

# 2018 Progress Report to the Australian Medical Council and Medical Council of New Zealand

## Royal Australasian College of Physicians

September 2018



**RACP**  
Specialists. Together  
EDUCATE ADVOCATE INNOVATE

## College details

Name: **The Royal Australasian College of Physicians**

Address: **145 Macquarie Street, Sydney NSW 2000**

Date of last AMC accreditation decision: **2015 (2014 reaccreditation assessment)**

Periodic reports since last AMC assessment: **2015, 2016, 2017 Progress Reports**

Reaccreditation due: **March 2021**

This report due: **1 October 2018**

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The RACP trains, educates and advocates on behalf of physicians and trainee physicians across Australia and New Zealand.

The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. In the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

The College offers 61 training pathways. These lead to the award of one of seven qualifications that align with 45 specialist titles recognised by the Medical Board of Australia and allow for registration in nine vocational scopes with the Medical Council of New Zealand.

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## Executive summary

### Our goal

We continue to execute our ambitious program of Education Renewal. Our goal is to improve the experience and outcomes of our training and education programs to promote high standards of physician practice and enable excellent healthcare experiences and outcomes for the patients, families, and communities we serve.

We are moving towards competency-based training programs, a new accreditation system, enhanced support resources for trainees and supervisors and an improved continuing professional development framework.

### Our progress

In the last year we have implemented initiatives which link to Australian Medical Council standards, conditions and recommendations.

We have employed a new approach to co-designing our educational innovations which is more agile and better balances the need to advance innovations while safeguarding stakeholder input and robust governance and decision making.

We have delivered new education resources for our members to support them in training, supervision and practice. Our College Learning Series, Podcasts, curated collections, e-learning modules and Online Professionalism Program focus on cross-specialty topics and physician health and wellbeing.

We have faced challenges this year with the unfortunate cancellation of our first computer-based Divisional Written Examination in Adult Medicine and Paediatrics and Child Health. This required a swift response to support our trainees and Directors of Physician Education during a difficult time. We expect the findings of the independent inquiry will provide important learning opportunities.

Our new Consumer Advisory Group is established, and we have moved to strengthen the consumer voice in our activities. We are also implementing our Indigenous Strategic Framework to contribute to addressing Indigenous health equity differences, grow the Indigenous workforce, equip and educate the broader physician workforce to improve Indigenous health and foster a culturally safe and competent College.

### Our current focus

We are focussing on finalising the remaining elements of our new Basic Training Program and readying our membership and health services across Australia and New Zealand to implement these improvements. We are prioritising communication, training, support and change management with the help of member champions. This builds on the release of the new Basic Training Standards and Training Provider Standards earlier this year.

Through implementation planning we are attempting to identify unintended consequences, so they can be proactively addressed. A supported transition that meets the needs of trainees and supervisors is crucial to success. We are consulting on how this can be best achieved.

Though we have made considerable progress, a significant agenda of important work remains, particularly as we renew our many Advanced Training curricula. This work is gathering momentum and will benefit from the learnings from the renewal of our Basic Training Program.

The scope of change under way within our education programs, a complex implementation landscape and potential impacts on both members and health services demand that we progress carefully to ensure that intended benefits are realised for our members and ultimately patients and communities.

## Summary of 2018 progress



### Better support and resources for our members

We launched our new College Learning Series providing access to 227 recorded lectures. 3,200 members have registered.

We delivered 7 new Podcasts for members on cross-specialty topics and won an industry award for these resources.

We developed a framework to better support member wellbeing and delivered an online module about self-care and wellbeing.

We delivered 111 Supervisor Professional Development Workshops across Australia and New Zealand with over 2,000 supervisors participating.

### Better training programs

We published our new RACP Professional Practice Framework.

We published new Basic Training Standards including Competencies, Entrustable Professional Activities and Knowledge Guides.

We are consulting widely to finalise the structure and implementation approach for our new Learning, Teaching and Assessment structure for Basic Training.

We completed the evaluation of work-based assessment tools used in Advanced Training.

We progressed the Advanced Training curricula review with scoping work underway.

### Better governance and program management

We implemented a smaller skills-based Board.

We established a Consumer Advisory Group which is helping us strengthen the consumer voice across our activities.

We began implementing our Indigenous Strategic Framework to embed cultural safety and competency across the RACP.

We implemented more agile ways of incorporating stakeholder feedback into our design processes.

### Current challenges

We need to balance the impetus to implement the new Basic Training program with member readiness and careful consideration of unintended consequences. We have deliberately slowed implementation to ensure we achieve the most optimal outcome. Providing in time support and training resources for supervisors to implement Entrustable Professional Activities will be a focus in the coming year.

Our learnings from the cancellation of the computer-based exam will inform future efforts to progress this and other changes we are introducing.

Renewal of our 38 Advanced Training curricula is complex, and we expect it will take beyond 2020 to complete. Learnings from renewal of our Basic Training curricula will be important.

	Remaining open conditions	Year due
C4	Finalise the RACP Standards Framework and strategies for incorporating those standards into the basic and advanced training curricula.	2017
C5	Complete the basic training curricula review including the integration of the Professional Qualities Curriculum and its implementation.	2018
C6	In relation to the advanced training curricula: (i) Complete the review and implementation plan for the revised advanced training curricula. (ii) Implement the revised advanced training curricula.	2018
		2020
C8	Demonstrate that the trainee experience and curricula align to the College's 70:20:10 model.	2019
C9	Develop and implement a structured approach to ensure the trainee's increasing degree of independence is systematically evaluated.	2019
C11	Ensure that the summative assessments apply reliable and valid methodologies and are aligned to both basic training curricula.	2018
C12	Ensure that the summative assessments apply reliable and valid methodologies and are aligned to all advanced training curricula.	2020
C13	Pending the adoption of the new curricula and linked assessments: (i) blueprint the basic training written examination to the basic training curricula. (ii) review and revise the College's current clinical examination calibration processes. (iii) review and revise the marking methodology for the clinical examination.	2017
C14	Develop and implement an assessment strategy for domains in the Professional Qualities Curriculum.	2019
C15	Develop and implement methods for systematic and confidential trainee feedback on the quality of supervision, training and clinical experience and use this information for analysis and monitoring.	2017
C16	Develop and implement structured methods for supervisors of training to contribute to the ongoing monitoring of the training program.	2017
C18	Implement processes for health care administrators, other health care professionals and consumers to contribute to evaluation.	2018
C20	Develop and publish the College's selection criteria, including the weighting and marking system of the various elements.	2017
C21	Monitor the consistent application of selection policies across all training sites.	2019
C24	Promulgate and implement the revised educational supervision policy that defines the new responsibilities of supervisors.	2017
C25	Develop and implement a formal selection process for supervisors including criteria for selection.	2018



## Standard 1. The context of training and education

Areas covered by this standard: Governance of the college; program management; reconsideration, review and appeals processes; educational expertise and exchange; educational resources; interaction with the health sector; continuous renewal.



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<b>2017 AMC assessment:</b>	Standard Met
<b>Conditions open:</b>	Nil
<b>Recommendations open:</b>	Nil

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- We have a smaller skills-based Board
- Our education staff have been reorganised to support progress of projects and operations
- We have employed a lead Fellow to support implementation of Education Renewal innovations
- Our Consumer Advisory Group is established and we have moved to strengthen the consumer voice across our activities
- We have developed an indigenous Health Strategic Framework and started implementation

## Significant developments since last report

### Governance

In June 2018, our Board transitioned from its previous 19-member structure to a 10-member skill-based Board, in alignment with the Governance Reform of the preceding years. The President-elect has taken on the role of Chair, College Education Committee.

The Board has committed to the following values, principles, and behaviours:

- collaboration
- being proactive
- being relevant
- being transparent, and
- recognising the deeply human nature of our joint endeavours.

The Board has published its intent to achieve outcomes in the following areas:

- respectful, inclusive engagement with trainees and Fellows
- ensuring our ongoing credibility in healthcare policy and advocacy
- continuous improvement of structures and processes to optimise member engagement
- effective and sustainable operations and internal procedures; and
- monitoring, evaluating and reporting on performance.

The current Strategic Plan is due for renewal by the end of 2018 and a widely consultative approach will be taken for that planning process, engaging with all parts of the RACP and external stakeholders throughout Australia and New Zealand.

Earlier this year we established a new committee of the Board, the [Consumer Advisory Group](#), comprised of community members with a background in health consumer affairs and representing a wide variety of consumer groups across Australia and New Zealand. The Group will advise us on how to improve consumer engagement and patient-centred care across our professional standards, education approaches, and policy and advocacy activities.

Our Consumer Advisory Group has met twice this year. The second meeting, in August, was focussed on developing a work plan for the remainder of 2018 and 2019. The Group has identified opportunities to strengthen the consumer voice in our activities. The draft work plan has several focus areas aimed at strengthening engagement with existing peak RACP governance structures including the Board, College Council, College Education Committee and College Policy and Advocacy Committee.

Other planned activities relate to promulgating our strategies in education for teaching and assessing cultural competence and patient-centred care, as well as our agenda for health policy and advocacy.

At the RACP Congress this year a patient advocate gave a plenary talk on the effects of disruption in healthcare on doctors and patients and delivered a workshop, in partnership with one of our Palliative Care Physicians on the importance of acknowledging patient and doctor stories in healthcare improvement.

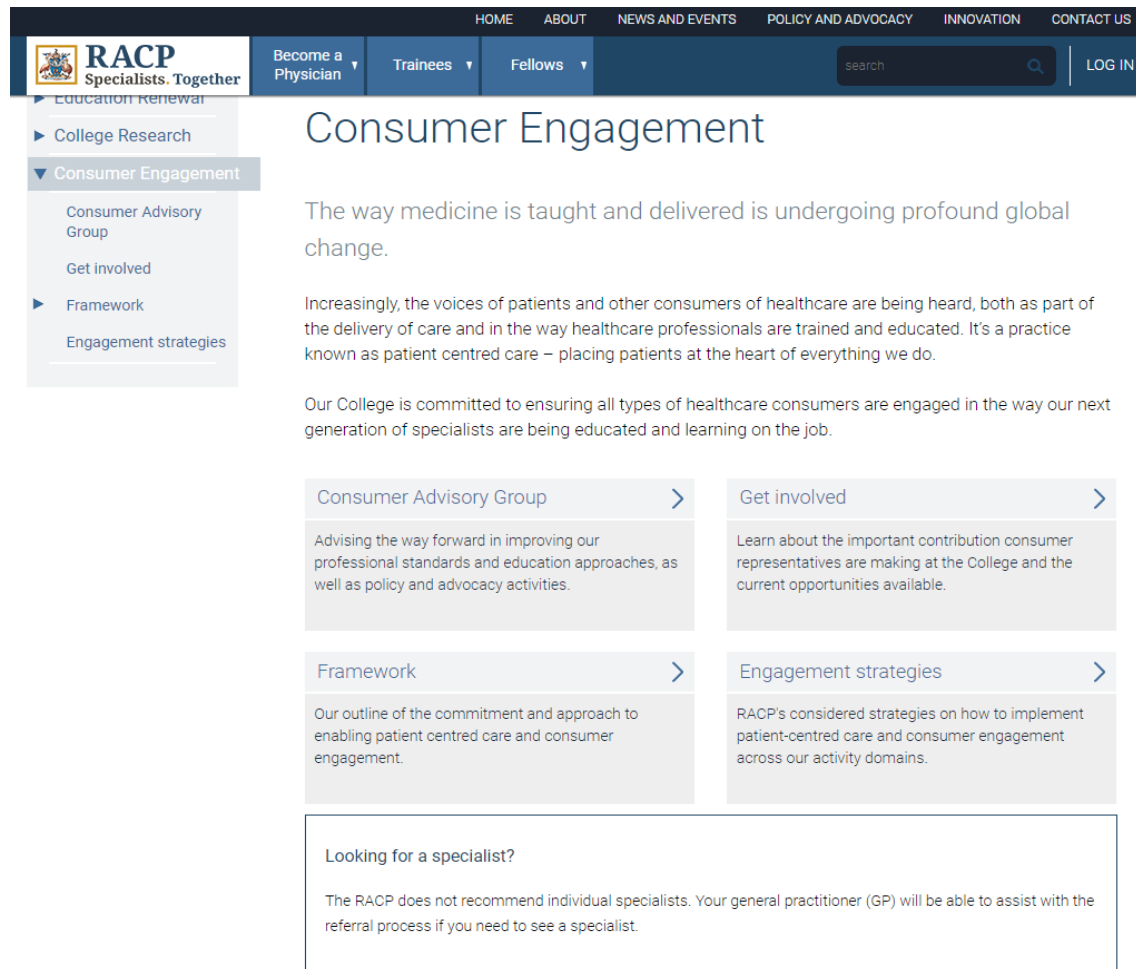
Building on activities at the RACP 2018 Congress, the Consumer Advisory Group is planning to increase involvement of patients at next year's congress.

A new [Consumer Engagement webpage](#) (Figure 1) has been launched to facilitate communication with patients and healthcare consumers about our Consumer Engagement Strategy. It outlines consumer engagement, provides links to the framework, describes our engagement strategies and opportunities for involvement with the RACP, lists events related to Patient-Centred Care and



Consumer Engagement, and publishes Expressions of Interest for positions focussed on furthering patient-centred care.

Figure 1. The Consumer Engagement webpage - extract from website



## Program Management

No significant developments or changes to report.

## Reconsideration review and appeals process

The following are outcomes of the processes for evaluating reconsiderations and reviews relating to training programs to identify system issues for 2017:

- Better tracking tools have enabled staff to complete periodic reporting and show transactional data, reducing the timeframe for notification of a Reconsideration, Review, or Appeal decision by up to 30% (from 12-14 weeks to 8-12 weeks).
- Analysis has shown that committees usually vary their decision due to an applicant submitting additional information or evidence. A minority are varied where the applicant demonstrates exceptional circumstances.
- To support good decision-making, we are reviewing our communication to trainees and training settings to promote a better understanding of the documentation required at the time of application and the importance of supplying all relevant information.

