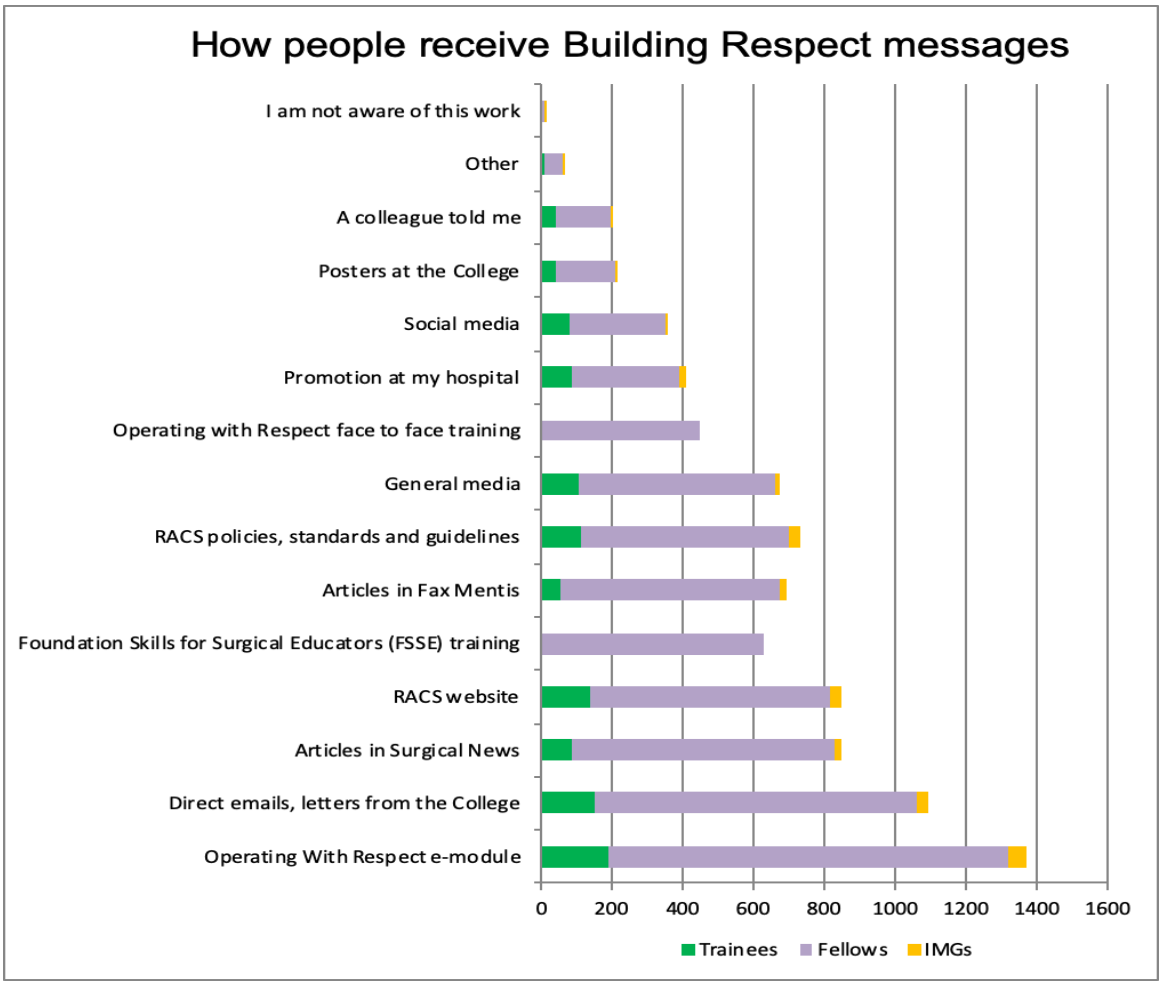
Community views on bullying, discrimination and sexual harassment have moved a long way since the early days of development of the Action Plan. The College is now seen to be in step with public opinion and broader societal shifts. More than this, the College is now seen as leading the way as an institution that has acknowledged these problems and made a serious commitment to addressing them. Evidence of the links between behaviour and patient safety continues to grow, providing further support for the Action Plan and providing a strong base for communication with members.

Building Respect elements are reaching target audiences.

People are receiving communications from multiple sources

The Action Plan, its messages, activities and achievements have been extensively communicated to the target audiences of Fellows, Trainees and IMGs via multiple streams. Figure 3.1 below shows that almost every survey respondent was aware of the Action Plan through one or more of twelve different types of communication. The most successful communication mechanisms in terms of reach, were through completion of the e-module, direct emails from the College, articles in the Surgical News and the RACS website. This finding was confirmed by the majority of interviewees, who had all completed the e-module and stated that this was the main way they had become aware of the Action Plan.

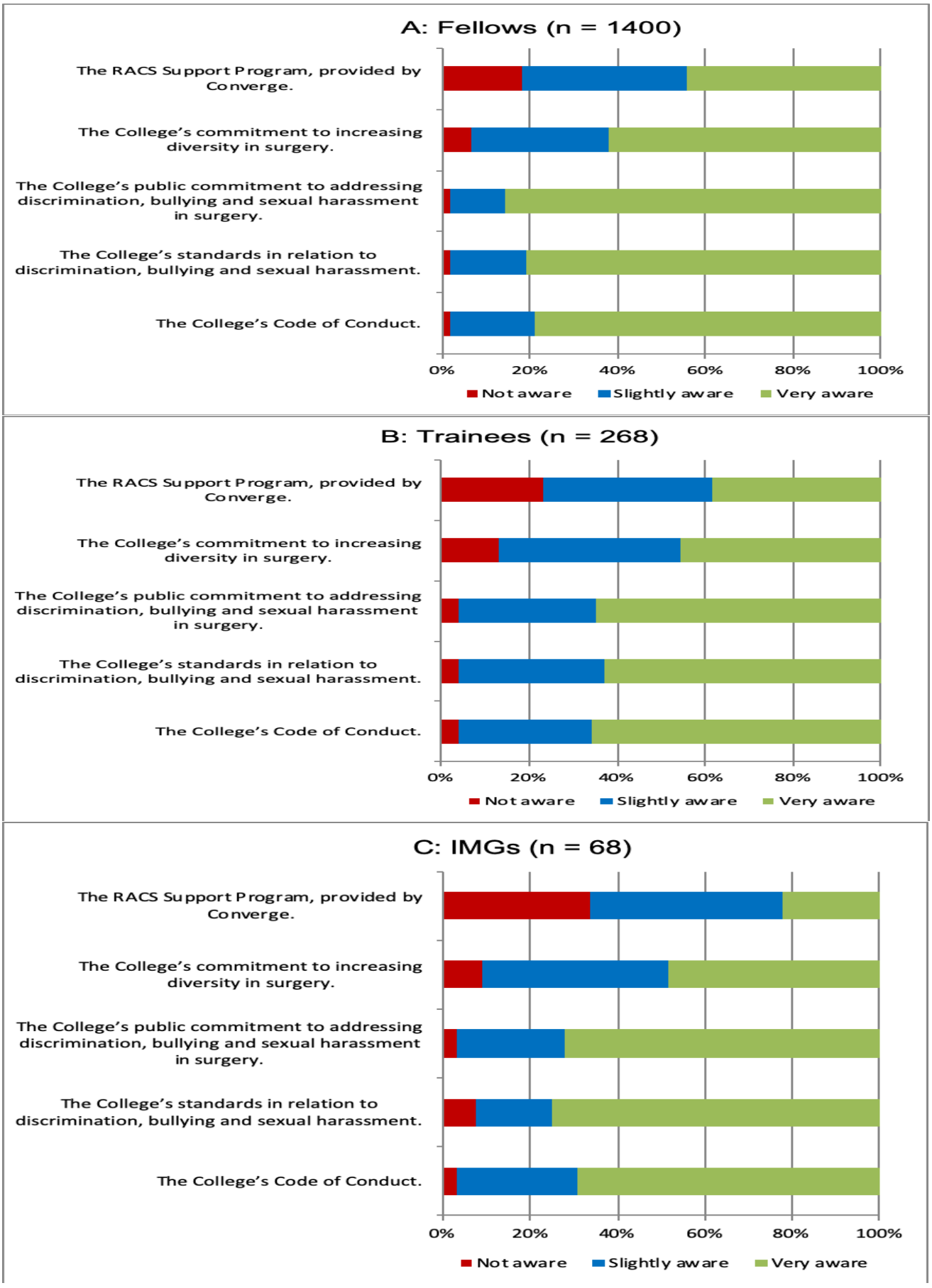
Figure 3.1 Mechanisms of communication for the Building Respect messages



Less awareness of RACS Support Program (Converge) and the commitment to diversity

Moving beyond audience reach to the actual penetration of messages, there has been significant success in raising awareness of the College's key activities to build a culture of respect. Figure 3.2 shows that there is strong awareness of the College's Code of conduct, standards and public commitment to addressing discrimination, bullying and sexual harassment. The survey showed that over 80% of Fellows (Panel A, n = 1400), over 60% of Trainees (Panel B, n = 268) and more than 70% of IMGs (Panel C, n = 68) indicated they are aware of these College activities. However, awareness of the RACS Support Program (Converge) program is relatively lower, with 43% of Fellows, 38% of Trainees and only 22% of IMGs indicating awareness of these items. Trainees and IMGs generally have a lower awareness of all of the Action Plan elements.

Figure 3.2 Awareness of RACS' actions to build respect and improve patient safety



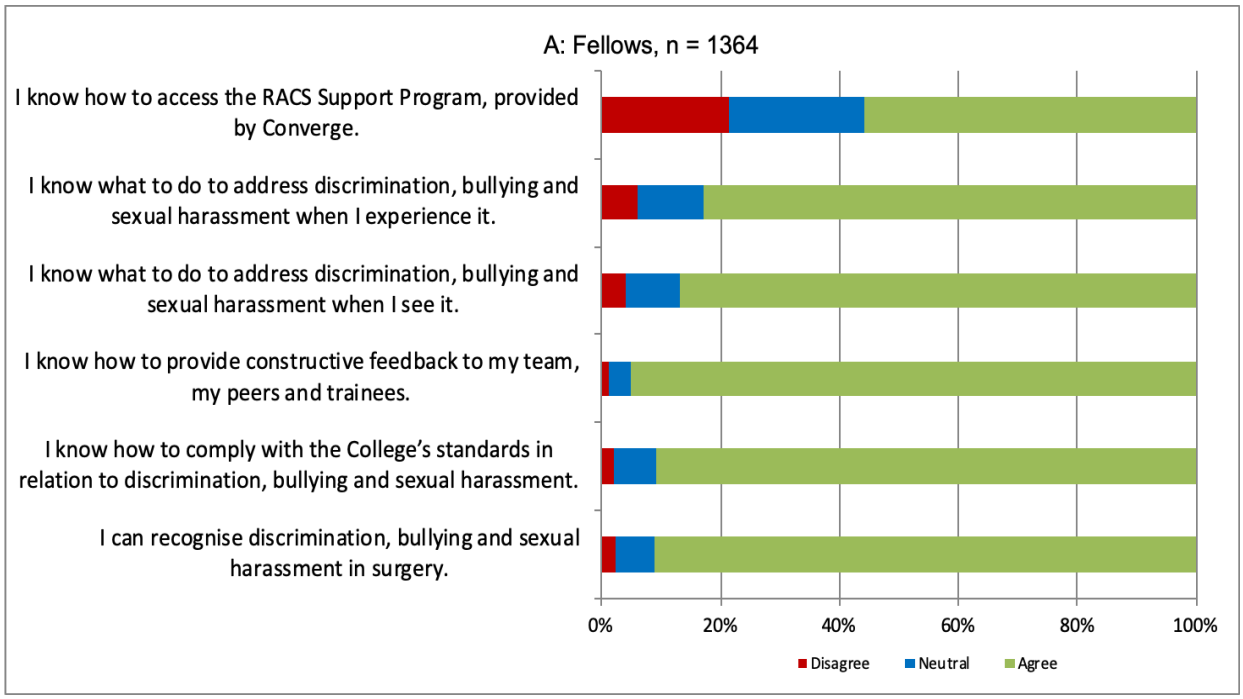
There is very strong permeation of the key messages

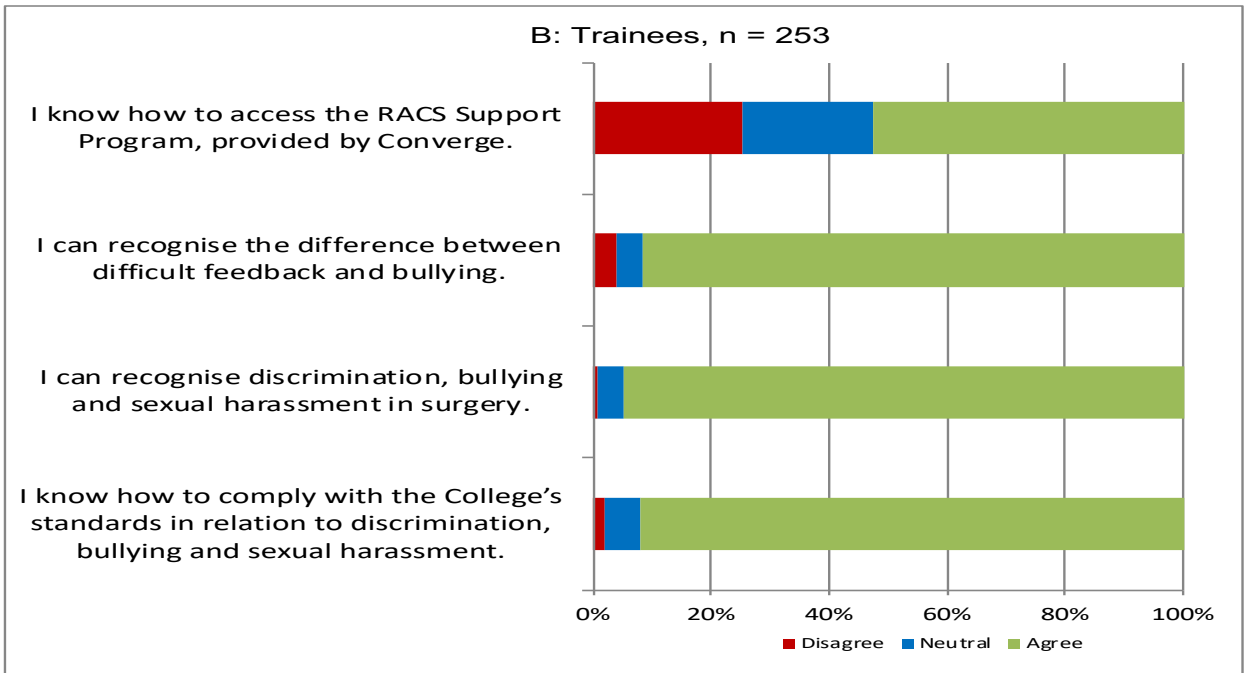
Interviewees reported that, since the beginning of the Action Plan, the issues of discrimination, bullying and sexual harassment have become very high profile in hospitals.

