Reaccreditation Submission

Assessment of Specialist Medical Programs

The Royal Australasian College of Physicians 2024

Submitted 19 February 2024

Contents

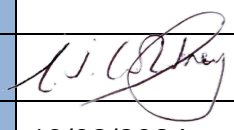
Education Provider Details

Name of College:	The Royal Australasian College of Physicians
Address:	145 Macquarie Street Sydney NSW 2000

Chief Executive Officer:	Lee Whitney
Telephone number:	+61 (02) 9256 5444
Email:	ceo@racp.edu.au
Officer at College to contact regarding the submission:	Prof Inam Haq / Libby Newton
Telephone number:	+61 (02) 9256 5444
Email:	Inam.Haq@racp.edu.au / Libby.Newton@racp.edu.au
If the organisation provides training in New Zealand, please provide contact details or a contact person in New Zealand:	
Address in New Zealand	Level 10, 3 Hunter Street Te Whanganui-a-Tara | Wellington 6011
Executive Officer:	Bi-national contact details listed as above
Telephone number:	-
Email:	-

Verify submission reviewed

The information presented to the AMC in this submission is complete, and it represents an accurate response to the relevant requirements.

Verified by: (*Chief Executive Officer/executive officer responsible for the program*)	Lee Whitney
Signature:	
Date:	19/02/2024

Part A
Executive Summary

Executive summary

The College's programs

The RACP offers 40 training programs across Australia and Aotearoa New Zealand. These include two Basic Training programs in Paediatrics and Child Health, and Adult Medicine and 38 specialty training programs.

RACP training programs are governed by the College's Divisions, Chapters and Faculties. At the end of specialty training eligible trainees are invited to be admitted to Fellowship of the RACP or relevant Faculty or Chapter. Seven different fellowship qualifications are offered:

- FRACP – Fellowship of the Royal Australasian College of Physicians (awarded to graduates of Adult Medicine or Paediatrics & Child Health Division training programs)
- FAChAM – Fellowship of the Chapter of Addiction Medicine
- FAChPM – Fellowship of the Chapter of Palliative Medicine
- FAChSHM – Fellowship of the Chapter of Sexual Health Medicine
- FAFRM – Fellowship of the Faculty of Rehabilitation Medicine
- FAFOEM – Fellowship of the Faculty of Occupational and Environmental Medicine
- FAFPHM – Fellowship of the Faculty of Public Health Medicine.

The RACP also offers two training programs which don't result in the award of Fellowship or confer eligibility for specialist recognition:

- Clinical Foundations (titled Clinical Diploma prior to 2024) in Palliative Medicine
- Advanced Training in Adolescent and Young Adult Medicine.

All programs are offered throughout Australia and Aotearoa New Zealand, with the exception of Advanced Training in Dermatology, which is only offered in Aotearoa New Zealand.

Amongst the 38 specialty programs offered by the RACP, there are four joint programs offered with the Royal College of Pathologists Australia (RCPA). Successful completion of one of these programs results in the award of both FRACP and FRCPA.

The reaccreditation submission provides details of these programs for both the RACP's current programs and our renewed programs.

Significant developments and achievements

The RACP is undertaking a range of initiatives to contemporise our education programs and improve governance and service delivery. These initiatives are in varying stages of execution and being approached as a suite of interrelated activities.

Curricula Renewal

Our curricula renewal initiative is a multi-year project to transform the RACP's training programs into a hybrid time- and competency-based approach with programmatic assessment, to align training programs to RACP curricula frameworks and models and update and rationalise existing curricula content and training requirements. The scale of this initiative is significant, spanning the following elements across 40 training programs:

- competency-based learning goals (curricula standards)
- refined learning, teaching, and assessment training requirements, incorporating a programmatic assessment approach, and ensuring alignment with curricula standards

- competency-based progression criteria
- refined governance roles and responsibilities for progression decision-making
- implementation, change management, and transition to business plans and processes.

The initiative has achieved major foundational milestones, including development of the RACP Professional Practice Framework, which defines the ten domains and associated standards of professional practice for all physicians and provides a comprehensive foundation for physician education across the continuum of practice.

The curricula renewal initiative has also delivered the new RACP curriculum model as an organising framework for curricula content. The curriculum model is structured around the concept of what trainees need to **be** (competencies), **do** (entrustable professional activities), and **know** (knowledge guides). The curriculum model integrates the Professional Practice Framework into the curriculum standards to ensure the ten domains of the framework are embedded in the learning goals of each RACP training program.

In 2019, the design of two new Basic Training programs was completed. This was followed by the Common Advanced Training standards and Learning, Teaching and Assessment (LTA) requirements in early 2021.

The first six of 38 Advanced Training specialty curricula (Wave 1) were renewed and approved by the College Education Committee in early 2023. A further 15 (Wave 2) Advanced Training curricula have been renewed in 2023 and are currently out for broad consultation. The remaining 17 curricula will be renewed in 2024.

These achievements are the culmination of extensive collaborative efforts of College members and staff, and informed by regular consultation with a broad array of stakeholders, including supervisors, specialty societies and consumer bodies. Furthermore, the RACP has enacted measures to expedite the curricula renewal work for Waves 2 and 3, while maintaining appropriate expert and stakeholder input, reducing the development timeline by approximately one year when compared to Wave 1.

Implementation of new programs

We commenced implementation of the new Basic Training programs in 2021, with nine early adopter settings across Australia and Aotearoa New Zealand. Implementation was continually challenged by useability issues and delayed release of functionality enhancements to the program's original supporting technology, Tracc. The RACP worked closely with the technology provider to deliver enhancements while maintaining manual workarounds to support the training process for early adopters. Following substantial efforts to resolve these issues, in March 2023 the RACP disengaged with the software vendor for Tracc and rolled back the early adopter delivery of the new Basic Training programs.

While the technology challenges hindered early adopter ability to engage fully with the new learning, teaching and assessment program, our program evaluation indicated that participants endorsed the new curriculum as valuable and representative of physician practice. The Progress Review Panels, which were introduced to support progression decision making, were seen as especially valuable as a way of assessing trainee progress using objective datasets reviewed by a group of calibrated expert assessors.

We are currently planning for implementation of the new programs in a staged rollout schedule, with the new Basic Training programs implemented with first year trainees from 2025; six new Wave 1 programs being implemented with a transition year for first year trainees in 2024; Wave 2 in 2025; and Wave 3 in 2026. From 2027, all trainees will be undertaking the new programs and the legacy PREP programs will be retired.

New technology investments to support delivery of our new training programs

Effective technology is critical for supporting the implementation of our new training programs.

We initiated the Training Management Platform (TMP) project following disengagement with the vendor for Tracc in March 2023. We rapidly commenced efforts to expedite a comprehensive technology solution (the TMP) for the management and administration of our new Basic and

Advanced Training programs. It will be developed using the Microsoft suite of products, including Microsoft (MS) Dynamics and Power Platform. This platform was recommended by KPMG in Q1 of 2023 after a review of our high-level business requirements.

A Proof of Concept TMP was created in Q2 and Q3 2023 in collaboration with a vendor using more detailed functional requirements and confirmed that the Microsoft Dynamics suite was a suitable platform, using the principles of configuration rather than extensive customisation.

A Request for Proposal procurement process was initiated in late December 2023 to contract a Systems Integration (SI) partner to design, build, test and release the TMP. The RACP has engaged KPMG to commence the project's Vision and Validation stage, starting mid-January 2024. Full contracting negotiations for the remaining construction and implementation phases has now commenced.

We anticipate the TMP project will be delivered progressively over two years across four distinct phases. The plan is to have an initial release of back-office functionality in the second half of 2024 followed by subsequent releases throughout the remainder of 2024 and into 2025. Full implementation is planned for completion by the end of 2025.

The College is proud that is has demonstrated the ability to rapidly progress with our alternative technology solution for delivery of our new programs with appropriate governance oversight and implementing the lessons learned from Tracc.

Cross College Review of Examinations

Commencing in January 2024, we are undertaking a significant Cross College Review of Examinations. This review was initiated in response to several factors, including curriculum renewal, evolution of assessment processes and technology, candidate feedback and challenges in implementing computer-based delivery of examinations. The review will explore the role and purpose of examinations and provide recommendations as to appropriate contemporary exam models within systems of assessment. It will be guided by an advisory group of RACP members. Planning is in the early stages at the time of lodging this reaccreditation submission, and we look forward to keeping the AMC and MCNZ appraised of developments throughout the reaccreditation assessment process.

Accreditation Renewal

Following extensive development and consultation activities, the RACP commenced implementation of its Accreditation Renewal program in 2021. The Accreditation Renewal program sets out a strategy and program for promoting high quality workplace training. It links explicitly to RACP curricula, streamlines and coordinates processes, provides flexibility in accrediting a range of settings and assesses capacity to train. It sets forth a regular accreditation cycle that spans the interrelated goals of quality improvement and accountability.

Due to the significant scope of the program, the Accreditation Renewal program is being implemented in a phased approach. So far, we have implemented Phase 1 of the program, which incorporated the introduction of the Training Provider Standards and Basic Training Accreditation Requirements for both Adult Internal Medicine and Paediatrics and Child Health. We are now implementing Phase 2, which incorporates the introduction of network accreditation and tools as well as processes to support both the monitoring and reporting stages of the accreditation cycle.

The RACP is providing a flexible approach to accrediting networks, acknowledging differences in governance and approach across jurisdictions. The implementation of network accreditation is an important step towards the continued formalisation of networks and integrated training pathways that accommodate a diversity of training experiences and expand opportunities for training in ambulatory, community and rural/regional settings.

The RACP's new Active Management process articulates the RACP's approach to a very small proportion of Training Providers where serious non-compliance issues are identified. Through this process Training Providers and the RACP collaborate to create an action plan to regain compliance with the relevant standards, requirements, or criteria. Throughout the process, the RACP collaborates with accreditation stakeholders such as the trainees, DPEs, supervisors, Setting Executive and relevant health department, aligning with the agreed Protocol, whose development was led by the AMC.

We have developed an action plan to respond to the National Health Practitioner Ombudsman's 62 recommendations, which is being delivered across 2023 and 2024. This includes a review of the Training Provider Standards to explore opportunities to reduce burden on stakeholders, development of a risk-based framework for accreditation and expansion of the Accreditation Renewal program into Advanced Training.

We feel that the Accreditation Renewal program has demonstrated a commitment to transparent and high-quality decision-making that is done in collaboration with internal and external stakeholders. There is still work to do working with other colleges, AMC, MCNZ and government on developing revised sets of accreditation standards that can be shared (in whole or part) between colleges.

Education Governance Review

While we acknowledge the strengths of our current arrangements for governance of our education and training programs, we have observed that these arrangements are under strain due to the extensive scope of the RACP's activities, increases in the volume of physician trainees and concomitant increased operational load and fragmentation in decision-making and issue/risk reporting pathways.

In March 2023, the RACP Board formed a working group to lead an Education Governance Review. The aim of the review is to develop and implement a contemporary education governance and reporting structure that aligns with College values, prioritises effective decision-making and timely communication, and improves the member experience. Extensive pre-consultation on a proposed model was carried out in late 2023 and after subsequent iteration, full consultation will occur throughout February and March 2024, with additional consultation in April and May as required. The final proposal will be considered by the RACP Board in June, 2024.

Our membership

The RACP's operating model for governing and delivering physician training continues to be founded upon the significant efforts of the RACP Membership. As an indication of these extraordinary contributions, in 2023, there were over 770 Member positions on RACP education and training committees, 6,000 supervisors and over 1,000 examiners.

Directors of Physician/Paediatric Education (DPEs) lead large scale education programs in their local health services and we recognise the critical contributions of Members who occupy these roles in sustaining our Basic Training Programs throughout recent periods of both planned and unprecedented change. We have been working to increase support, recognition and foster communities of practice for DPEs and supervisors as a whole. We are pleased to see 92% of active supervisors have satisfied our supervisor credentialling requirements and will continue to implement and evolve our well-regarded Supervisor Professional Development Program (SPDP). We recognise that a key part of ensuring the continued viability of workplace educational leadership and supervision is to ensure there is adequate recognition and protected time for fulfilment of these functions. We are addressing this through our Accreditation Renewal program.

Indigenous leadership and growing the Indigenous physician workforce

We have a range of established and new initiatives in place to progress health, social justice and equity for Indigenous peoples. In 2023, an Indigenous Object was added to the RACP Constitution which reaffirms and embeds the RACP's ongoing commitment to supporting Indigenous aspirations and outcomes in Australia and Aotearoa New Zealand. The Indigenous Object also provides a strong foundation to continue to implement strategic priorities under the College's Indigenous Strategic Framework 2018 – 2028.

The RACP recognises that Indigenous leadership is critical to championing the vision of the College, improves accountability, helping to embed cultural safety across the College and ensuring activities continue to align with strategic priorities. Indigenous leadership is provided by the Aboriginal and Torres Strait Islander Health Committee and Māori Health Committee, the Kaitohutohu Ahurea | Māori Cultural Advisor, Marnu Wiru (Aboriginal Knowledge Holder) and Manager, Indigenous

Strategy. In 2024, we are expanding Māori Member leadership through the establishment of positions for Lead Fellow Māori Health and two Māori Health Registrars, for a fixed term of 12 months in the first instance.

We have a range of multifaceted initiatives to support the increased selection and retention of Aboriginal and/or Torres Strait Islander or Māori trainees in physician training programs. These include a Fee Reimbursement Initiative, Coaching Program and Leadership and Equipment Funds.

Flexible Training

In response to Member feedback, from January 2023, we implemented significant changes to our policies regarding flexible training. The changes are intended to improve flexibility, equity, wellbeing and inclusion in training, while ensuring a focus on educational outcomes is maintained. These now position the RACP's programs as some of the most flexible postgraduate medical programs in the world.

Trainees can now access unlimited parental leave and certified medical leave, without encroaching on their time limit to complete training. Trainees can now access part-time training, down to 0.2 full-time equivalent, provided the proposed training plan meets learning objectives.

We're working to implement and monitor the changes, and, in recognition that the flexible training policy change is one aspect of deeper systematic change, also working to understand and address barriers to flexible working arrangements.

Assessment of OTPs

We have robust and streamlined processes for assessment of Overseas Trained Physicians and Paediatricians (OTPs) that ensure assessment quality and efficiency. We have introduced limited scope of practice assessment outcomes in all specialties to ensure there are pathways available for 'super-specialists' to practice in Australia, particularly those that might have trained many years ago and since focused their practice on a specific area of medicine. We have enhanced the governance of these processes through introduction of an overarching OTP Committee, which establishes policy and oversees performance of the three assessment committees. Introduction of paper-based reviews, improved assessor training, decision-making guidelines and digital technology have further strengthened the quality and efficiency of our activity.

We've introduced a range of new supports for OTPs including an online community to connect Specialist International Medical Graduates (SIMGs) throughout the process as well as improvements to ensure SIMGs receive support to upskill whilst in the Australian and Aotearoa New Zealand healthcare systems.

We're working closely with regulators to improve the assessment framework and processes in response to a range of reviews, including the NHPO and the Kruk review.

The volume of SIMG applications for assessment have markedly increased in the past few years. This places demand on resources to continue assessing to timeframes. Employers want OTPs to commence practice as soon as possible and the College continues to balance efficient but robust assessment processes.

Key challenges

Selection into Training

The College's primary role in selection into training is to articulate, support and monitor provisions and standards for selection, which are in turn implemented by training providers, as employers. We do this through our Selection into Training Policy and Standards, and in recent years have released a comprehensive Trainee Selection and Recruitment Guide and partnered with jurisdictions to release enhanced information on local selection processes on the RACP website. We also piloted the implementation of a Situational Judgement Test for entry into Basic Paediatric Training, which

yielded promising evidence that it could produce reliable performance measures of professional attributes.

The RACP is aware that there is variation in how local and specialty selection and recruitment occurs. Some of this variation is defensible as it reflects differing contexts and a range of best practices. However, a small number of trainees report adverse experiences in selection processes and the RACP does not have a sufficiently robust system in place for systematically monitoring selection program outcomes.

We are in the process of reviewing our Selection into Training Policy and Standards to ensure that the policy supports selection outcomes and experiences that are aligned to the RACP's current strategic objectives. The revision is an opportunity to progress Indigenous equity and entry into training, and gender equity objectives. The review will also address the recommendations emerging from the College's pilot implementation of a situational judgement test, including the potential for introduction of a monitoring database that tracks application intentions and outcomes. The RACP is not proposing change to the overarching arrangements for responsibilities for selection and recruitment.

COVID-19 adaptations

As physician trainees formed a large proportion of the medical workforce for the COVID-19 response, the impacts of the pandemic on physician training were notable. We implemented a range of interim measures for training and accreditation in response to these impacts, which were updated as the COVID situation changed. All decisions were made in accordance with our education and training principles, seeking to minimise the disruptions to settings and to progression through training. Guidelines continue to be referenced by training committees to guide decision making in consideration of exceptional individual trainee circumstances.

The impacts of the COVID-19 pandemic on our ability to prepare for and deliver our examinations presented an unprecedented challenge, particularly for clinical examinations. The RACP worked with a range of stakeholders to develop and enact contingency plans for examination delivery. We remain proud of our collective efforts to continue delivery of examinations, maintain the integrity of these assessments and provide trainees with opportunities to continue to progress in their training throughout the COVID response.

Following the pandemic, we observe that the health workforce is increasingly strained by workload and cultural pressures, with increased and ongoing symptoms of burnout. While the RACP's initiatives related to Accreditation Renewal, Curricula Renewal, flexible training, and health and wellbeing are designed to address some of this strain, we are looking to partner with the broader sector for coordinated action.

Increasing oversight of specialist medical colleges

It is clear that governments and regulators are increasingly focused on ensuring that specialist medical colleges are accountable in their activities and decision-making and are working in collaboration with health jurisdictions, states and territories to fulfil their mandate and mission.

This is an opportunity for colleges to be open and pragmatic to change for the benefit of our communities and the RACP welcomes such opportunities to engage with our partners. The risk of not engaging is of increasing oversight and regulation and potentially removal of certain roles that have been historically those of a medical college.

Regional, rural, and remote training and workforce development

The RACP is committed to achieving equitable health outcomes for Australians and Aotearoa New Zealanders living in regional and rural locations We were pleased to launch our new Regional, Rural and Remote Physician Strategy in 2023, following wide-reaching collaboration and development efforts. We look forward to keeping the AMC and MCNZ informed about our implementation planning for the 26 recommendations in the strategy, which will occur in the first half of 2024.

We've worked closely with the Federal government to continue to deliver the Specialist Training Program (STP) in regional and rural training settings, engaged in advocacy and incentivisation to support uptake of positions and implemented measures to reduce the risk of professional isolation.

Member wellbeing, equity, diversity and inclusion

Member health and wellbeing remains a key focus for the College, aligning with the College's 2022-2026 Strategic Plan's commitment to 'Lifting member health and wellbeing'. The Member Health and Wellbeing Strategic Plan 2023-2026 was developed and launched with the vision that all RACP members flourish and achieve their full potential in all aspects of life. The Strategy's four focus areas are being progressed through a range of supporting initiatives.

Closely associated with our Member Health and Wellbeing Strategic Plan are our Action Plans for Gender Equity in Medicine, Membership Diversity and Inclusion, and Safe Training Environments. These all link closely with our cross-cutting Accreditation Renewal program. Through a collaborative approach across each of these areas, we are promoting and advocating for safe, inclusive, and equitable physician working environments.

Member engagement

The RACP's operational model is sustained by an engaged, effective and available Membership. We are conscious that there are risks to the viability of this volunteerism model in terms of both member engagement and availability. We are developing a Member Value Proposition (MVP) Framework to identify the pain points and needs of members and articulate the value of RACP membership at various stages in a physician's career. This will form the foundation for ensuring the RACP's services and products provide meaningful value for members and in turn support an engaged membership. Future iterations of the MVP framework will directly address the operational changes needed to deliver sustainable and respectful volunteer participation.

Conclusion

The RACP is a large and complex organisation. This makes for an extensive reaccreditation submission and in some cases has naturally limited the content of this submission to focus on observations across RACP programs. Should the Reaccreditation Team desire more detail, the RACP is able to provide this as required.

As detailed throughout the submission, the RACP is in the midst of a suite of significant, interrelated initiatives to contemporise our education programs, empower effective organisational performance and improve services and delivery. Following embarking on this ambitious world-class program of change, we acknowledge that our pace slowed throughout the COVID pandemic for a variety of reasons. Throughout 2023, we have rapidly regrouped and prioritised our efforts to expedite critical initiatives, whilst rationalising the large volume of other initiatives in motion. We are confident that our in-train initiatives sufficiently address the AMC's Standards for Assessment Accreditation of Specialist Medical Programs, yet acknowledge that several of these are yet to be implemented and demonstrate the intended impacts, and several are yet to be further impacted by wider contextual changes.

We remain committed and confident in our vision for *'world class specialist physicians, creating a healthier and more equitable future'.* We look forward to the ongoing guidance and support of the AMC, MCNZ and the broader medical education community as the College continues in its transformative journey.

Part B
Addressing the accreditation standards

Standard 1
The context of training and education

Standard 1 The context of training and education

1.1 Governance

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

Background

Established in 1938, the Royal Australasian College of Physicians (RACP or College) connects, trains and represents over 30,000 medical specialists and trainee specialists from 33 different specialties, across Australia and Aotearoa New Zealand.