- Committees will consider deferring an original decision pending submission of additional information in the interest of transparency and fairness, despite any delay it may cause.
- Evaluation suggests that our training requirements can be confusing. We have reviewed our training program requirements for 2018-2019 to make them clearer. We have revised our website to make access to training program content and resources easier.
- We are continuing to roll out good governance and decision-making training to new staff and committee members to ensure we make defensible, robust, and clear decisions that conform to our processes and policy.

### **Educational expertise and exchange**

To complement the educational expertise of our staff and committees, we have engaged several consultants with specialist expertise in education development, change management, procurement, and technology during the last 12 months to support the work of education renewal.

The College Education Committee continues to have an appointed member with specialist skills in education and training and our education working groups comprise members with experience in medical education. In August 2018, we employed a Fellow with educational expertise to provide leadership, advice, and support for our Education Renewal Program across the membership.

We continue to look to best practice demonstrated in other relevant programs to inform this work. Collaborative partnerships with other educational institutions continue, including our Tripartite Alliance with The Royal Australasian College of Surgeons, The Royal Australian and New Zealand College of Psychiatrists and the Australian and New Zealand College of Anaesthetists, and The Royal College of Physicians and Surgeons Canada, as well as The Committee of Presidents of Medical Colleges, among others.

Our education staff and members have exchanged ideas and learnings in medical education by attending and presenting at national and international medical education conferences, including the:

- Association for Medical Education in Europe
- International Conference on Residency Education
- Australian and New Zealand Prevocational Medical Education Conference
- International Selection into Health Conference
- Australian and New Zealand Association for Professional Health Educators.

Earlier this year we shared the lessons we have learned so far in our Education Renewal journey in a special issue of *Medical Teacher* (A1.1). These insights will also be broadly disseminated through a poster presentation at The International Conference on Residency Education (ICRE) in October 2018.

In January 2018, the RACP-led publication *Utility of selection methods for specialist medical training: A BEME (best evidence medical education) systematic review: BEME Guide no. 45.* was published in *Medical Teacher*.

### **Educational resources**

We have restructured work units within the Education, Learning and Assessment Directorate – all under the leadership of the Director of Education – to enable progression of our Education Renewal projects and optimise delivery of our training programs.

This restructuring, together with our new project management framework, is enabling us to successfully monitor and progress our project work with input from key stakeholders. To manage this work in a more agile way we have employed a new co-design approach. The approach involves a representative group of stakeholders being contacted individually and invited to participate in a

targeted review seeking their feedback about the desirability and feasibility of education innovations which are still in development. Participants are provided with an information pack prior to an individual consultation discussion and then asked a series of questions to illicit their views and feedback. This new approach provides us with valuable in time feedback to inform the iterative development of our educational products. It enables us to be more responsive during the design phase better balancing the need to advance innovations while safeguarding stakeholder input, with robust governance and decision-making. A Project Governance Group, project control groups and regular cross-unit project team meetings have also been effective mechanisms in the new project management framework.

The Education, Learning and Assessment Directorate now comprises the following work units:

- Projects and Business Operations
- Education Policy, Research and Evaluation
- Education Services
  - Assessment and Selection
  - Training Operations
  - Training Support
  - Trainee Education (New Zealand).

In May 2018, as part of the ongoing program of Business Transformation, a new Operations Directorate was established. It provides support to all internal directorates in delivering services to members. An important consideration in this change was improving the support and services provided to Education, Learning, and Assessment.

The Operations Directorate has the following functions:

- Communications (including Marketing and Media)
- Digital Products
- Information Technology
- Strategic Coordination
- Human Resources
- Risk
- Consumer Engagement, and
- Conference & Events.

The Operations Directorate supports the Information Technology and communications components of the Educational Renewal program in particular.

## **Interactions with the healthcare sector**

### *Promoting training and professional development within the sector*

We continue to maintain working relationships with health-related sectors of society and government, and relevant organisations and communities to promote the training, education and continuing professional development of medical specialists.

The President of the RACP met with the Australian Commonwealth Minister for Health, Shadow Minister for Health and Medicare, and Commonwealth Chief Medical Officer in August 2018 to discuss RACP priorities including Education Renewal, workforce and Indigenous Health.

The President and senior RACP office bearers and staff routinely interact with healthcare sector representatives through a range of forums and events where issues of mutual interest are discussed and relationships fostered.

We held two Basic Training Curricula forums in Sydney and Auckland in September 2018 to discuss planned educational changes with a broad range of stakeholders, including Directors of Physician

Education, trainees and supervisors as well as representatives from jurisdiction health departments, local health districts (or equivalent) and postgraduate medical councils (or equivalent). The focus was on socialising our proposed Basic Training program and gaining further insights on the feasibility and consequences of the new structure and its planned implementation.

During September we invited all interested individuals and groups to participate in digital consultation of the new proposed structure of Basic Training.

As part of the Training Provider Accreditation Review Project (see [Condition 16](#) and [Condition 21](#)) we are working closely with training providers and plan to hold specific consultations with jurisdictional representatives during 2019 to consider the impact of the changes in the Accreditation Standards on Basic Training.

### *Interactions with the Indigenous health sector*

We have developed and published our [Indigenous Strategic Framework](#) with the aim of contributing to addressing Indigenous health equity differences, growing the Indigenous workforce, equipping and educating the broader physician workforce to improve Indigenous health, fostering a culturally safe and competent College, and meeting the new regulatory standards and requirements of the Australian Medical Council and Medical Council of New Zealand.

We have begun implementing the Indigenous Strategic Framework as a key Board priority, taking a whole of organisation approach to embedding cultural safety and competency. This includes having a system of monitoring and reporting back against accountabilities across all parts of the College.

To progress the priority of growing the Indigenous workforce, we are liaising with the [Australian Indigenous Doctors Association \(AIDA\)](#) to undertake research with our Australian Indigenous trainees present and past, as well as our Australian Indigenous Fellows to explore the barriers experienced in training and practice with the aim of identifying how we can provide better support to Indigenous doctors beginning and moving through specialist training and practice.

We continue to sponsor the AIDA conference. We were a silver sponsor in 2018, participating in the *Growing Our Fellows* workshop for medical specialties and running the workshop on *Five Ways to Improve Indigenous Health as a Specialist*.

We have published a new resource to help our members improve healthcare experiences for Australian Aboriginal, Torres Strait Islander and Māori patients.

The Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence resource on the eLearning@RACP digital platform explores:

- how our own cultures and belief systems influence professional practice
- cultural competence and cultural safety within social, cultural and clinical environments
- how cultural competence and cultural safety principles can be applied to improve Indigenous patient health outcomes and experience of care.

Developed by experts and RACP Fellows, this user-friendly resource features a mix in-depth content, video scenarios, reflection and discussion activities and recommended supporting materials.

RACP Fellows can earn Continuing Professional Development credits for completing the course.

Cultural competency training is regularly offered to staff in the form of an in-house workshop.

### *Specialist Training Program and Integrated Rural Training Program*

Trainees can experience working with Aboriginal and Torres Strait Islander health service providers and communities through the Australian Commonwealth funded Specialist Training Program and Integrated Rural Training Program. These programs provide training positions outside the traditional

large metropolitan public hospital enabling doctors to gain a wider breadth of experience in expanded settings.

The Integrated Rural Training Program initiative is a targeted expansion of the Specialist Training Program. It provided 50 positions in 2017 and will provide a further 50 in 2018. These posts are designed to enable trainees to complete most of their training time within a rural region, with limited metropolitan rotations as necessary to meet RACP standards.

We were allocated six Integrated Rural Training Program training positions by the Commonwealth in 2017 and 2018, filling available positions through an expression of interest process in alignment with Integrated Rural Training Program criteria.

### **Continuous renewal**

We continue to review our structures, functions and resource allocation to meet needs and evolving best practice as part of our Business Transformation process and curricula renewal work.



## Standard 2. The outcomes of specialist training and education

Areas covered by this standard: educational purpose of the educational provider; and program and graduate outcomes



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**2017 AMC assessment:** Standard Met

**Conditions open:** Condition 4

**Recommendations open:** Nil

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- We have implemented the Professional Practice Framework
- Our new Basic Training standards are published
- We are developing new standards for Advanced Training

## Significant developments since last report

There has been no significant change to our educational purpose.

We have made considerable progress in relation to our program and graduate outcomes (see [Condition 4](#)).

## Progress against accreditation condition

### Condition 4

To enable the definition of consistent and clear graduate outcomes across all specialties that are aligned to community need, finalise the RACP Standards Framework and strategies for incorporating those standards into the basic and advanced training curricula. (Standard 2.3.1)

The College is to report on milestones in 2016 and completion in 2017

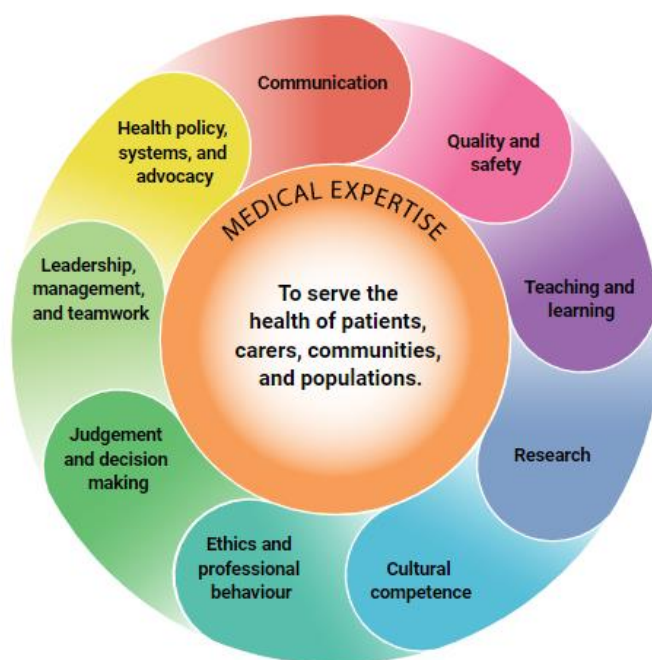
### 2017 AMC Commentary

*Significant progress on this condition has been made. The professional practice framework and associated professional standards are complete. The College expects to finalise Purpose statements and standards for basic training by the end of 2017. Standards for advanced training are at an earlier stage, being now under consideration by the curriculum advisory group, but the College does not state when they expect to finalise these and is working on a program plan including implementation strategies. Due to the standards for advanced training still being finalised this condition remains progressing.*

Our [Professional Practice Framework](#) (Framework), (Figure 2) previously referred to as the Standards Framework, integrates medical expertise and professional practice, recognising that physicians will be experts in their field of practice and use a range of professional skills to work in partnership with patients and their families or carers.

The Framework defines the ten domains of professional practice for all physicians across RACP specialties.

Figure 2. RACP Professional Practice Framework



The goal of serving the health of patients, carers, families, communities, and populations is at the centre of the Framework. This goal is underpinned by our principles of patient-centred care: respect and dignity; shared information; excellent clinical care; participation; collaboration; and Indigenous health as a priority.

For each domain of the Framework, a Professional Standard describes the expectations for all graduates of our training programs. The Framework and Professional Standards define clear and consistent graduate outcomes in ten domains of professional practice. They now apply across our training and Continuing Professional Development programs.

The Professional Standards have been incorporated into the renewed Basic Training curricula through the revised [Basic Training Curricula Standards](#). Since June 2018, these new standards have been publicly available on our website.

We incorporate the Curricula Standards into our Basic Training programs through the [RACP curriculum model](#). Based on this model, the Curricula Standards are structured around the concept of what trainees need to *Be, Do, and Know* reflected through [Competencies](#), [Entrustable Professional Activities](#) and [Knowledge Guides](#) respectively (Figure 3).

Figure 3. RACP Competencies, Entrustable Professional Activities and Knowledge Guides



The Curricula Standards reflect the medical expertise and high level of professional skills outlined in the Framework and the Professional Standards. They will be supported by:

- a Learning and Teaching program that helps trainees direct their own learning, and guides supervisors and accredited training settings in planning and delivering teaching activities; and
- an Assessment program that uses multiple measures to assess trainees' knowledge, skills, and professional qualities over time.

We are taking a similar approach to incorporate the Framework and Professional Standards into the Advanced Training curricula.

We have drafted a plan for renewing the Advanced Training curricula (A2.1). The Advanced Training committees will complete a scoping exercise during the remainder of 2018 to determine how closely the current curricula are aligned to the new curriculum model and identify how much change will be needed in the renewal process. Using this information, we will develop a timeline for prioritising and updating each Advanced Training curriculum (see [Condition 6](#)).