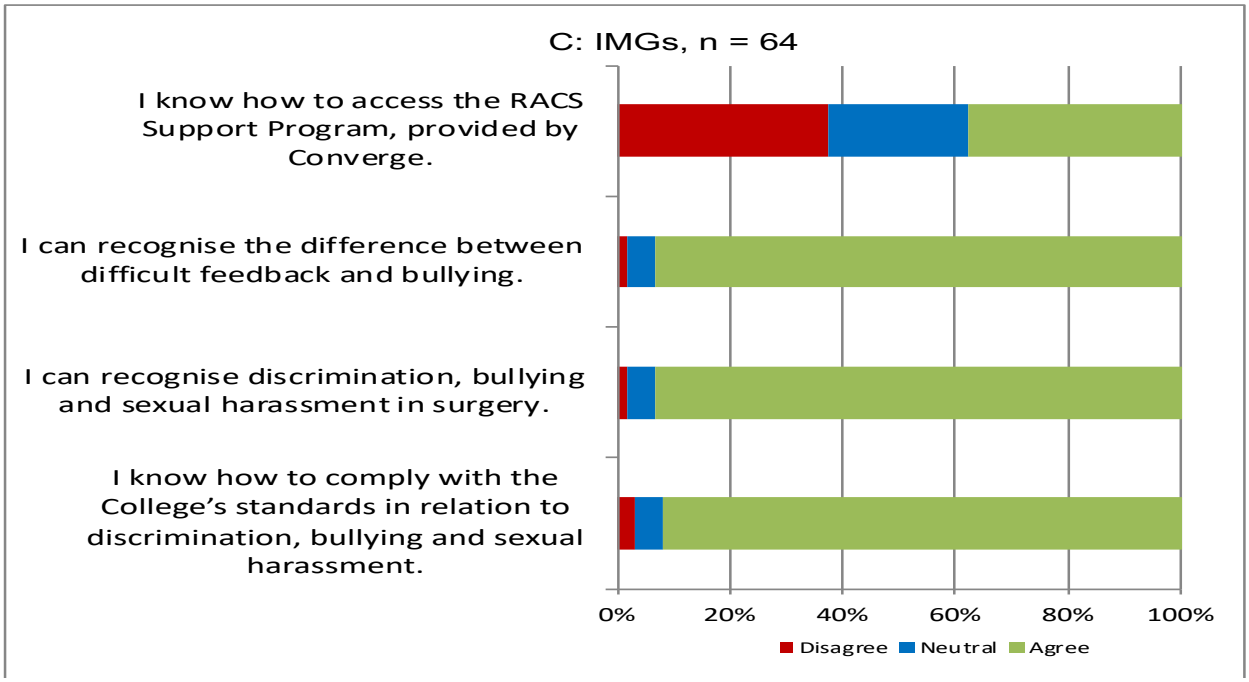
> *"Hospitals have posters everywhere"* (Fellow)
>
> *"Call to arms is being heeded"* (Councillor)
>
> *"The more it's in your face, on the College website and other places, the more its normalised."* (Trainee)
>
> *"It's 2019, are we allowed to say that anymore? We're supposed to Operate with Respect."* (Trainee referring to new forms of language in the workplace)

Both Trainees and Fellows declared that they had a strong understanding of the issues and the need to take action. The visibility of the issue has brought it out in the open, with many people describing a new and growing dialogue within the workplace around the issue of respectful behaviours, with the reach of awareness extending beyond surgery to encompass other medical disciplines. The survey confirmed that more than 90% of Fellows (Panel A, n = 1364), Trainees (Panel B, n = 253) and IMGs Panel C, n = 64) (Figure 3.3) perceive that they can recognise discrimination, bullying and sexual harassment, identify the difference between bullying and difficult feedback (Trainees and IMGs), know how to provide constructive feedback to their teams (Fellows) and know how to comply with the College's standards. Once again, the RACS Support Program (Converge) program was not as well understood as other aspects of the Action Plan, with nearly 50% of Fellows and Trainees and over 60% of IMGs not knowing how to access the program.

Figure 3.3 Knowledge about discrimination, bullying and sexual harassment







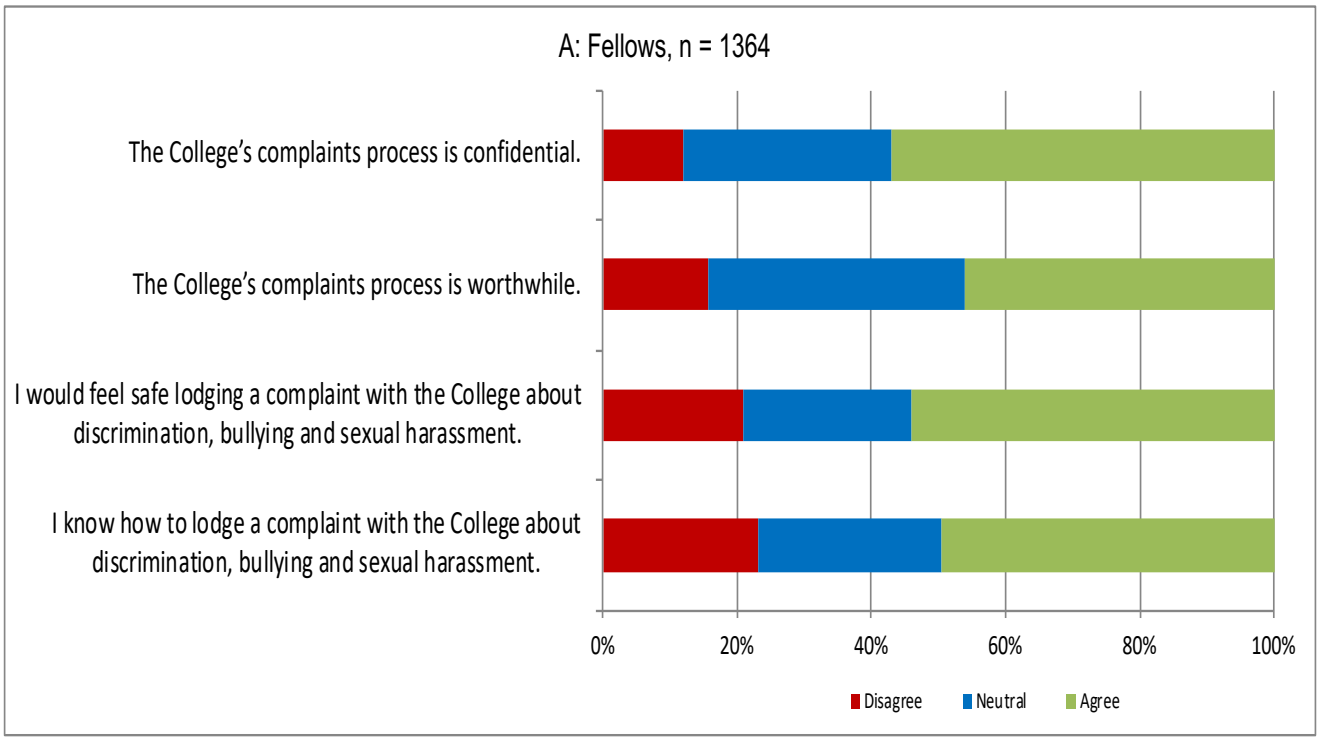
RACS' complaints process, like other complaints processes, is not perceived as safe.

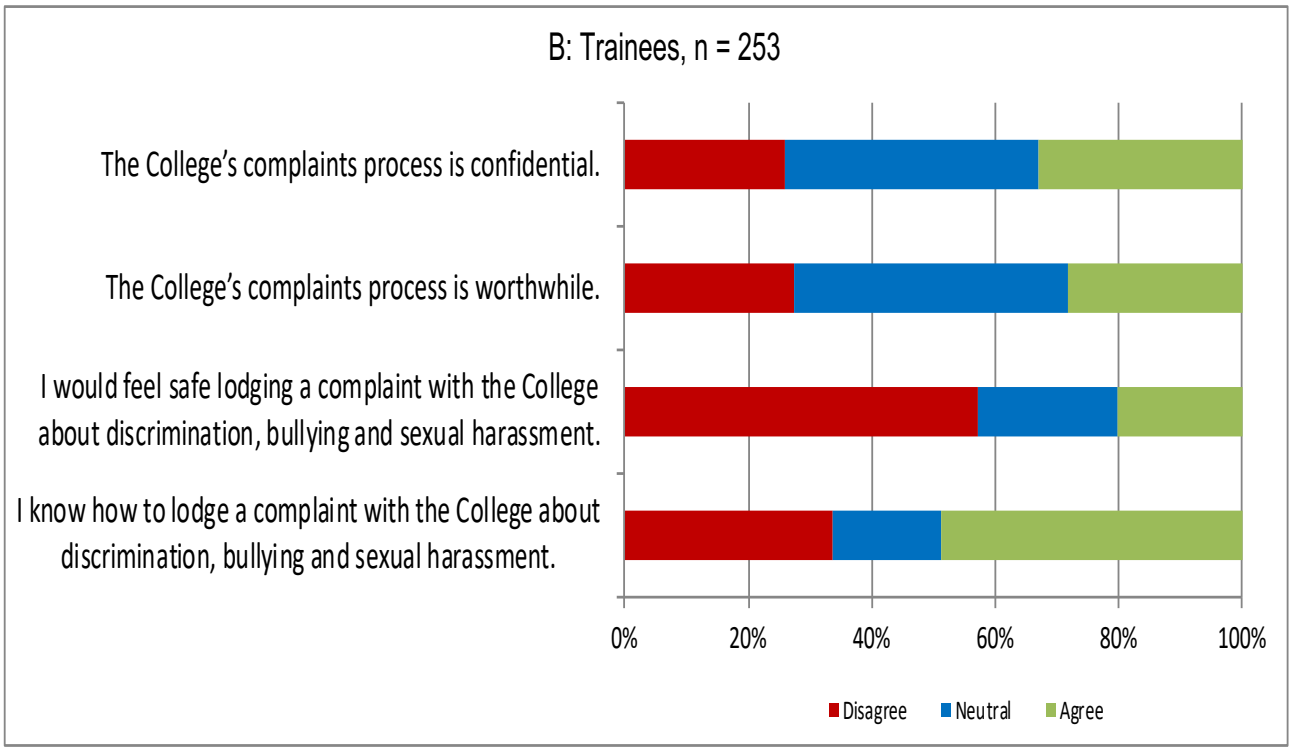
Figure 3.4 (Panels A-E) below highlights the differences in perception of the RACS complaint system. A significantly higher proportion of Trainees (55% of 253), IMGs (41% of 64) and females (37% of 265) do not feel safe to use the complaints system compared with males (17% of 1094) and Fellows (21% of 1364). These figures are comparable to the feelings of safety when making a complaint in the workplace (Figure 3.5, Panels A-C), where a greater proportion of Trainees (57% of 237) and IMGs (34% of 59) would not feel safe to lodge a complaint, compared to 22% of 1317 Fellows.

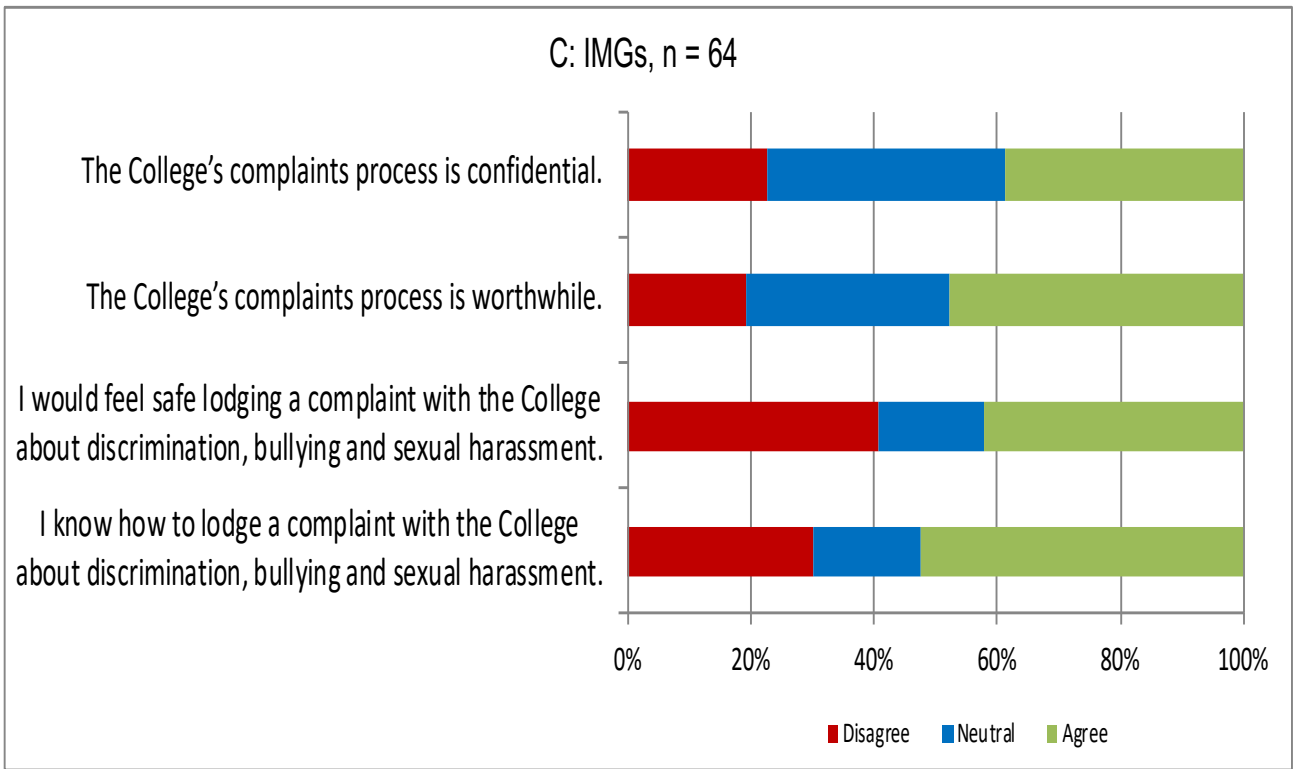
Overwhelmingly, the reason given for this perception was fear of being identified as the complainant and the potentially severe and negative career consequences, especially for those in small sub specialties. Other reasons given by Trainees included lack of time whilst completing studies; not knowing the detail of the process and a feeling that no action would be taken in response to their complaint. At least part of the perception about lack of action regarding complaints may be from historical experiences before implementation of the Action Plan.

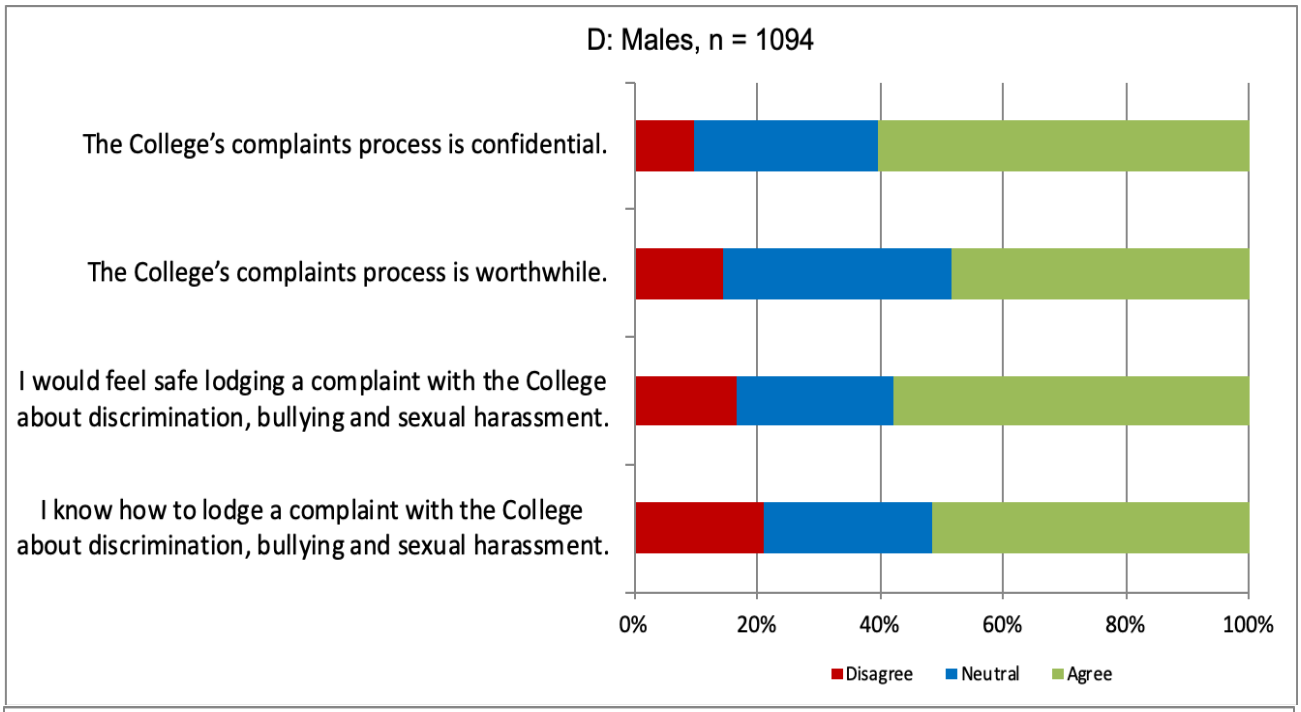
> *"My previous experience (of bullying) made me feel like I'm the bad one and nothing has been done about it."* (Trainee talking about a bullying complaint from 2014)
>
> *"… in 2019, I got swift action. There has been a culture change in that time…. This is no longer tolerated."* (same Trainee as above, about a complaint lodged in 2019)
>
> *"Every Trainee knows if you lodge a complaint you've shot yourself in the foot."* (Trainee)
>
> *"Complaints is the major thing holding back the Action Plan." (*Fellow)
>
> *"People need to be convinced that something will change before they will complain."* (Fellow)