The College Constitution (May, 2023), states (Appendix 1A.1):

"The College is a fellowship composed of specialist, and trainee specialist, medical practitioners drawn from Australia and [Aotearoa] New Zealand. They come together for their mutual benefit and companionship in a spirit of democracy and transparency with the ***objective of ensuring a high standard of medical care for the people of Australia and [Aotearoa] New Zealand****."*

The Constitution outlines the nine objects of the College, which are to:

1. promote the highest quality health care and patient safety through education, training and assessment;
2. educate and train future generations of physicians;
3. maintain professional standards and ethics among physicians through continuing professional development and other activities;
4. promote the study of the science and art of medicine;
5. bring together physicians for their common benefit and for scientific discussions;
6. increase the evidence and knowledge on which the practice of physicians is based through research and dissemination of new knowledge and innovation to the profession and the community;
7. seek improved health for all people by developing and advocating health and social policy in partnership with health consumers and jurisdictions;
8. support and develop physicians as clinicians, public health practitioners, teachers and researchers;

9. demonstrate a commitment to Indigenous aspirations and outcomes by:
    a) respecting and promoting the principles as enshrined in the Uluru Statement from the Heart, Te Tiriti o Waitangi, and the United Nations Declaration on the Rights of Indigenous Peoples;
    b) advancing justice and equity in health care for Aboriginal and Torres Strait Islander and Māori communities; and
    c) acknowledge the world views, protocols and cultures of the Aboriginal and Torres Strait Islander and Māori peoples.

The RACP Constitution was updated in May 2023 to include Object 9. Refer to the update in Standard 1.6.4 for further details regarding this change.

RACP Board

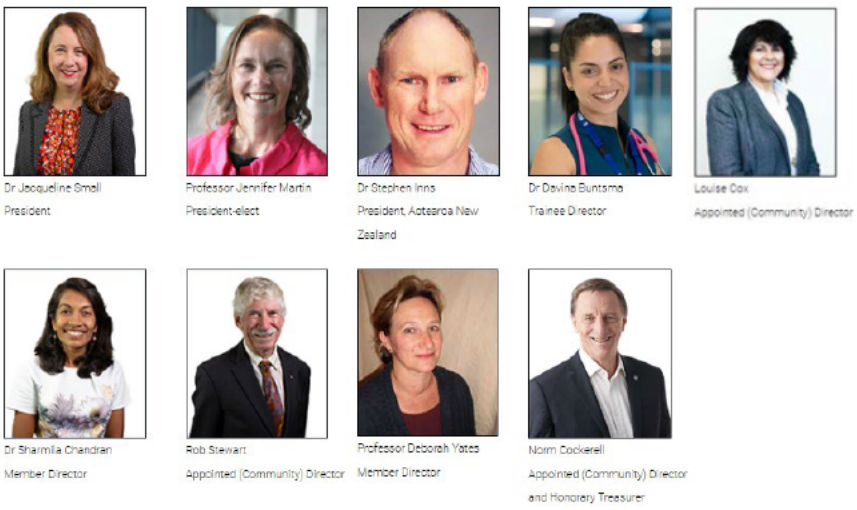
The RACP is governed by a Board of Directors, in accordance with the RACP's Board Charter By-Law (Appendix 1A.2). The Board is the peak decision-making body within the College's structure and its role is to govern the College and to promote the College's interests in the pursuit of its objectives. The Board does this by setting strategic direction and context and focussing on issues critical to the College's success. The Board may delegate some of its accountabilities and responsibilities to be discharged by other bodies, however the accountability and responsibility for these ultimately remain with the Board.

In 2018, the Board composition was changed to facilitate a mix of skills and diversity of backgrounds to enable the Board to discharge its duties effectively. Most positions, including that of the President-elect, are elected by the Members of the College in accordance with the Nomination and Election Process By-Law (Appendix 1A.3). As outlined in the RACP Constitution, the Board is composed of up to ten Directors, including:

- the President
- the President-Elect
- the President of the Aotearoa New Zealand Committee
- one Trainee Director
- up to three Member Directors
- up to three other persons appointed as Appointed Directors by the Board.

The current membership of the RACP Board is provided in Figure 1. RACP Board. The current RACP President, Dr Jacqueline Small, will complete her two-year term at the end of the RACP's Annual General Meeting in May 2024. At that time, the President-Elect, Professor Jennifer Martin, will commence her two-year term as President.

Figure 1. RACP Board



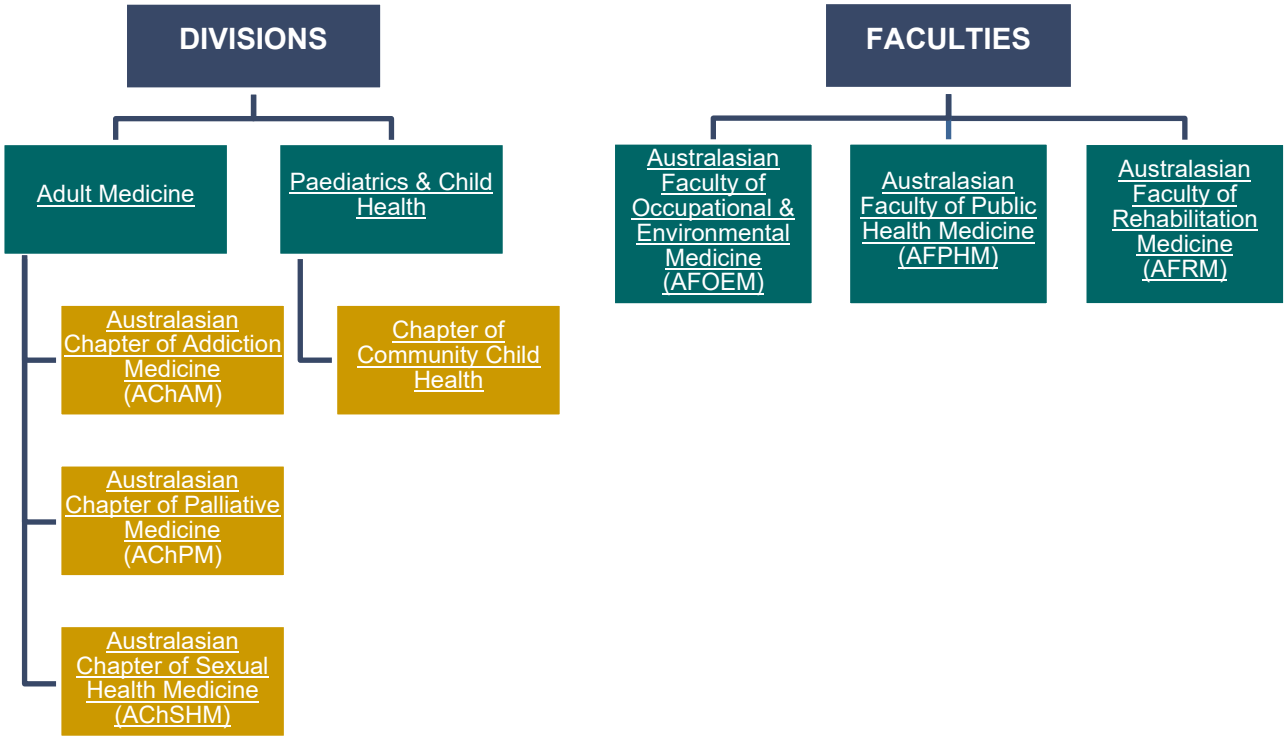
Corporate structure

The RACP is an Australian Public Company. It is registered as a large charity with the Australian Charities and Not-for-profits Commission.

The RACP has two Divisions, four Chapters and three Faculties, as shown in Figure 2. The Divisions, Chapters and Faculties offer vocational training, continuing professional development/ recertification programs and assess specialist international medical graduate applications in a wide variety of medical specialties, as outlined in Table 5.

All Divisions, Chapters and Faculties ultimately report to the RACP Board, consistent with the one-College format introduced in 2008.

Figure 2. RACP Divisions, Chapters and Faculties

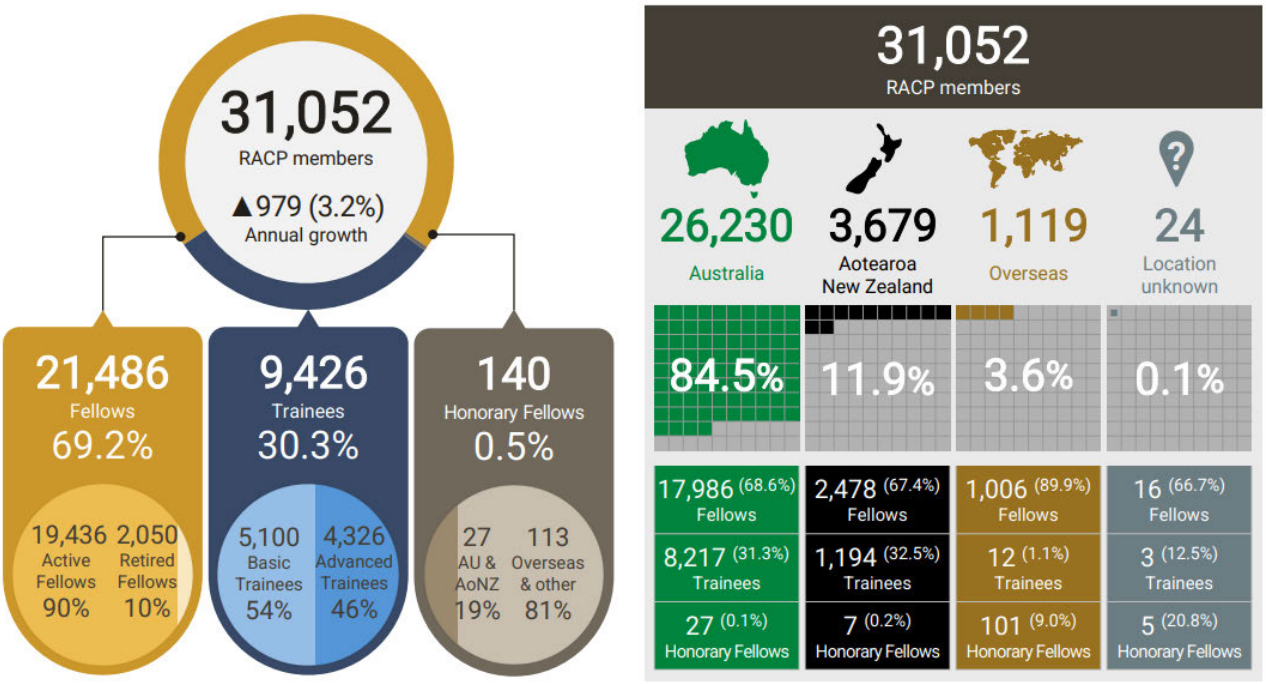


Membership

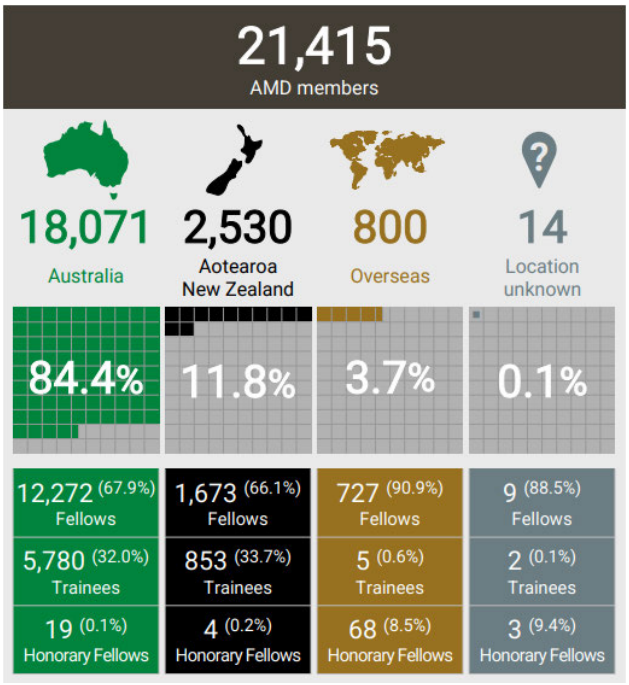
The RACP has a range of Membership and Fellowship categories. Fellows and Trainees are classed as Members of the College, with full voting rights. Our Member Statistics and Insights Report, 2023, (Appendix 1A.4), provides an aggregated snapshot of College membership as at 30 June 2023. We produce and share this report with Members each year in a password-protected area of the College website.

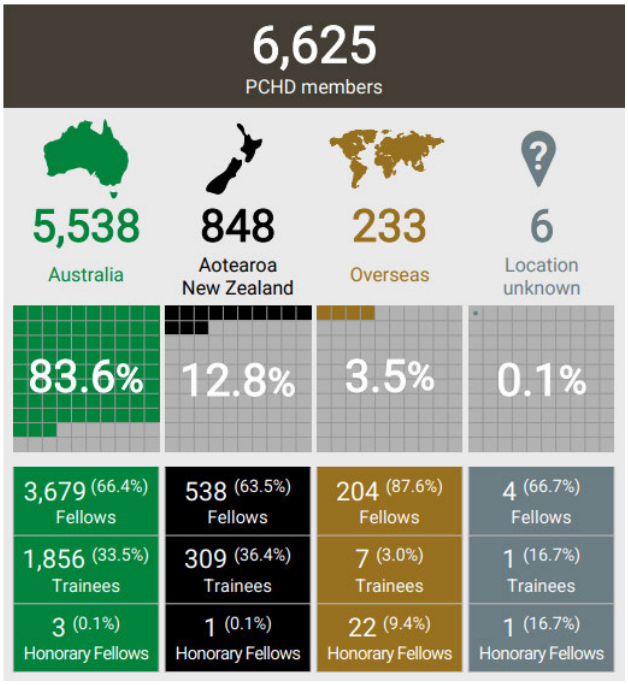
Figure 3 is an extract of this report, depicting the volume and distribution of Fellows and trainees across Australia, Aotearoa New Zealand and internationally, in 2023. Further data is provided in the full Report in Appendix 1A.4, including breakdowns of members across the RACP's Divisions, Faculties and Chapters.

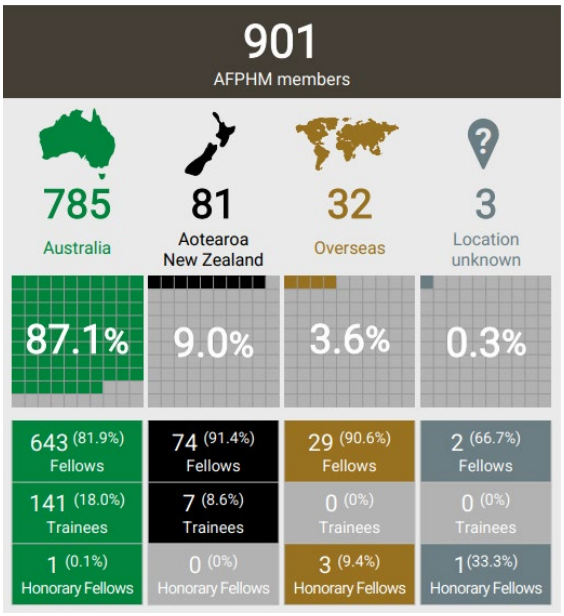
Figure 3. RACP members by location

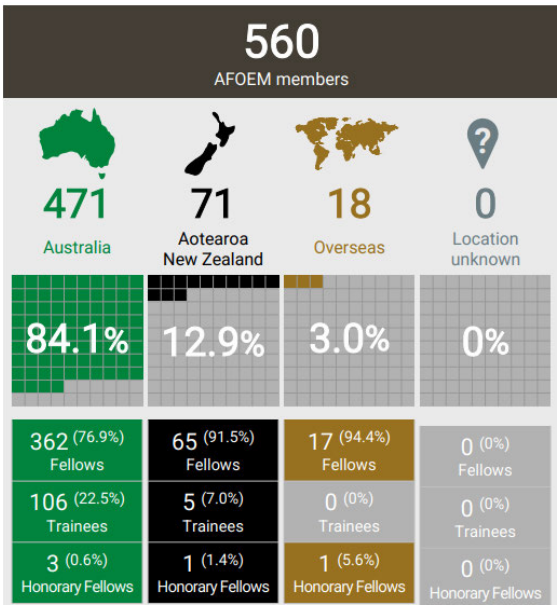


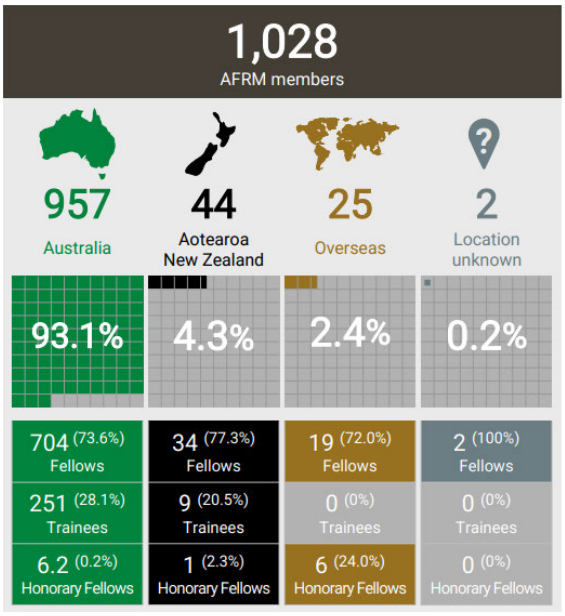
This report reflects members' financial status as defined in the RACP Constitution. In this report, 91 Fellows and 128 trainees are excluded from RACP membership count as they were not financial members at 30 June 2023.

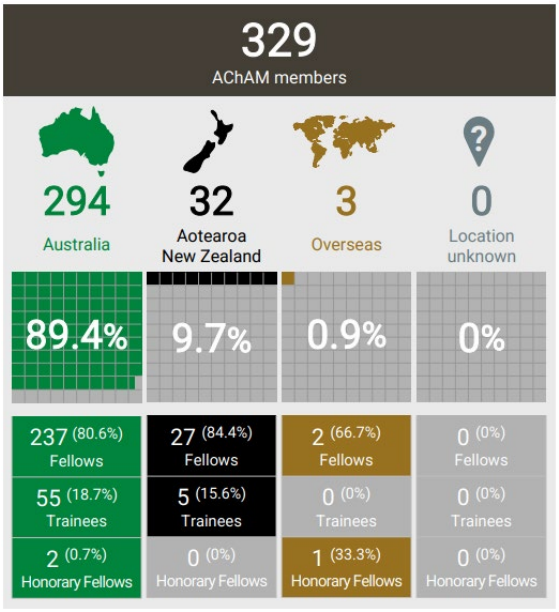


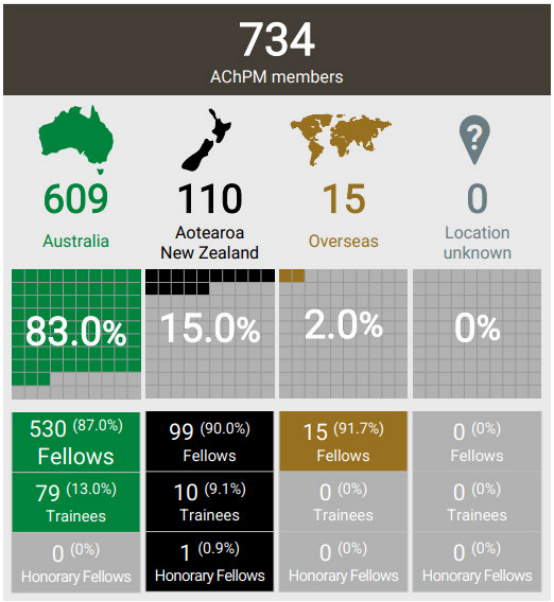


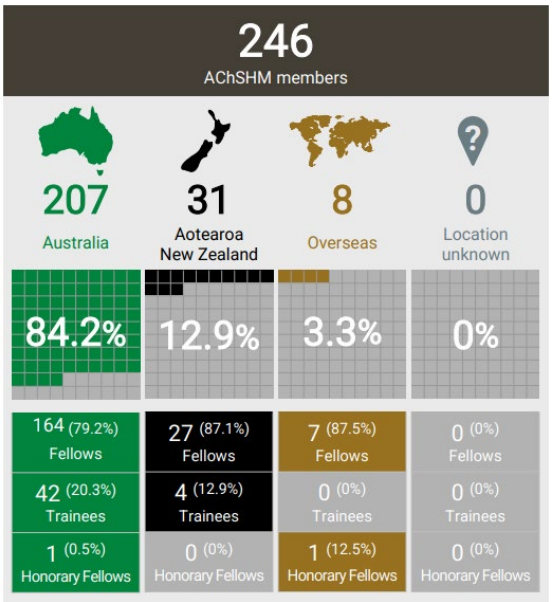

901
AFPHM members
785
Australia
81
Aotearoa New Zealand
32
Overseas
3
Location unknown
87.1%
9.0%
3.6%
0.3%
643 (81.9%) Fellows
141 (18.0%) Trainees
1 (0.1%) Honorary Fellows
74 (91.4%) Fellows
7 (8.6%) Trainees
0 (0%) Honorary Fellows
29 (90.6%) Fellows
0 (0%) Trainees
3 (9.4%) Honorary Fellows
2 (66.7%) Fellows
0 (0%) Trainees
1 (33.3%) Honorary Fellows


560
AFOEM members
471
Australia
71
Aotearoa New Zealand
18
Overseas
0
Location unknown
84.1%
12.9%
3.0%
0%
362 (76.9%) Fellows
106 (22.5%) Trainees
3 (0.6%) Honorary Fellows
65 (91.5%) Fellows
5 (7.0%) Trainees
1 (1.4%) Honorary Fellows
17 (94.4%) Fellows
0 (0%) Trainees
1 (5.6%) Honorary Fellows
0 (0%) Fellows
0 (0%) Trainees
0 (0%) Honorary Fellows


1,028
AFRM members
957
Australia
44
Aotearoa New Zealand
25
Overseas
2
Location unknown
93.1%
4.3%
2.4%
0.2%
704 (73.6%) Fellows
251 (28.1%) Trainees
6.2 (0.2%) Honorary Fellows
34 (77.3%) Fellows
9 (20.5%) Trainees
1 (2.3%) Honorary Fellows
19 (72.0%) Fellows
0 (0%) Trainees
6 (24.0%) Honorary Fellows
2 (100%) Fellows
0 (0%) Trainees
0 (0%) Honorary Fellows


329
AChAM members
294
Australia
32
Aotearoa New Zealand
3
Overseas
0
Location unknown
89.4%
9.7%
0.9%
0%
237 (80.6%) Fellows
55 (18.7%) Trainees
2 (0.7%) Honorary Fellows
27 (84.4%) Fellows
5 (15.6%) Trainees
0 (0%) Honorary Fellows
2 (66.7%) Fellows
0 (0%) Trainees
1 (33.3%) Honorary Fellows
0 (0%) Fellows
0 (0%) Trainees
0 (0%) Honorary Fellows


734
AChPM members
609
Australia
110
Aotearoa New Zealand
15
Overseas
0
Location unknown
83.0%
15.0%
2.0%
0%
530 (87.0%) Fellows
79 (13.0%) Trainees
0 (0%) Honorary Fellows
99 (90.0%) Fellows
10 (9.1%) Trainees
1 (0.9%) Honorary Fellows
15 (91.7%) Fellows
0 (0%) Trainees
0 (0%) Honorary Fellows
0 (0%) Fellows
0 (0%) Trainees
0 (0%) Honorary Fellows


246
AChSHM members
207
Australia
31
Aotearoa New Zealand
8
Overseas
0
Location unknown
84.2%
12.9%
3.3%
0%
164 (79.2%) Fellows
42 (20.3%) Trainees
1 (0.5%) Honorary Fellows
27 (87.1%) Fellows
4 (12.9%) Trainees
0 (0%) Honorary Fellows
7 (87.5%) Fellows
0 (0%) Trainees
1 (12.5%) Honorary Fellows
0 (0%) Fellows
0 (0%) Trainees
0 (0%) Honorary Fellows

Organisational directions

Organisation vision | Tō mātou matawhānui

World-class specialist physicians creating a healthier and more equitable future.