## Standard 3. The specialist medical training and education framework

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



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**2017 AMC assessment:** Standard Substantially Met

**Conditions open:** Condition 5, Condition 6

**Recommendations open:** Recommendation HH

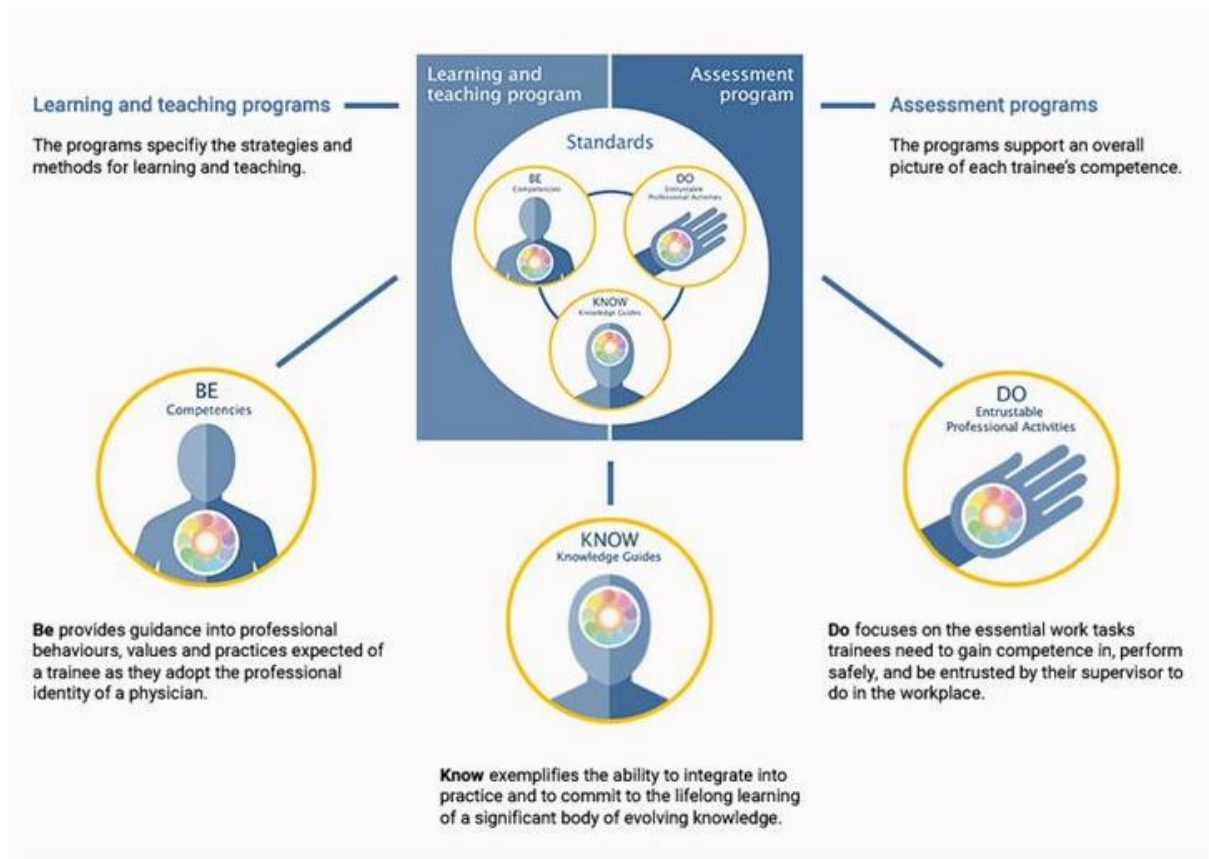
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- We have a new curriculum model
- We have completed renewal of the Basic Training curricula and published competencies, entrustable professional activities and knowledge guides
- Our new 3 phase Basic Training program is defined. We are consulting on implementation options to meet members' needs

## Significant developments since last report

We have made progress with the sizeable task of renewing our 40 curricula to align with the revised [RACP curriculum model](#) (Figure 4).

Figure 4. RACP curriculum model



This progress is detailed below in [Condition 5](#) and [Condition 6](#).

## Progress against accreditation conditions

### Condition 5

Complete the basic training curricula review including the integration of the Professional Qualities Curriculum and its implementation. (Standard 3.2)

The College is to report on milestones in 2016 and 2017 and completion in 2018.

### 2017 AMC Commentary

*The College expects to complete the review of the basic training curricula by 2018 followed by progressive implementation. However, the College notes that full implementation will not be complete by 2018, when it is due.*

We have progressed significantly with the Basic Training [Curricula Renewal](#), with the [Competencies, Knowledge Guides](#) and [Entrustable Professional Activities](#) being approved. Our new approach integrates the Professional Qualities Curriculum into the revised [RACP curriculum model](#) through the [Professional Practice Framework](#).

In mid-2018, we started implementing the new Basic Training curricula, with the release of the Basic Training Curricula Standards. We will provide guidance for trainees and supervisors on how the Standards can be used to support Basic Training before they are mandated through the formal implementation of the new Basic Training program.

We are developing a Learning, Teaching and Assessment program to deliver the Basic Training Curricula. It explains the structure of our Basic Training programs, the foundations of the assessment programs, duration of the training programs, and associated training requirements, policies and processes.

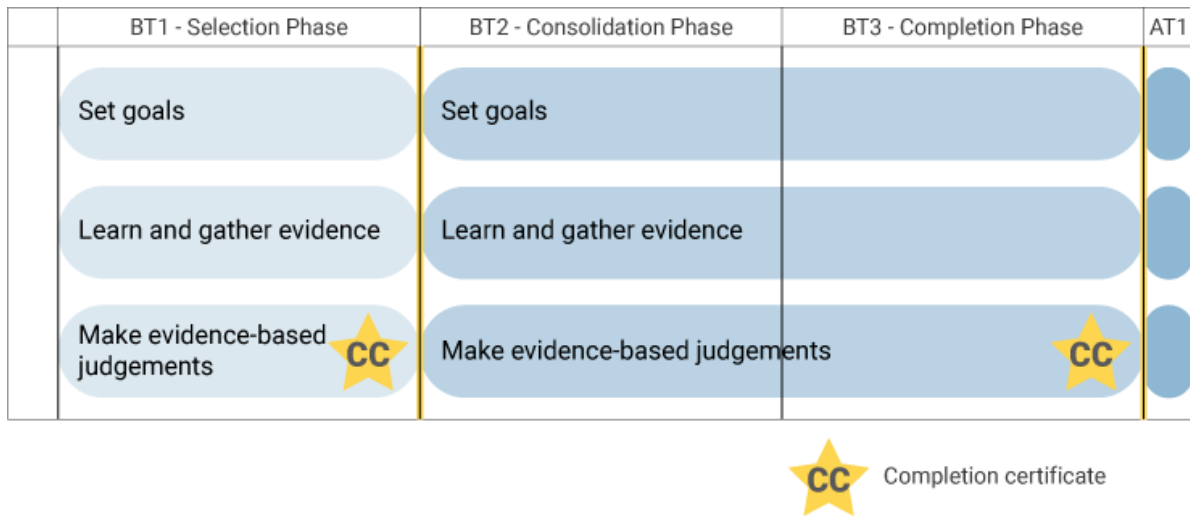
The design of the Learning, Teaching and Assessment program has been informed by the following principles (Figure 5).

**Figure 5. Basic Training design principles for Learning, Teaching, and Assessment**

 <b>We want to:</b>	 <b>We don't want to:</b>
<p>make the curriculum relevant to workplace practice</p> <p>improve the educational design of our training programs:</p> <ul style="list-style-type: none"> <li>• focus on performance over time spent in the program (a hybrid of competency- and time-based training)</li> <li>• design assessments to optimise learning and decision-making on progress (programmatic assessment)</li> <li>• unite the selection into training and curricula plans in a cohesive training program.</li> </ul> <p>design training programs that:</p> <ul style="list-style-type: none"> <li>• are flexible and fit-for-purpose for the health jurisdictions of Australia and New Zealand</li> <li>• meet the requirements of our regulators.</li> </ul>	<p>make training unnecessarily complicated</p> <p>increase the burden on supervisors and DPEs</p> <p>lengthen the overall duration of specialist training</p> <p>unnecessarily disrupt existing structures and processes that are working well</p> <p>make training less flexible.</p>

Our new Basic Training program design comprises three phases: Selection, Consolidation, and Completion (Figure 6). We plan to embed a selection program within Basic Training, offer written examinations more frequently, and emphasise work-based assessment. Accordingly, we have integrated our Selection into Basic Training project into the Basic Training Curricula Renewal. This reflects the degree to which these projects are connected (see [Condition 20](#)).

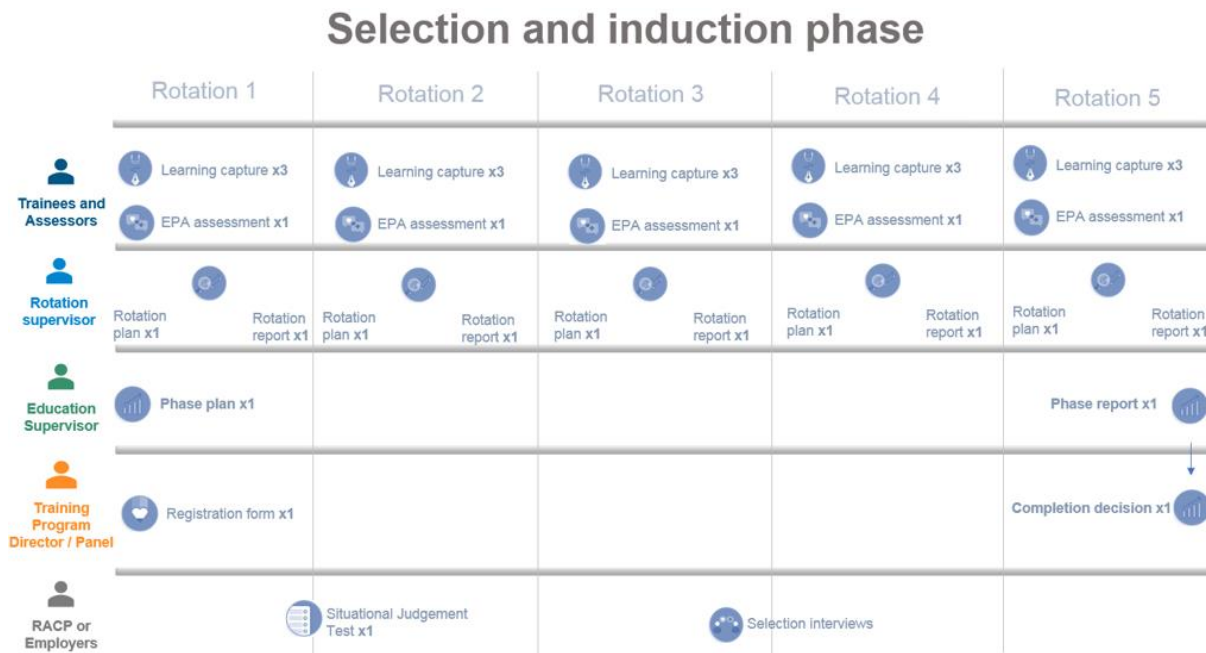
**Figure 6. Learning, Teaching and Assessment Structure**



We have refined the structure of Basic Training in response to member feedback received through a targeted review in July 2018. We gave participants targeted review packs in advance to prepare them for 30-60-minute consultation sessions, which were focussed on key discussion questions about the structure, assessment toolkit and blueprints. Discussion was facilitated on the desirability, defensibility and feasibility of the suggested phases of training that will form the Learning, Teaching and Assessment structure: the selection and induction phase; the consolidation phase and the completion phase (Figures 7,8 and 9).

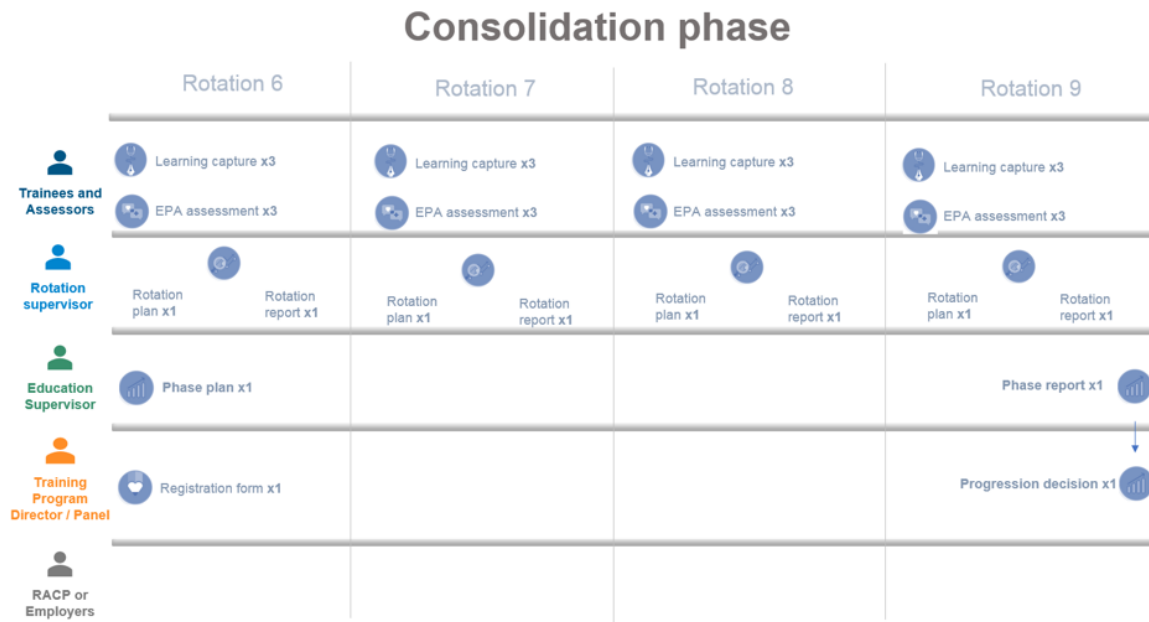
The selection and induction phase will orient trainees with the physician training pathway and confirm their readiness to progress in the Basic Training program.