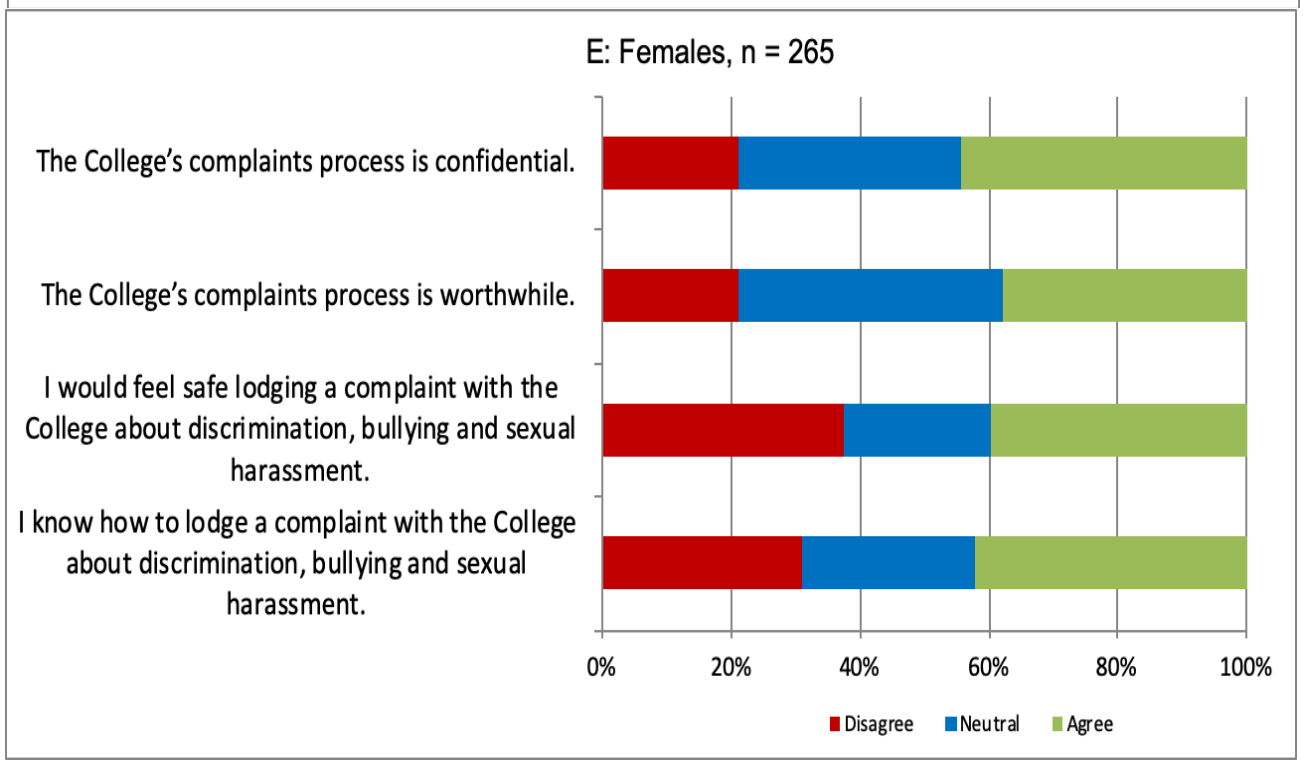
Figure 3.4 Perception of RACS complaints process




B: Trainees, n = 253
The College's complaints process is confidential.
The College's complaints process is worthwhile.
I would feel safe lodging a complaint with the College about discrimination, bullying and sexual harassment.
I know how to lodge a complaint with the College about discrimination, bullying and sexual harassment.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree


C: IMGs, n = 64
The College's complaints process is confidential.
The College's complaints process is worthwhile.
I would feel safe lodging a complaint with the College about discrimination, bullying and sexual harassment.
I know how to lodge a complaint with the College about discrimination, bullying and sexual harassment.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree

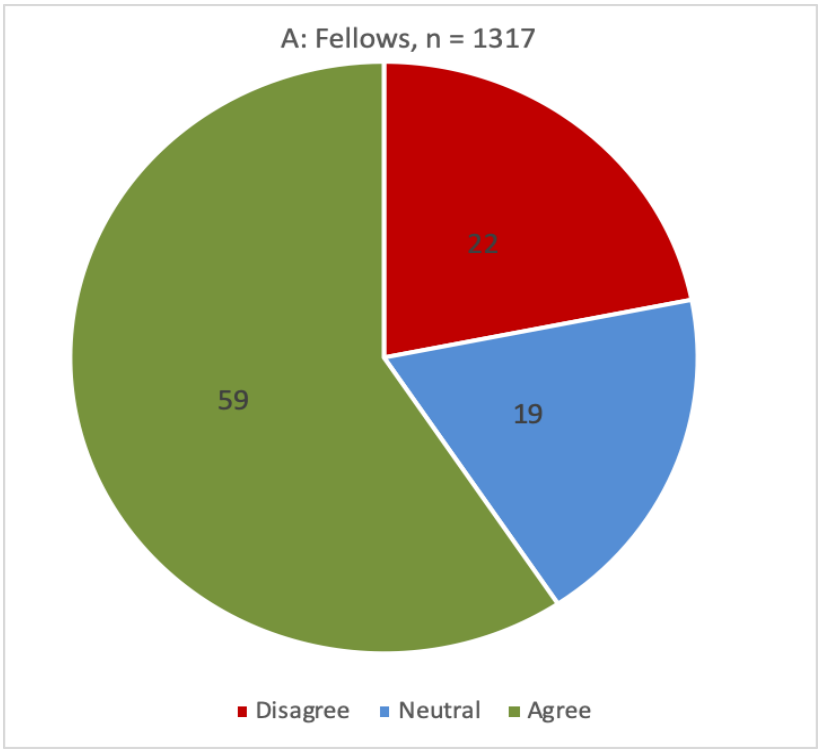


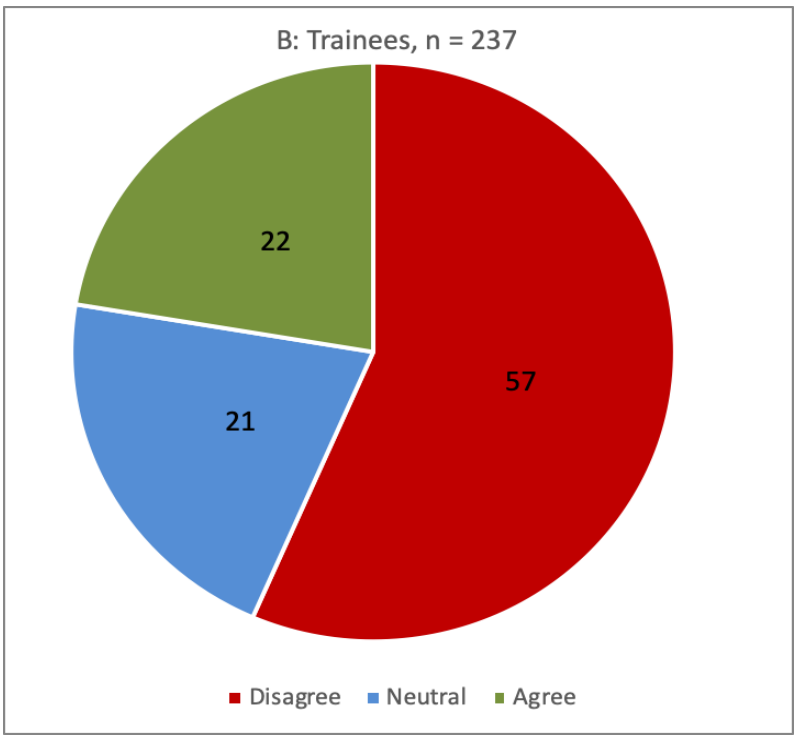


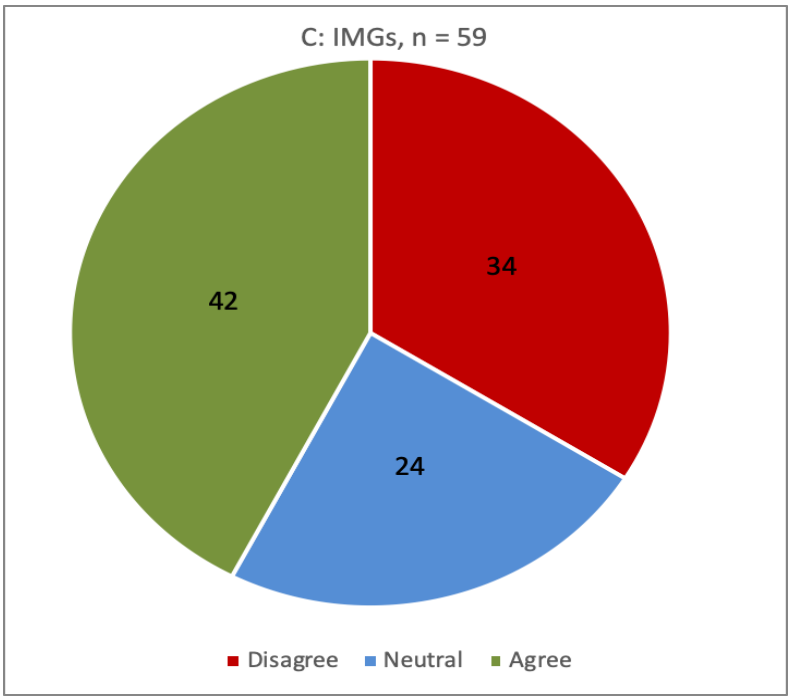
Whilst nearly 50% of Fellows and IMGs consider the College's complaints system to be worthwhile, slightly less than 30% of Trainees agree (Figure 3.4). A range of views were expressed about appropriate sanctions for offenders, ranging from removal from jobs to feelings of concern about harming another surgeon's career. However, there were many comments about known offenders staying in their jobs or being appointed to positions of power within the College. Interviewees and survey respondents expressed anger and frustration over times when the College has said it cannot take action as it is not the employer. This has been viewed amongst some as the College shirking its responsibility.

Trainees and IMGs also stand out as having far less confidence in the confidentiality of the complaints process, with only 33% of Trainees and 39% of IMGs feeling it is confidential, compared to 58% of Fellows. Other findings in relation to the RACS complaints process were that 50% of Fellows, Trainees and IMGs did not know how to lodge a complaint. Interviewees reported a lack of understanding of the processes, which is complicated by duplication with hospital process.

Figure 3.5 Feelings of safety regarding lodgement of a complaint about discrimination, bullying or sexual harassment at work







There is very strong support for the Action Plan.

The survey highlighted a remarkably high level of support for the College's commitment to addressing discrimination, bullying and sexual harassment in surgery, with 95% of 1346 Fellows, 96% of 244 Trainees and 93% of 62 IMGs supporting the College's commitment (Figure 3.6 Panels A, B and C respectively). When analysed by gender, the results show 92% of 1080 males and 96% of 261 females supporting the Action Plan (Panels D and E). These findings were confirmed at interview, with both Trainees and Fellows very supportive and impressed with how the College has approached the issue.

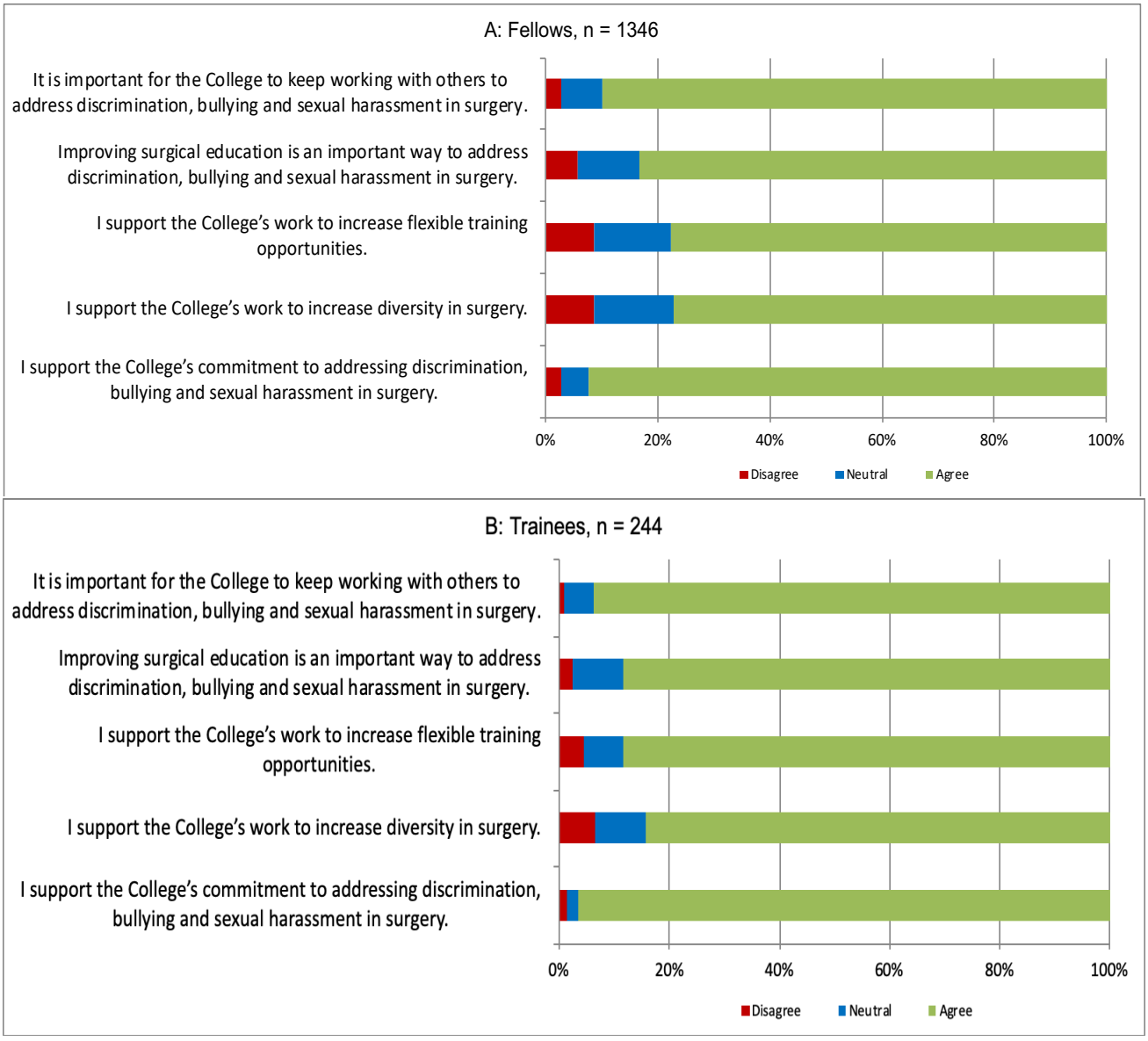
> *"The College is persistent. Hasn't let go of this." (Fellow)*

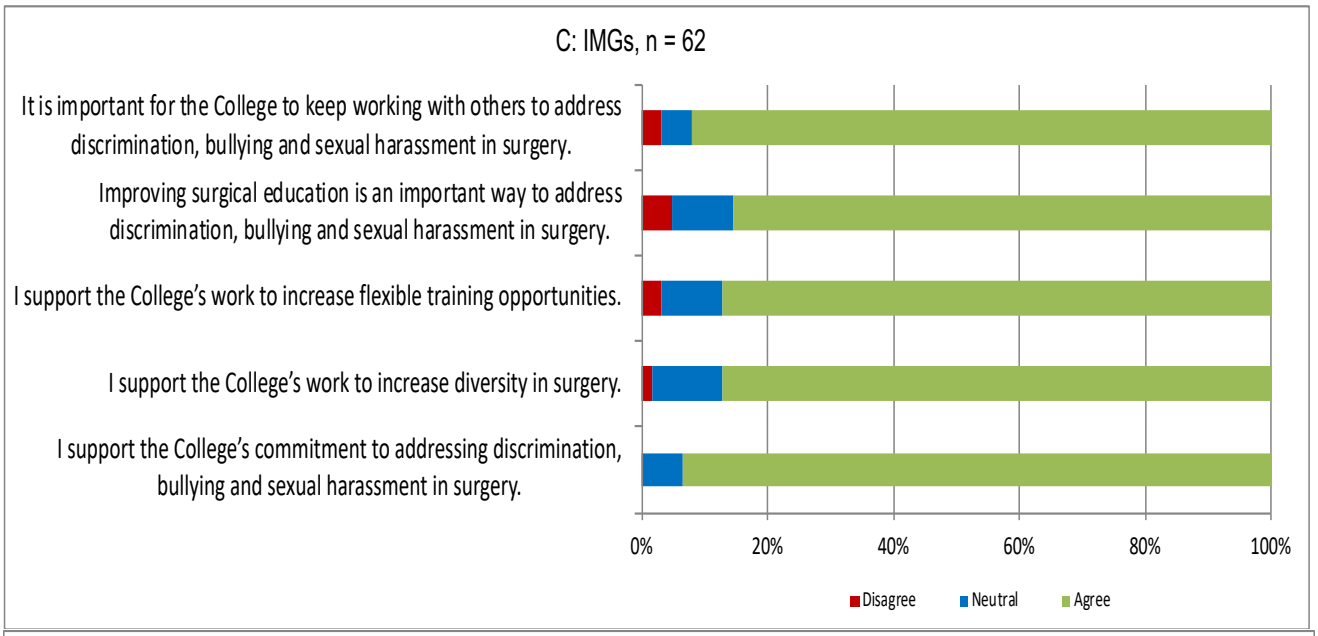
Survey respondents also indicated a high degree of support for the College to keep working with partners to achieve its goals, with 90% of 1346 Fellows, 94% of 244 Trainees and 92% of 62 IMGs expressing support (Figure 3.6 Panels A, B and C respectively).