Organisation role | Tā mātou whāinga

Educate
Through the RACP we work together to educate and train the next generation of specialists to deliver quality care and provide continuing professional development and education to Fellows.

Advocate
Our specialists work together to develop and advocate for policies that promote the interests of our profession, our patients and our communities.

Innovate
We collaborate to lead innovation in the delivery of specialist medicine in a constantly changing world and support innovative medical research through our Foundation.

Strategic plan | Mahere Rautaki

Our strategic plan 2022-2026 (Appendix 1A.5) defines where we want to be in the future. It sets out our four strategic focus areas and goals for the College. These will be key priorities for future delivery of our core role, while lifting the health outcomes for the Indigenous people of Australia and tangata whenua of Aotearoa New Zealand:

1. **Sustainable College**
   We will govern and operate in a responsible, sustainable and effective manner
2. **Member experience and belonging**
   We will deliver valuable member experiences, responsive to members' unique and changing needs
3. **Physician and practice of the future**
   We will create and support the next generation of physicians for the future of medicine and community health needs
4. **Equitable and healthier communities**
   We will lead change for better health and wellbeing across our profession, populations and healthcare systems.

Organisational values | Ō mātou wāriu

Our organisational values define how our employees and member volunteers work together to achieve our vision, and strategic goals. They set the tone and tenor of our culture, our interactions and they shape our practices and priorities.

We are Accountable We act with integrity, taking responsibility for actions and outcomes.

We Collaborate We share information, foster participation, and build relationships for common goals.

We are Respectful We value diversity and recognise each other's needs and contributions.

We Indigenise and Decolonise We partner, resource and embed Indigenous knowledge and ways to accelerate culturally safe change, to achieve equitable Indigenous futures.

We Lead the way We reflect, adapt and learn in delivering best practice.

Annual Reports

The College produces annual reports and shares these with members and the public in advance of the RACP's annual general meeting held in May of each year. All annual reports from 2022 and prior are available on the College website (Appendix 1A.6) and the annual report for 2023 will be shared in the same location in May 2024.

Operational Planning 2024

Annual business planning plays a pivotal role in delivering the 2022 – 2026 Strategic Plan, involving three key areas of work: strategic and operational planning, budgeting, and prioritisation. This process is underpinned by analysis of the external and internal operating environment with a strong focus on a member-oriented approach, concentrating on endeavours that enhance the member experience, uplift services and products, and improve operational practices whilst adhering to the standards set by the RACP's regulatory bodies to maintain accreditation across various facets of the College.

The 2024 Operating Plan (as shown in Figure 6) sets out the priority outcomes we want to achieve, the initiatives we plan to undertake and the performance indicators we will use to measure our progress. The 2024 Operating Plan influences our underlying Team and Committee Workplans and individual Professional Development Plans (PDPs), supporting alignment of priorities across the College.

Additionally, in preparing our operating plan for 2024 a shift in focus has occurred with the development of a Member Segmentation Framework and a Member Value Proposition (MVP) framework. This is a deliberate pivot towards a more proactive and considered approach of equitably and transparently incorporating the needs of our diverse membership into our strategic direction and future investments.

The Member Value Proposition Framework is currently under development and will identify the pain points and needs of members, and articulate the value of RACP membership at various stages in a physician's career. This will form the foundation for ensuring the RACP's services and products provide meaningful value for members, and be used in decision-making and prioritisation activities in future years.

2024 Priority Outcomes

As part of our efforts to continually uplift and mature our business planning processes, a key change we have made in planning for 2024 is to clearly articulate the strategic priorities and outcomes we're focusing on and incorporate the key performance indicators into the Operating Plan to establish greater alignment between what we want to achieve (outcomes), what we are doing to achieve it (initiatives) and how we measure our progress (key performance indicators) against the Operating Plan and broader strategy.

The 2024 Operating Plan focuses on five key strategic priorities:

1. Delivering AMC /MCNZ accreditation requirements;
2. Improving member services and lifting satisfaction;
3. Increasing team engagement and cultural safety;
4. Uplifting our technology and digital capabilities; and
5. Streamlining our governance.

These priorities, in alignment with our broader strategy, serve as the cornerstone of our outcomes and initiatives for 2024. As demonstrated in Figure 6, these priorities are linked to the four pillars of our Strategic Plan.

Facilitating FY24 prioritisation and budgeting

The purpose of RACP's prioritisation and budgeting process is to ensure that financial resources within the RACP align to our strategic goals and that we deliver value for members. For 2024, there was a stronger focus on closely aligning business plans and budgets and providing greater

transparency regarding what activities our financial resources are allocated to, while linking them to demonstrable outcomes that benefit the College and its Members.

The FY24 prioritisation adopted a more robust process for delineating and organising activities based on priority. It encompassed a thorough assessment of activities (initiatives and projects), evaluating their desirability, feasibility, and viability, alongside considerations of regulatory compliance, business-critical needs and risks, and alignment with the RACP's strategic priorities.

The initiatives included in the 2024 Operating Plan are the priority items that we believe will best deliver on our stated priority outcomes. They also represent a series of choices made from a broader set of candidate projects. Operating plans require some flexibility to allow for adjustment based on risks and opportunities that may arise within the strategic and operating environment during the year. We will need to continually assess the College's capacity for change and progress in implementing the 2024 Operating Plan and consider how we can respond to changing priorities in an agile way as risks and opportunities arise.

In tandem, the FY24 budgeting process focussed on closely governing expenditures and channelling financial resources strategically into initiatives deemed top priorities. This process ensured an appropriate allocation of financial resources, directing funds purposefully toward investments aligned with the specific needs of the RACP, identifying efficiencies and avoiding indiscriminate spending.

Prioritising education and training

The RACP's education and training landscape remains a key priority area for the RACP with a continued focus on Basic Training, Advanced Training and Continuing Professional Development, including:

- upholding quality standards for medical education and professional development
- renewing curriculum embedding best-practice medical education
- improving responsiveness to member enquiries and complaints
- improving member health and wellbeing support
- enhancing operating efficiency and digital capabilities.

Notably, strategic initiatives related to education and training (including investments in technology) assume a strong position and focus for 2024, including AMC/MCNZ Reaccreditation, AT Curricula Renewal, BT Curricula Renewal, Implementation of the Education Governance Review, and Training Management Platform Implementation.

Strong investments in education technology

In alignment with education and training being a key priority for the College, in December 2023 the Board approved a significant investment in our Training Management Platform (TMP). This technology is critical for supporting the implementation of our new curricula and to help meet the member services and digital engagement expectations of members and our team.

The TMP project was initiated following the RACP terminating the Master Agreement and subsequent disengagement with the vendor for Tracc, the originally intended enabling technology for the new Basic Training program, in March 2023. We rapidly commenced efforts to expedite a comprehensive technology solution (the TMP) for implementation of our new training programs.

The TMP will support the management and administration of our new Basic and Advanced Training programs. It will be developed using the Microsoft suite of products, including Microsoft Dynamics and Power Platform. The expected benefits of the technology include:

- delivery of a member experience that meets expectations and can be continuously improved.
- ability to deliver the new curricula for Basic and Advanced Training.
- more effective delivery of member services and response to member enquiries.
- reliable and supported technologies that reduces business continuity risk.
- improvement and efficiency of IT operations and training operations.

Our TMP project was informed by work undertaken in April 2023 in partnership with KPMG to develop a comprehensive strategy for education technology. KPMG recommended a technology solution, comprised of an established technology platform suited to meet our high-level customer relationship and training management requirements, paired with a learning management system. In April 2023,

the Board approved the CEO's proposal to commission of a proof of concept (POC) for this proposed technology solution and an intensive requirement gathering program.

We completed our thirteen week 'discovery phase' and POC in September 2023, on time, on budget and within scope. The purpose of the TMP POC project was to understand if the Microsoft (MS) Dynamics platform met our training management requirements. The project confirmed that MS Dynamics meets our requirements and the project delivered detailed requirements, a prototype of the MS Dynamics platform to demonstrate its capability to meet agreed requirements, a high-level solution architecture and an implementation roadmap.

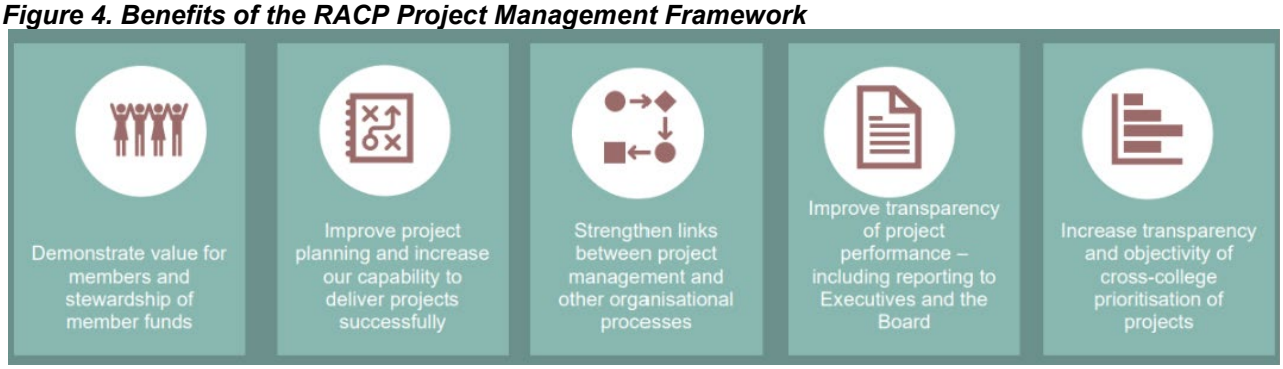
We conducted a procurement process for our Systems Integration (SI) partner to design, build, test and release the TMP through a Request for Proposal. In late December 2023, a Letter of Engagement was signed with KPMG to commence the Project's Vision and Validation stage starting 17 January 2024. Full contracting for the remaining stages commences end of January 2024.

We anticipate the TMP project will be progressively delivered over two years across four distinct phases. The plan is to have an initial release of back-office functionality in the second half of 2024 followed by subsequent releases throughout the remainder of 2024 and into 2025. Full implementation is planned for completion by the end of 2025.

Delivery and governance of major projects

In 2021, a project management framework was implemented across the College, establishing a more structured and standardised methodology for how the College delivers and governs projects. This framework equips projects with the necessary tools, guidance and expertise to achieve the following benefits outlined in Figure 4.

Figure 4. Benefits of the RACP Project Management Framework

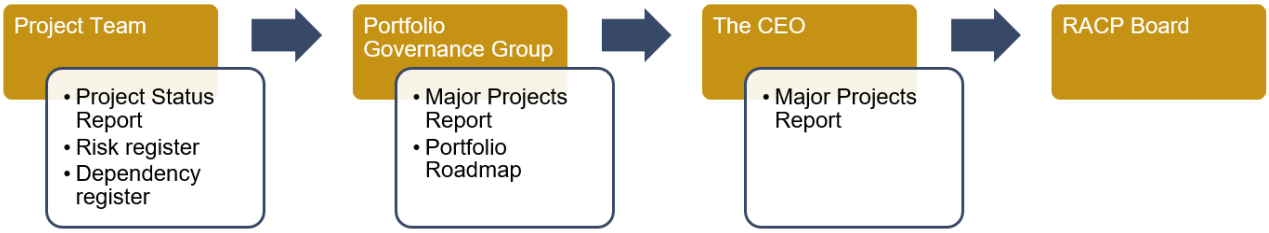


This framework ensures that College projects are governed by effective decision-making controls and processes that are embedded throughout the lifecycle of a project.

The RACP leverages this methodology in the delivery and governance of its major projects. This includes monthly reporting of project progress for all major projects, which is outlined in Figure 5. These reporting requirements enable oversight of all major projects, including for reported risks and issues by governance groups external to the project. This ensures that there is scrutiny of all reported risks and issues and that controls in place to manage these risks and issues are suitable. These groups also have the authority to raise additional risks and issues to ensure they have been documented anywhere necessary request that they are reported on.

In cases where the RACP's project management framework is applied to significant technology projects, the RACP's newly established Technology Committee will be closely involved in project monitoring and governance. Refer to Standard 1.2 for more information regarding the Technology Committee. We have further strengthened our ability to deliver major technology projects through the creation of a new Chief Information Officer role. Please refer to the section below on the RACP's Senior Leadership team for an update on this new role.

Figure 5. Major project monthly progress reporting requirements



The RACP's project management framework was selected by the business for external audit in 2022. This audit assessed the framework as "effective".

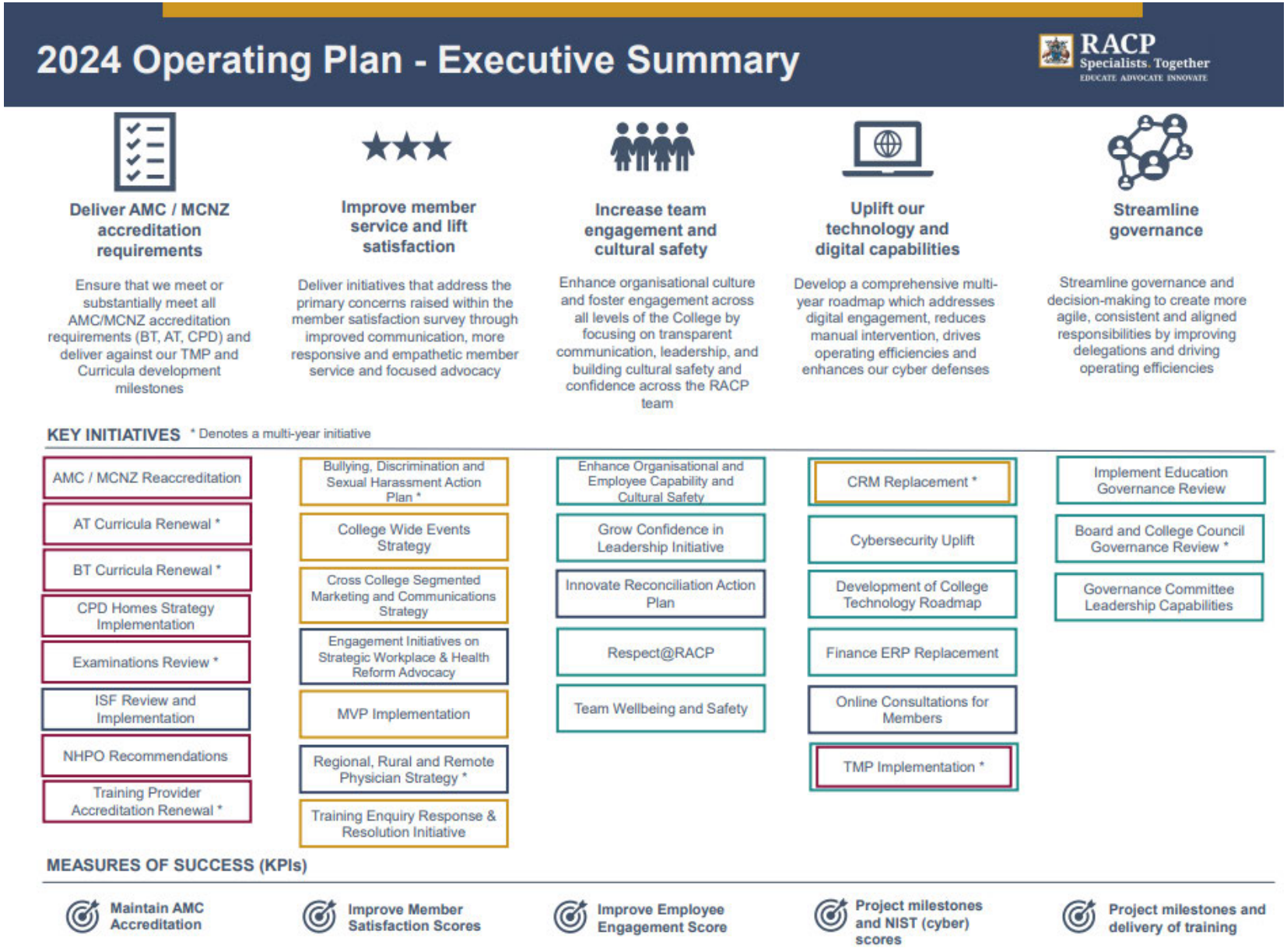
Monitoring and reporting on our operating plan

The RACP conducts regular monitoring and quarterly reporting against its operating plan which is crucial for maintaining accountability within the organisation and transparency with stakeholders.

Regular monitoring enables the College to identify any potential challenges early on, facilitating timely conversations and decision-making about its investments. By doing so, the RACP has positioned itself to strategically reallocate financial resources, shifting away from investments that may incur unrecoverable expenses and time inefficiencies. This approach will mitigate financial risks and enhance our ability to capitalise on new opportunities.

The quarterly reporting schedule serves as a touchpoint for transparently communicating our achievements, challenges, and performance to key stakeholders. Additionally, reporting will give these stakeholders an opportunity to address any concerns, solicit feedback, and allow us to pivot strategies if necessary.

Figure 6. 2024 Operating Plan



RACP Operating Plan 2024

RACP Specialists. Together
EDUCATE ADVOCATE INNOVATE

PILLAR 1: Sustainable College

Govern and operate in a responsible, sustainable and effective manner

2024 OUTCOMES

- Streamlined and agile governance processes and decision-making
- Enhanced operating efficiency and digital capabilities
- Improved employee engagement and company confidence

PILLAR 2: Member Belonging and Experience

Deliver valuable member experiences, responsive to members' unique and changing needs

2024 OUTCOMES

- Improved member engagement and satisfaction
- Improved responsiveness to member enquiries and complaints
- Clearer, more relevant communication and greater transparency for members
- Improved member health and wellbeing support

PILLAR 3: Physician and Practice of the Future

Create and support the next generation of specialist physicians for the future of medicine and community health needs

2024 OUTCOMES

- Uphold quality standards for medical education and professional development
- Renewed curriculum embedding best-practice medical education

PILLAR 4: Equitable and Healthier Communities

Lead change for better health and wellbeing across our profession, populations and healthcare systems

2024 OUTCOMES

- Improved satisfaction with advocacy by realigning with broader member priorities
- Embed the Indigenous object from the Constitution across the College

STRATEGIC INITIATIVES

AMC / MCNZ Reaccreditation	BT Curricula Renewal *	CRM Replacement *	Implement Education Governance Review	Governance Committee Leadership Capabilities	NHPO Recommendations
AT Curricula Renewal *	CPD Homes Strategy Implementation*	Cybersecurity Uplift	Finance ERP Replacement	Indigenous Strategic Framework Review and Implementation	TMP Implementation *

OPERATIONAL INITIATIVES

Board and College Council Governance Review *	Cross College Segmented Marketing and Communications Strategy	Enhance Organisational and Employee Capability and Cultural Safety	Innovate Reconciliation Action Plan	Regional, Rural and Remote Physician Strategy*	Training Enquiry Response & Resolution Initiative
Bullying, Discrimination and Sexual Harassment Action Plan *	Development of College Technology Roadmap	Examinations Review *	Member Value Proposition Implementation	Respect@RACP	Training Provider Accreditation Renewal *
College Wide Events Strategy	Engagement Initiatives on Strategic Workplace & Health Reform Advocacy	Grow Confidence in Leadership Initiative	Online Consultations for Members	Team Wellbeing and Safety	

* Denotes a multi-year initiative

Our people and culture

As a member-governed organisation, the RACP's operating model relies on effective working partnerships between members and RACP employees. This fundamental partnership remains a key strength of our organisation. We have a contemporary employee organisational structure, which is aligned to our organisational governance structure. This is supported by people and culture functions, ensuring we are equipped to deliver on our priorities.