**Figure 7. BT 1 - Selection and induction phase**



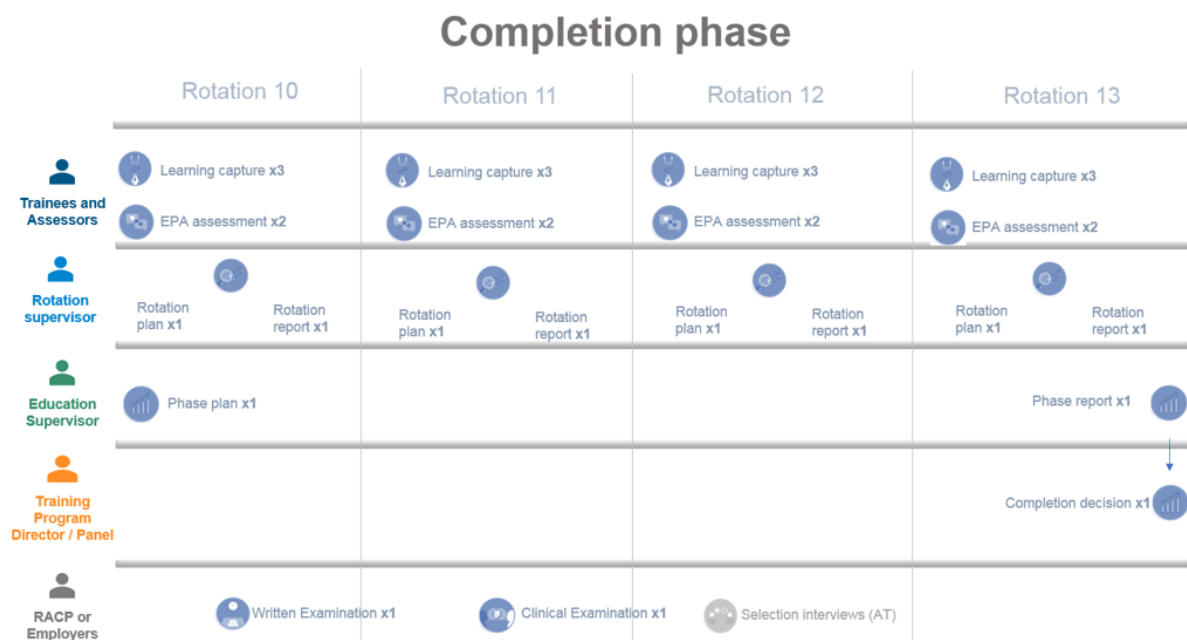
The consolidation phase will support trainees' professional development by focusing on their performance of required work-based tasks, their professional behaviours, and their ability to apply knowledge to patient management.

Figure 8. BT 2 - Consolidation phase



The completion phase will confirm trainees' consistent achievement of required work-based tasks, professional behaviours, and application of knowledge to patient assessment, diagnosis, and management; and support trainees' transition to Advanced Training.

Figure 9. BT 3 - Completion phase





Each phase of training will have its own:

- Minimum duration
- Criteria for entry and completion
- Learning program, consisting of:
  - clinical experience
  - courses and modules
  - supplementary resources
- Teaching program, that includes:
  - supervision roles and requirements
  - supplementary resources for supervisors
- Assessment program, consisting of:
  - required assessment tools
  - an assessment process.

The feedback received on each phase of the Learning, Teaching and Assessment structure and the assessment toolkit was generally positive. For each phase of the proposed structure, 90-100% of respondents considered the phase to be desirable and likely to enhance learning, feedback and evidence for decisions. The majority (77-81%) of respondents believed that each phase would be feasible to implement with a range of recommendations made for further consideration and consultation around this issue.

The curricula components still in development are:

- Assessment programs
- Learning and teaching programs
- Training requirements, policies, and processes
- Implementation and transition plans.

The Basic Training [Knowledge Guides](#) will be used as the basis for the 2020 Divisional Written Examinations (see [Condition 13](#)). We will consider the capacity and readiness of stakeholders and the health sector to implement change as we plan the implementation of the remaining elements of the Learning, Teaching and Assessment programs.

We are in the process of procuring new technology to support the implementation of the new curricula (see [Recommendation QQ](#)).

We are consulting with our members on the implementation options for the new Basic Training program. The four current options include cohort implementation and early adopter models.

In September 2018, we held [Basic Training Curricula forums](#) . They were interactive sessions to give our members and other key stakeholders the opportunity to:

- gain a shared understanding of the future state for the Basic Training programs
- consider the initial barriers and unintended consequences linked to implementation of the new programs, and how these might be resolved; and
- identify a preferred option for implementation of the new training programs.

By involving a wide range of stakeholders in the development and implementation planning process, we are aiming to meet member needs through fit-for-purpose design and implementation.

The structure is currently under broad digital consultation with the goal of refining and socialising the proposed structure, the assessment toolkit and blueprints before they are submitted to the College Education Committee for approval in November 2018. We also expect to finalise a full implementation plan covering the Learning, Teaching and Assessment program and tool development, resourcing, technology and timeframes by the end of 2018.

## Condition 6

In relation to the advanced training curricula:

- (i) Complete the review and implementation plan for the revised advanced training curricula including the integration of the Professional Qualities Curriculum. (Standard 3.2)
- (ii) Implement the revised advanced training curricula. (Standard 3.2)

The College expects to complete the review of the basic training curricula by 2018 followed by progressive implementation. However, the College notes that full implementation will not be complete by 2018, when it is due.

### 2017 AMC Commentary

- (i) *The College has now commenced further work in relation to the advanced training curricula, including a project plan and timeline which has been developed into a business case for designing and implementing the 38 new advanced training curricula.*
- (ii) *As before, this condition is dependent on progress in conditions 6 (i). The College does not have to satisfy this condition until 2020.*

In November 2017, we prioritised completing the review and implementation of the new Basic Training program with a focus on ensuring our members are ready to implement these important changes. This decision meant that progress was slowed on reviewing the 38 new Advanced Training Curricula.

In June 2018, we recalibrated our plan for Advanced Training curricula reviews, taking into account learnings from the Basic Training Curricula review and the size and complexity of the task. We mapped the key activities to progress these reviews in the second half of 2018 and beyond (A2.1).

We are progressing the Advanced Training curricula reviews by using the findings of the completed large-scale exploratory analysis of Advanced Training tools (A3.1, A3.2, A3.3). We are following the approach taken with the Basic Training Curricula Renewal and incorporating the domains in the Professional Practice Framework and the competencies in the Professional Standards. We have based the reviews on the new [RACP curriculum model](#), which integrates the Professional Qualities Curriculum. To promote continuity and consistency, we have progressed the identification and development of common curricula standards and Learning, Teaching and Assessment program elements between Advanced and Basic Training and across all Advanced Training programs. We are now completing a program review plan for each specialty, which includes:

- current state analysis including selection processes, training requirements and assessment activities
- equivalent international curricula
- known issues and risks with the current program
- numerical data including numbers of trainees and supervisors, median, minimum and maximum time taken to complete training and completion and withdrawal rates.

Finally, we are building a robust common template that applies to all Advanced Training programs before we start specialty-specific reviews, to maximise alignment across programs.

Due to the size and complexity of the task of reviewing 38 Advanced Training curricula, and as earlier advised, we do not expect to be able to complete both the review and implementation of the new Advanced Training curricula by the due date of 2020.

## Progress against accreditation recommendations

### Recommendation HH

Clarify in partnership with key stakeholders the linkages between the first two years of postgraduate experience and College training programs.

### 2017 AMC Commentary

*The College is progressing consultation with all jurisdictions and prevocational trainees, and working on a selection into training project.*

The new Learning, Teaching and Assessments programs outlined in [Condition 4](#) propose that Basic Training could commence as early as postgraduate Year Two. The programs will detail the first year of Basic Training and how it links to the first two years of postgraduate experience. Details about the phases of training are outlined in [Condition 20](#).

We will continue to collaborate with key stakeholders in prevocational training at local, state and national levels on areas of mutual concern and interest.

We note possible reforms to the first two years of postgraduate training following the Council of Australian Government's Health Council's national review of Medical Intern Training. We will need to consider the capabilities articulated for these two years of training as a result of this review and how they link with the entry to Basic Physician Training.

## Standard 4. Teaching and learning

Areas covered by this standard: practice-based training, teaching and learning approaches and methods, practical and theoretical instruction, increasing degree of independent trainee responsibility



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**2017 AMC assessment:** Standard Met  
**Conditions open:** Condition 8, Condition 9  
**Recommendations open:** Recommendation JJ

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- We are finalising teaching and learning programs to support our new Basic Training program
- Our new online College Learning Series has been implemented with excellent uptake



## Significant developments since last report

There has been no significant change to our teaching approach.

### **Implementation of interactive online College Learning Series**

In February 2018, as part of the Education Renewal Program, we introduced an interactive online College Learning Series.

Over 3,200 members (trainees and Fellows) have enrolled in the College Learning Series gaining access to 227 recorded lectures delivered by our Fellows.

This learning resource builds on the locally administered Victorian Physician Education Program lectures for Basic Trainees in Adult Medicine and engages a wider audience by including members in the development of digital content.

The College Learning Series relies on input from subject experts throughout Australia and New Zealand. This year we developed and recorded 82 new videos to add to the 145 lectures from the Victorian Physician Education Program.

The recorded lectures are clinically reviewed, mapped to the Basic Training curriculum, and made available to all our members. To ensure the material meets the educational needs of Basic Trainees, we are consulting with committees and member groups. We are also seeking to expand the series for Basic Trainees in Paediatrics & Child Health.

How the College Learning Series benefits our trainees:

- Learning is enriched by content from experienced Fellows.
- Trainees can access resources at times that are convenient for them.
- Trainees can interact online with peers and educators.
- The lectures are free as part of eLearning@RACP and are updated regularly.
- The content is regularly reviewed to ensure it is up-to-date and aligns with the revised Basic Training Curricula.

How the College Learning Series benefits our Educators, Fellows and the wider health sector:

- Supervisors and Directors of Physician Education can access additional resources that support training.
- Educators and Fellows can contribute content, share their knowledge and expertise, and interact with peers and trainees online.
- The College Learning Series is regularly reviewed to ensure training is clinically appropriate and current.

## Progress against accreditation conditions

### Condition 8

Demonstrate that the trainee experience and curricula align to the College's 70:20:10 model.

#### 2017 AMC Commentary

*The College notes an evaluation and have integrated the 70:20:10 model through the basic training curriculum Roadshow, the learning needs analysis, the College learning series (which was the basic training lectures), the e-learning resources the framework for education leadership and supervision, and the supervisor professional development program. The College remains committed to this model as the foundation for its learning approach. It has yet to rollout the integration of this model into the advanced training curricula.*

We have embedded the concept of the 70:20:10 model in our curricula, as evidenced by our current Basic and Advanced Training programs.

Our [Basic Training](#) and [Advanced Training](#) program requirements, underpinned by the relevant curricula, align to the 70:20:10 concept, which recognises the importance of experiential learning in the workplace.

The programs focus on work-based learning supported by structured work-based assessments with an emphasis on reflection. The Learning Needs Analysis Tool currently used in Basic and Advanced Training Programs (A4.1) was updated in 2017 to reflect the 70:20:10 model in planning learning and assessment activities by focussing on self-reflection.

The [College Learning Series](#) for Basic Trainees and the [eLearning resources](#) for both Basic and Advanced Trainees are aligned with the 70:20:10 approach, linking formal learning opportunities to reflection on work-based experiences, further, they are based on social learning models to encourage connections between learners.

The [Framework for Education Leadership and Supervision](#) is supported by the [Supervisor Professional Development Program](#) and the Supervisor Handbook, finalised in October 2017. The Supervisor Professional Development Program and the Supervisor Handbook refer to the 70:20:10 model and provide information to educational leaders and supervisors about aligning their teaching and supervisory activities with the model provided.

The 2017 [Supervisor Survey Evaluation Report](#) gave us insights into current supervisory practice, including the time that supervisors estimated they spend on learning and teaching and assessment activities for Basic and Advanced Training trainees. The survey data showed most of their learning and teaching time is spent on work-based learning.

Standard 7 of the new Training Provider Accreditation Standards (A4.2) addresses curriculum delivery by explicitly outlining expectations about the types of training opportunities which must be provided to trainees in relation to the three elements of the 70:20:10 model: experiential, social, and formal learning.

Our new Annual Physician Training Survey for trainees (A4.3) is based on the Training Provider Standards and includes questions about trainees' opportunities to learn through experiential, social, and formal learning (see [Condition 15](#)).

The 70:20:10 model is reflected in the design of the learning and teaching program component of the curriculum model and will be translated into all elements of the renewed Basic and Advanced Training programs (see [Condition 5](#) and [Condition 6](#)).



## Condition 9

As part of the curriculum review, develop and implement a structured approach to ensure the trainee's increasing degree of independence is systematically evaluated.

### 2017 AMC Commentary

*There has been significant work done in learning needs analysis, workplace based assessment and developing entrustable professional activities. The latter activities have not yet been implemented but are being currently refined. Again, it appears that this has not been rolled out into the advanced training curricula, which is to be expected because they are at an earlier stage of development.*

Implementing a structured approach to ensure that the trainee's increasing degree of independence is systematically evaluated has been central to the Basic and Advanced Training Curricula Renewal. The Curricula Renewal has focussed on embedding a competency-based program across all our curricula. A core part of this is the introduction of Entrustable Professional Activities for each training program. The assessment of Entrustable Professional Activities will lead to entrustment decisions. Entrustment decisions will use a scale based on the level of supervision required for each task to determine the level of autonomy at which trainees can be trusted to perform.

In August 2017, we finalised the eight [Entrustable Professional Activities](#) for Basic Training and published them for trainees to use as a learning resource. We have created a prototype for an Entrustable Professional Activities observation assessment tool and are now consulting and refining it. We expect the tool design to be submitted to the College Education Committee for approval by the end of 2018.

Assessment program design will continue to be guided by the expectation that trainees become more independent as they progress through their training requiring progressively less supervision.