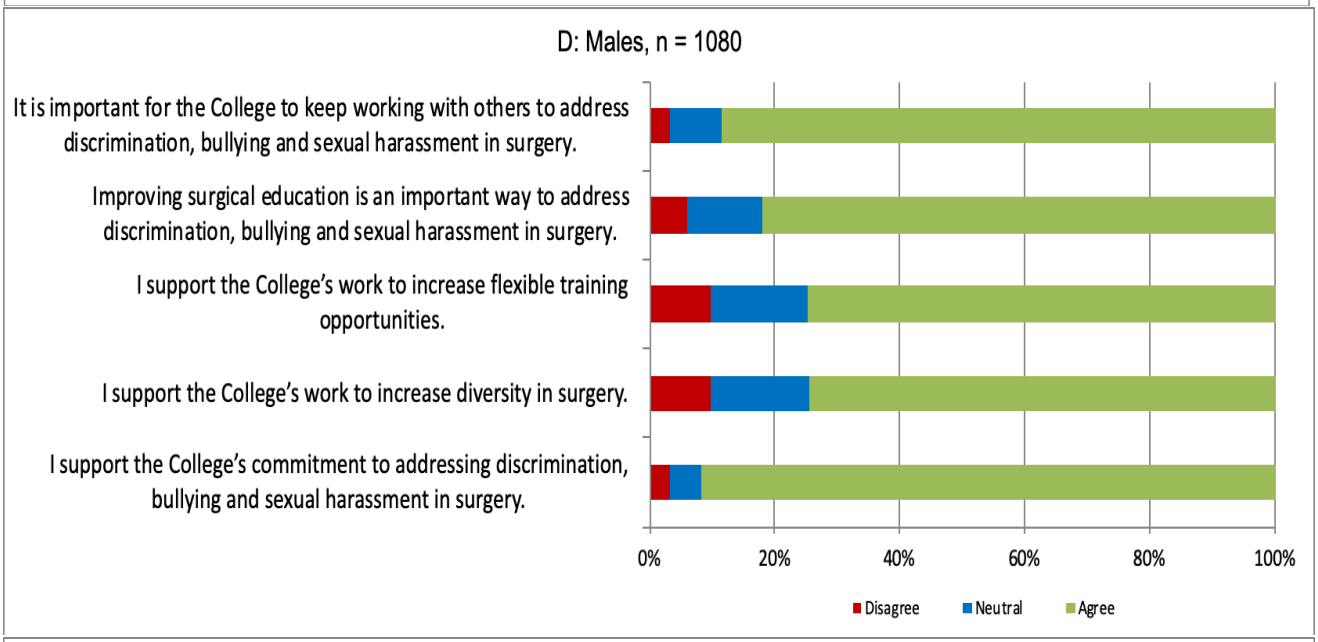
However, both at interview and through the survey, small but significant pockets of resistance to change were identified. Several interviewees (Fellows) expressed concerns regarding the availability of flexible training options, believing that this would dilute the experience of Trainees or significantly extend their training period to an unmanageable length. Concerns were expressed about the quality of surgical training in future if such measures were available. This finding was confirmed in the survey where 22% of 1346 Fellows either disagreed or were neutral about the availability of flexible training, and 18% were not convinced that education was the way to address discrimination, bullying and sexual harassment in surgery (Figure 3.6 Panel A). Work to increase diversity in surgery had similar levels of disagreement, with 22% of Fellows disagreeing or feeling neutral about this initiative. All of the more

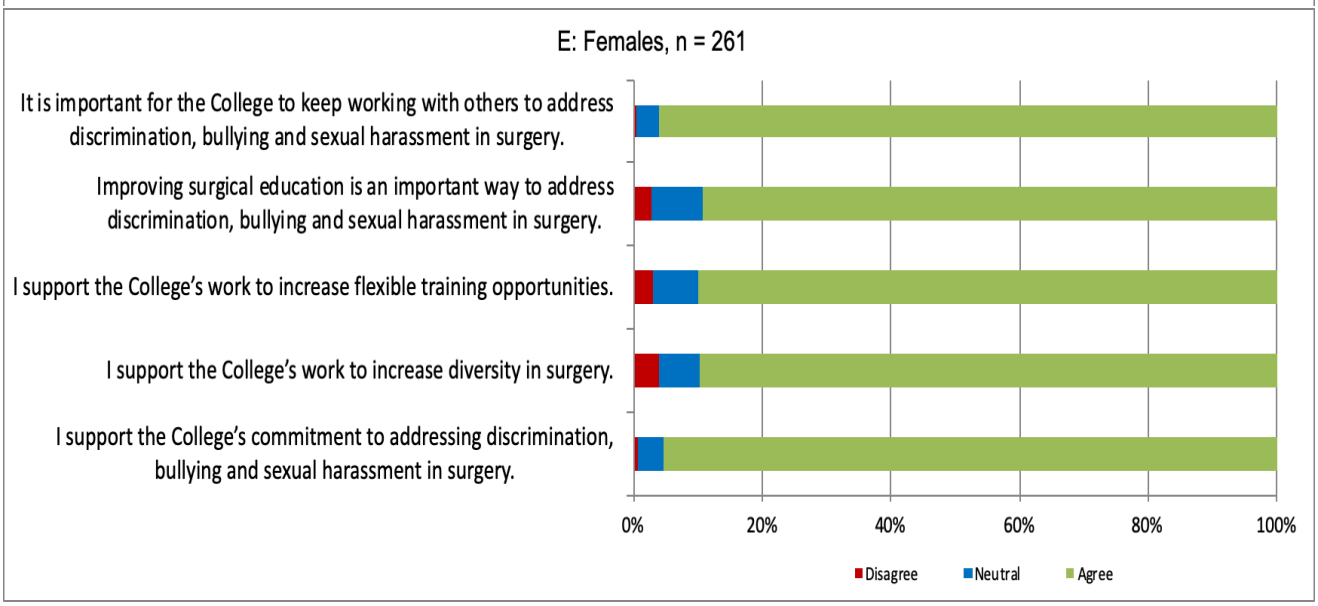
underrepresented groups, such as Trainees, IMGs and females, were more supportive of these changes (89% of 244 Trainees supporting flexible training and use of education to address the issues, 84% supporting work to increase diversity (Panel B) and similar figures for IMGs and females (Panels C and E). Overall, males were the least supportive of changes, with male Fellows the least supportive group of all. However, although this issue needs to be addressed, it is important to note that this represents only approximately 20% of Fellows, showing a high degree of support from the vast majority.

Figure 3.6 Level of support for key elements of the Action Plan




C: IMGs, n = 62
It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.
Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery.
I support the College's work to increase flexible training opportunities.
I support the College's work to increase diversity in surgery.
I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree


D: Males, n = 1080
It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.
Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery.
I support the College's work to increase flexible training opportunities.
I support the College's work to increase diversity in surgery.
I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree


E: Females, n = 261
It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.
Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery.
I support the College's work to increase flexible training opportunities.
I support the College's work to increase diversity in surgery.
I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery.
0%
20%
40%
60%
80%
100%
Disagree
Neutral
Agree

There is a strong understanding of the relationship between behaviour and patient safety.

The power of the message that an individual surgeon's behaviour or that of the team can impact on patient safety was demonstrated by the responses to the survey question shown in Figure 3.7 below, Panels A, B and C respectively. 95% of 1346 Fellows, 98% of 244 Trainees and 97% of 62 IMGs agreed. This message has been reported by interviewees as a strength of the Building Respect Action Plan and could be described as a critical success factor for the excellent outcomes achieved so far.

The FSSE course is seen as a strength.

Although only 65% of Fellows agreed that the FSSE course was relevant to their daily lives as surgeons, this course was also identified by interviewees as a key strength of the Action Plan. People delivering the courses were described as credible, enthusiastic and engaged, and the committee which runs the course is seen to be continually improving it and responsive to feedback. Interviewees reported observing people changing during the course, with some reluctant attendees saying, after the course, that they learned something.

> "*People who initially didn't want to be there come out and thank you at the end*." (FSSE trainer)
>
> "*FSSE course was brilliant on how to deal with pushback*." (Fellow)
>
> "*Big tick for convenors*." (Fellow)
>
> "*Engagement and enthusiasm of course presenters is infectious*". (Fellow)

Two thirds of respondents found the Action Plan elements to be relevant.

63% of Fellows and 62% of Trainees felt that the e-module was relevant to their daily lives as surgeons, compared with 84% of IMGs. The interviews did not clarify the reasons for this difference.

Several interviewees (Fellows) reported that they did not believe they need to learn how to behave more respectfully, whilst others had heard their colleagues say the e-module was a waste of their time.

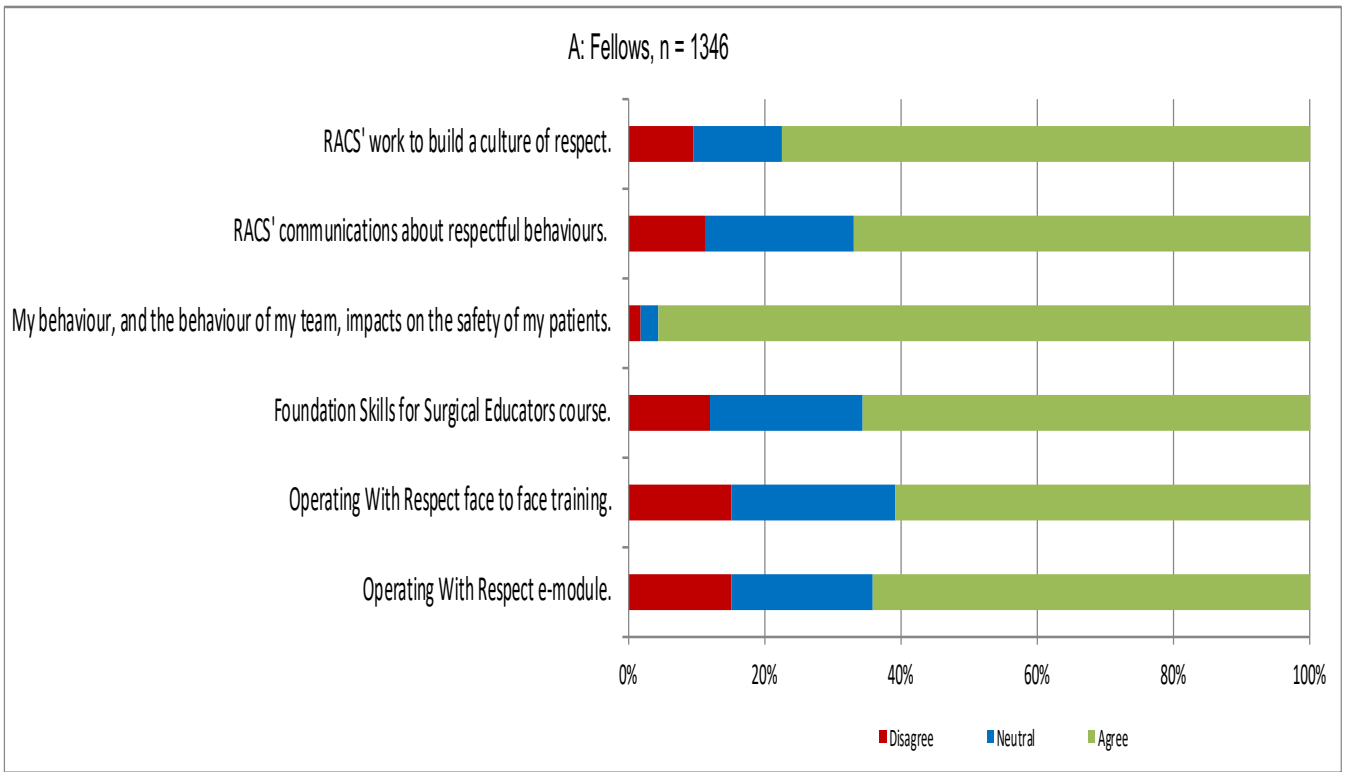
Interviewees who had completed the OWR face to face course spoke very positively about their experience. They believed that it is addressing a very relevant need and that it was well presented. They especially valued learning the practical use of the Vanderbilt approach. 61% of 1346 Fellows regarded the FSSE course as relevant (Figure 3.7 below, Panel A).

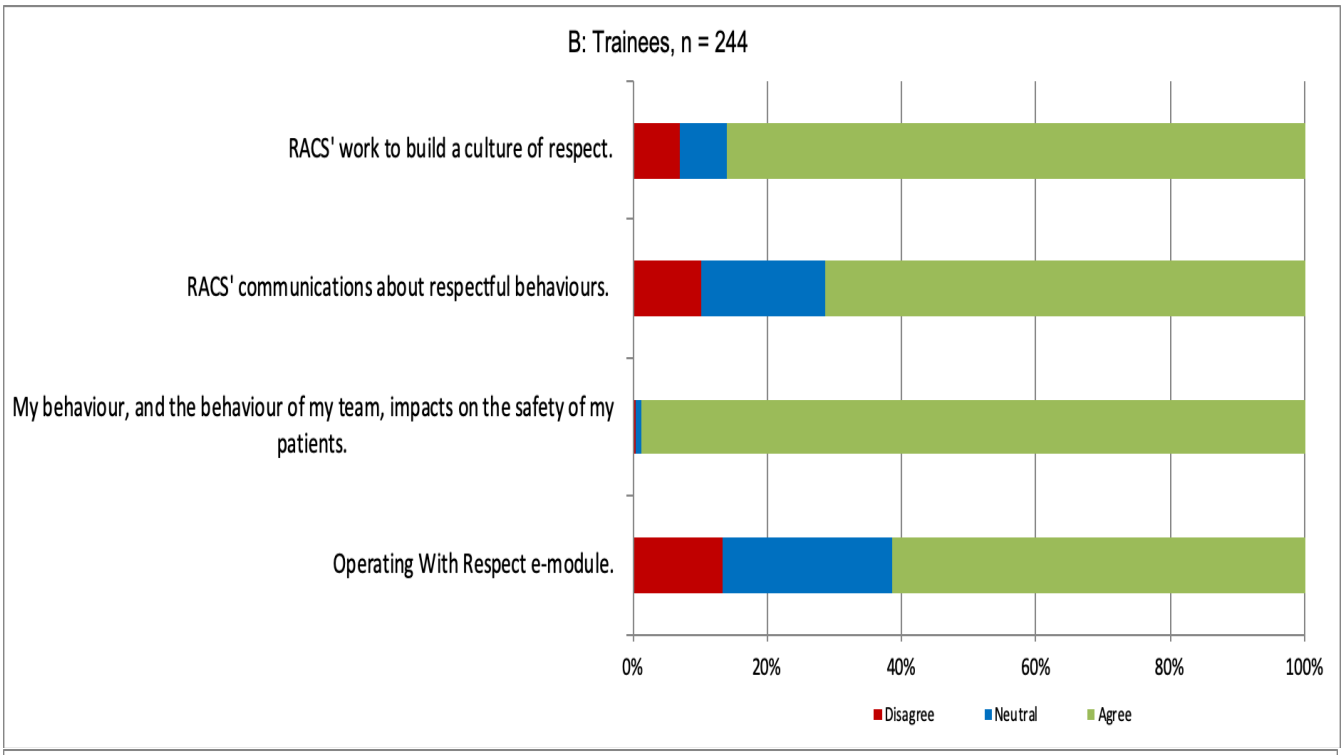
> The OWR e-module video was … "*exactly the same bullying I was receiving….it was subtle… glad it was displayed on the video.*" (Trainee)