Chief Executive Officer

The Chief Executive Officer, as appointed and delegated by the Board, oversees all College operations and functions, in accordance with the strategy, plans and delegations approved by the Board, and is accountable to the Board for the performance of the College.

Following a rigorous and thorough recruitment process, the Board has appointed Lee Whitney as Chief Executive Officer. Mr Whitney commenced in this role on 13 November 2023. His most recent prior role was at Chartered Accountants Australia and New Zealand (CA ANZ) as Group Executive – Finance, Strategy and Technology. During his nine years at CA ANZ, he also had ownership of account management, member engagement, product management, and set up CA ANZ's physical international presence in the UK, Hong Kong, Malaysia, and Singapore. He was also responsible for their two most recent strategic roadmap developments in 2017 and 2020.

Louise McElvogue was Interim CEO of the College from December 2022 to November 2023 whilst the recruitment process for a permanent CEO was underway.

Senior Leadership Team

The Senior Leadership Team is comprised of the CEO, College Dean, Chief Information Officer (CIO) and the College's five Executive General Managers. They work together to maximise member experience through effective strategy development in addition to overseeing the efficient operation of all College operations. Details of each role are outlined in Figure 7.

In early 2024, the Board approved the creation of a new Chief Information Officer role to provide vision and strategic leadership in navigating the rapidly evolving technology landscape and achieving the College's strategic goals for digital transformation and current operational needs.

In mid-February, 2024, David Bough commenced as Interim CIO. David was most recently Program Director at CPA Australia where he oversaw a multi-year digital transformation process. David was also formerly the interim CIO of CPA Australia. David will work with our IT team to gain momentum of our technology initiatives, provide technology oversight to our TMP initiative, and work with the team to provide strategic and tactical leadership while we commence the process for appointment of a permanent CIO.

Figure 7.The RACP Senior Leadership Team

Lee Whitney
Chief Executive Officer

The Office of CEO oversees all College operations and functions, General Counsel and Legal, and the RACP Board Secretariat.

Louise Rigby
Executive General Manager, Professional Practice

Professional Practice supports compliance and professional learning functions. These include professional development, performance of Fellows and assessment of overseas physicians, including registration.

Dr Kudzai Kanhutu FRACP
Dean of the College

The Dean is a senior Physician who represents members on clinical and medical-technical issues, advises on workforce issues and supports, engages and represents the RACP's physician membership base and partnerships internationally. The Dean helps to ensure that the RACP has the relevant infrastructure, systems, and processes in place to deliver value to current and future physicians.

John McConville
Chief Financial Officer
Executive General Manager, Shared Services

The Shared Services team delivers efficient and effective financial management of College funds and assets, and facilitates commercial services that support College operations.

Professor Inam Haq, FRACP, FRCP
Executive General Manager, Education, Learning and Assessment

Education, Learning and Assessment (ELA) coordinates the College's annual cycle of written and clinical examinations. It accredits healthcare workplaces that train our physicians and coordinates support for trainees in difficulty. ELA is responsible for our Education Renewal program, ensuring that our physician training remains world-class.

Lisa Penlington
Executive General Manager, Member Engagement and Support

Member Engagement and Support works to support our members and connect them with their College. It supports peak bodies of the College, including its Divisions, Faculties and Chapters. It also encompasses our Australian Regional and Aotearoa support teams, our online contact points and Contact Centre, Marketing and Communications and Events.

Nicola Lewis
Executive General Manager, Policy and Advocacy

The Policy and Advocacy team provides a strong voice in the public policy arena and ensures the College contributes to and influences the Australian and Aotearoa New Zealand debate on health.

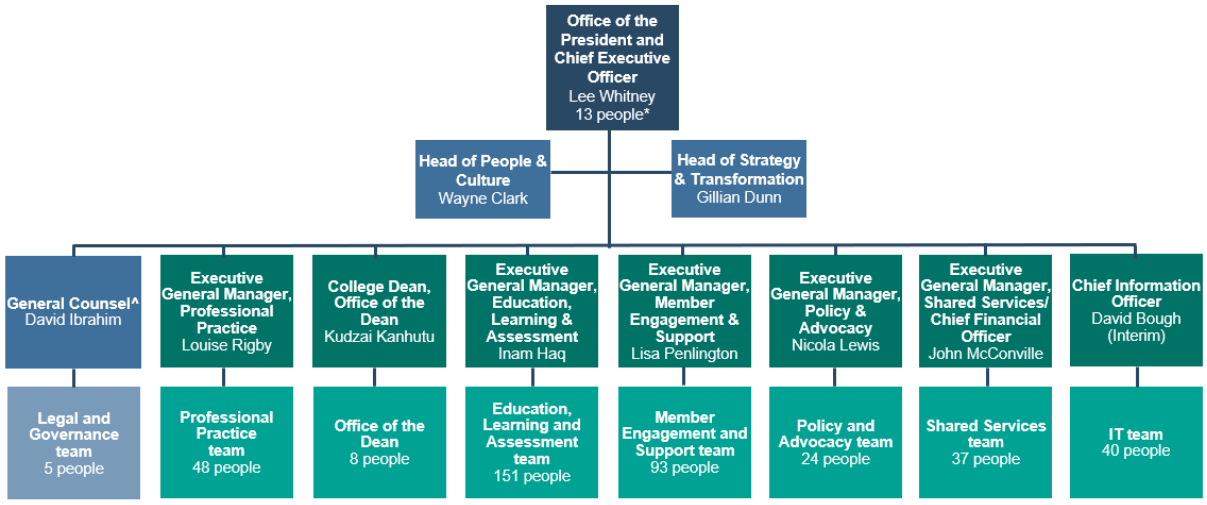
David Bough
Interim Chief Information Officer

The CIO provides strategic direction and leadership for all aspects of information technology to support College business objectives in growing member engagement and satisfaction, improving the digital experience of our teams, and supporting efficient service delivery.

RACP team structure

The RACP team is structured into seven high-level teams, each led by the relevant SLT leader, as shown in Figure 8.

Figure 8.Organisation chart of College teams



*inclusive of team members depicted in sky blue teams
^General Counsel is part of OPCEO team, and also participates in the SLT

The College employs a range of strategies to harness the strengths of cross team collaboration and avoid siloing of work, ranging from cross-functional communications (via staff newsletters, monthly All Team meetings and technology platforms such as an Intranet and Microsoft Teams), centralised prioritisation and resourcing planning through the SLT, use of best-practice project management methodologies through our ePMO (project management office), and formation of communities of practice for various interest areas across the college (such as medical education publications, project management and member wellbeing).

Supporting a high-performing team

The College has a range of initiatives to support our people to function as a high performing team. We offer flexible working arrangements and a hybrid working model. From January 2024, our teams will follow our new Hybrid Work Policy which sets out a 3-2-1 hybrid work model. This outlines the value of working two days in an RACP office location, one of which is with the employee's team, while the remaining three days are worked from the employee's location of choice.

This model provides a strong foundation for fostering the RACP community and sense of employee belonging, provides space for deep concentration work and acknowledges the value of face-to-face connection and collaboration. In conjunction with the implementation of our new Hybrid Work Policy, the RACP opened up new offices in the Sydney CBD and in Te Whanganui-a-Tara | Wellington, designed to support collaborative working across teams and the membership. We have maintained our existing offices at 145 Macquarie Street, Sydney, and in Melbourne, Brisbane, Perth and Adelaide.

Professional learning and development

These initiatives span from commencement of employment through to individual career progression within our organisation. Robust learning and development opportunities are provided to support the team to develop professionally, remain engaged and achieve their career goals in line with the strategic direction of the College. Learning, development and upskilling at the College is offered in many forms through on-the-job learning, internal and external training, secondments, internal transfers, lateral movement, promotions, higher duties and acting arrangements.

The College supports professional development by offering:

- seminars, workshops, and conference attendance
- leadership programs
- learning programs and training sessions
- coaching and mentoring
- career progression
- learning and Development Catalogue
- access to wide range of e-learning modules
- fortnightly DEAL (Drop Everything And Learn) hours from September 2023.

The RACP requires employees to complete nine compulsory learning modules that set out the competencies required to work at the organisation. These modules ensure a standardised skill set, improve efficiency, and fosters a safer and inclusive work environment.

The compulsory eLearning modules are:

- Cyber Security Awareness
- Fraud & Corruption Awareness
- Complaint Management for Members
- Risk Management

- Procurement & Contracting
- Indigenous Cultural Awareness
- EEO – Sexual Harassment
- EEO – Workplace Bullying
- EEO – Discrimination
- Wellbeing Health Safety System.

Reward and recognition

The College utilises several ways to support staff to achieve excellence and celebrate their contributions and achievements:

- Appreciation Program – a program directed at appreciating and recognising all employees at RACP, directly linked to demonstration of the RACP's Organisational Values.
- annual remuneration review with market benchmarks
- years of service rewards.

In 2023, our Appreciation Program resulted in the recognition of 165 employees across the RACP. Activities recognised through the Appreciation Program included:

- collaborations across departments
- improvements to business processes and service delivery
- member-focused behaviours
- positive adaptiveness to change.

Diversity and inclusion

We recognise the value of a diverse, equitable and inclusive work environment, where all staff are advocating and facilitating a culture of belonging. In addition to training and development on these topics, to facilitate this work environment the RACP offers the following:

- facilities for parents
- floating holiday, allowing employees to take a paid day off from work as a substitute for a public holiday, in alignment with their cultural and religious values
- Reconciliation Action Plan (RAP)
- cultural workshops and activities, such as Te Wiki o te Reo Māori | Māori Language Week, NAIDOC week, National Reconciliation week, Matariki
- observance and education about national awareness days (e.g. RUOK, International Women's Day, International Day Against Homophobia, Biphobia and Transphobia, and more)
- end of year party.

Supporting Wellbeing, Health and Safety

To support the wellbeing of RACP staff, they can access the Telus Employee Assistance Program (EAP), which provides immediate and confidential help for any work, health or life concern. The EAP is available at anytime and anywhere and is a confidential and voluntary support service. RACP employees and their immediate family members can access immediate and confidential support in a way that is most suited to their preferences, comfort level, and lifestyle.

The support is offered for concerns related to work, health, and life include topics such as communication, workplace challenges, stress, mental health concerns, parenting, management relationships and family.

The RACP recognises that spending time with family is important for staff wellbeing and work-life balance and offers the following:

- 18 weeks paid primary carer parental leave
- eight weeks paid secondary carer parental leave
- additional paid leave for returning parents

The RACP recognises the need to balance personal and family commitments with work. To assist in managing work-life balance the following additional leave options are offered:

- additional paid leave between Christmas and New Year
- option to purchase additional annual leave
- career break leave
- tertiary study leave
- additional paid domestic violence leave
- CEO gifted half-days.

The RACP recognises that offering financial support to employees is important for their financial stability, overall job satisfaction, and productivity. The following options are provided to support employees to manage day-to-day finances, planning and saving for future milestones by offering:

- competitive remuneration
- salary packaging options
- returning from parental leave bonus
- employee referral program.

Culture and Leadership Taskforce

The Culture and Leadership Taskforce was established in 2020 as a consultation mechanism to facilitate open dialogue between leadership and employees, ensuring diverse perspectives are considered in decision-making. This approach enhances organisational adaptability, promotes a collaborative culture, and helps address potential cultural issues proactively. The Taskforce serves as a valuable channel for feedback, contributing to continuous improvement and the establishment of inclusive policies that resonate with the workforce. For example, the Taskforce led the development and implementation of the College's Organisational Values, as outlined on page 19.

Staff retention and turnover

Our staff retention and turnover rates are comparable to the industry standard, reflecting the current climate of the employment market. Retention rates for employees are provided in Table 1. Employee retention for the past four years. There was a drop in employee retention in 2022, consistent with that experienced by other organisations, which we are pleased to see has improved in 2023.

The majority of employee-initiated separations were reportedly due to personal (health/family) reasons (27%) or pursuit of other career opportunities (38%).

Table 1. Employee retention

Year	Employer retention*	Employee retention**	Permanent headcount
2023	98.2%	83.7%	337
2022	100.0%	82.4%	306
2021	99.6%	87.1%	278
2020	99.6%	87.9%	281

**Employer retention- represents separations initiated by the College*
***Employee retention- represents separations initiated by employee*

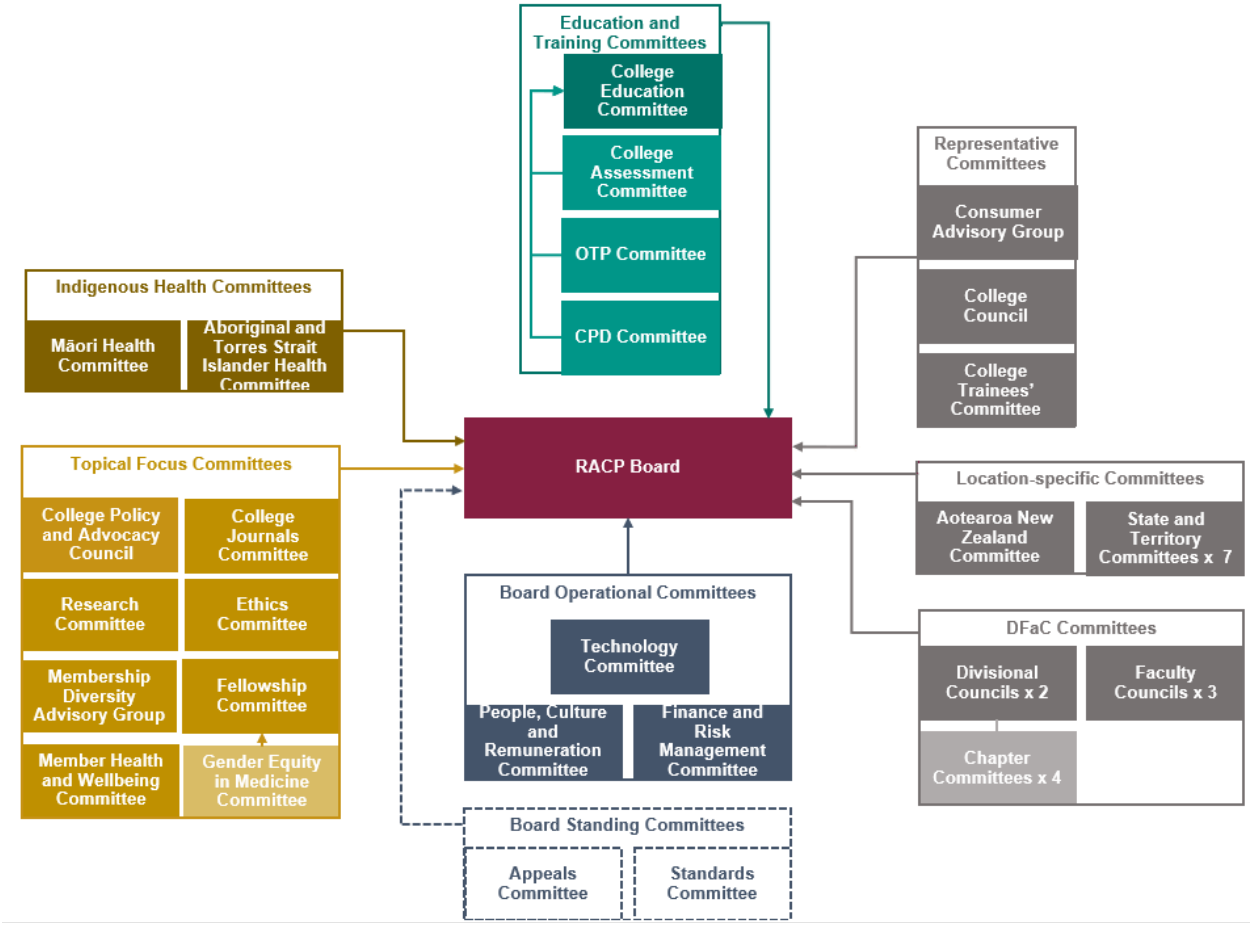
Pleasingly, our data in 2023 demonstrates that the RACP offers a range of well-utilised internal career development pathways, with 105 employees who were seconded or transferred into another role, took on higher duties or promoted in 2023.

Governance

Governance structure

The RACP is a member-governed organisation, with the RACP Board as the accountable body for delivering our education purpose and programs. Figure 9 summarises the RACP's governance structure. Educating, training and the continuing professional development of physicians are core roles of the RACP, as articulated in our Constitution, Strategic Plan and Operating Plan and reflected in governance structures.

Figure 9. RACP governance structure



The Board has identified potential benefit in reducing the number of committees that report to it, which would enable increased focus on strategic and operational performance. Scoping of this project is to commence in 2024 and will include consideration of the role of College Council (refer to section on College Council below).

Technology Committee

In December 2023, the Board approved the creation of a new Technology Committee to provide review and oversight of our technology strategy and roadmap, major new and in-progress technology initiatives, and monitor, advise and report on risks. This Committee will include two external technology and programme management experts as well as a Board Director, and will provide reports to the Board on TMP implementation. Terms of reference for the committee are available on the College website.

College Education Committee

Our current governance approach for education, in place since 2014, delineates between responsibilities for standard setting and program implementation. The College Education Committee is responsible for developing and overseeing College-wide education policy, frameworks and approving both new and amended training and education programs, thereby establishing the standards for education. The Division and Faculty Councils, and delegated Bodies thereof, are responsible for implementing training and education programs in accordance with the CEC's decisions.

Refer to Standard 1.2 for further details regarding Education Governance, reflections on the effectiveness of the current structure and plans for review and joint program management structures.

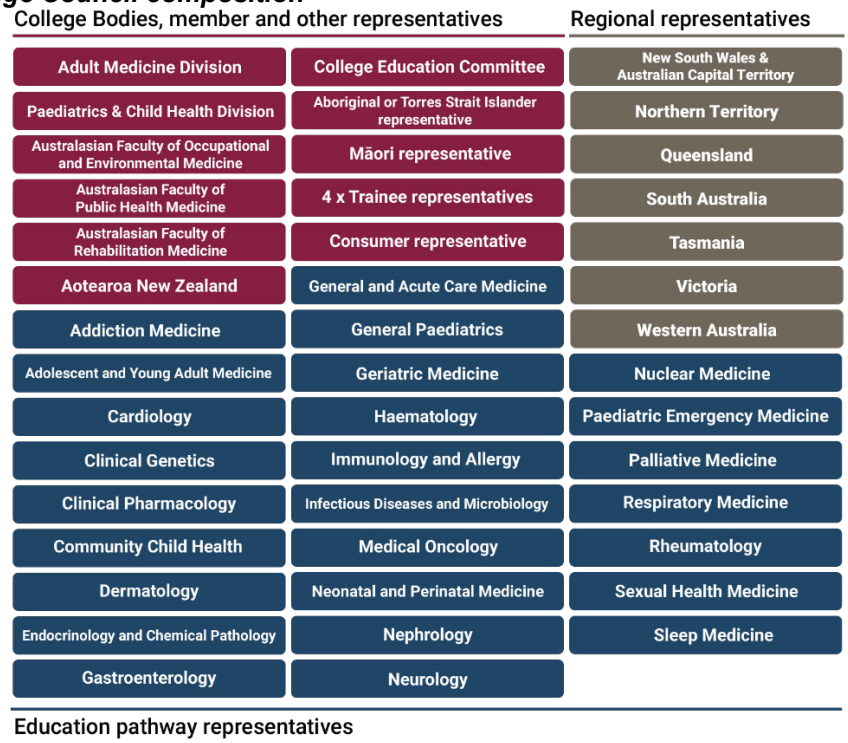
Indigenous Health Committees

The RACP Aboriginal and Torres Strait Islander Health Committee and Māori Health Committee are the peak bodies providing leadership to improve Indigenous health and social outcomes. Detail regarding these two committees is provided on pages 61-63.

College Council

The College Council (Appendix 1A.7) was established by the Board in 2015 to act as its peak advisory body on strategic and cross-College issues. The College Council responds to issues the Board refers to it and raises issues to the Board that the College Council feels need consideration. The Council empowers the voice of the fellowship, as it is composed of a variety of member and non-member perspectives to be heard in a single forum. The Council is a representative body of up to 47 representatives in both Australia and Aotearoa New Zealand. The Chair of the CEC sits on the College Council. Specialty societies are invited to nominate to education pathway representative positions. A list of positions on the College Council is provided in Figure 10.

Figure 10. College Council composition



Specialty societies

There are currently 49 specialty societies affiliated with the RACP, with two PCHD-affiliated societies having recently advised they had ceased operation in 2023. These societies bring together physicians, paediatricians, researchers, and clinical scientists actively involved in the practise and study of a particular specialty. The RACP values its relationships with the societies and gratefully draws upon their expertise for guidance on matters of shared interest ranging from training and education, research, workforce policy and advocacy initiatives.

Specialty societies play an especially important collaborative role in our advanced training programs. As the accredited education provider, the RACP is the primary body that governs physician training programs. However, we share common memberships and education goals with specialty societies.