We continue to build the capabilities of our educational leaders and supervisors. Our [Supervisor Professional Development Program](#) workshops focus on strategies to guide trainees towards expert performance, help with differentiated instructions for multi-level groups, create activities for trainees of different levels, and assess trainees' overall performance and progression. In the past year we have run 111 workshops across Australia and New Zealand with over 2,000 supervisors attending.

The current Advanced Training curriculum aims to develop and assess trainees' increasing independence in the workplace as they progress through the training program and towards Fellowship. This will be better enabled with the introduction of Entrustable Professional Activities over time. In the meantime, we have updated the Learning Needs Analysis and Direct Observation of Procedural Skills to explicitly embed competency-based concepts into Basic and Advanced Training programs. We continue to familiarise trainees and supervisors with the concept. Twelve Advanced Training programs, for example, use the [Direct Observation of Procedural Skills](#) tool that includes a graded independence scale.

## Progress against accreditation recommendations

### Recommendation JJ

Clarify, in partnership with the Specialty Societies, the role of College oversight in post Fellowship subspecialty training.

#### **2017 AMC Commentary**

*The College notes continuing work with the model of collaboration schedules and the various specialty societies. This is addressed in recommendation AA, a webinar series commencing as a pilot with 11 societies. This recommendation is progressing and will be dependent on completion of the model of collaboration schedules and consultation thereon.*

All specialty societies are actively progressing Models of Collaboration schedules. Four have now been completed and the remainder are in varying stages of completion (A4.4).

Some specialty societies have faced capacity issues, especially the smaller societies with limited or no staff resources to complete the schedule. In such cases, we have initiated the development of the first draft, ready for consultation with the specialty society. A master schedule is being established to facilitate this sensitively, to respect the societies' need to determine their own schedules.

Progress is continuing against this recommendation. The College Education Committee Chair is meeting with speciality society leaders to determine timelines for collaboration objectives.

## Standard 5. Assessment of learning

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



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**2017 AMC assessment:** Standard Met  
**Conditions open:** Condition 8, Condition 9  
**Recommendations open:** Recommendation JJ

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- We are finalising teaching and learning programs to support our new Basic Training program
- Our new online College Learning Series has been implemented with excellent uptake



## Significant developments since last report

### Shift towards Programmatic Assessment

We have progressed towards a more programmatic approach to assessment. In November 2017, we hosted a forum on programmatic assessment that was facilitated by assessment experts. This activity has been helpful in progressing the design phase of the Learning, Teaching and Assessment programs.

### Written Examination 2018

In February this year our first computer-based examination was cancelled due to a technical error. Exam provider Pearson VUE [acknowledged fault](#) for the examination failure and worked quickly with us in the aftermath to manage the situation.

It was a difficult time for our examination candidates and their families and friends. Our Directors of Physician Education, supervisors and staff were also affected. We responded by individually contacting each candidate to advise them personally about the [support services](#) available to them and to provide information about the alternative paper-based test scheduled in the following weeks. Candidates were also invited to share their experience of the event and provide their feedback. Two alternative paper-based tests were delivered in March.

We contacted the Australian Medical Council at the time of the examination cancellation to advise what had occurred and the actions we were taking to support our trainees following the event.

With a higher than usual pass rate for the Written Examination, we were appreciative of the strong support received from Health Services that enabled the accommodation of all eligible trainees to sit their Clinical Examinations for Paediatrics and Child Health, and Adult Medicine. The Adult Medicine Clinical Examination was conducted over an extended three-week period in August, with Health Services in both Australia and New Zealand providing exam places for a total of 900 candidates.

We are awaiting the report from an [independent inquiry](#) commissioned into the cancellation of the examination. The review will cover implementation of the computer-based examination addressing events on and preceding 19 February. It will include recommendations about how we can improve our examination process to move forward.

In the meantime, we have confirmed that the 2019 Divisional Written Examinations will be paper-based. We expect the inquiry findings will prove essential in learning opportunities and informing future implementation of computer-based testing.

## Progress against accreditation conditions

### Condition 11

As part of the basic training curricula review, ensure that the summative assessments apply reliable and valid methodologies and are aligned to both basic training curricula

#### **2017 AMC Commentary**

*The College is progressing with this condition, including developing a blueprinting process for the written, clinical, and workplace-based assessments. Further work is yet to be done.*

Our new Basic program will have a programmatic approach to assessment. This shift away from reliance on individual high-stakes assessments to a focus on a program of assessment will enable decisions to be made based on multiple data points, increasing reliability and validity.

The new Basic Training Assessment programs will be blueprinted against the Basic Training curricula standards. Expected outcomes of the program will be assessed using appropriate assessment methods and tools. Medical expertise and professional domains of practice will be assessed throughout the training program through an integrated program of learning, teaching, and assessment.

Ten learning goals have been identified for use in the assessment program and these link directly to the [Basic Training Curricula Standards](#).










The 10 key learning goals are:

1. Clinical assessment
2. Communication with patients
3. Documentation
4. Prescribing
5. Transfer of care
6. Investigations
7. Acutely unwell patients
8. Procedures
9. Professional behaviours
10. Knowledge

The learning goals for Basic Training will be mapped to the appropriate phases of training and will form the basis of blueprinting assessment tools to the curricula.

The proposed assessment toolkit for the new Basic Training program includes:

Figure 10. Basic Training Program assessment toolkit

	Annual registration form to enrol trainees and assess entry criteria
	Monthly learning capture to show evidence of work-based learning
	Monthly to quarterly <u>Entrustable Professional Activities</u> observations to assess trainee performance in relation to these
	One phase plan and progress report to plan learning and assess progress per phase of training
	One rotation plan and progress report to plan learning and assess progress per rotation
	Written examination to assess trainees' applied knowledge, offered twice per year
	Clinical examination to assess trainees' ability to perform clinical assessment of patients
	Situational Judgement Test (SJT) to assess trainees' non-academic attributes in relation to their judgement in a hypothetical workplace situation
	Selection interviews to assess candidates' suitability for physician training based on selection criteria

As part of our [targeted review in July 2018](#), we consulted members on the suitability of the proposed tools for assessing learning goals based on curricula standards and on identifying gaps in the toolkit.

The proposed toolkit was also discussed at our [Basic Training Curricula forums](#) and is being consulted on more broadly (see [Condition 5](#)) before it is finalised for approval by the College Education Committee in November 2018.

## Condition 12

As part of the advanced training curricula review, ensure that the summative assessments apply reliable and valid methodologies and are aligned to all advanced training curricula.

### 2017 AMC Commentary

*The College is now considering assessment in advanced training, with a large-scale exploratory analysis of advanced training assessment tools.*

As outlined in [Condition 6](#), we are identifying and developing the learning, teaching and assessment elements that are common across Basic and Advanced Training programs.



Like the Basic Training assessment tools, the Advanced Training Learning, Teaching and Assessment programs will follow the programmatic assessment design principles detailed in [Condition 11](#).

We will use the findings from the evaluation of three Advanced Training tools (A3.1, A3.2, A3.3) to support and embed our programmatic approach. In particular, we aim to ensure trainees' increasing degree of independence ([Condition 9](#)) and reflect the concept of the 70:20:10 model ([Condition 8](#)).

We anticipate that the common content across Advanced Training curricula will be finalised between 2019 and 2020. The updated tools will be implemented concurrently with the training-program level review phase of the Advanced Training Curricula Renewal (see [Condition 6](#) and [Condition 11](#)).

### Condition 13

Pending the adoption of the new curricula and linked assessments:

- (i) Blueprint the basic training written examination to the basic training curricula
- (ii) Review and revise the College's current clinical examination calibration processes.
- (iii) Review and revise the marking methodology for the clinical examination to ensure that the assessment as currently constructed performs optimally.

### 2017 AMC Commentary

*Condition 13 (i); has been completed and used in the 2017 written examination.*

*Condition 13 (ii); new processes for the clinical examination have been recommended and are being piloted for validation purposes. The results of the pilot will determine whether the launch of the new processes will be commencing 2018 or 2019.*

- (i) As reported last year, the Basic Training Written Examination was blueprinted to the current Basic Training curricula and used for the written examination in 2017.

Our work is now focussed on blueprinting the Basic Training Written Examination against the new curricula, as part of the examination development process. We have developed a draft blueprint in collaboration with the chairs of the written examination committees. It will be submitted for review and approval by the written examination committees, Adult Medicine Division Assessment Committee and Paediatric & Child Health Division Assessment Committee by the end of 2018.

The Basic Training [Knowledge Guides](#) will be used as the basis for the 2020 Divisional Written Examinations. The examination item development plan will be structured to ensure the items align with the blueprint.

To support quality item development, we are rolling out a comprehensive training package for new and existing item writers. The training will be made available to Fellows who register their interest in writing examination items and will allow us to broaden the pool of item writers to facilitate development of an extensive and robust item bank.

- (ii) We undertake annual reviews of the clinical examination calibration processes. Other improvements developed through the Clinical Examination Assessment Review (CLEAR) Project are being implemented to improve calibration processes and enhance examiner feedback tools, including a peer review component.
- (iii) We have completed review and revision of the marking methodology as part of the CLEAR Project. Our evaluation showed it was better than our current marking approach (known as the Traditional

rubric). The revised approach underwent an additional evaluation phase in 2018. It was used in most clinical examinations concurrently with the current marking process.

We have analysed candidate outcomes to compare the Traditional rubric to the new CLEAR rubric. Findings of the initial analysis of the 2018 Divisional Clinical Examination results from the Australian Paediatric & Child Health examination in Australia and New Zealand and the Adult Internal Medicine examination in New Zealand suggest that:

- The CLEAR approach improves the transparency and defensibility of the Clinical Examination process.
- Examiners prefer the new 6-point marking scale compared with the traditional 19-point scale.
- The inter-rater consistency is improved.
- The new 'Banded Model' Score Combination Grid is supported.

Analysis is now being undertaken of the Australian Adult Internal Medicine Divisional Clinical Examination results.

We will use the findings to inform the recommendations being provided to the CLEAR working group, clinical examination committees, Adult Medicine Division Assessment Committee, Paediatric Division Assessment Committee, College Assessment Committee and College Education Committee by the end of 2018. We plan to use the CLEAR rubric for all clinical examinations in 2019.

#### Condition 14

Develop and implement an assessment strategy for domains in the Professional Qualities Curriculum.

#### 2017 AMC Commentary

*The College's response is somewhat general, and does not specifically address the issue of domains in the professional qualities curriculum. Clearly activity is continuing on implementation of the assessment strategy in general. There is insufficient information specifically about competencies that were included in the professional qualities curricula.*

The [Professional Qualities Curriculum](#) has been integrated into the [Professional Practice Framework](#). The current [Basic Training](#) and [Advanced Training](#) program requirements are underpinned by the relevant curricula and the Professional Qualities Curriculum.

Within our current Basic and Advanced Training programs, the domains in the Professional Qualities Curriculum are assessed through the Professional Qualities Reflection tool and Supervisors' Reports.

The [Professional Qualities Reflection for Basic Training](#) and the [Professional Qualities Reflection for Advanced Training](#) both have the explicit aim of helping trainees identify the link between their everyday work experiences and the Professional Qualities Curriculum. The current Professional Qualities Reflection assesses domains in the Professional Practice Framework, as they largely align to the Professional Qualities Curriculum.

Supervisors' Reports (A5.1) for both Basic and Advanced Training programs currently require supervisors to assess trainees on expected behaviours which are drawn from domains of the Professional Qualities Curriculum as well as the relevant specialty specific curriculum.

The new Basic Training curricula (see [Condition 5](#)) is mapped to domains in the Framework. The renewed curricula in Advanced Training will also be mapped to the Framework (see [Condition 6](#)).

The new [Entrustable Professional Activities](#) for Basic Training have expected behaviours that are grouped under the Professional Practice Framework domains. The Entrustable Professional Activities 3 Documentation, for instance, lists behaviours under medical expertise; communication; quality and safety; ethics and professional behaviour; judgement and decision making; and leadership, management and teamwork.

The integration of professional qualities within the new Professional Standards Framework will enable more explicit assessment of these competencies. This will be achieved by blueprinting the assessment program to the Professional Standards Framework and ensuring that appropriate assessment tools are utilised to assess the development of a trainee's professional qualities over time and achievement of the required standard for progression.

## Progress against accreditation recommendations

### Recommendation LL

Provide enhanced structured feedback to individual examiners on their own performance to enhance the performance of the clinical examination.

### 2017 AMC Commentary

*The College continues to undertake calibration sessions and pair new examiners with senior examiners. Senior examiners provide feedback to new examiners and the progress report states that senior examiners discuss their performance with each other. The College has undertaken a barcoding, to enable further data analysis concerning the effects of examiner variation. To what extent the feedback is structured is unclear, as it is dependent on the individual examiners. It appears to be reliant on verbal feedback.*

We continue to provide pre-examination feedback to examiners through calibration sessions. Calibration sessions undergo regular review to ensure that they are providing relevant and targeted training for examiners.

We have trialled providing examiners with a report summarising their marking style using a Hawk-Dove methodology (A5.2). However, the feedback provided in the Examiner 'Hawk Dove' Analysis Report Survey suggested that the process in its current form may drive examiners to regress towards the mean or adversely change their marking behaviour. As a result, the Hawk Dove analysis was not used in 2018. The learnings will inform further work on providing structured feedback to examiners to support their development in the role.

We are exploring alternative examiner feedback methods as part of the Clinical Examination Assessment Review Project, to provide constructive individual feedback to examiners after clinical examinations based on the revised and renewed scoring system and the CLEAR rubric (A5.3).

## **Recommendation MM**

Adopt recommendations from the external review on assessment regarding: timing of the clinical examination; conducting the written examination twice a year; and de-coupling the medical sciences and clinical applications paper of the written examination.