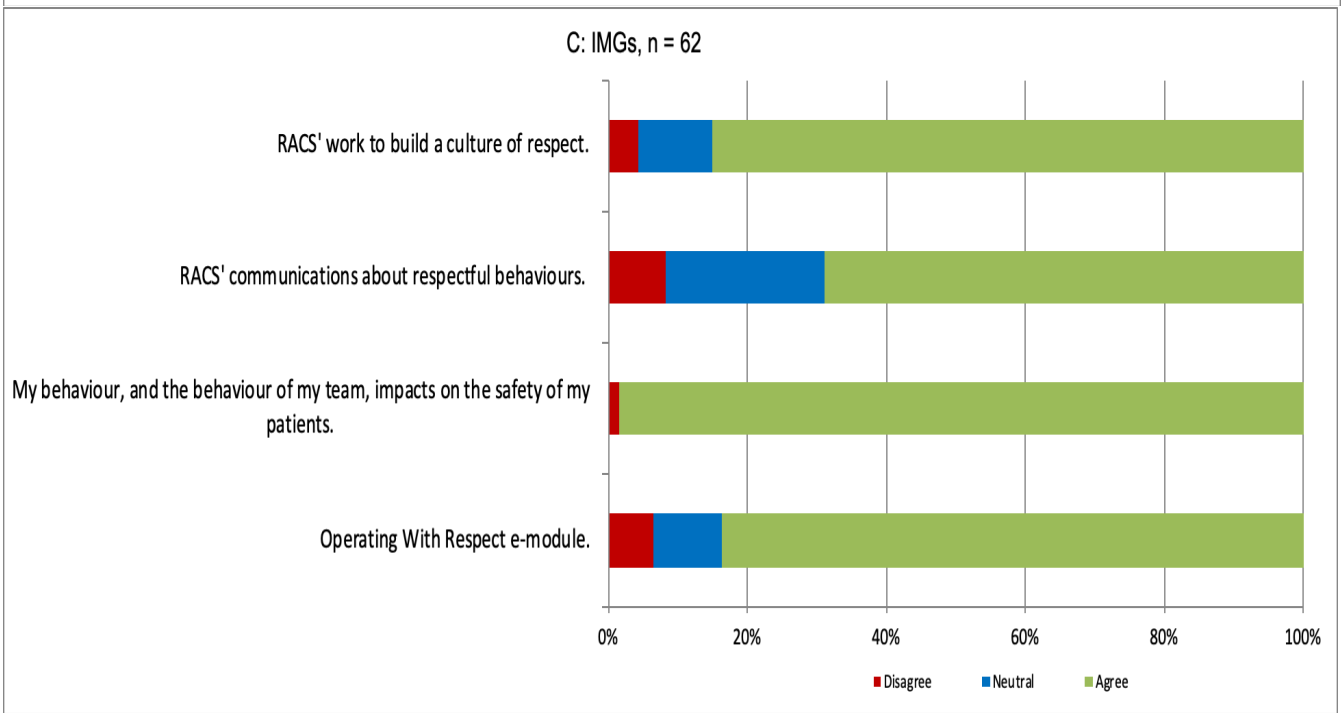
Around 70% of respondents found the communications to be relevant (68% of Fellows, 72% of Trainees and 68% of IMGs). More Trainees and IMGs felt that the College's work to build a culture of respect was relevant (87% of Trainees and 85% of IMGs compared with 78% of Fellows).

However, whilst all groups reported their support for the Action Plan and perceived it to be relevant to their surgical experiences, an incidental finding during this evaluation, was that Trainees do not seem to be as well engaged with the College as the other groups. This was evidenced by the extreme difficulty experienced in accessing Trainees for interviews, together with some reluctance of Trainees to discuss issues regarding unacceptable behaviours. The limited scope of this evaluation did not allow for this issue to be more fully explored, however it is possible that time limitations or fear of negative consequences for those highlighting unacceptable behaviours may be the underlying factors.

Figure 3.7 Perceived relevance of key elements of the Action Plan







Early outcomes are exceeding expectations.

Although this first phase evaluation was focussed on the implementation and governance of the Action Plan, one set of questions was included in the survey and interviews to obtain a baseline for comparison of future measurements of some of the important anticipated outcomes. The findings indicate some early changes are well progressed.

Increased awareness of the issues

Over 80% of survey respondents reported increased awareness of the issues of discrimination, bullying and sexual harassment in the workplace, including in other medical disciplines (81% of 1317 Fellows, 86% of 237 Trainees and 84% of 59 IMGs (Figure 3.8, Panels A, B and C respectively). 45-60% of respondents said that people are more likely to raise the issue (59% of 1317 Fellows, 45% of 237 Trainees and 58% of 59 IMGs (Figure 3.8, Panels A, B and C respectively). Although Trainees were the least likely to raise the issues, at interview they generally reported a change in workplace behaviour and feelings of increased confidence to call out unacceptable behaviour.

> "*Now I can speak for myself better than before. I can say this behaviour is not acceptable anymore.*" (Trainee with previous experience of bullying)

> "*Increased awareness of the problem in other disciplines.*" (Fellow)

Positive change in workplace culture

40 to 45% of respondents reported a positive change in workplace culture (41% of 1317 Fellows, 42% of 237 Trainees and 45% of 59 IMGs (Figure 3.8, Panels A, B and C respectively) whilst 38% of Trainees and 43% of IMGs felt that senior surgeons are more respectful when giving feedback. Some interviewees gave details of consultants now being much more aware of the need for care when providing negative feedback, and sometimes having a second person attend the meeting. Some Fellows said they are now less confident of providing negative feedback to their teams, because of a fear of being reported for bullying, however, 66% of Fellows in the survey, reported increased confidence.

Interviewees (Fellows and Trainees) stated that consultants are starting to understand what behaviours could be perceived as bullying, whilst others described the increased skills at addressing unacceptable behaviours as being really helpful. Although some interviewees felt that the pace of change was slow, others recognised that cultural change is gradual and the pace will increase over time.

> "*Floodgates are open now.*" (Fellow, about the likelihood of positive changes)

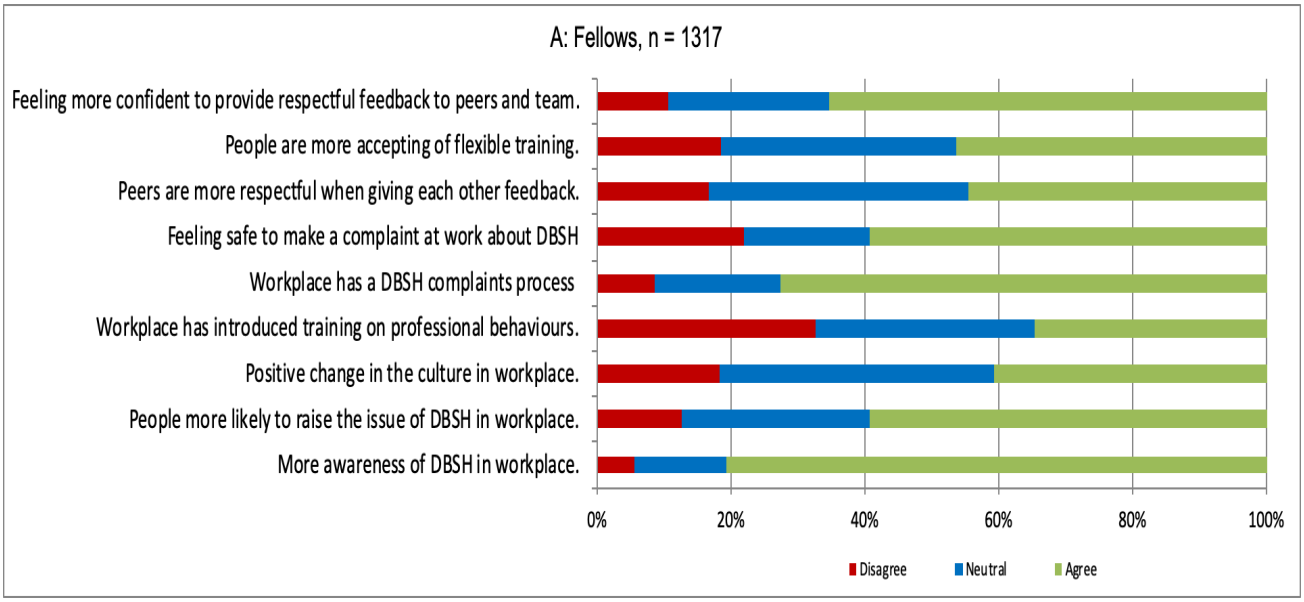
> "Slow pace of change is frustrating." (Fellow)

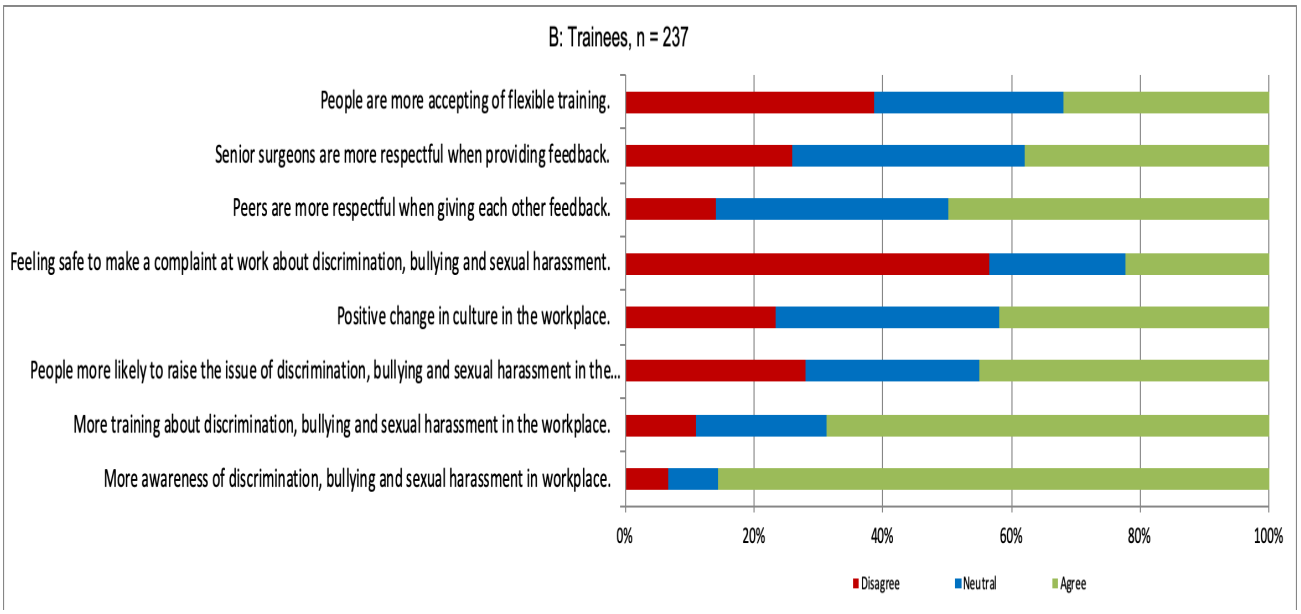
> "*Surgeons look after junior staff wellbeing*." (Trainee observing culture change)

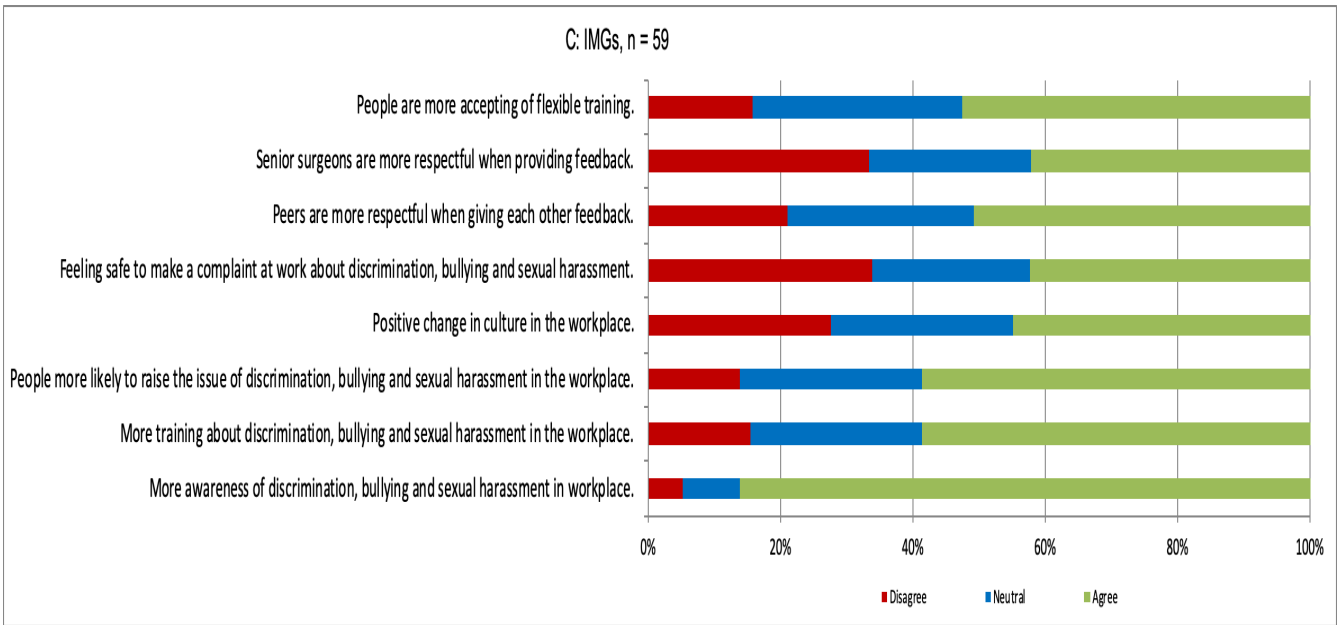
RACS is leading the way

The College is being quoted by other medical disciplines as a source of policy on acceptable behaviours. Although less than 40% of survey respondents reported that their workplace has introduced training in professional behaviours, many hospitals are now in the process of introducing the Vanderbilt principles, following the RACS example. The work of the College has also influenced other medical Colleges, including ANZCA, RANZCOG, RANZCO, ACEM and some international colleges, which are introducing the RACS model.

Figure 3.8 Perception of very early changes in the workplace







Representation of women is increasing towards gender equity targets.

Recent figures (Table 3.1) show that the representation of women is growing and progressing well towards gender equity targets. In 2018, 33% of applications for surgical training were from women, and 35% of those accepted into training were women, with the target for 2021 set at 40%. Representation of women on RACS Boards and Committees is ahead of target, at 27% in 2018, against a target of 20% by 2018 and 40% by 2020. Although this represents significant progress, there have been reports, by interviewees, of mixed reactions from a small number of female surgeons who do not want to be held up for special recognition because of their gender.

Table 3.1

	Applications to Surgical Training	Accepted into Surgical Training	New Fellows	Total Active Fellows	Women on Council and Main RACS Committees
2016	30%	25%	22%	12%	21%
2017	29%	31%	24%	14%	23%
2018	33%	35%	24%	13%	27%

KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?

Overall assessment of findings for this KEQ

The Building Respect Action Plan is extensively and effectively monitored. At this early stage of program implementation, the focus is on Action Plan outputs and activities, with regular reporting through senior management and the CEO, to Council, Board of Council and the Building Respect Implementation Group. External evaluation and review have been built in to provide outcomes reporting at the appropriate stage of program development and to inform the continuous improvement approach. There is evidence to indicate that adjustments are being made to the Action Plan as new evidence or practical barriers emerge. Importantly, RACS management and Council have identified the key strategic challenges for further implementation and already have plans to address them.

Strengths

Dedicated senior position

One of the major strengths of the Action Plan has been the establishment of a dedicated senior position to drive program implementation. This has achieved a focal point for advocacy, coordination and progress monitoring, which has contributed to the strong achievements to date.

Culture of continuous improvement

Another strength is the culture of continuous improvement, evident through the close monitoring of actions and outputs against plans, and the openness to receive recommendations from external reviewers and examine the evidence for emerging trends and ideas. This underpins the Action Plan's adaptability, agility and responsiveness.

Transparent reporting

Transparency is also a key strength of the Action Plan. There has been extensive reporting both within and externally to the College about progress towards a culture of respect and this has strengthened the College's position as a leader in this significant undertaking, and validated the importance of this work to its members.