Many RACP training committees have positions for specialty society representatives, and we consult regularly with specialty societies on matters related to training and education. Specifically, in relation to Advanced Training curricula renewal, we are working closely with specialty societies to ensure that curricula content reflects contemporary evidence-based practice. Each curriculum review group is convened as a sub-committee of the relevant RACP training committee and include specialty society representatives. Combined with targeted consultation with specialty society members on draft curricula, this approach ensures specialty societies are closely involved in shaping the renewed curricula.

Through our education governance review we are examining the structure and function of Advanced Training Committees, with consideration given to committee composition and reporting pathways. As part of this we will appraise the impact of existing measures for working with specialty societies and consider further opportunities to improve collaboration.

The College hosts quarterly fora with specialty society staff to share information. In 2023, a one-day forum with presidents of specialty societies was held, hosted by the RACP President. It was agreed that this becomes an annual forum and the 2024 forum is scheduled for March 2024. This forum is an opportunity to hear specialty society perspectives about preferred ways of working with the RACP and priority shared interests.

The RACP Model of Collaboration (MOC) was introduced in 2015 to provide a mechanism for articulating and recognising the relationships and interdependent activity of specialty societies affiliated with the RACP. Co-designed with the societies, the MOC states the principles underpinning these relationships and provides a schedule in which each society and the RACP can document their respective contributions, collaboration and activities in advancement of that field of specialty practice. The College continues to work with specialty societies to develop MOC schedules; however, there remains a low uptake from specialty societies in completing these, despite ongoing and regular attempts to engage, and offers to assist. We have 12 completed schedules and a further five at an advanced stage.

Working together through effective delegations

As the volume of physician trainees increases, the workload associated with governing trainee progression has significantly increased for our committees. To ensure our member-governed operational model is scalable, and committee members are working to their maximum scope and not weighed down with routine decisions, we are expanding our use of delegation schedules. We have these in place for routine approvals of training and certification decisions. In 2023, as outlined in Standard 1.2, we expanded and streamlined our processes for confirmation of completion of training requirements and this included an updated operations and delegations document for each relevant committee. Through the Education Governance Review, we will work to expand and support the consistent application of delegation schedules to support routine decision-making.

Collaboration for delivery and improvement

There is a large range of stakeholders associated with the RACP's diverse training programs. We work closely with representatives of stakeholder groups to collaborate for delivery and improvement of our programs. We describe how we work across the sector in Standard 1.6, including with jurisdictions, health services, agencies and Members.

We articulate our overarching approach to stakeholder collaboration in our Education Renewal Program Change and Communication Strategy (Appendix 1A.8). This document establishes the strategic direction and approach to managing change and identifies four pillars of change as shown in Figure 11.

Figure 11. Four pillars of change in the Education Renewal Program Change and Communication Strategy

The first pillar of change is Stakeholder Engagement. In accordance with this pillar, we define, segment and assess stakeholders that will require engagement across the lifecycle of the change. Stakeholders determined to be relevant to the period of change are blueprinted and analysed in a change impact assessment.

We conduct our change impact assessments using four frameworks as outlined below.

Change readiness assessment criteria

Not	Doesn't have the tools or knowledge to complete the change and/or is highly resistant to the change.
Somewhat	Has limited knowledge and access to tools to complete the change and/or is resistant to the changes.
Moderately	Has the tools and knowledge to complete the change and has limited resistance.
Ready	Fully informed and capable, no resistance to the change.

Impact scale

Impact is assessed based on the Complexity of Impact definition outlined in 'The Effective Change Manager's Handbook'[1] which is "an assessment of the impact of the change, the change activity and the unintended consequences."

When completing a change impact assessment, we assess the complexity of impact and determine whether a stakeholder is High impact, Low impact or No impact. We list the active impact on the stakeholder to show reasoning and help develop the correct change and communication activities to the impact and stakeholder.

ADKAR

We utilise the ADKAR change model, which is a goal-oriented change management model that guides both individual and organisational change. This methodology represents the five milestones an individual must achieve for change to be successful across five domains as shown in Table 2 below.

Table 2. ADKAR change management domains

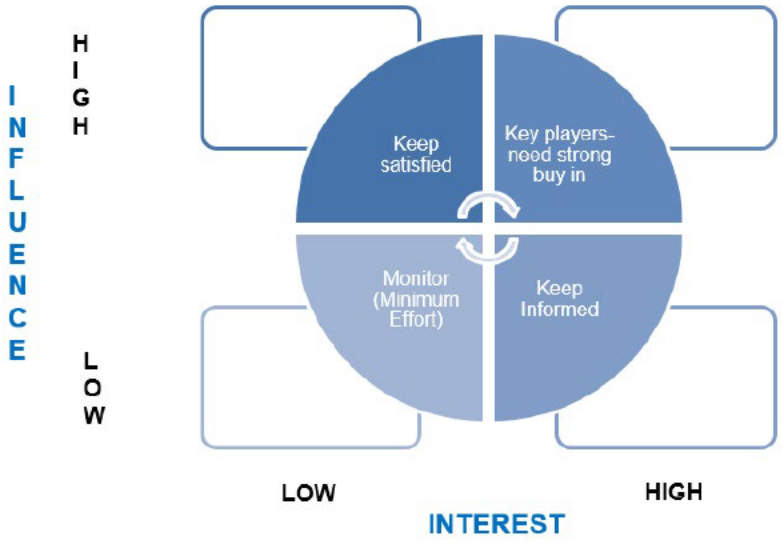
Awareness	Awareness of the need for change	• *Sponsor messages* • *Manager/Leader conversations* • *General communications for impacted parties*
Desire	Continuing to focus on the reasons for the change and the motivation to get onboard	• *Strong sponsorship coalition* • *Proactive management of resistance* • *Strong employee involvement in creating the needed solution*
Knowledge	How to change i.e., what to do during the transition and by having the knowledge on how to perform effectively in the future state	• *Training and education* • *Experience* • *Access to information*
Ability	Defined by an individual/team/group demonstrating the required changes such that overall expected performance results are achieved	• *Practice* • *Access to right tools* • *Feedback*
Reinforcement	Needs to remain strong so that changes are sustained and deliver the expected results over time	• *Celebrations* • *Rewards and recognition* • *Feedback*

[1] Smith, R; King, D; Sidhu, R; Skelsey, D (2014) The effective change manager's handbook, Kogan Page Publishers

Stakeholder analysis

We use the influence and interest matrix taken from 'The Effective Change Manager's Handbook, Essential guidance to the change management body of knowledge'[2], which is depicted in Figure 12.

Figure 12. Influence and interest matrix



An example of how we have applied the Education Renewal Program Change and Communication Strategy to an individual project is available in Appendix 1A.9, which provides the Training Provider Accreditation Renewal Phase 2 Implementation Change and Communications Strategy.

Managing conflicts of interest

The RACP has a range of policies and guidelines used to manage conflicts of interest and support effective decision making. These are outlined in Table 3 below.

Table 3. Breakdown of procedures for managing conflicts of interest and decision making

Document	Description	Associated documents
Managing Conflicts of Interest		
Conflict of Interest Policy	*Policy* This policy sets out how members of any College Body effectively identify, disclose and manage any actual, potential or perceived conflicts of interest in order to protect the integrity of the RACP and manage risk.	Policy (Appendix 1A.10)
	Declaring Conflict of Interest Once an actual, potential or perceived conflict of interest is identified, it must be entered into the RACP's register of interests, as well as being raised with the Board or relevant College Body.	
	Participation of College or Board Members Once the conflict of interest has been appropriately disclosed, the College Body Members (excluding the Member(s) who has made the disclosure) must decide whether or not the Member(s) should vote on the matter (this is a	

[2] Smith, R; King, D; Sidhu, R; Skelsey, D (2014) The effective change manager's handbook, Kogan Page Publishers

Document	Description	Associated documents
	minimum), participate in any debate or be present in the room during the debate and voting.	
	Decision of actions by committee In deciding what approach to take where a College Body Member has a conflict of interest, the relevant College Body will consider: whether the conflict needs to be avoided or simply documented; whether the conflict will realistically impair the disclosing person's capacity to impartially participate in decision-making; alternative options to avoid the conflict; the RACP's objects and resources; and the possibility of creating an appearance of improper conduct that might impair confidence in, or the reputation of, the RACP.	
	Maintaining the register of interests The approval of any action requires the agreement of a majority of the relevant College Body (excluding any conflicted College Body Members, if applicable) who are present and voting at the meeting. RACP's register of interests must be maintained as outlined in the policy.	
Declaration of Interest Register Guideline	Guideline assists College Body Secretariats in establishing and maintaining the declarations of interest of College Members and comply with the Australian Charities and Not for Profits Commission expectations and the College's Conflict of Interest Policy. The Declaration of Interest Register is held internally to manage confidentiality and privacy requirements.	Guidelines (Appendix 1A.11) Form guidelines (Appendix 1A.12) Form (Appendix 1A.13) Template (Appendix 1A.14)
Support for effective decision-making		
Decision Making for College Bodies Guidelines	Guideline provides a process for decision making for the Board and its College Bodies. The College is committed to procedural and substantive fairness and sound decision making. This guideline is provided to support directors and college body members in considering and deciding on matters before them when discharging their duties.	Guidelines (Appendix 1A.15) Checklist (Appendix 1A.16)

Training and development to support effective governance

We have a range of monitoring and development initiatives to support effective governance.

From 2021, we have an annual skill and experience review process in place for all Board committees (committees that report to the Board). Using a self-assessment form, members of each committee appraise their skills and experience against the core purpose and functions of the committee along with core governance and behavioural skills required under the ACNC Governance Standards. The scores on these forms are collated for each committee to identify any competency gaps. The committee collectively reviews the options to address any gaps identified and a central register is maintained by the Governance team to ensure organisation-wide monitoring and achievement.

Commencing from 2022, biennial performance reviews are issued to key governing Board Committees. To assess the performance of each committee against the purpose and functions delegated to them by the Board. This enables the Board to have oversight of the Board Committees.

The Board Induction is held in May each year, following the appointment of elected Board Directors at the annual general meeting. All new Board Directors attend at least the first year of their appointment and existing Board Directors are invited to attend each year for a refresher. Newly appointed members of key Board committees are also invited to attend the induction

access the information through the College Body inductions pack, which is issued annually to Board committees.

The Board have a Professional Development Register that requires all Board Directors to complete the Australian Institute of Company Directors (AICD) Company Directors Course. Additional funding is provided for training to maintain Director's skills in undertaking their duties and responsibilities.

The Board offered Governance Foundation training to Chairs and some Deputy Chairs of Board Committees; this was implemented in 2023. This training was provided through AICD or the Institute of Directors New Zealand.

All secretariats of College Bodies completed the Governance for Secretaries training module which outlines the requirements for managing a College Body. A College Body includes a Division, Faculty, Chapter, committee, council, working group, advisory group, special interest group, working party, reference group.

The Board has completed Indigenous cultural training and a number of Directors have completed Te Tiriti cultural training. Provision of cultural training for the Board is ongoing as Director terms end and new Directors are appointed. All College staff are required to complete cultural awareness training, as discussed earlier in Standard 1.1.

1.2 Program Management

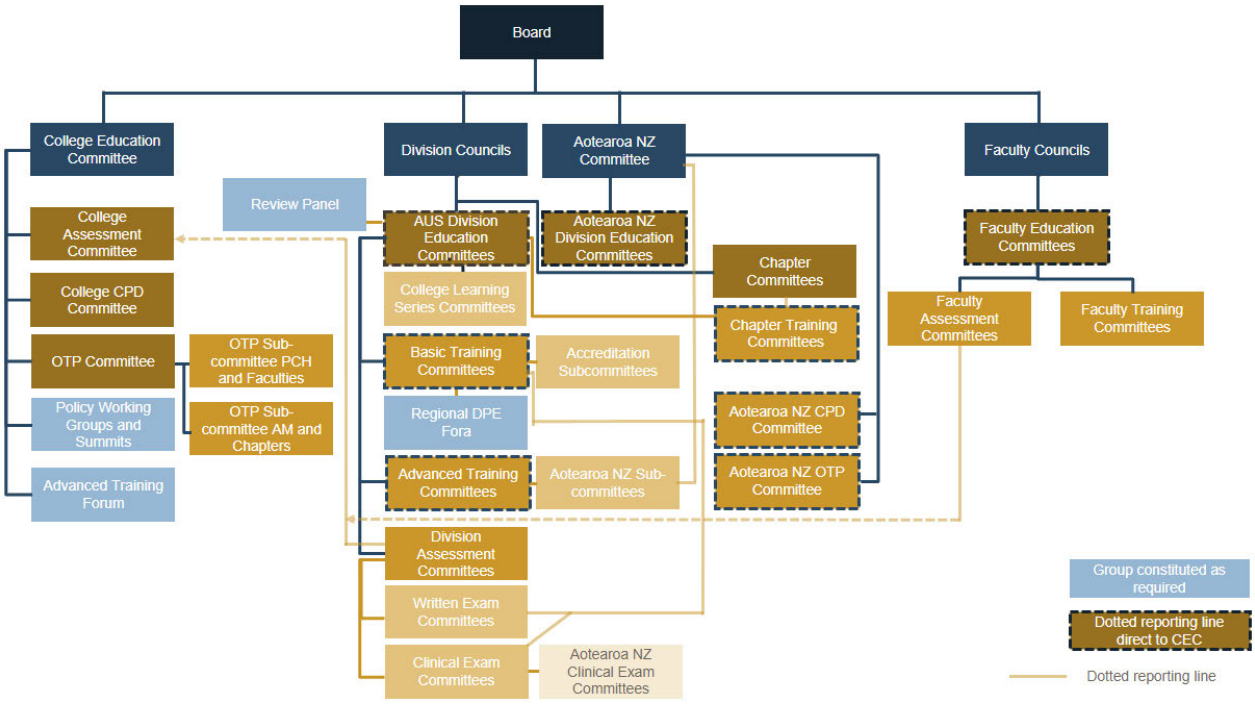
AMC accreditation standards:	
1.2.1	The education provider has structures with the responsibility, authority and capacity to direct the following key functions: o planning, implementing and evaluating the specialist medical program(s) and curriculum, and setting relevant policy and procedures o setting, implementing and evaluating policy and procedures relating to the assessment of specialist international medical graduates o certifying successful completion of the training and education programs.

Education governance reporting relationships

The current education governance arrangements of the College reflect the significant scope and size of the College's education and training programs. There are 109 education and training College Bodies, with 83 of these being standing committees. These provide over 700 positions for college members to contribute across the lifecycle of the College's education programs.

Our education governance structure is summarised in Figure 13.

Figure 13. Summary of the RACP's education governance structure



College Education Committee

As outlined in Standard 1.1, the College Education Committee (CEC) is the peak body responsible for developing and overseeing College-wide education policy and approving both new and amended training and education programs.

The purpose of the CEC is to ensure consistent quality of education and training across all College training programs in Australia and Aotearoa New Zealand, with overarching responsibility for education policy, philosophy and principles.

The CEC is composed of 17 members, including a Chair (Associate Professor Mitra Guha) appointed by the RACP Board; Deputy Chair; College Censor; a Board Director; representatives from key education and training committees; the Chair or delegate of the Continuing Professional Development Committee and Overseas Trained Physicians Committee; two trainee members nominated by the College Trainees' Committee; an appointed member with specialist skills in education and training; and a representative from the Consumer Advisory Group.

Since 2020, several changes have been made to the CEC By-law to strengthen the committee's functions, including:

- CEC Chair is appointed through an open expression of interest process throughout the RACP Fellowship, with selection and approval by the Board
- a Board Director is appointed as an ex-officio member of the CEC to strengthen reporting and alignment between the CEC and Board
- a consumer representative now contributes to CEC business
- an Executive Committee has been established to conduct business on behalf of the CEC in the intervening periods between meetings
- two new Trainee Observer positions have been created to increase the availability of the trainee voice (see Standard 7) and to distribute the load on Trainee Representatives. On

occasions where Trainee Members are not able to attend a specific meeting, the Trainee Observers can vote as proxy members.

As with all Bodies that report to the RACP Board, the CEC undertakes a skill and experience review annually to support the completion of its workplan, balance the workload across members and demonstrate areas where the members need additional assistance.

In 2022, the CEC developed its Strategic Plan 2022-2024 and 2023-2024 Work Plan which outlines its projects and initiatives in line with strategic priorities. Progress updates are provided to the Board annually.

The CEC by-law is available on the College website and provided in Appendix 1A.17.

Education policy development and review process

Education policies underpin all College training programs and are developed and revised regularly under the auspices of the CEC, in alignment with the College-wide policy framework. Our education policy development process (Appendix 1A.18), summarised in Figure 14 below, is designed to ensure that policies are collaboratively developed in alignment with the strategic objectives of the College.

Through this staged process, we seek to contextualise educational best practice while addressing business, regulator and stakeholder needs. Regular decision points facilitate continued steering by the College Education Committee throughout the process. A list of all education policies is provided in Table 4. Details of recent and in-progress revisions of policies are provided in the relevant standards.

Figure 14. Education policy development and revision process

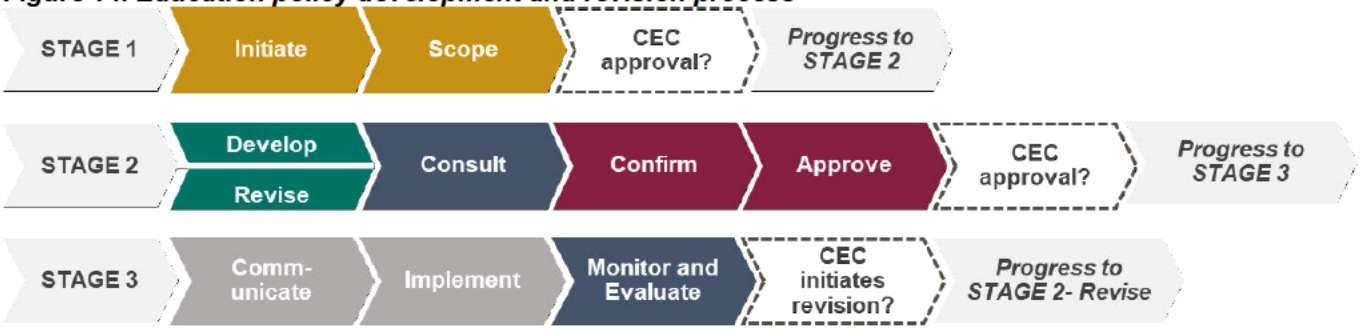


Table 4. Education policies

Policy	Description	Associated documents
Training		
Academic Integrity in Training Policy	Defines the principles that underpin the RACP approach to academic integrity in its training programs and the roles and the process to adhere to when academic misconduct is identified.	Policy (Appendix 1A.19) Process (Appendix 1A.20)
Assessment Policy	Standards and policy to which RACP training programs should adhere so that quality of assessment processes is ensured.	Policy (Appendix 1A.21) Standards (Appendix 1A.22)
Educational Leadership and Supervision Policy	Policy and framework to support and ensure high quality supervision and leadership across RACP training programs.	Policy (Appendix 1A.23) Framework (Appendix 1A.24)

Policy	Description	Associated documents
Flexible Training Policy	Policy outlines the flexible training options available for RACP trainees (including Fellows in training) enrolled in training programs.	Policy (Appendix 1A.25) FAQs (Appendix 1A.26)
Progression through Training Policy	Policy outlines provisions for completion of training requirements, time limits to complete training programs, prospective approval and certification of training, and failure to progress in training.	Policy (Appendix 1A.27)
Recognition of Prior Learning Policy	Policy outlines the requirements for the formal recognition of experience obtained prior to entry to an RACP training program.	Policy (Appendix 1A.28) FAQs (Appendix 1A.29) Guide for Applicants (Appendix 1A.30)
Selection Into Training Policy	Policy sets out the principles which underpin selection into RACP training programs including criteria for eligibility and selection into RACP training programs, and standards for the process of selection into training at RACP accredited training settings.	Policy (Appendix 1A.31)
Special Consideration for Assessment Policy	Policy to enable mitigation of unreasonable barriers to assessment activities of the RACP caused by exceptional circumstances.	Policy (Appendix 1A.32)
Trainee in Difficulty Support Policy	Policy outlines what 'in difficulty' means in the context of RACP training. It defines the principles to be employed by the trainee, the supervisor and the College when a difficulty is identified, and the roles and responsibilities of the parties involved.	Policy (Appendix 1A.33) FAQs (Appendix 1A.34) Process (Appendix 1A.35) Pathway (Appendix 1A.36)
Training Provider Accreditation Policy	Policy sets out how the RACP will assess, accredit and monitor training providers that deliver RACP training programs.	Policy (Appendix 1A.37)
Post-training		
Overseas Trained Physicians and Paediatricians Assessment Policy	Policy outlines the assessment process of specialist international medical graduates by RACP to determine their eligibility for medical registration and eligibility for Fellowship of the RACP.	Policy (Appendix 1A.38) Guidelines (Appendix 1A.39)
Continuing Professional Development Participation Policy	Policy outlines the RACP standards for participation in the MyCPD program for all participants to ensure a high standard of practice through the training and continuing professional development of Fellows and Trainees is established and maintained.	Policy (Appendix 1A.40)
Participation by Fellows in Preparatory Courses for Assessment Policy	Policy articulates RACP's position on Members directly involved in centrally administered summative written and clinical assessments participating in preparatory courses/lectures for these same assessments	Policy (Appendix 1A.41)
Post-Fellowship Specialty Recognition Policy	Policy outlines a framework through which Fellows can be recognised by the RACP in a specialty related to an RACP training program. This is usually for the purpose of supporting an application for specialist registration with the relevant regulatory bodies in Australia or Aotearoa New Zealand.	Policy (Appendix 1A.42) Guide (Appendix 1A.43)

Program changes process

We recognise that an essential part of continuous improvement is the regular review of training program requirements. This helps ensure the College responds appropriately to changes in the regulatory and training environments and delivers better training outcomes.