### **2017 AMC Commentary**

*The timing of the clinical examination has been altered for the paediatric examination. Timing for the adult examination is under consideration. The College is introducing computer-based testing for the written examination in 2018, but note they are dependent, before they transition to an examination twice a year to generating sufficient items from the bank to deliver this. The College has deferred consideration of decoupling of the medical sciences and clinical applications paper for the time being.*

### **Timing of the Clinical Examination**

The Paediatric and Child Health Clinical Examination was successfully brought forward from July to May in 2016. Regarding the Adult Medicine Clinical Examination, both the Adult Medicine Basic Training Committee and the Adult Medicine Division Education Committee support keeping the examination in May/June, not wishing to reduce the gap between the Divisional Written and Clinical Examinations. Delivery dates for the Clinical Examinations are reviewed annually in conjunction with health sector and RACP timelines to ensure minimal impact on stakeholders.

During 2018, we undertook significant external engagement (see sample letter A5.4) in relation to clinical examinations because of capacity issues experienced with increasing numbers of candidates. We collaborated with the health services across Australia and New Zealand and were appreciative of the excellent support received to enable accommodation of a larger number of clinical examination candidates this year.

### **Written Examinations twice a year**

High-level plans to deliver the Divisional Written Examination twice a year have been developed as part of the curricula renewal process. The issues that arose during the launch of computer-based testing (see [Written Examination 2018](#)) in 2018 delayed their implementation, so this will not be achievable in 2019. An implementation plan is being developed to support computer-based testing. Significant development work is required to build an item bank of a suitable size and quality to create the required number of examination forms (see [Condition 13](#)).

### **Decoupling the medical science and clinical application papers of the Written Examination**

Consultation undertaken as part of the curricula renewal (A5.5) determined that members do not generally support de-coupling the medical sciences and clinical applications papers of the Divisional Written Examination. Members considered that splitting the examination would not necessarily reduce the burden of assessment on trainees, and may increase it, by adding another high-stakes event to assessment requirements. The change was seen as increasing the priority of examination preparation at the cost of workplace skill development. Further, our programmatic assessment focus favours a more integrated approach to assessment and decoupling the papers of this examination risks undermining such an approach.

Decoupling the Written Examination papers remains a consideration as part of the ongoing assessment review.

## Standard 6. Monitoring and evaluation

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



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<b>2017 AMC assessment:</b>	Standard Substantially Met
<b>Conditions open:</b>	Condition 15, Condition 16, Condition 18
<b>Recommendations open:</b>	Recommendation NN

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- Our new Annual Training Survey and Annual Educator Survey are being implemented in October 2018
- We have approved an evaluation strategy and progressed plans and activities to measure the impact of innovations



## Significant developments since last report

### Monitoring

We have made significant progress towards implementing methods for systematic and confidential feedback on the quality of the training experience. Following a successful pilot in late 2017 of the Annual Physician Training Surveys for Trainees and Educators, these feedback tools will be implemented in late 2018. This progress is detailed below in the response to [Condition 15](#) and [Condition 16](#).

### Evaluation

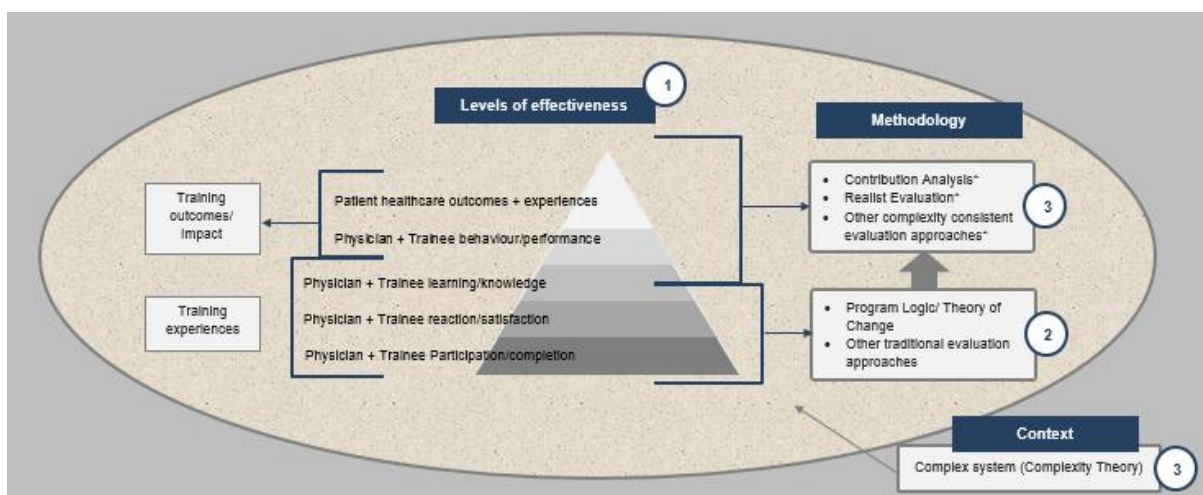
Medical education research and evaluation is a key priority and function for us in our role as a provider of specialist medical training. Research and evaluation activities guide innovation, ensure the quality improvement of the training programs and embed change in a robust evidence-base.

Our overarching strategy for evaluating the impact of our program of Education Renewal was approved by the College Education Committee in November 2017 (A6.1).

The Education Renewal Research and Evaluation Strategy aims to evidence and monitor change intended to improve physician training and healthcare experiences and outcomes.

The strategy defines our approach to evaluation and the systematic mapping of evaluation activities and methodologies required to build the evidence needed to make value judgements about the impact of our educational innovations. The organising framework for our evaluation strategy is set out in Figure 11 below. The knowledge gathered through this process will inform quality improvement in the design and delivery of our training programs. It can be shared with others involved in medical education to inform future approaches to similar initiatives.

Figure 11. Organising framework for Education Renewal Research and Evaluation Strategy



**Note.** The numbers in this diagram refer to the three areas of theoretical thinking that combine to form the foundation for our Education Renewal Research and Evaluation Strategy:

1 - Examining impacts: Kirkpatrick's levels of evaluation

2 - Tracking change interventions: Theory of Change and Logic Models

3 - Unsurfacing Complexity: Complexity theory, Realist Evaluation and Contribution Analysis

\* these activities will draw upon evaluations of lower levels, which will have been designed and conducted in ways that can be leveraged for Contribution Analysis, Realist Evaluation and other complexity consistent evaluation approaches such as Phenomenology and Ethnography



We have developed evaluation plans for the College Learning Series and Training Support Program and will be conducting evaluation activities linked to these plans from October 2018.

## Progress against accreditation conditions

### Condition 15

Develop and implement methods for systematic and confidential trainee feedback on the quality of supervision, training and clinical experience and use this information for analysis and monitoring.

#### **2017 AMC Commentary**

*The College states it is still progressing this condition. It is developing an annual training survey schedule to be piloted in late 2017. The College notes the proposed National Training Survey will augment its activities.*

In 2017, we developed the Annual Physician Training Survey for trainees (A4.3) in conjunction with the new Training Provider Accreditation Standards (A4.2) to collect confidential feedback from trainees about their training experience at the local level. The annual survey focuses on trainees' views of the learning environment at their training setting, the governance and management of training, and support for training. The survey questions are linked to the criteria in the Training Provider Standards and are one form of evidence we will use to measure compliance with the Standards.

The survey was piloted in 2017 and the findings have been released to the pilot training settings and training committees. The training indicators are: safety and quality; learning environment and culture; training management; training resources; supervisor workload; trainee workload; trainee support and wellbeing; experiential learning; social learning; formal learning; and feedback and assessment.

For each hospital, the Training Settings Findings report (A6.2):

- highlights key findings from the survey responses
- provides a high-level overview of its overall performance
- gives a detailed analysis of performance by indicator
- provides a summary of the hospital's indicator performance the against national and state averages and the average of all settings.

The Annual Physician Training Survey for Trainees will be sent out to all trainees in clinical training programs in October 2018.

## Condition 16

Develop and implement structured methods for supervisors of training to contribute to the ongoing monitoring of the training program.

### 2017 AMC Commentary

*The College intends to pilot an annual supervisor survey in late 2017.*

We have developed the Annual Physician Training Survey for Educators (A6.3) in conjunction with the Annual Physician Training Survey for Trainees (see [Condition 15](#)). The survey focuses on key supervision areas including workload, responsibilities, training, support and resources. It also captures supervisors' views of the trainee experience, training programs, culture and patient safety.

The Annual Physician Training Survey for Educators was piloted in late 2017 and survey findings (A6.2) have been released to the pilot settings and training committees. The 2018 survey will be rolled out to all educators supporting a clinical training program in October 2018.

Figure 12. Physicians Training Surveys information from website



Seeking continuous feedback from supervisors remains integral to our Education Renewal program. This includes opportunities to provide feedback through participation in interviews, online surveys, correspondence, and face-to-face workshops. Our new [co-design](#) approach to consultation also offers new opportunities to provide feedback to inform projects relating to Selection into Training, Curriculum Renewal, Patient Centred Care and Consumer Engagement, Education Policy, Assessment, and Accreditation Renewal.

The [RACP Framework for Educational Leadership and Supervision](#) covers evaluation of training programs and teaching practice at the local level. This provides educational leaders and supervisors with theory and best practice to evaluate learning processes with reference to Kirkpatrick's Evaluation Model (1994) within the context of our training programs. We encourage supervisors and educational leaders to use Kirkpatrick's Evaluation Model to engage in on-going monitoring and evaluation practices that adopt a strengths-based approach to improving training programs at their local settings.

## Condition 18

Implement processes for health care administrators, other health care professionals and consumers to contribute to evaluation.

### **2017 AMC Commentary**

*The College has developed a framework for improving patient centred care and consumer engagement and states that a staged implementation of this framework is underway (see condition 2(ii)).*

*While it appears the College has introduced a process for consumer engagement it is unclear how healthcare administrators and other healthcare professionals are engaged.*

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In 2017, we began implementing the [RACP Framework for Improving Patient Centred Care and Consumer Engagement](#) (see [Governance](#) regarding our Consumer Advisory Group) which identifies the need for greater collaboration with our key partners in the sector if the aim of a more patient-centred system is to be achieved. The Framework sets out the importance of an approach to care that is grounded in mutually beneficial partnership and collaboration of healthcare providers, patients, families, and communities in the planning, delivery, and evaluation of healthcare. The Framework identifies hospitals, community health, general practitioners and healthcare teams, including health care administrators and professionals, as [key collaborative partners](#).

Further, healthcare executives and administrators evaluated locally delivered training programs through the collaborative approach used to develop our Training Provider Standards. We also routinely seek input from these key partners as part of ongoing quality improvement through our current accreditation processes.

The Education Renewal program has a stakeholder consultation register which offers another opportunity for representatives of health settings and jurisdictions to provide feedback on education initiatives and project deliverables. We have purchased a subscription to health business database, HealthGovBiz to maintain the register.

In addition, the [Basic Training Curricula Renewal Forums](#) in September 2018 provided another avenue for health departments to consider program structure and implementation approach. Constructive feedback was received in relation to alignment of training conditions across jurisdictions. Targeted engagement of health department partners will be undertaken in 2019 to consider changes to Basic Training accreditation and impact on workplace planning.

## Progress against accreditation recommendations

### Recommendation NN

Share information about the quality of training by uploading training site accreditation reports to the College's websites.

### 2017 AMC Commentary

*The training provider accreditation renewal project has proposed that summary accreditation reports are available on the website, however it is not clear whether this has actually occurred and to what extent.*

We continue to publish information about the accreditation status of all settings on our [website](#).

Our new Training Provider Accreditation Program (A4.2) model has a five-step accreditation cycle consisting of self-assessment, external assessment, external validation, reporting, and monitoring. As part of the reporting stage, executive summary reports for all training settings will be available to trainees and Fellows on our website. The Training Provider Accreditation Program will be piloted in 2019.

## Standard 7. Trainees

Areas covered by this standard: admission policy and selection; trainee participation in education provider governance; communication with trainees; trainee wellbeing; resolution of training problems and disputes



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**2017 AMC assessment:** Standard Substantially Met

**Conditions open:** Condition 20, Condition 21

**Recommendations open:** Recommendation QQ

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- We are implementing our new physician wellbeing strategy
- We responded swiftly to support trainees affected by the cancellation of the computer-based written examination
- We have shifted our approach to selection, embedding it within the new Basic Training Program and we have developed a Selection Guide to support local selection activities

## Significant developments since last report

### Wellbeing strategy

We have developed a Doctors' Health and Wellbeing Strategic Roadmap and Action Plan to guide our priorities and contributions to Doctors' Health and Wellbeing. Through this strategy we aim to foster a stronger community of doctors supported and enabled by the RACP and employers that nurtures the health and wellbeing of members and their families.

These are the guiding principles of the strategy:

- *Collaborative*: Doctors' health is a sector-wide issue and all stakeholders have a shared responsibility to take action on improving health and wellbeing for all doctors.
- *Evidence-based*: Effective prevention and intervention strategies must be evidence-based to ensure initiatives have high impact and link to measurement.
- *Action-oriented*: Stakeholder expertise and contribution is focussed on action. All strategy practically translates to action that can be implemented.
- *Sustainable*: Changing culture is a long-term commitment; any strategy needs to be resistant to environmental and organisational change.
- *Measurable*: Critical to create a baseline, then continue to monitor and evaluate outcomes.
- *Flexible and diverse*: Addresses the unique differences of individual and changing needs through career lifecycles and ensure access to all members.

An overarching framework and an action plan and was developed in consultation with members, with assistance from an external consultant. A Health and Wellbeing Reference Group has recently been established to progress implementation of the strategic roadmap.

We are currently supporting member wellbeing by offering the [Converge](#) service, a fully confidential and independent helpline available 24-hours a day, seven days a week, which was launched in 2016.