Opportunities for improvement

Addressing the cost of the Action Plan

Action Plan implementation has been resource-intensive, particularly the mandatory education, which has been funded by diverting resources from other priorities. There is no comprehensive cost recovery plan which could support sustainability of the Action Plan in the longer term.

Incorporating Building Respect principles into Business as Usual

Although the Action Plan is nominally mentioned in the current RACS Strategic Plan, the Building Respect principles are not incorporated into the all the elements of the Plan.

Inform Council about the introduction of outcome reporting

Councillors spoke of their need to see outcomes reporting against the Action Plan, however, it is very early in the program implementation to be able to measure many of the outcomes with any certainty. It is important to inform the Council about the planned schedule for outcome reporting over the remaining two phases of the evaluation.

Detailed findings

The Action Plan has been resource-intensive.

Councillors reported that the College has committed significant funds, and has diverted resources from other priorities, in order to implement the Action Plan. At this stage, the education program, which has been the major area of activity in the Action Plan, has no cost recovery plan. Although Councillors are committed to the Action Plan, some concern was raised by interviewees about the need to develop a cost recovery plan so that activities can be sustained over the longer term.

Action Plan outputs and activities are being closely monitored.

Documentary evidence and discussions with the Executive Project Lead indicate that the Action Plan implementation is being closely monitored. The Executive Project Lead monitors all activities under the Action Plan and produces a detailed monthly Progress Update for the Building Respect Implementation Group, against each proposed action, highlighting achievements against targets, status and next steps. Monthly Building Respect progress reports are also submitted to Council and Board of Council as part of the CEO Report. The Expert Advisory Group meet biennially to review progress against the Action Plan.

Annual Progress Reports highlighting progress against the major action areas of Culture Change and Leadership, Diversity and Inclusion, Strengthening Surgical Education and Complaints Management, and including proposed next steps, are published and widely distributed both within the College and to external stakeholders.

Interviews with Council members confirmed that they feel well-informed and that the Action Plan is discussed at every meeting, with a focus on education, which has so far been the major thrust of the Action Plan. Councillors reported some concern that the information they received on complaints may not have reflected the most accurate status of complaints, however this is currently being reviewed.

One area for improvement raised by Councillors was that this reporting is focussed on activities, and outputs, such as attendance figures for education courses, compliance and numbers of complaints, and they have not received any information on outcomes. At this stage of implementation, it is appropriate to focus on outputs, as the Action Plan is still in the early phase of implementation and it is too early to formally measure any significant outcomes. This evaluation will provide the first evidence of the very early outcomes being achieved. It will be followed by a second phase evaluation, with a greater emphasis on outcomes, due to report in mid 2021.

Program outcomes are being evaluated as they develop.

Behaviour change programs are based on changes firstly to awareness or knowledge, then to attitude, followed by behaviour change, noting that this process is not actually linear in practice and often many of these outcomes can be observed happening at once. The outcomes for a cultural change program such as the Building Respect Action Plan, take considerable time, often years, to develop to the extent that they can be measured. Therefore, it is important to measure the outcomes after an appropriate implementation period has been in place, and it is not practical to measure or report on progress in time periods of less than 12-24 months.

An Evaluation Framework for the Building Respect Action Plan was developed in 2018. This was specifically designed to build on data already being collected to evaluate the outcomes of the Building Respect Action Plan over the short, medium and long term (at 3-, 5- and 10-years after implementation). The three planned evaluations will provide a measure of the extent to which the program outcomes have been achieved, and will inform program improvement.

In addition to the formal evaluations of the overall Action Plan, RACS has engaged an independent external reviewer for the complaints process, to provide continuous improvement opportunity in this critical area. The first review took place in late 2017 and reported in January 2018, however, due to delays in completing the response to the recommendations, the second review has not yet taken place i.e. it is six months behind schedule.

The Diversity and Inclusion plan has not been subject to evaluation in its entirety however, progress against all actions in the plan are reported on a twice-yearly basis. A gender diversity dashboard is also updated twice yearly and includes figures showing female participation in a range of activities including selection to surgical training. Evaluation of this plan is to be included as part of Phase 2 evaluation of the program as a whole.

Emerging evidence and lessons learned inform practice.

Evidence continues to inform practice in adapting the Action Plan to new developments. Gerald Hickson, a leading researcher, was invited by the College to Australia to present his insights and the latest research findings, in October 2018 at select meetings and May 2019 at the Annual Scientific Conference and to RACS staff and partners. This evidence-based information continuously informs the complaints handling and education programs of the Action Plan.

RACS has responded to the external review of its Discrimination, Bullying and Sexual Harassment complaints process by completing implementation of the majority of the recommendations within less than six months. The remaining actions are either in progress or under review due to subsequent changes to the complaints process.

RACS is also supporting research to inform its gender diversity commitment. Research into the reasons why women leave surgical training at higher rates than men has been completed and published, with the findings progressively informing the Action Plan

activities. Separate research into the barriers for women selecting surgery as a specialty is underway, and the findings expected to inform future activity.

RACS has also made a commitment to evaluating its Action Plan at three time points (2019, 2020 and 2026) and to adapting the Action Plan in response to the recommendations.

RACS is addressing identified strategic challenges for further implementation.

A key strength of the Action Plan oversight is that RACS has identified the major challenges ahead and has begun to plan how they will be addressed. In a presentation made in November 2018, the Council President identified the following challenges and illustrated how Council intends to address them.

- Measuring progress: Already addressed through development of the Evaluation Framework.
- Overcoming communications fatigue: A refreshed communications campaign has already begun to be implemented, targeting new behaviours.
- Overcoming training fatigue: No new mandatory training is planned; however, all new Trainees must complete the online module as part of their application for a training place.
- Resonating with a diverse membership: Constant review and updating of communications.
- Cynicism (and fears) around complaints management and information sharing: The complaints process is currently under review.
- Fear of identification and reprisal in raising a complaint (trainees): As above, but also acknowledging the need to communicate positive stories.
- Stigma associated with flexible training: Plans to share experiences of good outcomes to show acceptability.
- How to maintain progress in achieving gender equity targets? Possible insights from the work of other colleges, plus other groups such as male Champions of Change.
- Maintaining momentum: Planning for integration of the Action Plan into Business as Usual.

However, despite a commitment to integrating the Building Respect principles into Business as Usual, it is not explicit in the 2019-2022 RACS Strategic Plan.

RACS reports transparently to stakeholders about progress towards building a culture of respect.

The commitment and achievements of the RACS Building Respect Action Plan have been widely reported, both internally and externally. This has been achieved through publication and external dissemination of the Annual Progress Updates, presentations by the Council President at the Annual Scientific Conference and by invitation to various audiences throughout the year, through updates provided by STANZ Chairs at State-level meetings and via MOU meetings with representatives from jurisdictional health departments and hospital or employer partner meetings.

In addition, the RACS website has a significant amount of up to date information and reports, there has been much information dissemination via social media and regular articles appear in the RACS member newsletters, *Surgical News and Fax Mentis.*

4. Conclusions and Recommendations

4.1 Conclusions

The Building Respect Action Plan is being implemented effectively and is achieving its intended goals so far. This is a significant achievement, given the size and complexity of the task, which involves coordination of a broad range of activities through partnerships with health jurisdiction and hospitals across two countries.

A strong and effective communications campaign, together with an extensive and targeted education program, conducted in the context of a society that no longer tolerates disrespectful behaviour, has resulted in strong permeation of the Building Respect messages throughout the membership. This is leading to very positive early changes in behaviour and attitudes in workplaces across Australia and New Zealand.

Visible support from the most senior levels of the College is a strength which underpins the success of the implementation, and it is essential that this level of support continues into the future, to maintain the momentum of early implementation success.

Opportunities for improvement centre on review and adjustment of the complaints process, to achieve best practice principles and improve trust and acceptance of the process. Related to this is the opportunity to improve the messaging to Trainees and IMGs and increasing understanding of their issues and experiences. Integrating Action Plan activities into Business as Usual, including incorporation of the education into the core curriculum, will ensure ongoing and cost-effective actions towards a building a culture of respect.

4.2 Recommendations

1. Maintain momentum through visible high-level support for the Action Plan

Why it is important

The strong and visible commitment of the RACS Council to deliver the Action Plan goals has been a critical success factor for the successful implementation of the Building Respect Action Plan. This is evidenced by the level of resourcing for Action Plan implementation and the focus that Council has maintained at every meeting. It is important not to lose sight of the contribution of this commitment to keeping the College in the lead on this issue. Maintaining this level of focus on the Action Plan goals will keep the momentum as the Action Plan enters the next phase of delivery.

How it would look in practice

1.1 Maintain focus and drive through the Executive Leadership Team.

Maintain the momentum for implementation by continuing to focus on Action Plan outcomes at senior level.

1.2 Maintain the high visibility of Council support through external reporting and presentations.

Continue with the President's presentations, other presentations at conferences and both internal and external annual reporting to demonstrate the commitment of the Council and other office bearers, including at the STANZ level, to building a culture of respect.

1.3 Maintain high visibility of the Action Plan through a strong communications function.

Continue to fund and support the communications function, to review and update the messages and to refocus the communications on changing priority areas as the Action Plan is implemented.

1.4 Ensure Business as Usual integration by incorporating the Action Plan principles throughout the RACS Strategic Plan and annual workplans.

Demonstrate Council's commitment to the Action Plan goals by visibly integrating the principles into Business as Usual and make it central to how all College activities are delivered. Strengthen its place in the Strategic Plan and annual workplans to underpin all activities and values.

2. Review the complaints process to increase confidence that problems will be dealt with proportionately

Why it is important

Establishment of a trustworthy, effective and reliable complaints process is a critical success factor for achievement of the Action Plan goals. Cultural change towards a more respectful workplace depends substantially on the ability to call out offenders, which, in turn, relies on having an effective complaints system in place.

How it would look in practice

2.1 Clarify and articulate RACS's role in the complaints process

Establish and agree the appropriate role for the College in the overall complaints system, including its legal and moral obligations to ensure a safe training environment, and to support cultural change in the practice of surgery. Once agreed, this should be clearly communicated to members.

2.2 Review the complaints process to ensure alignment with best practice

Ensure incorporation of best practice complaints handling, as outlined in the EAG recommendations, with the current review of the RACS complaints system. This includes a system which is clearly communicated to members, is transparent, timely and procedurally fair. As far as practical, align the RACS complaints process with hospital and regulatory systems.

2.3 Continue with regular external reviews of the complaints process

Maintain the practice of regular review and revision of the complaints process to ensure alignment with best practice principles and maintain a continuous improvement approach.

2.4 Increase the capacity of the mediation and advice/support process
Create positions within the College or in workplaces, to act as a source of informal advice and support as an alternative to making a formal complaint. Ensure these positions cover a diverse range of age, gender and geographical distribution.

2.5 Build expectations and rebuild confidence
Manage expectations around the potential outcomes of complaints and the proportionate responses for each level of inappropriate behaviour. Continue to publish the statistics from the complaints process, to highlight actions taken in response to complaints.

2.6 Monitor data, analyse trends and act to prevent further issues
Gather and regularly analyse complaints and other related data so that repeat offenders or hotspots can be identified. Continue to monitor workplaces where complaints have been unsubstantiated. Build a stronger partnership with RACSTA to facilitate Trainee engagement. Take action through training post accreditation.

3. Leverage the strengths of the existing Building Respect communications approach.

Why it is important
The communications function has been a critical success factor for the Building Respect Action Plan. The strong messages have permeated through the membership and support and underpin the cultural change activities by keeping the call to action at the front of mind. Messages have been updated for year three of the Action Plan. Maintaining the focus on strong and effective messaging, whilst adapting the messages for each new phase of implementation will be critical to support the Action Plan goals.

How it would look in practice
3.1 Maintain high visibility of the Action Plan through a strong communications function.
Continue to fund and support the communications function. Continue to build understanding of issues underlying discrimination, bullying and sexual harassment, to inform review and update of the messages. Refocus the communications on emerging priority areas as the Action Plan is implemented, to keep these issues at top of mind across the profession.

3.2 Use local champions to amplify the message
Establish a diverse group of local champions, for peer to peer communication and amplification of the key messages. Continue with work on development of the Surgical Directors groups and development of Key Opinion Leaders in each craft group.

3.3 Target communications to Trainees and IMGs
Develop specific messages and communication mechanisms for Trainees and IMGs to improve their awareness of key messages, the complaint system and the available support services.

4. Embed Action Plan into College planning and governance.

Why it is important

A major goal of the Action Plan implementation is to embed it into Business as Usual for the College. Incorporating Building Respect principles into College planning, including strategic planning, will ensure that all activities will include Building Respect performance indicators and help to maintain a focus on the Action Plan goals in everything the College does.

How it would look in practice

4.1 Align Action Plan reviews with RACS strategic planning

Align periodic reviews of the Action Plan with the Action Plan evaluation schedule and RACS strategic and annual planning to ensure consistency and embed building respect principles into the College's planning process. Align contextual reviews so that emerging priority action areas such as safe working hours, rotation of training impact on leave or the status of unaccredited trainees can be incorporated into Action Plan activities, where relevant. Reviews should consider updating of measurable targets and timelines for the implementation so progress can be readily measured.

5. Investigate cost recovery options for Building Respect courses.

Why it is important

The Action Plan has been an expensive initiative for the College, with education as the centrepiece of the first two years of activity. It would not be sustainable for the College to maintain this level of financial commitment to the education component into the future. Now that over 98% of members have completed the mandatory training, it is timely for the College to examine a cost-effective way to integrate the Building Respect principles into future education and training.

How it would look in practice

5.1 Integrate the Building Respect principles into RACS core curriculum.

Identification of opportunities to incorporate the Building Respect principles into the core RACS curriculum is in progress. This will avoid the need for separate and expensive courses.

5.2 Investigate other cost recovery models for delivering professional skills training.

Consider other options for delivery of the Building Respect messages, including through partnerships with hospitals and other colleges.

6. Improve understanding of the issues faced by Trainees.

Why it is important

One of the main drivers for the establishment of the Action Plan was the wish to improve the experience for surgical Trainees. Understanding their daily experiences, their issues and their viewpoints in relation to the culture of surgical education is therefore a crucial part of ensuring that the Action Plan continues to adapt to address issues relevant to this important cohort.

How it would look in practice

6.1 Conduct an extensive consultation with Trainees.

Develop and deliver a comprehensive, staged and targeted consultation process to engage with surgical Trainees and gain understanding and insights into their issues, views and challenges in relation to the culture of surgical education and other related matters. This could be achieved through a combination of existing mechanisms such as the RACSTA survey and through internally or externally facilitated surveys, interviews and focus groups. Incorporate findings into the review of the Action Plan and adapt the Action Plan accordingly.

5. Attachments

Attachment 1: Building Respect, Improving Patient Safety Action Plan

Attachment 2: Building Respect Program Evaluation Framework

Attachment 3: Building Respect Program Logic Model

Attachment 4: Stakeholder Engagement Plan

Attachment 5: Survey Questions

Attachment 6: Semi-structured Interview Questions

Attachment 7: Definitions and common terminology

Attachment 1: Building Respect, Improving Patient Safety Action Plan

https://www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf

Attachment 2: Building Respect Program Evaluation Framework

https://www.surgeons.org/media/25716928/Building-Respect-Action-Plan-Evaluation-Framework-FINAL-REPORT-SHORT-VERSION-2018-08-08.pdf

Attachment 3: Building Respect Program Logic Model

The issue

In 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG) to investigate the extent of discrimination, bullying and sexual harassment within the surgical profession. EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. This is of concern for the wellbeing of individual surgeons and surgical trainees, of surgical teams and especially for the quality of care and safety of patients.

The response

RACS responded by apologising to all people affected by these unacceptable behaviours, accepting all of the EAG's recommendations and developing an Action Plan, *Building Respect, Improving Patient Safety,* which outlines how RACS intends to counter and drive out these unacceptable behaviours from surgical practice and surgical training.

Values underpinning the Action Plan

- Every healthcare worker has the right to a workplace free of unacceptable behaviours and every student/Trainee has the right to an education free of unacceptable behaviours.
- Patient safety should be the absolute and common priority in the workplace and every patient has the right to expect that their healthcare will not be compromised by unacceptable behaviours.
- Every applicant, trainee and surgeon has the right to be treated equally and with respect, regardless of their gender or cultural background.
- Teams work most effectively when there is respect for the skills, experience and contribution of each member.
- The success of work-based teams is measured by the safety of the workplace and the educational environment and by the extent to which all team members recognise that what they achieve together is more valuable than anything they can achieve on their own.