We have a well-established training program requirements and assessments change process with an accompanying Guide (refer to Appendix 1A.44) for committees which:

- lists the principles that training and assessment committees should follow when recommending changes to training programs
- explains how to assess the potential effects of changes on trainees, supervisors, health services and the College
- outlines the process for consultation, approval, and implementation of changes to training programs.

The Guide supports achievement of three key outcomes:

- **Consistency**. The College oversees more than 60 training pathways, with over 40 supervising committees. Within these programs, candidates take part in several assessments and several RACP administered examinations. The Guide establishes a common mechanism for managing changes to College training programs and assessments.
- **Flexibility**. The environment in which physician training takes place is constantly evolving due to changes in technologies, work practices, increasing trainee numbers, and innovations in medical education. The Guide outlines the processes for adapting training programs and assessments in response to changing training environments.
- **Transparency**. The Guide provides transparency around the College's processes to ensure our training programs and assessments have requirements that are clear, defensible and robust.

Reporting and communication

Reporting between committees and risk escalation are articulated in each education/training committee's Terms of Reference.

Communication between the College Education Committee and relevant education committees is facilitated through its ex-officio membership. The chairs and representatives provide verbal reports to the CEC as a standard agenda item and regularly update their respective committees on education matters, such as the CEC's direct-reporting committees, the Divisions, Chapters and Faculties Councils and Aotearoa New Zealand committees, and the College Trainees' Committee. A triannual communique outlining the progress of the CEC's projects and initiatives is also distributed to these committees.

Further, the CEC actively engages with the Advanced Training Committee chairs through the Advanced Training Forum, which is a key education body with a crucial role in establishing and maintaining alignment across Advanced Training Programs. At the Forum, key discussions are

held regarding policy and program changes from a strategic and operational perspective; standardisation and continuous improvement of training delivery across specialty areas; and adoption of best practice standards in training and assessment.

The RACP is seeking to strengthen these reporting and communication mechanisms and further ensure consistency across Divisions, Faculties and Chapters across both nations through the education governance review by future implementation of standardised reporting templates and processes.

Streamlining our admission to Fellowship procedures

In its Strategic Plan 2022-2024, the CEC identified expanding delegations to staff for straight forward decisions as a strategic priority in improving education governance and member service.

The previous process for confirmation of training program requirements to progress to Fellowship entails staff checking completion of training program requirements, preparing a trainee summary, and then seeking approval from the Chair, delegated member of the relevant training committee or full committee at the next meeting. This process was a compliance exercise and did not require specialty expertise.

In September 2023, the CEC resolved to establish a directive that all Advanced, Faculty and Chapter Training Committees and Subcommittees delegate this process to nominated College staff as determined by the Executive General Manager, Education, Learning and Assessment.

This delegation may extend to straight forward completion of training cases, with complex case management still referred to the Chair, committee delegate or full committee as per established processes. A report of completing trainees will be sent to the relevant committee for noting at each meeting. This process enhancement aims to shorten processing time and reduce committee workload.

Education Committees

Reporting to the respective Division or Faculty Council (DFaC), with a dotted reporting line to the CEC, the role of the four Division (Australian Adult Medicine; Aotearoa New Zealand Adult Medicine; Australian Paediatrics and Child Health; Aotearoa New Zealand Paediatrics and Child Health) and three Faculty Education Committees is to within their own DFaC:

- implement College Education Policy as approved by the CEC
- implement the College's Strategic Direction in relation to education
- ensure standardisation in training delivery
- ensure all forms of assessment are conducted in accordance with College assessment standards
- ensure accreditation is conducted in accordance with College accreditation standards
- advise CEC on education policy and program development for relevant programs
- work collaboratively with Specialty Societies and other key stakeholders on education development and delivery
- monitor training program requirements and curricula, recommending changes to the CEC
- review reports from the Continuing Professional Development Committee and provide feedback and advice, as appropriate
- undertake other functions as required by the relevant DFaC Council or Board approved policy or By-Law. This may include acting as a Review Committee pursuant to the Reconsideration, Review and Appeals Process By-Law (Appendix 1A.45) or reviewing subordinate committee decisions relating to individual trainee or Fellow progress.

Notably, due to the smaller volume of trainees, the two Aotearoa New Zealand Division Education Committees retain the responsibilities that in Australia have been delegated to the Basic Training and Accreditation Subcommittees as outlined below.

Training Committees

Each training program is governed by a training committee, as identified in Figure 13 above. There is some variation in the committee structures across Australia and Aotearoa New Zealand to accommodate the different volumes of trainees and responsibilities.

For Basic Training in Australia, the Paediatrics and Child Health Division Basic Training Committee and Adult Medicine Division Basic Training Committee provide oversight in the implementation of College Education Policy in the Basic Training program nationally. This includes minimum PREP requirements, accreditation, examinations and supervision, working collaboratively with Directors of Physician/Paediatric Education and relevant Aotearoa New Zealand Committees. They are responsible for overseeing and monitoring the progression of Basic Training and approving requests for special consideration.

The terms of reference (example provided in Appendix 1A.46) outline the membership, which includes delegates of the Divisional Written and Clinical Examinations Committees, Site Accreditation Committee, Aotearoa New Zealand Division Education Committee, and a Director of Physician Education from each Australian state/territory and two trainee positions appointed by the College Trainees' Committee. The two committees report to the relevant Division Education Committee.

Advanced Training programs, inclusive of Chapter and Faculty training programs, are overseen by 41 training committees, as outlined in Table 5. Reporting to the relevant Division or Faculty Education Committee, these Training Committees are responsible for the development and implementation of the respective training programs in their geographic remit, in accordance with the curricula and policies of the College Education Committee. They monitor and assess trainee progress, confirm completion of requirements for admission to Fellowship, monitor training and provide support to supervisors, accredit training settings and monitor and review curricula and program requirements including through oversight of Curricula Review Groups established for the training program. Larger programs have both Australian and Aotearoa New Zealand committees working in alignment but with separate reporting lines, mid-sized programs have an Aotearoa New Zealand Subcommittee reporting into the overarching bi-national committee and smaller programs have a single bi-national committee.

Management structures for joint programs are outlined in Standard 2.

Table 5. Education and Training Committees and associated programs

Name	Programs	Geographic remit
Education Committees		
Adult Medicine Division Education Committee (Australia)	All Adult Medicine programs, inclusive of Chapter programs	Australia
Paediatrics & Child Health Division Education Committee (Australia)	All Paediatrics and Child Health programs, inclusive of Chapter programs	Australia
Aotearoa NZ Adult Medicine Division Education Committee	All Adult Medicine programs, inclusive of Chapter programs	Aotearoa NZ
Aotearoa NZ Paediatrics & Child Health Division Education Committee	All Paediatrics and Child Health programs, inclusive of Chapter programs	Aotearoa NZ
Australasian Faculty of Occupational & Environmental Medicine Education Committee	Occupational & Environmental Medicine training	Australia and Aotearoa NZ
Australasian Faculty of Public Health Medicine Education Committee	Public Health Medicine training	Australia and Aotearoa NZ

Name	Programs	Geographic remit
Australasian Faculty of Rehabilitation Medicine Education Committee	Rehabilitation Medicine training	Australia and Aotearoa NZ
Basic Training Committees		
Basic Training Committee in Adult Internal Medicine	Adult Medicine Basic Training	Australia
Basic Training Committee in Paediatrics and Child Health	Paediatrics and Child Health Basic Training	Australia
Advanced Training Committees		
Advanced Training Committee in Cardiology	Advanced Training in Cardiology	Australia (and Aotearoa NZ)
Aotearoa NZ Advanced Training Subcommittee in Cardiology	Advanced Training in Cardiology	Aotearoa NZ
Advanced Training Committee in Clinical Genetics	Advanced Training in Clinical Genetics	Australia and Aotearoa NZ
Advanced Training Committee in Clinical Pharmacology	Advanced Training in Clinical Pharmacology	Australia and Aotearoa NZ
Advanced Training Committee in Community Child Health	Advanced Training in Community Child Health	Australia and Aotearoa NZ
Aotearoa NZ Advanced Training Committee in Dermatology	Advanced Training in Dermatology	Aotearoa NZ
Advanced Training Committee in Endocrinology	Advanced Training in Endocrinology	Australia (and Aotearoa NZ)
Aotearoa NZ Advanced Training Subcommittee in Endocrinology	Advanced Training in Endocrinology	Aotearoa NZ
Advanced Training Committee in Gastroenterology	Advanced Training in Gastroenterology	Australia (and Aotearoa NZ)
Aotearoa NZ Advanced Training Subcommittee in Gastroenterology	Advanced Training in Gastroenterology	Aotearoa NZ
Advanced Training Committee in General and Acute Care Medicine (AU)	Advanced Training in General and Acute Care Medicine	Australia
Aotearoa New Zealand Advanced Training Committee in General and Acute Care Medicine	Advanced Training in General and Acute Care Medicine	Aotearoa NZ
Advanced Training Committee in General Paediatrics (AU)	Advanced Training in General Paediatrics	Australia
Aotearoa New Zealand Advanced Training Committee in General Paediatrics	Advanced Training in General Paediatrics	Aotearoa NZ
Advanced Training Committee in Geriatric Medicine	Advanced Training in Geriatric Medicine	Australia (and Aotearoa NZ)
Aotearoa NZ Advanced Training Subcommittee in Geriatric Medicine	Advanced Training in Geriatric Medicine	Aotearoa NZ
Advanced Training Committee in Infectious Diseases	Advanced Training in Infectious Diseases	Australia (and Aotearoa NZ)
Aotearoa NZ Advanced Training Subcommittee in Infectious Diseases	Advanced Training in Infectious Diseases	Aotearoa NZ
Advanced Training Committee in Medical Oncology	Advanced Training in Medical Oncology	Australia (and Aotearoa NZ)
Aotearoa NZ Advanced Training Subcommittee in Medical Oncology	Advanced Training in Medical Oncology	Aotearoa NZ
Advanced Training Committee in Neonatal/Perinatal Medicine	Advanced Training in Neonatal/Perinatal Medicine	Australia and Aotearoa NZ
Advanced Training Committee in Nephrology	Advanced Training in Nephrology	Australia (and Aotearoa NZ)
Aotearoa NZ Advanced Training Subcommittee in Nephrology	Advanced Training in Nephrology	Aotearoa NZ
Advanced Training Committee in Neurology	Advanced Training in Neurology	Australia and Aotearoa NZ

Name	Programs	Geographic remit
Advanced Training Committee in Respiratory and Sleep Medicine	Advanced Training in Respiratory Medicine; Advanced Training in Sleep Medicine	Australia (and Aotearoa NZ)
Aotearoa NZ Advanced Training Subcommittee in Respiratory and Sleep Medicine	Advanced Training in Respiratory Medicine; Advanced Training in Sleep Medicine	Aotearoa NZ
Advanced Training Committee in Rheumatology	Advanced Training in Rheumatology	Australia and Aotearoa NZ
Chapter Training Committees		
Training Committee in Addiction Medicine	Addiction Medicine – Chapter Training	Australia and Aotearoa NZ
Training Committee in Palliative Medicine	Palliative Medicine- Chapter Training; Advanced Training in Palliative Medicine; Clinical Foundations (previously Diploma) in Palliative Medicine	Australia and Aotearoa NZ
Training Committee in Sexual Health Medicine	Sexual Health Medicine– Chapter Training	Australia and Aotearoa NZ
Faculty Training Committees		
Faculty Paediatric Training and Assessment Committee in Rehabilitation Medicine	Paediatric Rehabilitation Medicine Training	Australia and Aotearoa NZ
Faculty Training Committee in Occupational and Environmental Medicine	Occupational and Environmental Medicine – Faculty Training	Australia and Aotearoa NZ
Faculty Training Committee in Public Health Medicine	Public Health Medicine- Faculty Training	Australia and Aotearoa NZ
Faculty Training Committee in Rehabilitation Medicine	General Rehabilitation Medicine – Faculty Training	Australia and Aotearoa NZ
Joint College Training Committees		
Committee for Joint College Training in Endocrinology and Chemical Pathology	Joint Training in Endocrinology and Chemical Pathology	Australia and Aotearoa NZ
Committee for Joint College Training in Haematology	Advanced Training in Clinical Haematology; Joint Training in Haematology	Australia and Aotearoa NZ
Aotearoa New Zealand Joint College Training Subcommittee in Haematology	Advanced Training in Clinical Haematology; Joint Training in Haematology	Australia and Aotearoa NZ
Committee for Joint College Training in Immunology & Allergy	Advanced Training in Clinical Immunology and Allergy; Joint Training in Immunology and Allergy	Australia and Aotearoa NZ
Committee for Joint College Training in Infectious Diseases & Microbiology	Advanced Training in Infectious Diseases; Joint Training in Infectious Diseases and Microbiology	Australia and Aotearoa NZ
Committee for Joint College Training in Nuclear Medicine	Advanced Training in Nuclear Medicine (including stream open to RANZCR trainees)	Australia and Aotearoa NZ
Committee for Joint College Training in Paediatric Emergency Medicine	Advanced Training in Paediatric Emergency Medicine (including stream open to ACEM trainees)	Australia and Aotearoa NZ

Knowledge and expertise underpinning education governance structures

In addition to specialty expertise, stage of professional development and geographic representation, which are hallmarks of our member governance structure, our education governance structure is further strengthened with a suite of additional specialist knowledge and

expertise. This mapping is primarily blueprinted using committee terms of reference and monitored via our skills and experience registers, as outlined in Standard 1.1.

- **Knowledge and expertise in medical education**- our peak bodies with specialist expertise in medical education are the College Education Committee, College Assessment Committee and Curricula Advisory Group. Members of these committees are appointed on merit, with reference to their possession of the relevant medical education expertise and experience to discharge the responsibilities of the body as defined in the relevant By-Laws/Terms of Reference, as stipulated in the Governance of College Bodies By-Law. For example:
    - The Curriculum Advisory Group (Appendix 1A.47) is composed of appointed individuals with 'interest and expertise in curricula development'. Members include those with professorial, Fellow, senior lecturer and executive roles in medical schools/education institutions, and together hold MDs, PhDs, Masters and Graduate Certificates pertaining to medical education, along with significant practical experience as educators.
    - The College Education Committee has a position for an appointed member with specialist skills in Education and Training. This is currently Dr Chloë-Maryse Baxter. She completed the Master of Health Professions Education at Maastricht University in 2003 and is a Professional Practice tutor at Melbourne University.
    - The College Assessment Committee is Chaired by the College Censor (Appendix 1A.48), a senior Fellow with assessment credentials and/or significant experience in assessment and appointed on merit through an expression of interest process. Dr Mike Tweed took up this position in 2023, bringing his expertise in assessment practice and research. He extends upon the pioneering work of Professor Tim Wilkinson, who was the inaugural incumbent in this position.

  In addition to the expertise brought by members of these groups, we also recognise that individuals on other committees bring substantial practical experience and academic expertise to their work, many of them having long histories of contributions such as through educational leadership and examination activities.
- **Knowledge and expertise in national health priorities and regulatory requirements**- by virtue of merit-based appointments, members of our College Bodies commonly hold leadership positions in health services across a range of jurisdictions, reflecting a wide range of knowledge and expertise regarding national health priorities. This expertise is further bolstered through regular consultation through our College Council, and by extension our College Policy and Advocacy Committee. For key topical activities, we form working or reference groups to guide our activity. For example:
    - The College formed a reference group to inform the RACP's participation and response to Public Hearing 10 of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.
    - The College formed a COVID-19 Training and Accreditation Advisory Group and COVID-19 Examinations Advisory Group. With management, these groups worked extensively with Chief Health Officers, state and territory departments of health and vocational training councils (Australia) and Chief Medical Officers and representatives from the Ministry of Health (Aotearoa New Zealand) during the COVID-19 pandemic to guide and adapt our education programs' pandemic response.

- **Knowledge of local and national needs in healthcare and service delivery-**
    - Our College Dean sits on the College Education Committee and regularly participates in Australian and Aotearoa New Zealand health workforce strategic initiatives, including contributing to the Australian National Medical Workforce Strategy and Te Whatu Ora's health workforce planning.
    - A member of the Consumer Advisory Committee sits upon the College Education Committee, ensuring that the consumer voice is represented in education strategy and frameworks.
    - Our Directors of Physician/Paediatric Education are a key group that have local knowledge of healthcare and service delivery, and regularly meet in state/territory (Australia) and national levels (Australia and Aotearoa) to identify and address local common challenges. These discussions are raised with respective parent committees for further action as required.
    - Indigenous equity, health and cultural safety – refer to our updates on Indigenous leadership in Standard 1.6.4.

Future directions for education governance

The Education Governance Working Group (EGWG) was formed in early 2023 to lead the Education Governance Review, under the auspices of the RACP Board. The aim of the review is to develop and implement a contemporary education governance and reporting structure that aligns with College values, prioritises effective decision-making and timely communication, and improves the member experience.

Co-chaired by the RACP President and Executive General Manager, ELA, the EGWG has made good progress as follows:

- June 2023 – Survey sent to education committee chairs for feedback on current governance structure and ideas for improvements.
- July 2023 – Design principles developed by EGWG and consulted on with Advanced Training (AT) committee chairs at the AT Forum.
- August 2023 – Vision and proposed state of governance developed and refined by the EGWG.
- September 2023 – EGWG endorsed the proposed state of governance to progress towards consultation.
- November 2023 – CEC endorsed the progression to consultation of the proposed state of governance. AT committee chairs were consulted at the AT Forum on 21 November 2023. Feedback received will inform the iterations on the proposed state of governance.

Committee and staff consultations will progress until March 2024, with a view to submit an education governance proposal to the Board in Q2 2024. Subject to the Board approval, implementation will commence from Q4 2024 and onwards.

Vision for the future state of education governance

The future state vision we are aiming to achieve through our Education Governance Review is:

The committee structure is simple, efficient and organised by education function reducing duplication and promoting harmonisation of programs. Largely bi-national committees share good practice and recognise contextual differences with a balanced member representation for Australia and Aotearoa.

The voices of our diverse stakeholder groups are heard and inform decision-making through representation and consultation (Trainees, Fellows, Divisions, Faculties and Chapters, Indigenous Committees, and Specialty Societies).

Emerging risks and issues are efficiently escalated and visible to the peak education committee and Board and there is effective performance monitoring of all our education programs.

There are clear terms of reference and a comprehensive delegation schedule articulating the committee, committee member or staff position responsible for all our education functions. Functions that do not require member expertise are delegated to College staff enabling faster decision-making and processing.

Member and staff contributions are rewarding and an effective use of time and expertise. Less member volunteer and College staff time is needed to support education governance. Operating costs are minimised.

Members are highly satisfied with the speed and rigour of decisions and responses to queries, applications and concerns. They understand how education is governed and decisions are made.

In parallel to education committee structural reform, new technology will enable further improvements to education governance and member service.

A collaborative approach to consultation

To ensure a collaborative stakeholder approach, preliminary meetings were held with select RACP staff and committee representatives from the Divisions, Faculties, Chapters Councils and Aotearoa New Zealand committees. Their feedback contributed to the development and refinement of the EGWG's proposed state of governance. Formal consultation commenced with the CEC in early November 2023, and the CEC endorsed progression to wider committee consultation. On 21 November 2023, the proposed governance model was discussed at the Advanced Training Forum to inform further iterations to the model.

Broad consultation is continuing until March 2024, with approximately 110 committees across the College including education and training committees from Aotearoa New Zealand and Australia, committees from Divisions, Faculties, Chapters Councils and Aotearoa New Zealand Committees, College Trainees' Committee, Māori Health Committee, and Aboriginal and Torres Strait Islander Health Committee, and Consumer Advisory Group. This approach ensures that the final governance proposal incorporates balanced representation of our diverse stakeholder while addressing their key needs and concerns regarding our trainees and Fellows. We are determined to align the consultation process with the College's strategic priorities and to ensure that we address the concerns raised by the AMC in its response to the RACP's 2023 Monitoring Submission.

1.3 Reconsideration, review and appeals processes

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

Reconsideration, review and appeals process by-law (1.3.1)

Our Reconsideration, Review and Appeals Process By-law (Appendix 1A.45) sets out our three-stage internal process for reassessment of specified decisions made by College Bodies. The three stages are:

1. Reconsideration- by the same body that made the Decision.
2. Review- by the College Body that oversees the College Body that made the Decision. An application for Review can be made without first seeking Reconsideration.
3. Appeal- to an Appeals Committee appointed by the Board. The membership of the Appeals Committee is determined specifically for each appeal, although the committee always includes a Fellow of the College and a member of the legal profession.

Decisions are reassessed through these stages 'on the merits', meaning that the decision maker is required to reassess all of the facts and circumstances relating to the decision, including any new material, and make a new decision.

Following the release of the National Health Practitioner Ombudsman's recommendations, we are working to ensure our training setting accreditation and Overseas Trained Physician Reconsideration, Review and Appeals Process activities are aligned. Refer to Standards 8 and 9 for further details.

Communication

The RRA Process By-law is provided on the RACP website, along with application forms and Frequently Asked Questions (Appendix 1A.49). Correspondence issued as part of RRA activities, such as decision letters in each stage of the process reiterate available provisions.