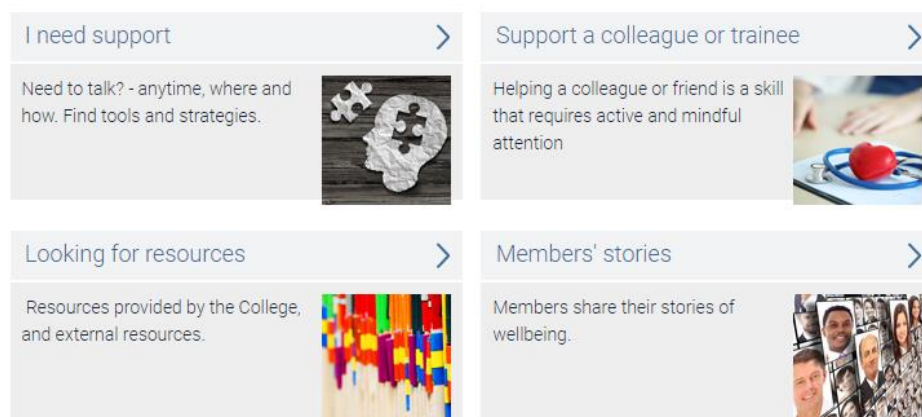
To promote trainee wellbeing, we have also:

- published a Health of Doctors position statement (2013 and updated in 2017)
- implemented the Trainee in Difficulty Support Policy and Process (2016)
- incorporated wellbeing into the new Training Provider Accreditation Standards (A4.2)
- included wellbeing in the Annual Physician Training surveys for Trainees and Educators (A4.3 and A6.3)
- published several Pomegranate Health [podcasts](#) relevant to doctors' health and wellbeing:
  - [Episode 5: Physician, Heal Thyself](#)
  - [Episode 7: The Art of Supervision](#)
  - [Episode 16: Mind the \(Gender\) Gap](#)
  - [Episode 22: Transitions to Retirement](#)
  - [Episode 30: Being Human](#)
- published [e-learning resources](#) including a module on Physician Self-Care and Wellbeing
- published a [health and wellbeing webpage](#) (Figure 13) with easily accessible links and curated resources.
- implemented a Complaints Management Policy and Procedure, and a Discrimination, Bullying, Harassment & Victimisation Policy to ensure that all complaints and concerns are appropriately managed.



Figure 13. RACP Physician Health and Wellbeing website page

## Physician Health and Wellbeing



### Support for trainees during the 2018 Written Exam

Difficulties experienced by trainees due to the cancellation of the computer-based written exam in February 2018 demanded that we initiate a targeted and comprehensive response to ensure that our trainees (and Directors of Physician Training) were supported after the event.

We employed a range of methods to support candidates during this time. We contacted candidates individually by telephone and gave them the most up-to-date information regarding the exam. We asked them to provide feedback on their experience. We provided regular updates to ensure that all candidates could be accommodated to re-sit the written exam. We released the computer-based exam to candidates to ensure that they all had the same access to examination materials. We offered more trainee wellbeing and support services through Converge, Doctors' Health Advisory Service, NSW Health, and the Junior Medical Officers Wellbeing and Support Plan helplines. We gave full refunds of the fees paid for this year's exam. We did not charge candidates for attempting the alternative exams held on 2 March and 23 March. For candidates who did not pass the alternative exam, we did not count the exam as an attempt.

## Progress against accreditation conditions

### Condition 20

Develop and publish the College's selection criteria, including the weighting and marking system of the various elements.

#### 2017 AMC Commentary

*This condition is progressing but has not been completed. The College does not indicate when it expects to be able to complete this.*

Planned development activities for the selection into Basic Training process were based on recommendations from the *Developing a Good Practice Model for Selection into Basic Training: A quality and feasibility study*. This model made design assumptions for the Selection into Basic

Training project and the Curricula Renewal project that would have implications for the timing of entry into and duration of Basic Training including:

**1. Selection will occur in PGY2 for commencement in PGY3**

We made this choice as it was deemed impractical to select earlier than postgraduate year 2, as prospective trainees would have had insufficient experience to move through a robust selection process and would not yet have secured general registration status.

**2. The Basic Training programs will have a three-year minimum time requirement.**

We made this choice as it is a continuation of the current state and allows trainees to have sufficient workplace experiences to achieve the curricula standards.

We consulted on each of the design assumptions, and these were met with general support, within the context of the individual Education Renewal projects. However, when we brought these projects together in readiness for implementation, the consequence was a perception that we were adding a year to physician training. This would have had a significant impact on a large proportion of trainees and on the hospital systems of Australia and New Zealand.

To address this, we proposed a new Learning, Teaching and Assessment structure (see [Condition 5](#)) which recommends that Basic Training commences in postgraduate year two at the earliest and is a minimum of a three-year program with the first year acting as a selection phase, embedding selection into the Basic Training program, rather than acting as a point-in-time event. The College Education Committee approved this model to be developed further in April 2018.

Under the new structure, selection activities will occur in the Selection and Induction Phase, in the first year of Basic Training. Selection will operate as a discrete program-within-a-program where trainees will complete a series of focused assessments which inform decisions about selection into the next phase of the training program. Embedding the selection process in this way facilitates valid, robust decisions based on workplace performance to ensure that trainees are ready to progress to the second phase of the Basic Training program.

Trainees will complete an eligibility check to enter the selection phase at the start of PGY2 (at the earliest) and will then progress through the Selection and Induction phase of training completing the learning, teaching and assessment requirements of this phase (refer to Figure 9).

Towards the end of this phase, a progression panel will consider the completed assessments and other evidence of learning so that a decision can be made regarding completion of the phase and suitability to progress in the training program. We will develop specific assessment tool and weightings for selection as part of the Learning Teaching and Assessment programs.

The structure of the new Basic Training program, including the proposed selection phase, is currently being consulted on broadly with members and stakeholders and will be refined and finalised once consultation closes in October this year (see [Condition 5](#)).

We have drafted [entry criteria and selection \(completion\) criteria](#) and will seek rapid, targeted feedback as part of our new [co-design](#) approach. We expect to complete this part of the Basic Training Learning Teaching and Assessment programs in late 2018.

In addition, we have developed guidance for local settings and networks on selection into training (see Condition 21). This includes guides on how to conduct interviews, collecting references and options for weighting selection criteria within the local selection process. We have also provided advice on the College's expectation of its members and their role in [recruitment and selection](#) for its training programs, which includes clarity about acceptable and unacceptable interview practices.

## Condition 21

Monitor the consistent application of selection policies across all training sites.

### **2017 AMC Commentary**

*Work in this condition is consequent upon previous conditions. The College's progress report indicates that it is being considered in the draft training provider standards, but progressing to application and then monitoring is some way off.*

Our new Training Provider Accreditation Standards (A4.2) require training providers to have fair, rigorous, transparent and documented processes for trainee recruitment, selection and appointment. Standard 4 relating to Training Management obligates training providers to comply with the principles and standards set out in the [Selection into Training policy](#) and [Recruitment Practices statement](#).

The standards have been published to allow time for our training providers to ensure their structures and processes will meet the new standards when they are progressively implemented from 2020.

To assist training providers to comply with our new standards and improve the rigour and transparency of selection practices we developed a Selection into Training Guide. The guide provides practical information about selection and recruitment recommending strategies to improve the rigour of processes and supporting the translation of innovation into practice. We engaged the Great Mynds consultancy, with expertise in medical education recruitment, selection and human resources, to develop the guide.

Topics covered by the Guide:

- the role of the RACP in Selection into Training
- the recruitment cycle and selecting
- the selection committee
- establishing the process
- job design and posting
- application phase
- references
- interview phase
- deciding
- after the decision is made
- achieving diversity in selection

We are currently consulting with stakeholders, particularly Directors of Physician Education, about the content and presentation of the Guide to ensure that it is accessible and useable.

## Progress against accreditation recommendations

### Recommendation QQ

Improve communication with trainees by:

- (i) implementing a communication strategy to ensure consistent and targeted trainee-oriented communication across all College training program (Closed)
- (ii) implementing the Online System for Administration and Reporting (OSCAR) or similar system

### 2017 AMC Commentary

*Recommendation (i) has been closed. Please see commentary for Recommendation PP.*

*For recommendation (ii), the College is currently exploring appropriate software and learning management systems, but these do not appear to have been implemented.*

---

We have been exploring new technology to support the implementation of Education Renewal projects including Selection into Basic Training, Curricula Renewal and the Training Provider Accreditation Review.

We undertook extensive scoping to identify the requirements for the system. The new technology will provide a multifaceted approach to improving communications with trainees. It will incorporate:

- mobile and tablet applicability
- a personalised dashboard to view, manage and track their own training and to interact with us
- personalised notification centre and reminders of due dates
- real-time ability to view training progression and requirements
- streamlined communication between trainees, supervisors, and staff
- automation of workflow
- forums and collaborative tool capability, e.g. communities of practice, study groups, sharing of educational resources.

The technology will be the single source of truth for trainees and their supervisors.

Requests for Information were issued to 25 vendors working with medical colleges worldwide. Following demonstrations from the nine vendors who responded, we sent requests for proposals to the five vendors who met the key requirements of our Education Renewal projects as well as our business-as-usual requirements. The successful vendor was engaged in September 2018 to complete the discovery phase with confirmed requirements. The deployment schedule is on track to be agreed by the end of 2018 and piloted during 2019.

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

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



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**2017 AMC assessment:** Standard Met  
**Conditions open:** Condition 24, Condition 25  
**Recommendations open:** Recommendation TT

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- We have finalised our new Training Provider System
- We have confirmed our new Training Provider Accreditation Standards, Accreditation Policy and Network Principles
- Our supervisors have reported overall satisfaction with the supervisor training program

## Significant developments since last report

### Supervisor Professional Development Program

In 2018, we undertook an evaluation of our Supervisor Professional Development Program, a three-part program designed specifically for supervisors in collaboration with leaders in education. The focus was to evaluate each of the three workshops (Practical Skills for Supervisors, Teaching and Learning in Healthcare Settings and Work-based Learning and Assessment) separately via a questionnaire given to workshop attendees.

The report findings were very positive overall and indicated that the Supervisor Professional Development Program workshops were meeting supervisors' training needs. Supervisors were very satisfied with the development program and its practical, skills-based focus. They reported positive changes in attitudes towards teaching and professional development. The workshops appeared to increase their motivation and enthusiasm for teaching, and they valued the opportunity for professional development. Respondents reported gains in knowledge and skills, such as how to provide negative feedback to trainees. Respondents also reported their intentions to make changes in teaching behaviours, for example, to make time to plan teaching and to make more effective use of clinical ward rounds as a teaching opportunity.

The chance to interact with peers emerged as a theme in this evaluation and was positively valued by respondents. The creation of networks of colleagues may be a positive outcome of the Supervisor Professional Development Program workshops.

## Progress against accreditation conditions

### Condition 24

Promulgate and implement the revised educational supervision policy that defines the new responsibilities of supervisors

### Condition 25

Develop and implement a formal selection process for supervisors including criteria for selection

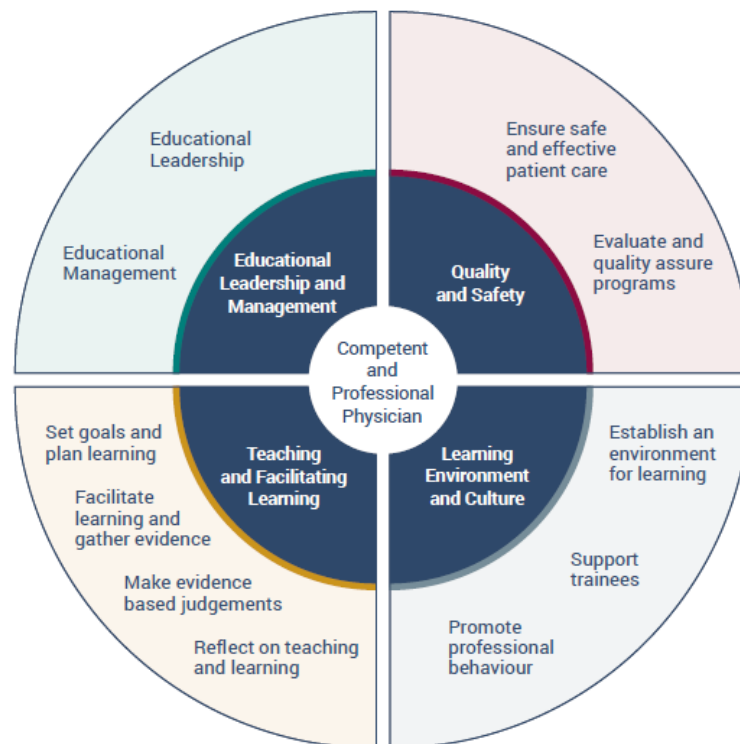
### 2017 AMC Commentary

*The educational leadership and supervision policy, framework and associated implementation has been approved. Implementation is scheduled to be staged over the period 2017 to 2019. Following communication in 2017 implementation is due to commence in 2018.*

During 2018 and 2019, we are focussing on building a culture that supports supervisor professional development and continual improvement and in which supervisors are expected to undertake Continuing Professional Development in this domain of practice.



Figure 14. The RACP Standards for Educational Leadership and Supervision



The [RACP Framework for Educational Leadership and Supervision](#) has been published for use by Education Leaders and Supervisors as a tool for self-reflection and professional development.

We are offering additional opportunities for supervisors to meet the requirement to complete the three Supervisor Professional Development workshops and attain supervisor accreditation by 2020. We will then begin the formal selection process. In the meantime, we have developed a formal appointment process for supervisors. It includes formal appointment letters and a process for the termination of supervisors who do not meet the expectations, requirements and competencies documented in the Supervisor Handbook and Educational Leadership and Supervision Framework.