The vision of RACS' Action Plan

The Action Plan's vision is *to build a culture of respect in surgical practice and education*, which will contribute towards:

1. Improved patient safety.
2. Surgical workplaces that are safe and free from unacceptable behaviours.
3. A surgical profession that is more representative of the cultural and gender diversity across the community.

Cultural Change and Leadership					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Revise and introduce new policies and procedures which incorporate standards of respectful behaviour and value diversity and collaborative practice Lead the surgical profession (Surgical Training Boards, RACS Committees and Specialty Societies) on introduction of policies and practices that promote respectful behaviours	Principles, policies, procedures, codes of conduct, terms of reference, RACS Code of Conduct, Standards of behaviour Terms of reference for Training Boards revised to include external representatives, access to medical education experts, female surgeons and Trainees	Implementation of a structure and policy framework to underpin desired behaviours Fellows, trainees and IMGs are aware of the expected standard of conduct	Specialty Societies, Specialty Society Training Boards and RACS collaborate on incorporation of respectful behaviours into policy and practice More diverse membership of Specialty Societies, Specialty Society Training Boards and RACS committees including external, non-surgical representatives	Fellows, trainees and IMGs feel safer and less at risk of unacceptable behaviours and more confident to speak up about unacceptable behaviours The membership of RACS reflects the diversity of the general community	
RACS Diversity Plan published and communicated Conduct cultural competency training promoting awareness of Aboriginal and Torres Strait Islander, and Maori culture	Targets established for the involvement of female surgeons in leadership positions, such as on Training Boards and as examiners System of monitoring, reporting and acting on the rates of application, selection and attrition Cultural competence training programs conducted	RACS Diversity and Inclusion Plan developed and disseminated Diversity principles are communicated to RACS employees, partners, selection and training bodies and the whole surgical profession Barriers to provision and uptake of flexible training options are identified Diversity opportunities are communicated to Trainees Regular review of monitoring data on the rates of application, selection and attrition to identify barriers for women, Aboriginal and Torres Strait Islanders, Maori, and people from other diverse cultural backgrounds in surgical training and RACS committees	Trainees are aware of opportunities for flexible training and more confident to seek these out Increase in flexible options for surgical training (eg part time placements) Review of training program and selection process to address identified barriers The applicant field for surgical training is increasingly diverse	More women and culturally diverse surgeons, trainees, IMGs and Fellows remain in surgical training Reduced barriers based on gender or culture for entry to or progression within the surgical profession RACS becomes the industry leader in facilitation and promotion of flexible training opportunities	

Cultural Change and Leadership					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Conduct communication, awareness raising and capacity building activities to increase recognition of and skills in managing unacceptable behaviours	*Let's operate with respect* campaign, posters, blogs, newsletter articles, promoting training courses, events, presentations, speakers, commentators, research	Fellows, Trainees and IMGs can recognise unacceptable and reportable behaviours in themselves and others Fellows, Trainees and IMGs understand the need to address unacceptable behaviours in themselves and others Fellows, Trainees and IMGs understand the need to demonstrate professional behaviours Open discussion of what constitutes 'respectful' and 'unacceptable' behaviour	Fellows, Trainees and IMGs have the confidence to address unacceptable behaviours Fellows Trainees and IMGs have the required skills to speak up about unacceptable behaviours Fellows, Trainees and IMGs observed engaging in unacceptable behaviours receive constructive feedback	Fellows, Trainees and IMGs take appropriate action to address unacceptable behaviours in themselves and others Fellows, Trainees, IMGs and patients perceive a fair and safe surgical workplace People who work with surgeons perceive improvement in teamwork, collaboration and communication	
Develop and progress implementation of models for collaboration with hospitals, governments and universities in Australia and New Zealand on programs to incorporate respectful behaviours Lead and create partnerships within the health sector in Australia and New Zealand to improve management of unacceptable behaviours	Recognition of common goals, roles and responsibilities with partner organisations MOUs with collaborating orgs Established partnerships	Increased cooperation / collaboration with hospitals, governments and employers about prevention and management of unacceptable behaviours Increased communication and sharing of knowledge on respectful behaviours across organisations and within the profession Active engagement of the RACS Surgical Directors Section and STANZCommittees and Boards Established agreements, MOUs and SOIs with partner organisations	Development of joint or aligned processes for cultural change programs Development of joint or aligned processes for complaints management and sanctions Organisations employing or training surgeons collaborate to improve standards of behaviour and training Government policies in Australia and New Zealand consistent with the goals of this Action Plan Alignment and information sharing with MOU partners (within the law) about complaints management	MOU partner organisations, where surgeons work, align policies, practices and management of unacceptable behaviours with the principles of the Vanderbilt model Hospitals and other employers of surgeons, who are MOU partner organisations, actively support RACS initiatives in building a respectful culture Successful pilot models and strategies are progressively shared with and promoted to other hospitals and employers Hospitals and other employers of surgeons, who are MOU partner organisations, effectively implement and actively monitor respectful behaviour policies and action plans	

Cultural Change and Leadership					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Advocate for integration of respectful behaviour training into medical training	Dialogue with universities about respectful behaviour training	Medical schools incorporate respectful behaviour training and its links to patient safety as part of the curriculum	SET-1 Trainees begin their surgical training with knowledge and skills about respectful behaviour	Acceptance across SET Trainees of the relationship between patient safety and respectful behaviour RACS is recognised as a leader in promoting respectful behaviour in surgical practice	
Monitor, evaluate and continuously improve the *About respect* program of work	Evaluation framework developed Planned evaluations conducted Repeat DBSH prevalence surveys every five years Publication of annual reports and activities reports	RACS systematically gathers data to measure the effectiveness and impact of the Action Plan Data analysis leads to understanding of program effectiveness and identifies areas for improvement / refinement Pilot programs are evaluated RACS' activities in building a culture of respect are transparently reported to members Data gathered to monitor FTI's understanding of the need for and importance of the Action Plan	The Action Plan is adapted and improved as part of continuous improvement activities and response to progress and the changing context Learning from Pilot programs is used to extend successful models to other locations Learning from pilot programs is used to inform FTIs of the need for and importance of the Action Plan	A culture of continuous improvement is reinforced within RACS Fellows, Trainees and IMGs are aware of the Action Plan and support its requirements and achievements	
Ensure appropriate governance and oversight of the Action Plan	Regular reports within RACS to Council, CEO and management	Transparent and accountable processes in place to oversight the implementation of the Action Plan	Action plan principles are embedded in the RACS strategic plan thus becoming normal business	All RACS activities incorporate respectful behaviours as a matter of course Respectful behaviours are normalised across the surgical profession	

Surgical Education					A culture of respect in surgical practice and education
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	
Establish training in respectful behaviours as a mandatory component of continuing professional development and in Surgical Education and Training (SET) Provide face to face advanced training (OWR) in respectful behaviours to all members of Training Boards and other major committees of RACS, including surgical, IMG and research supervisors/assessors Conduct training on respectful behaviours and provision of constructive feedback for Fellows, trainees, IMGs, Training Boards and RACS Committees Develop advanced feedback module for surgical educators Develop Surgical Leadership Program for surgeons Improve FSSE course to include training in respectful behaviours and provision of constructive feedback for Fellows involved in surgical education	Mandated training via e-learning module (Operating with Respect) for all Fellows, IMGs and Trainees on identifying, preventing and taking action on unacceptable behaviours and on building a respectful culture Face to face OWR course is mandated for surgical supervisors and trainers, IMG assessors, Training Boards and RACS Committees. Advanced feedback module piloted Surgical Leadership course developed Train the trainer courses for OWR trainers Mandated FSSE course for all surgical supervisors and trainers and IMG assessors includes training in providing respectful and constructive feedback to trainees	Fellows, IMGs and Trainees recognise unacceptable behaviours in themselves and others and increase their understanding of respectful behaviours Fellows, IMGs and Trainees appreciate that professional behaviours are a determinant of patient safety Surgical educators and IMG assessors gain skills in identifying and addressing unacceptable behaviours Surgical educators and IMG assessors understand their professional obligations regarding respectful behaviours Surgical educators and IMG assessors increase their knowledge of how to provide respectful, constructive and effective feedback to trainees Surgeons have access to leadership training Increased capacity to deliver the OWR course to a broader audience Feedback from Trainees and IMGs indicates that surgeons are becoming better educators Continuous monitoring of FSSE, specifically on outcomes relating to provision of feedback	Fellows, IMGs and Trainees gain skills in identifying and addressing unacceptable behaviours More people feel confident in speaking up about unacceptable behaviours Surgical educators and IMG assessors provide respectful, constructive and effective educational feedback to trainees, in line with new policies Fellows in leadership positions accept that they have a responsibility for addressing unacceptable behaviours by regulating their own behaviours and modulating the behaviour of others Advanced feedback module is accessible to surgical educators Faculty members feel adequately prepared to teach the OWR and FSSE courses Course participants perceive the courses as credible and high quality	Integration of respectful behaviours within surgical education is normalised Training in respectful behaviours becomes normalised and embedded in all training curricula Trainees recognise the values underpinning RACS surgical education Increased retention of trainees Decreased attrition of trainees due to unacceptable behaviours Surgical leaders model respectful behaviours and advocate for these behaviours in the workplace Respectful and constructive feedback is normalised Trainees seek out and value feedback from their supervisors	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Revise accreditation standards for surgical education posts to include respectful behaviours	Agreed accreditation standards across all Training Boards Agreed safe and confidential pathways for communicating training concerns to Specialist Training Boards and RACS	New standard for respectful behaviour is included in the accreditation guidelines Accreditation of training posts in hospitals includes respectful behaviours Safe and confidential pathways for identifying and addressing concerns about behaviours in educational posts are developed, defined and communicated Model for conducting bi-annual reviews of training posts is developed	RACS, Training Boards and hospitals understand their roles and responsibilities in addressing behavioural issues Trainees are aware of processes for raising concerns about behaviours Bi annual review of training posts conducted and de-identified results published RACSTA survey shows improvement of educational experience against the accreditation standards	Responsibilities between hospitals and RACS are aligned and consistent All surgical education posts demonstrate respectful behaviour standards and agreed complaints resolution processes Trainees feel safe and confident to raise concerns RACS acts on the findings of surgical education surveys	
Establish a process for independent review of training rotations for SET	Agreed model for RACS-led independent reviews of training rotations	Development of criteria to trigger a review Specialist Training Boards support the training rotation review process Pilot methodology established	Process for independent review of training posts established Independent reviews of training rotations conducted Learnings from pilots inform model development and improvement Improved review model implemented	Agreed and sustainable model achieved Stakeholders are confident in the review methodology The training environment is optimised Trainee satisfaction with SET improves Trainee attrition reduces	
Establish a process for independent review of IMG training rotations	Agreed model for IMG reviews	Development of criteria to trigger a review Pilot methodology established Reassessment process is standardised and transparent	Process for independent review of IMG training posts established Independent reviews of IMG training rotations conducted Learnings from pilots inform model development and improvement Improved review model implemented	Agreed and sustainable model achieved Stakeholders are confident in the review methodology The training environment is optimised IMGs are confident in the system IMG attrition reduces	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Ensure independent review of SET selection processes to support diversity of surgical trainees	SET selection panels modified to include external, non-medical panel members	Selection weightings are revised Selection interviewers are trained Consistent selection principles are applied across selection panels	An industry approach to knowledge, skills and attributes is implemented SJTs are piloted Template referee reports are developed and introduced	Selection into SET is transparent and consistent Reduced SET attrition rates	
Ensure the surgical education training (SET) program includes a focus on building resilience and managing stress	Evidence-informed resources, self-assessment tools, are identified and made available Accreditation standards for evidence-informed external courses are agreed Courses, tools in building resilience and managing stress/ personal wellbeing developed and made compulsory within SET program. Resilience and managing wellbeing is integrated into the SET program	External courses and tools are identified and appropriately accredited Trainees have access to appropriate courses and tools to gain skills and awareness about building resilience	Trainees are aware of the importance of resilience to support their own wellness Trainees gain skills and awareness of methods to build resilience	Trainees consistently demonstrate more resilience in maintaining professional behaviour Resilience becomes part of surgical training and feedback Resilience and stress management are recognised as a necessary component of surgical skills	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Develop respectful behaviour standards for all surgeons involved in education and supervision of research Provide underperforming supervisors with a remedial education plan to improve skills	Explicit standards developed for all surgeons involved in education and supervision of research Standards promoted to Fellows Formal assessment process against standards is established Processes established for individual coaching to support behaviour change	Fellows are aware of and understand how to comply with the standards of professional behaviour Standards for surgical supervisors incorporate respectful behaviours	Fellows have the skills to remain professional and respectful when under stress Fellows access individual coaching Underperforming supervisors are identified in a formal assessment process Underperforming supervisors participate in educational programs and individual coaching for behavioural change	Fellows comply with identified standards of behaviour Individuals who do not meet the standards are managed appropriately, including through individual support for behavioural change as needed Underperforming supervisors show improvement after support and intervention from the Boards and RACS RACS recognises that some surgeons are not suited to supervision and leadership	
Review selection criteria for all supervisors to include training as educators including respectful behaviours Provide underperforming supervisors with a remedial education plan to improve skills	Defined standards for heads of departments, supervisors and other senior positions, include demonstration of leadership regarding respectful behaviours New selection criteria for all supervisors (including training as educators, understanding respectful behaviours and dealing with concerns of unprofessional behaviour) Within two years Training Boards review all supervisors to ensure that underperforming supervisors are being provided with remedial education plan to improve skills Educational, coaching and support programs established for underperforming supervisors	Leadership positions are increasingly filled by people who demonstrate respectful behaviours Supervisory positions increasingly filled by people who demonstrate respectful behaviours	Leaders comply with and are accountable to identified standards of behaviour Supervisors comply with and are accountable to identified standards of behaviour Underperforming supervisors are identified in a formal assessment process (through Trainee feedback/multi-source feedback (MSF)/complaints mechanisms) Underperforming supervisors participate in educational programs and individual coaching for behavioural change	Appointments to hospital leadership positions have regard to the RACS standards Underperforming supervisors show improvement after support and intervention from the Boards and RACS	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Advocate for integration of respectful behaviour training into pre-vocational training	Dialogue about respectful behaviour training with pre-vocational medical councils, hospitals and networks	J-Docs program administrators recognise the importance of respectful behaviours as part of surgical practice	Pre-vocational training incorporates respectful behaviours and its links to patient safety as part of the curriculum SET-1 Trainees begin their surgical training with knowledge and skills about respectful behaviour	Acceptance across SET Trainees of the relationship between patient safety and respectful behaviour RACS is recognised as a leader in promoting respectful behaviour in surgical practice	
Develop policies, procedures and systems for introduction of Multi source feedback (MSF)	Clear criteria developed and in place for the successful introduction of MSF inclusive of respectful behaviours MSF introduced in reviews of all Trainees, supervisors, surgical department heads Systems established to ensure feedback is recorded, acknowledged and used to improve quality A program for Trainees to engage constructively with feedback is developed	Pilot activities are conducted to define the most appropriate model of MSF for surgical education and training Post-Pilot review by Training Boards of all pilot supervisors to ensure they are using MSF	Learnings from pilot inform development of MSF model for upscaling across the profession Adequate resources provided to support implementation of MSF Supervisors across the surgical profession begin to participate in training about MSF Supervisors understand how to provide constructive feedback using MSF	MSF is implemented across the profession Supervisors provide constructive feedback to trainees through MSF Trainees engage constructively with MSF feedback MSF is evaluated and adapted for continuous improvement of the program MSF is the standard approach for reviews of all trainees, supervisors, surgical department heads	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Review IMG assessment process Ensure cultural awareness is incorporated into assessment and management of IMGs Review composition of IMG committee	Composition of IMG assessment panels reviewed Training on unconscious bias provided to IMG supervisors An independent review process is established for all Trainees and IMGs placed on probation to ensure all cultural issues are being addressed IMG Committee membership is diverse and includes representatives external to RACS Dedicated ongoing support for IMGs provided	Increased independent oversight of IMG assessment Position established for a Clinical Director IMG Assessment and Support IMG assessment panels are composed of more diverse people, including people external to RACS Clear, culturally sensitive criteria are developed for assessment of IMGs IMGs on probation are provided with constructive and culturally effective feedback for improvement	Cultural issues are addressed when reviewing trainees and IMGs Process for mitigating unconscious bias established in IMG assessment Implementation of the 2 Day Work-based Assessment approach	IMG assessment meets AMC accreditation standards for cultural competence	
Explore and understand the percentage of women choosing surgery as a career	Research methodology developed Research findings / insights available to inform future work	Research undertaken to explore and understand barriers for women in choosing surgery as a career Research undertaken into reasons for leaving surgical training	Key barriers to participation and completion of surgical training are understood and addressed	More women participate in and complete surgical training	
Advocate for and facilitate flexible training opportunities for surgical training	CBME principles support flexible training	RACS engages with jurisdictions to advocate for provision of flexible training Training regulations and accreditation standards appropriately reflect the provision of flexible training	Trainees access flexible training options	Flexible training for all surgical trainees is destigmatised and seen as acceptable	