Costs

RRA application costs are determined on a cost recovery basis. Applying for a reconsideration is free. In 2023, applying for a review incurs a fee of $1,199AUD / $1,253.50NZD. Applying for an appeal incurs a fee of $7,180AUD / $7,506.36 NZD. Fee waiver opportunities are available for those with special circumstances.

Applications and outcomes

Table 6 provides the number of reconsideration, review and appeals heard within the last three years, the reason for the requests and the outcomes.

Table 6. Requests for reconsideration, review and appeals

	2020			2021			2022		
	# received	# upheld	# dismissed	# received	# upheld	# dismissed	# received	# upheld	# dismissed
Reconsideration									
Approval/certification of training	62	23	40	77	41	36	44	22	22
Assessment – Research Project	0	0	0	3	3	0	0	0	0
Recognition of Prior Learning	8	5	3	10	7	3	5	2	3
Training Setting Accreditation	5	4	1	2	1	1	8	2	6
OTP assessment	12	8	4	13	11	2	13	7	6
Total	**87**	**40**	**48**	**105**	**63**	**42**	**60**	**33**	**37**
Review									
Approval/certification of training	8	4	4	9	5	4	3	2	1
Assessment – Research Project	0	0	0	0	0	0	1	0	1
Recognition of Prior Learning	0	0	0	1	1	0	1	0	1
Training Setting Accreditation	3	3	0	0	0	0	0	0	0
OTP assessment	2	0	2	5	2	3	0	0	0
Total	**13**	**7**	**6**	**15**	**8**	**7**	**5**	**2**	**3**
Appeal									
Approval/certification of training	1	0	1	1	1	0	1	1	0
Assessment – Research Project	0	0	0	0	0	0	0	0	0
Recognition of Prior Learning	0	0	0	0	0	0	0	0	0
Training Setting Accreditation	0	0	0	0	0	0	0	0	0
OTP assessment	0	0	0	0	0	0	0	0	0
Total	**1**	**0**	**1**	**1**	**1**	**0**	**1**	**1**	**0**

Upheld= decision affirmed ie. request not granted
Dismissed= decision varied ie. partial/full request granted

Monitoring and improvement in response to complaints and appeals (1.3.2)

Appeals committees provide reports directly to the College Board including recommendations for further investigation into possible system problems or identified opportunities for system improvements. The Board may delegate further investigation of deidentified appeals issues to the College Education Committee or other appropriate College Body to report back on issues with recommendations.

The RACP's Complaint Management Policy and Procedure (Appendix 1A.50) makes provision for the management of anonymous complaints that do not otherwise fall under other designated College policies, and notes the course of action taken is dependent on the information that has been provided by the complainant. Information about all complaints received by the RACP is regularly reported to the Senior Leadership Team, Finance and Risk Management Committee and the RACP Board. The reporting is de-identified and includes the following information:

- Volume of complaints received by member type i.e., OTP, trainees, supervisors
- Median resolution timeframe for complaint management
- Key themes for complaints

- Commentary about the key themes and actions being taken to address these (may be a process or system change or informs a new project)
- Potential risk impact of complaint key themes.

The roles, responsibilities and accountabilities section of the policy makes clear the committees and staff responsible for reviewing reports on feedback and complaints and where appropriate, implementing improvements to products, services, and delivery. For example, changes have been made to the Special Consideration for Assessment procedure relating to the Divisional Clinical Examinations (DCE) as a result of trainee complaints:

- Trainees reported that they were unaware of the five-day timeframe to submit an Application for Special Consideration for Assessment after their examination. The DCE application form has been updated to include information on this process and trainees must declare their awareness of the policy and process upon application.
- Trainee complaints indicated that the five-day timeframe to submit an Application for Special Consideration after an examination was insufficient. This is now under review with a policy amendment to extend the timeframe planned in 2024.

Complaints regarding the RRA process can be lodged via the Complaint Management Policy and Procedure. To date, no complaints have been lodged.

1.4 Educational expertise and exchange

AMC accreditation standards:	
1.4.1	The education provider uses educational expertise in the development, management and continuous improvement of its training and education functions
1.4.2	The education provider collaborates with other educational institutions and compares its curriculum, specialist medical program and assessment with that of other relevant programs

Drawing on our strengths to work together (1.4.1)

Standard 1.2 outlines the educational expertise our members bring to our education governance structures. In addition to this, we have a wide range of employed staff who possess the relevant skills and expertise to perform their functions, we have leadership with significant industry experience leading large-scale education and strategic initiatives and have more recently piloted new models of working to secure rapid specialty expertise, as outlined below.

Academic and industry leadership

We are fortunate to have two practising physicians in our Senior Leadership Team, Professor Inam Haq and A/Professor Kudzai Kanhutu.

Prior to joining the RACP in January 2023 as Executive General Manager, Education, Learning and Assessment, Professor Haq worked at the University of Sydney in the role of inaugural Associate Dean of Education at the Faculty of Medicine and Health. He has deep and broad experience in medical education, having merged five faculties of health into one, and bringing people together from different cultures and ways of working over four years.

As a Rheumatologist, Professor Haq has a strong understanding of the health system and the expectations of members and has been able to apply this through his leadership at the College.

Prof Haq is also a member of the AMC Medical School Accreditation Committee and has led accreditation visits to Medical Schools and specialist medical colleges.

A/Professor Kudzai Kanhutu MBBS (Hons) BA BSc MPH EMBA FRACP GAICD, the College Dean, is an Infectious Diseases physician. A/Professor Kanhutu applies her special research interests in public health policy, economics and digital innovation to the benefit of a wide range of College activities. She represents the RACP at the National Medical Workforce Reform Advisory Council and is a Ministerial appointee to the Australian Multicultural Council.

As outlined in Standard 1.6.4, we have several senior appointments to Indigenous leadership positions that add strength to our education functions.

In alignment with the College's strategic priorities, our new CEO Lee Whitney, brings significant technology leadership and strategy experience, bolstering our executive leadership to deliver our strategic program of education renewal.

We have several other key staff with doctoral qualifications in medical education fields, including Dr Louise Rigby, Executive General Manager, Professional Practice, Dr Imogene Rothnie, Research and Evaluation Lead and acting Psychometrician, Dr Sarah Champion, Senior Executive Officer, Digital Learning, and Dr Philip Munro, Manager, Peak Bodies.

As discussed in Standard 1.2, numerous members of our College Bodies have academic and industry appointments and qualifications related to medical education.

Evidence-based practice

Notwithstanding our in-house and committee-based expertise in medical education, we underpin College initiatives through robust appraisal of contemporary evidence bases, appropriately contextualised to RACP environments. Staff have access to current journals and use both grey literature and peer-reviewed publications to inform the development, management and continuous improvement of its training and education functions. See Standard 1.7 for an example of our use of evidence in the development of a discussion paper on AI in Medical Education.

An appropriately skilled RACP team

Working in partnership with members, we have a wide range of staff with relevant expertise in the development, management and continuous improvement of our training and education functions. Staff are appointed based on their experience and qualifications, as relevant to the role and offered appropriate development opportunities.

Bringing in external expertise as required

When not available in house, or when an independent perspective is required, through a robust procurement process, the RACP contracts third party providers for specific activities. For example, we have used KPMG to conduct reviews of our computer-based examination functions (see Standard 5) and in helping College develop and define high-level requirements for its education technology infrastructure.

In 2023, we piloted the use of specialist contractors to support expediting our Advanced Training Curricula Renewal project. See Standard 3 for details.

Working across the field (1.4.2)

We are longstanding members of the Tri-Nations Alliance of Specialist Medical Colleges from Australia, Aotearoa New Zealand and Canada. Through this, we contribute to the International

Medical Symposium which has now been running for nine years. In 2023, the theme for this was Providing equitable care to all our communities (Appendix A.51).

Another example of an international collaboration is the trip the RACP President undertook in July 2022 to England and Ireland to build connections with medical colleges and colleagues. During that visit, the RACP President met with Presidents or Presidents-elect and other leaders at the Royal College of Physicians and the Royal College of Physicians of Ireland, and the Royal College of Paediatrics and Child Health. During the visit, issues in common were discussed including:

- medical specialist burnout and wellbeing
- the importance of lifelong education and training in an ever-changing medical world
- health inequities and discrimination in health services, especially racial discrimination
- integrated and new models of innovative care
- climate change and heath
- investing in generalist training
- the importance of building community through our medical colleges.

As further outlined in Standard 8.1, we have established collaborative relationships with Training Providers and health departments on educational matters. We also work closely with Directors of Physician/Paediatric Education (DPEs) and Network DPEs. This includes hosting regular fora with them to seek their perspectives. Each year we host state-based meetings of DPEs, a meeting of DPEs in Aotearoa New Zealand and a meeting of Directors of Paediatric Education.

We collaborate with other providers of specialist medical programs, through CPMC meetings and manager participation in cross-College networks.

We provide an update on our relationship with specialty societies in Standard 1.2.

We provide an update on our work with Indigenous health and education organisations in Standard 1.6.4.

The RACP has presented at numerous local and international medical education related conferences, as outlined in Standard 6.3.2.

Keeping pace with best practice (1.4.2)

Significant changes made to our curricula and training programs have been detailed in Standards 2 and 3. These changes have been informed by appraisal of the RACP curricula with those of other relevant local and international programs.

1.5 Educational resources

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

As outlined in Standard 1.1, we have an established RACP team with assigned management capacity to sustain and deliver our training and education functions. As outlined in Standard 1.2, this team works closely with our education and training committees.

We use a College-wide prioritisation process each year when developing annual operating plans and budgets to ensure that resources are directed to priority outcomes. This is described in Standard 1.1.

Resourcing was challenged throughout the peak of the COVID-19 pandemic, particularly in high volume operational teams such as the Training Services team. Significant backlogs contributed to delays in trainees receiving responses to enquiries. Leadership in this team has worked to stabilise resourcing and shifted turnover rates from 31% in July 2022 to 11.7% in December 2023. This stabilising, combined with process improvements, information sharing, technology add-ins and team training has resulted in improved response timelines and communication quality to members.

As outlined in Standard 1.1, we have shifted our education technology solution to support implementation of our new training programs. We are working thoroughly and rapidly to expedite this solution.

As outlined in Standard 3, we have invested in resourcing and expedited processes to deliver our Curricula Renewal program. This includes enhancing the College's specialist expertise, through the use of Specialist Contractors paid an honorarium fee.

Our Fees and benchmarking report to members, 2022 (Appendix 1A.52), provides an analysis of how member fees are used by the RACP, including to support salaries and wages and committee operating costs. As shown in Figure 15, relative to other specialist medical colleges, the RACP directs a moderate budget towards people and resources (wages) costs. Figure 16 depicts the expenditure on Information Technology, illustrating that in 2022/2023 the RACP spent a relatively small amount on IT. Recent decisions to invest in technology will change this balance.

Figure 15. People and Resources Costs (wages) per Member 2021

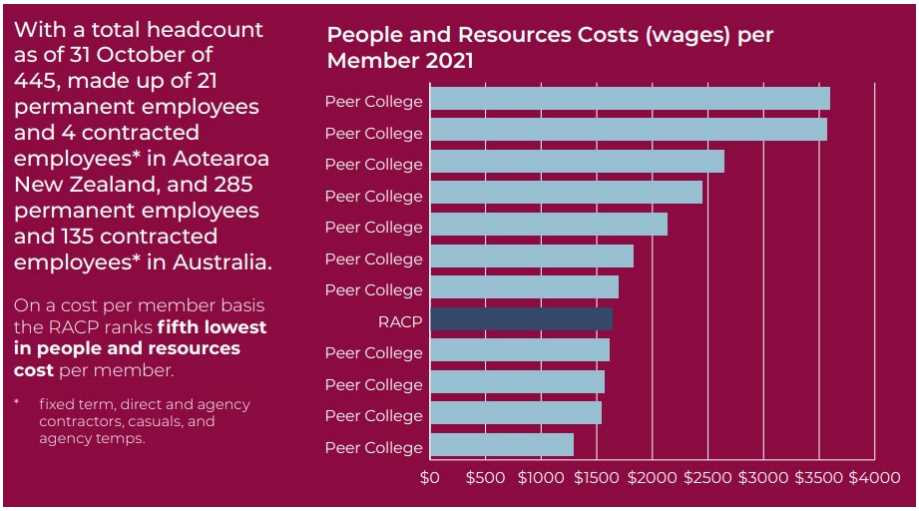
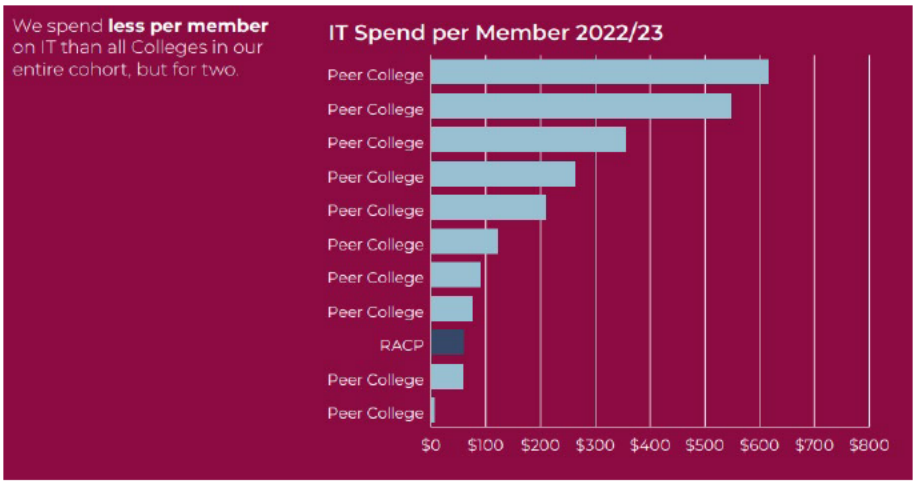


Figure 16. IT Spend per Member 2022/23



1.6 Interaction with the health sector

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

Working with jurisdictions, government and community agencies (1.6.1 and 1.6.3)

Standards 5 and 8 provide updates on how we work with jurisdictions and government for examination delivery and work-based training, supervision and educational leadership, respectively.

We describe our relationships with organisations in the Indigenous health sector in Standard 1.6.4.

We work closely with the Australian Government Department of Health and Aged Care on the following training and education related matters, amongst other things:

- deliver the Specialist Training Program (Appendix 1A.53), including FATES, Integrated Rural Pipeline Initiative and Tasmanian Project and other associated programs.
- refine and deliver the National Medical Workforce Strategy 2021-2031
- annual reporting regarding the National Roadmap for Improving the Health of People with Intellectual Disability (Appendix 1A.54)

- Australian Digital Health Agency on delivery of the Australian Digital Health Capability Framework
- participation in national research and health systems improvement projects. e.g. Quality use of Medicines Program.

We also contributed to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Appendix 1A.55), through submissions, expert witness appearances, responses and updates in regards to Public Hearing 10 (Appendix 1A.56) which concerned the education and training of health professionals in relation to people with cognitive disability, and subsequent related activities.

We provide an update on our work with prevocational training councils in Standard 3.3.1 and have been actively supporting the National Framework for Prevocational Medical Training through consultation input and integrated implementation with RACP programs.

Our work with consumers through our Consumer Advisory Group is described in Standard 3.2.4.

Partnering with training settings and clinicians (1.6.2-1.6.3)

Standard 8 provides comprehensive updates on how we work with Training Providers and clinicians to deliver quality work-based training, educational leadership and supervision, with consideration of capacity to train, patient safety and addressing healthcare needs.

We discuss our work with training settings to promote trainee welfare in Standard 7.

Regional, rural and remote physician strategy (1.6.1-1.6.4)

In 2020, the College Council developed a vision to achieve equitable health outcomes for Australians and Aotearoa New Zealanders living in regional and rural locations, approved by the College Board in 2020:

> *"The RACP commits to achieving equitable health outcomes for Australians and New Zealanders living in regional and rural locations by prioritising, advocating, and supporting regional and rural workforce and training initiatives.*
>
> *One means of achieving this will be to facilitate collaboration between governments, employers and the College to increase the number of high quality, well-resourced and attractive accredited training settings and training positions in regional and rural locations so that trainees competitively seek these and consider remaining in these settings following the completion of their training."*

A Rural and Regional Physicians Working Group (RRPWG) (see here for Terms of Reference (Appendix 1A.57)) was established under the College Council to:

- consider options for strategies to advance the College Council's vision statement
- develop a project plan to advance the College Council's vision statement
- ensure appropriate consultation with relevant external and internal stakeholders such as, but not limited to, the College Education Committee and the College Trainees Committee, in developing the project plan
- present recommendations to the College Council for endorsement prior to presentation to the College Board for approval.

The Regional, Rural and Remote Physician Strategy (RRRP Strategy) (Appendix 1A.58) was endorsed by the College Council and approved by the RACP Board in June 2023.

The RACP's Indigenous Strategic Framework (see update below), the [Australian] National Medical Workforce Strategy and Te Whatu Ora workforce strategies were considered in development of the RRRP Strategy. Principles, developed by Ostini, O'Sullivan, and Strasser[3] guided the development and structure of the RRPWG strategy and recommendations. These principles include:

1. Grow your own "connected to" place.
2. Select trainees invested in rural practice.
3. Ground training in community need
4. Rural immersion — not exposure.
5. Optimise and invest in general medicine.
6. Include service and academic learning components.
7. Join up the steps in rural training.
8. Plan sustainable specialist roles.

The 26 recommendations are grouped within the following focus areas:

- prioritise regional, rural, and remote (RRR) healthcare at the RACP
- build capacity and capability to provide physician training in RRR areas
- improve the attraction and retention of RRR physicians
- collaborate to improve RRR healthcare provision
- respect, promote and acknowledge Indigenous peoples.

A draft implementation plan structure is currently being developed and the RRPWG will continue to identify relevant action steps. It is anticipated that it will be brought to the College Council for endorsement in Q2 2024, before being referred to the Board for approval.

Indigenous initiatives and collaborations (1.6.4)

The RACP acknowledges the distinct histories, cultures, roles and responsibilities of Australian Aboriginal and Torres Strait Islander peoples and Māori of Aotearoa New Zealand. In this document Indigenous is used when referring to these groups collectively, otherwise, the terms "Aboriginal and /or Torres Strait Islander peoples" and "Māori" will be used.

We have a range of established and new initiatives in place to progress health, social justice and equity for Indigenous peoples as outlined in the sections below.

Indigenous Health enshrined in the College's Constitution

As outlined in Standard 1.1, on 5 May 2023, RACP members voted to include an Indigenous Object in the College's Constitution. The Indigenous Object reaffirms and embeds the RACP's ongoing commitment to supporting Indigenous aspirations and outcomes in Australia and Aotearoa New Zealand. Object 1.1.9 of the RACP Constitution now provides that the College will demonstrate commitment to Indigenous aspirations and outcomes by:

[3] Ostini R, O'Sullivan B, Strasser S. Principles to guide training and professional support for a sustainable rural specialist physician workforce. Med J Aust 2021; 215 (1 Suppl): S29–S33

a. Respecting and promoting the principles of the Uluru Statement from the Heart, Te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples.
b. Advancing justice and equity in health care for Aboriginal and Torres Strait Islander and Māori communities; and
c. Acknowledging the world views, protocols, and cultures of Aboriginal and Torres Strait Islander peoples and Māori.

The Indigenous Object also provides a strong foundation to continue to implement strategic priorities under the Indigenous Strategic Framework 2018 - 2028 (ISF) (Appendix 1A.59).

Indigenous Strategic Framework 2018 – 2028

The RACP is committed to improving Indigenous health and education equity through the College's ISF and embedding its priorities across all levels of RACP governance and operations as core business of the College.

The ISF outlines the College's commitment to develop and implement initiatives that improve health outcomes for Aboriginal and / or Torres Strait Islander peoples and Māori. It was developed in close consultation with the Aboriginal and Torres Strait Islander Health Committee (ATSIHC), the Māori Health Committee, the RACP Board and leading Indigenous health organisations in Australia and Aotearoa New Zealand. The ISF aligns with the College's vision and values under its Strategic Plan 2022 – 2026 (Appendix 1A.60).

The RACP recognises the adverse impacts of colonisation, and ongoing colonialism, on the physical, emotional, and spiritual health and wellbeing of Aboriginal and Torres Strait Islander peoples and Māori– the legacy of which has led to unacceptable gaps in life expectancy and health outcomes in both jurisdictions. The RACP also recognises that to effectively address health inequity, strategic initiatives need to be self-determined, and grounded in Indigenous aspirations and priorities.

There are five strategic priorities under the ISF, which include:

1. Contribute to addressing Indigenous health equity differences.
2. Grow the Indigenous physician workforce.
3. Equip and educate the broader physician workforce to improve Indigenous health.
4. Foster a culturally safe and competent College.
5. Meet the new regulatory standards and requirements of the AMC and MCNZ.

The College's Strategic Plan also calls for Indigenous representation in College Leadership to reflect the voices of Indigenous people at the highest possible level of discussions and decision-making processes.

The ISF supports the RACP in reflecting on what's needed to shape a College, a physician workforce, and health system that values and encompasses Indigenous perspectives on health and wellbeing. It also provides an opportunity to ensure we are effective in our work to bring about an Australia and Aotearoa New Zealand that honours and draws on Indigenous cultures, knowledge and histories; that roots out and does not tolerate racism or discrimination; and drives equitable access to healthcare through incorporating the social determinants of health leads better health outcomes for Aboriginal and/or Torres Strait Islander peoples and Māori and more employment opportunities for Indigenous physicians across healthcare systems.

The Aboriginal and Torres Strait Islander (ASTIHC) and Māori Health (MHC) Committees provide leadership – together with the cultural, clinical knowledge and expertise – to strategically direct

and coordinate College efforts to promote and support Indigenous health equity. This is critical to achieving outcomes under the ISF.