Our anti-bullying, discrimination and harassment policy is supported by processes to respond to situations where educational leaders, supervisors and trainees have been found to have been involved in these behaviours. This links to our new Complaints Management Policy (A8.1) and Procedure (A8.2).

## Progress against accreditation recommendations

### Recommendation TT

Work with employers to develop processes that ensure supervisors at each training site have adequate resource, including time to undertake supervisory activities and that allows a sufficient amount of contact per week with each trainee.

### 2017 AMC Commentary

*The College's initial approach using a computational modelling tool was limited in its value. Instead the College has developed a guide for employers to plan medical education availability. There are new training providers accreditation standards, which will be released for consultation later in 2017, and there is a recommendation for the maximum ratio of supervisors to trainees in basic training. The outcomes of these approaches are as yet unclear.*

Our new Training Provider Accreditation Standards (A4.2), specifically Standards 4 and 5, set expectations for training providers to provide the necessary resources to ensure supervisors have the capacity to train our trainees. This issue was discussed at our Basic Training Curriculum Implementation meeting in September 2018, when trainees, trainers and jurisdictional representatives provided views on service provision and training in the workplace.

Standard 4, Training Management, requires that training providers have a physician-led structure with the authority, time, funding and staff to plan, administer and deliver physician training and the educational resources to support training. The standard requires training providers to ensure that educators have the necessary knowledge and skills for their role and are given the support and resources they need to deliver effective training and maintain their wellbeing.

Standard 5, Educator Leadership, Support and Wellbeing, requires that training providers provide an appropriate environment for an educator to have the capacity to train and lead. This includes having a workload, trainee numbers, allocated time and resources which enable them to fulfil their training and assessment responsibilities. Training providers are expected to support educators by monitoring their capacity to train and lead, providing appropriate training, addressing any concerns they raise about their responsibilities, ensuring a supportive environment and helping them manage trainees in difficulty and challenging situations in training.

In addition, our Annual Physician Training Survey for Educators ([Condition 16](#)) covers questions about training resources, the time required to complete supervisory activities and the amount of contact time with trainees. This will allow the RACP and training providers to monitor and evaluate supervisor workload and the support provided to supervisors at individual training settings. We have given the findings report from the 2017 survey to the pilot training providers to support them in identifying and facilitating continuous improvement for their supervisory workforce.

## Standard 9. Continuing professional development further training and remediation

Areas covered by this standard: continuing professional development; further training of individual specialists; remediation



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**2017 AMC assessment:** Standard Met

**Conditions open:** Nil

**Recommendations open:** Nil

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- We have improved our online Continuing Professional Development program in response to member feedback and to align with Medical Board of Australia requirements
- We have delivered a wide range of educational resources for members

## Significant developments since last report

### Continuing Professional Development

#### *Continuing Professional Development Framework*

In December 2017, we successfully upgraded our online Continuing Professional Development program, 'MyCPD'. The upgrade made the program more user-friendly and easier to use on mobile devices. We undertook the upgrade in response to feedback from Fellows. Enhancements support effective planning and recording of Continuing Professional Development, including a revised Professional Development Plan for future learning, planning and reflection on professional development relevant to participants' scope of practice.

Preparations are underway for changes to the 2019 Continuing Professional Development framework to support its transition to the [Medical Board of Australia's Professional Performance Framework](#). This will introduce the three pillars of 'Strengthened Continuing Professional Development', requiring that Continuing Professional Development includes activities to review performance and measure outcomes, in addition to other educational activities. Subsequent changes will introduce an hours-based system to meet the Medical Board of Australia and Medical Council of New Zealand's Continuing Professional Development requirements.

#### *Monitoring*

Monitoring and follow up of the outstanding 2017 Continuing Professional Development submissions required of Fellows and Continuing Professional Development participants were successful: the total completion rate was 98.4%.

We conducted the annual audit process on 5% of participants in Australia and New Zealand. The audit reinforces awareness and robust monitoring of Continuing Professional Development requirements and supports a high completion rate.

#### *Support and guidance on meeting Continuing Professional Development requirements*

Help and guidance for Fellows on understanding how to meet the requirements is kept under review and continues to be regularly updated. All Continuing Professional Development participants can contact us to clarify and discuss their requirements.

The [Continuing Professional Development helpdesk](#) provides articles on Continuing Professional Development requirements. Participants can use MyCPD to access links to relevant RACP resources for their Continuing Professional Development.

#### *Continuing Professional Development resources*

We provide a range of [resources](#) that are available to all members, focusing on cross-specialty topics and emerging areas of need. We provide resources to support new Fellows in their first role as a consultant and to raise awareness of the importance of physician health and wellbeing.

[Pomegranate Health](#), our monthly Continuing Professional Development podcast, presents stories on clinical decision-making, physician wellbeing and socio-ethical challenges in medicine. Each episode links to further Continuing Professional Development tools. Consistently ranked among Australia's most popular medical education podcasts, Pomegranate Health has reached almost half a million downloads across 38 episodes. In early 2018, it won the prestigious Australian Podcast 'Career and Industry' award.

[Curated Collections](#) are our digital Continuing Professional Development resource guides, based on the contributions and peer review of Fellows and other experts. Each guide presents key readings, online courses, webcasts, and other tools for Continuing Professional Development. In 2017, Curated Collections resources received 6,869 unique visits, more than three times the number of visits in 2016.

[Online Professionalism Program delivered by QStream](#) enhances physicians' practice and performance through guided case study discussion. The program content is based on real scenarios, developed by our Fellows to challenge physicians' thinking and improve professional practice through discussion and reflection. Over 1,500 members have participated in a Qstream course since the program was launched. Two new courses were developed and run in 2017, along with reiterations of popular past courses. Two additional new courses are in development for 2018.

Our [e-learning portal](#) leverages the benefits of digital multimedia for social learning. The courses make use of video and audio scenarios as a method of delivery, and encourage interaction through discussion forums, polls, and reflection and practice activities. Over 30 e-learning courses are available with four new courses launched in 2017 and seven in development for 2018.

Our online [College Learning Series](#) was introduced in February 2018 (see Standard 4- [The College Learning Series](#)).

We hold a biennial Continuing Professional Development Forum to develop a Fellow-led strategic direction for professional development. In 2017, the Forum focused on four themes: new technology upgrades to MyCPD, the expected revalidation framework, Continuing Professional Development accreditation, and collaboration with specialty societies.

#### *Trials of multisource feedback (MSF) and Regular Practice Review Framework*

Reports on the following trials were made at the end of 2017.

- Trials of a multisource feedback (MSF) protocol including a debrief of the MSF report: MSF is recognised as an evidence-based, peer- and practice-review tool that will become more widely used as the Professional Performance Framework is implemented. Results from the trial have influenced communication with Fellows about completing MSF in ways that will maximise its impact. We will continue to seek feedback from Fellows completing MSF and have begun a cycle of continuous improvement of tools and process.
- Trial of a Regular Practice Review Framework at two Hospital units in New Zealand: While focussed on meeting Medical Council of New Zealand requirements for Recertification, the lessons learned from these trials will influence development of an annual performance review and associated professional development plan for Australian Fellows. These tools will be designed to support Fellows who are not currently involved in annual review and development with their employer.

#### **Further training of individual specialists**

There are no significant developments to report.

#### **Remediation**

There are no significant developments to report.



## Standard 10. Assessment of the specialist international medical graduates

Areas covered by this standard: assessment framework; assessment methods; assessment decision; communication with specialist international medical graduate applicants



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**2017 AMC assessment:** Standard Met

**Conditions open:** Nil

**Recommendations open:** Nil

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- Our Overseas Trained Physician assessment process was found to comply with the Medical Board Good Practice Guidelines (Deloitte review 2017)
- We have improved our orientation program and other resources to better support applicants through the assessment process



## Significant developments since last report

### Assessment Framework

#### *Regular review of Overseas Trained Physician guidelines and specialist assessment processes*

We regularly review the specialist assessment procedures and processes for international medical graduates:

- to maintain alignment with the [Medical Board Good Practice Guidelines](#) including working to procedural fairness principles
- to meet Medical Council of New Zealand requirements under its Memorandum of Understanding with specialist medical colleges, including timeframes
- for continuous improvement and enhancements to the process and the engagement and experience of Overseas Trained Physicians and Fellows
- to support participation in robust procedures that meet the aims and objectives set out in:
  - the Advanced Training outcomes for each specialty for advanced trainees
  - our Professional Practice Framework and Standards (the public statement of the standards to be met by physicians and paediatricians in Australia and New Zealand)

The [RACP Guidelines for Overseas Trained Physician applicants](#) are aligned with the Medical Board of Australia's Good Practice Guidelines. They set out all stages of the processes with clear contact points for further information or clarification on the process. Our Guidelines are regularly reviewed to provide up-to-date information for applicants. The latest edition was issued in February 2018.

In July 2018, we made the revised editions of the Guidelines available to supervisors of top-up training and for peer reviewers.

All Overseas Trained Physicians in New Zealand are provided with up-to-date information to support and align with the requirements of the Medical Council of New Zealand, including reference to relevant documentation and guidance from the Medical Council of New Zealand.

### Assessment methods

#### *Fit for purpose assessment*

In December 2017, we were found to substantially comply with the Medical Board Good Practice Guidelines in the Deloitte review of Specialist Medical Colleges' assessment of International Medical Graduates the Australian Health Practitioner Regulation Agency (AHPRA). We were also found to meet all AHPRA's compliance measures for the Specialist Medical Colleges' assessment processes for International Medical Graduates.

We operate our International Medical Graduate assessment processes according to the principles of procedural fairness, as recommended in the review. Our processes already provide applicants with the documentation considered for their application and the opportunity to respond to their interview report for accuracy, clarification and gaps in relevant information. In 2017, there has been a decrease of almost 50% in the total number of reconsiderations, reviews and appeals on Overseas Trained Physician decisions, compared to 2016. The total number reduced from 19 to 10 applications (relevant for processes for which the RACP is responsible in Australia only).

#### *Overseas Trained Physicians Orientation program*

All Overseas Trained Physicians complete our Orientation program to help acclimatise applicants to the Australian healthcare system. At the end of 2017, we introduced a revised program, based on

feedback from former Overseas Trained Physicians on the most helpful focus for applicants to maximise the use of their time in completing the program. Access to a discussion forum is provided with the program so that Overseas Trained Physicians can engage on current topics with other applicants going through the process.

## **Assessment decision**

### *Numbers of Overseas Trained Physician applications*

A total of 244 specialist assessment decisions and recommendations were determined in 2017. We determined 169 interim assessment decisions on the comparability of Overseas Trained Physicians with Australian-trained physicians in 2017. We made recommendations on 75 specialist assessment decisions to the Medical Council of New Zealand (preliminary and interview advice applications) on the equivalence of Overseas Trained Physician applicants with New Zealand-trained physicians.

### *Resources to support Overseas Trained Physicians decision making*

We have continued to develop resources to support decision-making by Overseas Trained Physician Committees, interviewers and other Fellows involved in Overseas Trained Physician processes.

Resources that are available or under development and consultation to support the Overseas Trained Physicians assessment process include:

- **Country guides:** Country guides provide accessible information compiled on training and qualification pathways in countries where there are significant numbers of applicants. The provision of country guides has been kept under ongoing review and expanded to be more comprehensive for the regions from which Overseas Trained Physician applications are received.
- **Overseas Trained Physician Decision making Guidelines:** General guidelines have been drafted to support the decision making of committees, interviewers and other Fellows involved in the Overseas Trained Physicians process. The guidelines have been consulted on extensively with Overseas Trained Physician Committees. They are designed to reinforce a consistent approach across the Committees, while assessing applicants on a case-by-case basis on their comparability or equivalence to an Australian or New Zealand physician, from an assessment of their training, qualifications and experience as a whole.
- **Interviewer training:** We piloted training for interviewers, including committee members, from November 2017. More than 30 interviewers have undertaken the training with further programs provided early in 2018 in Australia and New Zealand. A number of Fellows have been confirmed as facilitators for future programs.

The intent of the training is to ensure a robust interview process, engage the Overseas Trained Physicians and enhance their interview experience. It will ensure that interviewers obtain the information and clarifications required to build on information provided in the written application. The programs use a variety of educational approaches to engage participants, including role plays, videos, and group work.

The next programs are scheduled to take place late in 2018.

## **Trainee Wellbeing**

### *Information on fees for specialist assessment*

We have improved the [information on fees for specialist assessment](#) to make the types of fee that apply for different applicants more transparent, in line with the recommendation from the Australian Health Practitioner Regulation Agency review of Specialist Medical Colleges' assessment of International Medical Graduates. This includes clear information on the fees that apply, before being able to receive an initial assessment decision and for subsequent completion of specialist recognition assessment requirements for those Overseas Trained Physicians who proceed.

### *Data on assessment decisions*

We have added links on our website to workforce data and the [AHPRA data report on Specialist Medical Colleges' assessment of IMGs](#), in line with the recommendations of the Australian Health Practitioner Regulation Agency review. The data provide relevant information on the numbers of specialist assessments by specialty and the level of comparability, so that applicants considering the specialist pathway can make an informed decision about whether to apply for assessment.

### *Access to relevant workforce data*

The link to workforce data provides access to the [Australian Government Health workforce data](#) fact sheets, with information on the extent to which opportunities are available in different specialties. This provides transparency on employment opportunities available in Australia for consideration by applicants before they apply for specialist assessment.

### *Support for Overseas Trained Physician applicants*

We substantially meet the specialist assessment benchmarks set by the Medical Board of Australia for timely communication with Overseas Trained Physicians throughout the application and assessment process.

All Overseas Trained Physician applicants are assigned a Case Officer as their contact point for advice on the process throughout their application and assessment. They can also access the [Converge Support Helpline](#), a fully confidential and independent helpline.

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