Complaints Management					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Develop effective, fair and timely complaint mechanisms that are consistent with best practice Establish a framework of accountability for taking, and reporting on, the actions and outcomes arising from complaints to participants in the process Conduct communication and awareness raising activities about complaints procedures and available support Work in partnership with hospitals and other health sector organisations to develop a commonly understood approach to sanctions, including mechanisms for identifying, preventing and eliminating illegal and inappropriate behaviour and reporting surgeons as needed	Revised RACS Code of Conduct and sanctions policy Introduction of centralised lodgement, assessment, co-ordination and ongoing oversight of complaints across all specialities of the College, including complaints about surgical practice, education and behaviour. Clear and straightforward information about complaints management is accessible centrally Provide external expert mediation for complaints where required Provide support for investigations, when mediation fails Oversight by independent review including the appointment of an external reviewer Communication to all stakeholders about the changes to the policy and about the process	Fellows, trainees and IMGs are aware of avenues for making complaints about unacceptable behaviour Development and implementation of supports for people experiencing unacceptable behaviour Complaints confidentiality is strengthened Complaints management is centralised within RACS External reviewer appointed to review College processes and make recommendations where processes not followed or are inadequate	Fellows, trainees and IMGs are aware of supports for people experiencing unacceptable behaviour Fellows, trainees and IMGs experiencing unacceptable behaviour have improved access to support Fellows, trainees and IMGs are more confident to make complaints Recommendations from external review of complaints management are implemented for program improvement Improved feedback from surgeons and complainants about the RACS complaints process. Surgeons subject to a complaint learn from the process and change their behaviour External stakeholders are aware of the revised policy and process	Workplace culture supports the effective and timely reporting and management of unacceptable behaviour Calling out unacceptable behaviour is normalised in the surgical workplace Reduced recidivism regarding unacceptable behaviours	

Complaints Management					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Establish a Peer Support program for respondents and complainants	Promotion of Peer Support program to Fellows, Trainees and IMGs Supports for behavioural change provided	Complainants and respondents receive peer support throughout the process	Fellows, Trainees and IMGs who are the subject of a complaint are supported to change their behaviour Fellows, Trainees and IMGs who have received peer support perceive it as a useful intervention	Fellows, trainees and IMGs have increased confidence and trust that the complaints process has been fair	
Monitor complaint issues/trends, resolution rates and user satisfaction to inform continuous improvement and improve the quality and effectiveness of complaint mechanisms and make further interventions as needed.	All complaints received are effectively recorded and monitored Data about complaints is recorded centrally and reported regularly User satisfaction is regularly monitored and reviewed	Consistent with privacy and confidentiality principles, complaints and their outcomes are publicly reported including Activities reports, Annual report User satisfaction measures or indicators are introduced	User satisfaction data informs process improvements User satisfaction data is published	User satisfaction in the complaints process continues to increase Continuous improvement is incorporated into the complaints process	

Attachment 4: Stakeholder Engagement Plan

Objective
To hear and understand the breadth and depth of views of Fellows, Trainees and IMGs on issues relating to the scope of the evaluation.

Approach
A mixed methods approach is best practice. For this evaluation we have designed the following:

1. QUAL ⟶ 2. QUANT ⟶ 3. QUAL

1. The first step was to conduct eight open ended interviews with a range of representative stakeholders to identify the issues and experiences from their perspective. Representatives were purposively sampled from each stakeholder type: Fellows, Trainees and IMGs, for their ability to provide insights and stories of their experience. This allowed us to ensure all further data collection was based on issues grounded in the real experience of stakeholders and not from the assumptions of the evaluator. Data from this step of the process has been presented in qualitative form, as themes.

2. Analysis of the themes and issues supported development of an online survey which was sent out to all (7988) Fellows, Trainees and IMGs. This provided the breadth of information about the issues, ie it answers the question '*what is happening*'. This approach also ensures all Fellows, Trainees and IMGs have been given the opportunity to have a voice in the evaluation. Data from this step of the process has been presented in quantitative form, as graphs and tables.

3. Once the survey was analysed, we had a broad understanding of the views on particular issues. This provided an insight into areas where further exploration may be needed, to gain an answer to the question '*why is this happening?*' For this step of the process, 5 Fellows, 3 Councillors, 3 IMGs and 5 Trainees were randomly selected for a telephone interview. We used stratified random sampling, to ensure a representative mix of gender and location across all groups, and that selection was not biased. But it is important to note that this was a qualitative exercise, to gain deep dive insights into the issues highlighted by the survey. Data from this step of the process was presented in qualitative form, as themes.

Attachment 5: Survey Questions

RACS Action Plan: *Building Respect, Improving Patient Safety*
Phase 1 Evaluation Survey

Introduction
Thank you for agreeing to take part in this short survey.

In 2015, RACS committed to dealing with discrimination, bullying and sexual harassment in surgery, through the *Action Plan: Building Respect, Improving Patient Safety*. The plan sets out a multi-year program of work which requires a sustained commitment.

After three years, we want to track our progress. This survey checks whether we have done the work we said we would do. Future evaluations will check what difference it is making. This survey is one part of our evaluation methodology and gives everyone a chance to have their say.

Please note: This is not a prevalence survey. A second prevalence survey will be conducted in 2021.

Privacy and Confidentiality
Your answers will remain strictly confidential. The information gathered from this survey will not be identifiable. We will aggregate the results and use the information to improve our work.

Consent
This survey is voluntary, but we are very interested in your views and ask you to give us this important feedback.

Questions?
If you have any questions about this survey or any of the evaluation activities, please feel free to contact the evaluator, Ruth Friedman, from The Thread Consulting at ruth@thethreadconsulting.com.au

Support
A reminder: the RACS Support Program, provided by Converge, offers confidential support to RACS members and their families, at no cost.

This survey will close on Monday 4th March 2019.

Demographics

Please indicate your age:
Under 30
30-40
41-50
51-60
61-70
71+

Please indicate the sector where you do most of your work: (Please tick one)
Public sector
Private sector

Please indicate the location where you do most of your work: (Please tick one)
Metropolitan
Rural

What is your gender? (Please tick one)
Male
Female
Intersex/ Indeterminate

I am a: (Please tick one)
Fellow of the College
Surgical Trainee
International Medical Graduate

How are you involved with the College? (Please tick all that apply)
Not involved
Surgical supervisor
Surgical trainer
IMG supervisor
Member of a Specialty Training Board
Member of a College committee
RACS Councillor
Other

Awareness

Survey Q Fellows	Survey Q Trainees/IMGs
Q1: How did you become aware of RACS' work to address discrimination, bullying and sexual harassment in surgery? (Tick all that apply) I completed the *Operating With Respect* e-module I completed the *Operating with Respect* face to face training course I completed the Foundation Skills for Surgical Education (FSSE) training Promotion at my hospital Posters at the College Articles in Fax Mentis Articles in Surgical News RACS policies, standards and guidelines Direct emails, letters from the College RACS website Social media General media A colleague told me I am not aware of this work. Other	**Q1: How did you become aware of RACS' work to address discrimination, bullying and sexual harassment in surgery? (Tick all that apply)** I completed the *Operating With Respect* e-module Promotion at my hospital Posters at the College Articles in Fax Mentis Articles in Surgical News RACS policies, standards and guidelines Direct emails, letters from the College RACS website Social media General media A colleague told me I am not aware of this work. Other

Q 2: How aware are you of the following RACS actions to build respect and improve patient safety in surgery? (1 = Not at all aware; 2 = Slightly aware; 3 = Moderately aware; 4 = Very aware; 5 = Extremely aware; 6 = NA/Don't know) The College's Code of Conduct. The College's standards in relation to discrimination, bullying and sexual harassment. The College's public commitment to addressing discrimination, bullying and sexual harassment in surgery. The College's commitment to increasing diversity in surgery. The RACS support program, provided by Converge. **Knowledge** **Q 3. Thinking about what you know about discrimination, bullying and sexual harassment, how strongly do you agree or disagree with the following?** (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I know how to comply with the College's standards in relation to discrimination, bullying and sexual harassment. I know how to provide constructive feedback to my team, my peers and trainees. I can recognise discrimination, bullying and sexual harassment in surgery. I know what to do to address discrimination, bullying and sexual harassment when I see it. I know what to do to address discrimination, bullying and sexual harassment when I experience it. I know how to access the RACS support program, provided by Converge.	**Q 2: How aware are you of the following RACS actions to build respect and improve patient safety in surgery?** (1 = Not at all aware; 2 = Slightly aware; 3 = Moderately aware; 4 = Very aware; 5 = Extremely aware; 6 = NA/Don't know) The College's Code of Conduct. The College's standards in relation to discrimination, bullying and sexual harassment. The College's public commitment to addressing discrimination, bullying and sexual harassment in surgery. The College's commitment to increasing diversity in surgery. The RACS support program, provided by Converge. **Knowledge** **Q 3: Thinking about what you know about discrimination, bullying and sexual harassment, how strongly you agree or disagree with the following?** (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I know how to comply with the College's standards in relation to discrimination, bullying and sexual harassment. I can recognise discrimination, bullying and sexual harassment in surgery. I can recognise the difference between difficult feedback and bullying. I know how to access the RACS support program, provided by Converge.

Q 4: Thinking about RACS' complaints process, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I know how to lodge a complaint with the College about discrimination, bullying and sexual harassment. I would feel safe lodging a complaint with the College about discrimination, bullying and sexual harassment. The College's complaints process is worthwhile. The College's complaints process is confidential.	**Q 4: Thinking about RACS' complaints process, how strongly do you agree or disagree with the following?** (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I know how to lodge a complaint with the College about discrimination, bullying and sexual harassment. I would feel safe lodging a complaint with the College about discrimination, bullying and sexual harassment. The College's complaints process is worthwhile. The College's complaints process is confidential.

Support and relevance

Q5: Thinking about your views on RACS' work to build a culture of respect in surgery, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery. I support the College's work to increase diversity in surgery. I support the College's work to increase flexible training opportunities. Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery. It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.	**Q5: Thinking about your views on RACS' work to build a culture of respect in surgery, how strongly do you agree or disagree with the following?** (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) I support the College's commitment to addressing discrimination, bullying and sexual harassment in surgery. I support the College's work to increase diversity in surgery. I support the College's work to increase flexible training opportunities. Improving surgical education is an important way to address discrimination, bullying and sexual harassment in surgery. It is important for the College to keep working with others to address discrimination, bullying and sexual harassment in surgery.

Q 6: Thinking about the relevance to you of RACS' work to build a culture of respect in surgery, how strongly do you agree or disagree with the following? (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) The *Operating With Respect* e-module was relevant to me. The *Operating With Respect* face to face training was relevant to me. The FSSE course was relevant to me. My behaviour, and the behaviour of my team, impacts on the safety of my patients. The College's communications about respectful behaviours have been relevant to me. The College's work to build a culture of respect is relevant to my daily experience as a surgeon.	**Q 6: Thinking about the relevance to you of RACS' work to build a culture of respect in surgery, how strongly do you agree or disagree with the following?** (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) The *Operating With Respect* e-module was relevant to me. My behaviour, and the behaviour of my team, impacts on the safety of my patients. The College's communications about respectful behaviours have been relevant to me. The college's work to build a culture of respect is relevant to my daily experience as a surgical trainee.

Changes in the workplace **Q 7: Thinking about your workplace, how strongly do you agree or disagree with the following?** (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) There is more awareness of discrimination, bullying and sexual harassment in my workplace. People are more likely to raise the issue of discrimination, bullying and sexual harassment at my workplace. I can see a positive change in the culture in my workplace. My workplace has introduced training on professional behaviours. My workplace has a complaints process for raising concerns about discrimination, bullying and sexual harassment. I would feel safe to make a complaint <u>at work</u> about discrimination, bullying and sexual harassment. My peers are more respectful when giving each other feedback. People are more accepting of flexible training. I feel more confident about providing respectful feedback to my peers and my team.	**Changes in the workplace** **Q 7: Thinking about the workplace, how strongly do you agree or disagree with the following?** (1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know) There is more awareness of discrimination, bullying and sexual harassment in the workplace. There is more training about discrimination, bullying and sexual harassment in the workplace. People are more likely to raise the issue of discrimination, bullying and sexual harassment in the workplace. I can see a positive change in the culture in the workplace. I would feel safe to make a complaint <u>at work</u> about discrimination, bullying and sexual harassment. My peers are more respectful when giving each other feedback. Senior surgeons are more respectful when providing feedback. People are more accepting of flexible training.
Q.8 Please provide any further feedback below: Thank you for your time.	**Q.8 Please provide any further feedback below:** Thank you for your time.

Attachment 6: Semi-structured Interview Questions

Thankyou for your time. This interview is part of the evaluation for the Building Respect Action Plan evaluation.
All your answers will be collated and presented in de-identified form.

Role
Please describe your role and interaction with the College.

Action Plan activities

Which of the Building Respect activities have you participated in?
E module
OWR F2F
FSSE
Advanced feedback
Surgeons as Leaders
Other?

What did you think of the way they have been presented and offered to Fellows? What could be improved?

Have you learned anything new from the Building Respect activities? What, if anything, do you do differently since you completed the activities?

Barriers/enablers
What do you see as the major successes of the action Plan?

What are the major challenges for implementing this change? How can they be addressed?

Have there been any unintended consequences from the program?

Complaints

Do you know how to lodge a complaint with the College about DBSH?

Do you think people feel safe to make a complaint through the RACS process?

What needs to be done to increase confidence in the complaints process?

Diversity

What do you see as the challenges to increasing diversity across the surgical profession?

What do you see as the challenges to increasing flexible training opportunities across the surgical profession?

Outcomes

Can you see any changes in your workplace/or the profession as a result of the action plan? Training, culture, awareness, feeling safe, likelihood of raising issues, calling it out

Governance (for Councillors)

How do you feel the program is tracking? How do you know that? Ie what reports are you getting?

Do you feel adequately informed about the progress of the Action Plan?

What decisions, if any, have been made about changes to the action plan ie in light of emerging information?

What could be improved about the way the action plan is monitored and governed?

Resourcing

Do you think the action plan is adequately resourced to do this work?

Attachment 7: Definitions and common terminology

Term	Definition
Action Plan	The RACS *Building Respect, Improving Patient Safety* Action Plan
AMC	Australian Medical Council
BRIPS	Building Respect, Improving Patient Safety
BSET	Board of Surgical Education and Training
Bullying	Unreasonable and inappropriate behaviour that is repeated over time, or forms a pattern of behaviour, that places physical or mental health at risk.
CBME	Competency Based Medical Education
DBSH	Discrimination, Bullying and Sexual Harassment
DBSH Prevalence Survey	A survey of Fellows, Trainees and IMGs which has been conducted once by RACS in 2015 and will be conducted again in 2020 and 2026
Discrimination	Treating a person less favourably on the basis of a legally protected attribute or personal characteristic
EAG	RACS Expert Advisory group
Evaluation Survey	An online survey containing any relevant questions that are not covered in the DBSH Prevalence Survey
FSSE	Foundation Skills for Surgical Educators
FTIs	Surgical Fellows, Trainees and International Medical Graduates
Harassment	Unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended based on a legally protected attribute or personal characteristic. Harassment is a form of discrimination.
IMGs	International Medical Graduates
IRR	Independent Rotation Review
JDocs	Surgical competency framework for junior doctors
Key Informant Interviews	Telephone or face to face interviews with representatives from a range of stakeholder groups

MOU	Memorandum of Understanding
MSF	Multi Source Feedback
OWR	Operating With Respect training course
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainees' Association
SET	Surgical Education and Training
Sexual harassment	Unwanted, unwelcome or uninvited behaviour of a sexual nature that makes a person feel humiliated, intimidated or offended.
SJT	Situational Judgement Test
SOI	Statement of Intent
STANZ	State and Territory Offices of Australia and New Zealand
TOR	Terms of Reference
Unacceptable behaviours	Bullying, discrimination or sexual harassment