Under the leadership of these Committees, the College continues to pursue a cross-college reform process to strengthen its commitment to equity for all Indigenous peoples in Australia and Aotearoa New Zealand.

The College plans to review the ISF in 2024. A key reason for the review is the amendment of the RACP Constitution to include an Indigenous Object, as well as external events (e.g. political and socio-cultural). It is important that the Framework continues to reflect the current governance and health contexts in both Australia and Aotearoa New Zealand. The 2024 review will be carried out in close consultation with ATSIHC, the MHC, and the ISF Steering Group.

ISF Leadership

As of 2023, the ISF SG produces quarterly reports in addition to an annual report to the Senior Leadership Team and the Board. ISF Reporting is used to monitor key activities and initiatives that support the implementation of the strategic priorities in, and external to, the College. This also enables the RACP to identify key areas of strength and areas for improvement to ensure the College remains on track to achieving critical success factors under the ISF. The proposed 2024 review of the ISF will include a review of the ISF SG's terms of reference, membership, and reporting structures.

ISF activities

Activities undertaken to support the implementation of ISF strategic priorities, include (but are not limited to) are summarised in Figures 17 and 18.

Work is also underway to develop a 'live' dashboard, where departments from across the College can input information about activities undertaken to support the implementation of ISF strategic priorities. The College hopes to complete this work in 2024.

Figure 17. Summary of ISF activities

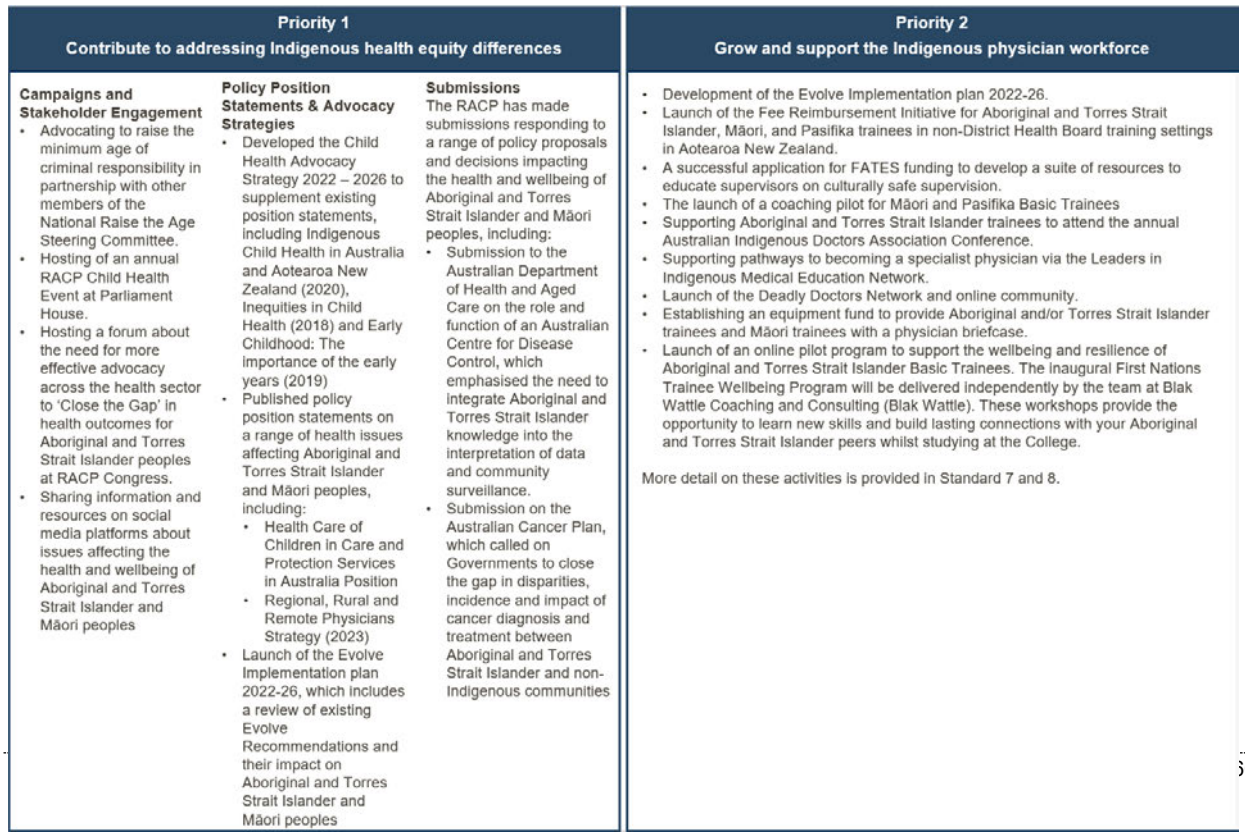


Figure 18. Summary of ISF activities, continued

Priority 3 Equip and educate the broader physician workforce to improve Indigenous health	Priority 4 Foster a Culturally Safe and Competent College	Priority 5 Meet the new regulatory standards and requirements of the AMC and MCNZ
• Incorporating Indigenous health content and cultural competency into RACP training curricula, supervisor training programs, and CPD programs. • Advocating for opportunities for non-Indigenous physician workforce to undertake placements in areas with significant Indigenous populations. • New Fellow Welcome Packs amended to include information and links to the ISF, Medical Specialist Access Framework, College Pomegranate series relevant to Indigenous health and the Aboriginal and Torres Strait Islander and the Māori Cultural Safety Curated Resources Collection.	• Amendment of the RACP Constitution to include an Indigenous Object • Development of a draft Indigenous Data Governance Framework to support the collection and quality of Indigenous identity data, which will enable the MHC and ATSIHC to exercise good governance over their respective member data and fulfill the strategic priorities of the ISF. • Inclusion of mutual benefits of procurement from Aboriginal and Torres Strait Islander owned businesses in the College procurement training modules. • Identification of Aboriginal and Torres Strait Islander businesses in the College's approved supplier list so that staff are aware when selecting a supplier to purchase. • Supply Nation training sessions on the Indigenous Business Directory and Member Opportunity Board.	• Adoption of the MCNZ's definition of cultural safety. • Implementation of the 2023 MyCPD Framework, which includes an emphasis on embedding cultural safety into CPD activities. • Improving member access to the RACP's online Cultural Safety Module: The Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence and Cultural Safety training. • Partnering with the Australian Indigenous Doctors' Association when possible, to build cultural safety capability. • MyCPD system enables members to develop an understanding of how they can embed cultural safety into their professional development activities. • Development of a data collection statement and a data usage statement for AMC regulatory reporting purposes.

Relationships with agencies to support specialist medical education and training that includes the educational expertise of Indigenous people (1.6.4)

The RACP works with a range of internal and external stakeholders across health sectors in Australia and Aotearoa New Zealand to facilitate the sharing of cultural knowledge, expertise, influence and community connections.

These partnerships and collaborations offer skills and expertise to guide our work in Indigenous Health, facilitating Indigenous agency and leadership, strengthening the College's cultural capability and the provision of culturally safe best practice approaches in our activities across education, policy development and advocacy. Through our partnerships, the College now has access to a broader set of data to better understand the Indigenous medical pipeline and the experience of Indigenous members across the RACP training pathway. This data will help to inform us about how we can best support the experience of those members that identify as Aboriginal and / or Torres Strait Islander or Māori.

Indigenous leadership at the College

The RACP recognises that Indigenous leadership is critical to championing the vision of the College, which is to produce *'world class specialist physicians, creating a healthier and more equitable future'*. Indigenous leadership improves accountability, helping to embed cultural safety across the College and ensuring activities continue to align with strategic priorities. This is critical to ensuring that Aboriginal and Torres Strait Islander and Māori members have the appropriate support available throughout their journey to becoming specialist physicians and post completion of their training requirements.

The RACP recognises the diversity (e.g. cultural, linguistic, geographic and demographic) that exists across Aboriginal and Torres Strait Islander and /or Māori communities. It is critical that leadership captures cultural nuances across communities, as well as the broader Australian and Aotearoa New Zealand health contexts. To support this aspect of Indigenous leadership, the College has developed and implemented strategic initiatives to promote better representation across the committee structures and to drive systems change. The College plans to expand and build on these opportunities into the future.

Our work to provide and expand our support for Aboriginal and/or Torres Strait Islander and Māori members outcomes is led by key Indigenous leaders and committees, as outlined below.

The Aboriginal and Torres Strait Islander Health Committee (ATSHIC)

The ATSIHC continues to support the implementation of the ISF across the RACP. Building the Indigenous workforce and cultural safety is a top priority of the Committee, which was established to strengthen the College's capacity to develop a coordinated approach to improving health and social outcomes for Aboriginal and Torres Strait Islander peoples. Dr Ngiare Brown recently finished her term as Chair of the committee in late 2023 and a successor is being arranged. ATSIHC members and the Board will appoint a new Chair in 2024. Committee membership is outlined in Table 7 below.

Table 7. Membership of the Aboriginal and Torres Strait Islander Health Committee

Name	Position
Dr Ngiare Brown	Chair (ended term in late 2023)
Dr Angela Titmuss	Deputy Chair
Dr Jenny Martin	President Elect Member
Noel Hayman	Fellow Member
Mr Phillip Mills AO	Honorary Fellow Member
Dr Angela dos Santos	Fellow Member
Dr Melissa Carroll	Trainee Member
Dr Blake Jones	Trainee Member
Ms Donna Burns	AIDA Representative
Ms Dawn Casey AO Ms Monica Barolits-McCabe	NACCHO Representatives
Dr Naru Pal	Community Member

Māori Health Committee (MHC)

In recognition of the place of Te Tiriti o Waitangi in Aotearoa, the Aotearoa New Zealand Committee established the MHC in December 2007. In December 2019, the MHC became a standing Board committee.

The MHC, like the ATSHIC, provide leadership together with the cultural and clinical knowledge and expertise to strategically direct and coordinate cross-college efforts to promote and improve health outcomes for the Māori of Aotearoa New Zealand.

The MHC is responsible for:

- assisting in the education and training of physicians and paediatricians, facilitating their understanding, knowledge and skills when dealing with Māori patients
- contributing to the development of College policy relating to cultural competence in training, education and assessment
- actively developing all College policies in respect to Māori health
- informing and advising the College of existing inequalities with Indigenous populations
- ensuring that it and the College promotes the highest standard of Indigenous health in Aotearoa New Zealand and Australia
- promoting an increase in Māori participation and retention in the Aotearoa New Zealand physician and paediatric workforce

- supporting initiatives that develop Fellows' and trainees' cultural competence and understanding of tikanga Māori values — manaakitanga (hospitality, kindness and support), whanaungatanga (relationships and sense of family connection) and mōhiotanga (knowledge, understanding and insight).

The MHC hosts a biennial Māori Health Hui for the College's Māori members to reflect, connect and set the direction towards our goal of population parity for Māori in the physician and paediatrician workforce in Aotearoa New Zealand. This event is important for pastoral and cultural care and for strengthening connection between the cohort which benefits retention. Committee membership is outlined in Table 8 below.

Table 8. Membership of the Māori Health Committee

Dr Matthew Wheeler	Chair, Fellow representative
Dr Danny De Lore	PCHD Representative and Cultural Safety Strategic Partnership Group representative
Dr Diana McNeill	Fellow representative
Dr Myra Ruka	AMD representative and Education Strategic Partnership Group representative
Dr Kennedy Sarich	Basic Trainee representative
Dr Fergus Stewart	Advanced Trainee representative
Dr Jade Tamatea	AMD Representative and Education Strategic Partnership Group representative
Dr Tambra Trist	Fellow representative
Dr Julia Reid	Fellow representative

Joint meetings of the Indigenous health committees

In May 2023, the Aboriginal and Torres Strait Islander Health Committee and the Māori Health Committee met in Sydney. This meeting focused on building the Indigenous workforce and cultural safety. The two committees also visited the Redfern Aboriginal Medical Service to exchange knowledge and information about culturally safe models of care.

The joint meeting provided an opportunity to strengthen the relationship between the two committees and set the groundwork for an ongoing dialogue into the future. Following this meeting, a standing item was introduced to the agenda of the Māori Health Committee to include an update from the Chair of the Aboriginal and Torres Strait Islander Health Committee, and vice versa.

A joint meeting of the MHC, ATSIHC and the RACP Board was held in November 2023. A key focus of both committees, moving into 2024, will be operationalising the terms of the Indigenous Object in the RACP Constitution.

Strategic Partners for Growing the Indigenous Physician Workforce

Strategic partners have been identified within the two Indigenous Health Committees for key topics. These partners are key contacts for college staff for advice and guidance of relevant initiatives outside the routine cycle of committee meetings which is crucial to supporting the continued timely delivery of work.

Māori member leadership at the College

In June 2023, the Board approved the establishment of a Lead Fellow Māori Health and two Māori Health Registrar positions for a fixed term of 12 months in the first instance. These positions will reduce cultural loading on Māori Health Committee leadership and provide 'bridge builder' capacity that will assist the College to achieve its strategic goals and meet Constitutional objectives. The Māori Health Registrars, Dr Samantha Jackson and Dr Tawera Wharetohunga were welcomed with a mihi whakatau into their roles in January 2024 and Dr Dawn Adair will commence as the Lead Fellow Māori in early February 2024.

The Lead Fellow Māori Health is a part-time role and is responsible for providing leadership in the development and implementation of initiatives and policies in respect of Hauora Māori (Māori health). This includes, but is not limited to, activity associated with the 2018-2028 Indigenous Strategic Framework, Hauora Māori, cultural safety and competency, growing the Māori Physician, Paediatrics and child health workforce, and other initiatives as directed by the Māori Health Committee.

The Māori Health Registrar positions are part time, member facing, primarily focused on supporting a mana enhancing experience for our Māori trainees and progression to Fellowship.

An evaluation of all three positions will be done through a Māori lens. The Board has approved a range of outcome measures for the roles. Funding for the continuation of the initiative is dependent on the achievement of measurable outcomes within the twelve-month period.

Indigenous staff

In addition to the new Māori lead member roles, the RACP employs three senior Indigenous staff leaders. Each of these roles works closely with ATSHIC and MHC and are supported by dedicated staff across the organisation to ensure that the College's new organisational value "We Indigenise and Decolonise" is progressed in all areas of business. Embedding of this value is a significant and deep-reaching undertaking and we recognise we have much yet to learn and achieve on this journey.

Associate Professor Wendy Edmondson is the College's Marnu Wiru (Knowledge Holder). Wendy works to ensure Aboriginal and Torres Strait Islander priorities are considered with a particular focus on cultural safety, education initiatives and curriculum. Wendy is a key touchstone for Aboriginal and Torres Strait Islander members during their training journey across the College. Wendy works together with Alexandra Kinsey, Project Lead, Growing the Indigenous Physician Workforce, to develop and deliver a range of workforce initiatives to support cultural safety and the growth of the RACP's Indigenous physician workforce.

Lee Bradfield, Manager, Indigenous Strategy has a key advocacy role which includes strengthening partnerships with Indigenous partner organisations including AIDA and developing policy and strategy to support the College's commitment to Indigenous health equity. Lee was instrumental in supporting approval for the recent RACP constitution change to recognise Aboriginal and / or Torres Strait Islander Peoples and Māori.

Nicky McCurdy, Kaitohutohu Ahurea | Māori Cultural Advisor, leads Māori strategy, advocacy and partnerships and provides enhanced support for Māori members in Aotearoa.

Partner organisations for Indigenous equity

The College collaborates with partner organisations in Australia and Aotearoa New Zealand on Indigenous health advocacy, cultural safety, and policy development. The RACP recognises the importance of Indigenous leadership within these partnerships and relationships. We have a

longstanding established relationships with the National Aboriginal Community Controlled Health Organisation (NACCHO), and the Australian Indigenous Doctors' Association (AIDA) and the Leaders in Medical Education Network (LIME). Governmental relationships exist with Minister for Indigenous Australians Linda Burney.

The RACP is a founding member of the Close the Gap Campaign Steering Committee and is a member of the Council of Presidents of Medical Colleges (CPMC). CPMC, NACCHO, AIDA and the Australian government have a partnership agreement to contribute to the revision and implementation of the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 which is the new national policy to improve health and wellbeing outcomes for Aboriginal and Torres Strait Islander people over the next ten years.

More details about the RACP's key partners in this work are outlined below.

Australian Indigenous Doctors' Association (AIDA)

AIDA is a key partner, influencing the strategic direction of the College in relation to Aboriginal and / or Torres Strait Islander health and supporting efforts to increase the number of Aboriginal and Torres Strait Islander physicians and paediatricians. This partnership is evident through:

- AIDA's membership on ATSHIC
- The College's ongoing sponsorship of and participation in the annual AIDA conference which provides an opportunity for the College to promote its training pathways to Aboriginal and / or Torres Strait Islander doctors, provide a networking opportunity for existing physician trainees and Fellows and make connections with other organisations striving to improve Indigenous health outcomes. In 2022, RACP's participation included running a well-regarded workshop on addressing burnout using the 'River of Life' methodology, attended by the RACP President, RACP trainees and Chair of the Medical Board of Australia.
- RACP's participation in AIDA's Specialist Trainee Support Program (STSP). This is a cross-college program, aimed at developing initiatives to support the growth of the Aboriginal and/or Torres Strait Islander specialist workforce (more information in Standard 7).
- The RACP's sponsorship of a number of Aboriginal and / or Torres Strait Islander members to attend AIDA's annual gala dinner in 2022.
- The College's annual reporting to AIDA against their minimum and best practice standards aimed at attracting, recruiting and retaining Aboriginal and / or Torres Strait Islander specialist trainees. AIDA monitor and report on information collected from participating colleges on their progress to *'Grow the number of Aboriginal and Torres Strait Islander medical specialists'.* Reporting provides a valuable supplementary source of information such as the College's range of:
    - Scholarships, bursaries, awards, resources
    - Targeted selection strategies
    - Mentoring and support
    - Cultural safety training
    - Trainee, Fellow, applicant numbers.

A key aspect of our partnership with AIDA includes access to a wealth of both quantitative and qualitative information about the pipeline of Aboriginal and / or Torres Strait Islander medical students and graduates, and Aboriginal and / or Torres Strait Islander doctors and specialists.

AIDA's reporting is valuable for the College because it provides a broader understanding of aspects of the training journey of Indigenous doctors and improvements to:

- the promotion of College pathways into training
- support the College can offer to improve trainees' overall experience, cultural safety and success as they progress along their training pathway and in their future careers as physicians
- the knowledge bank of best practice approaches to contribute to equitable health and life outcomes and the cultural wellbeing of Aboriginal and/or Torres Strait Islander people.

Te Ohu Rata o Aotearoa (Te ORA) and Medical Council of New Zealand

RACP partners with Te ORA and the Medical Council of New Zealand who advocate and support Māori Medical practitioners and provide comprehensive information on the medical specialty pipeline. We sponsor Te ORA's Annual Scientific Meeting.

The College is currently working with Te Kaunihera o Ngā Kāreti Rata of Aotearoa | the Council of Medical Colleges, New Zealand and Te ORA to implement the Cultural Safety Training Plan for Vocational Medicine in Aotearoa (Appendix 1A.61). In early 2024, we will appoint a project lead for this work.

Aotearoa New Zealand Medical Students Association and Māori Medical Students Association

The RACP's Aotearoa NZ team has participated in a range of events with the Aotearoa NZ Medical Students Association, and the Māori Medical Students Association to promote pathways for Indigenous medical graduates to enter physician training.

Leaders in Medical Education (LIME) Network

The LIME Network's focus has been on working with medical schools to facilitate collaboration, build the capacity of these working in Indigenous health and to develop resources that encourage best practice approaches. LIME has more recently been focused on engaging more directly with Specialist Medical Colleges.
Activities the RACP participates in with LIME include:

- Major sponsor and participant in LIME and the LIME Network conference. Recently this included attendance at the LIME conference in Canberra which explored wise practice for decolonisation and Indigenisation of systems. The conference provided opportunities to network and learn from experts and see examples of how organisations like the RACP can decolonise their structures, procedures and processes and support Indigenisation which aligns to our new college value, "We Indigenise and Decolonise".
- Participation in the Pathways in Specialisation online resource which is designed to help new medical graduates determine which Specialist Medical College might be the best fit for them, as they contemplate specialist training. This resource is a searchable database which provides information comparing all Specialist Medical Colleges in Australia and Aotearoa New Zealand. It details targeted entry pathways for Indigenous doctors, scholarship opportunities and other support available from the College. The RACP updates this resource as new initiatives are developed.

LIME was a key consultation partner in the finalisation of the College's professional standard on cultural safety in July 2022 and Dr Lilon Bandler, Associate Professor and Principal Research Fellow for LIME, facilitated a workshop to develop a draft of the definition. The new Cultural Safety Professional Standard for Fellows was revised in 2021 and released in 2022 in collaboration with LIME and our Indigenous Health Committees. The new standard is part of the Professional

Practice Framework which outlines all the standards expected of RACP Fellows. Refer to Standard 2.1.2 for more details.

National Aboriginal Community Controlled Health Organisation (NACCHO)

NACCHO is the national leadership body for Aboriginal and Torres Strait Islander health in Australia. It provides advice and guidance to the Australian Government on policy and budget matters while advocating for community-developed health solutions that contribute to the quality of life and improved health outcomes for Aboriginal and Torres Strait Islander people. NACCHO has a representative on the RACP's Aboriginal and Torres Strait Island Health Committee.

Cross-College Initiatives

The College also participates in several cross-College initiatives including the following:

AIDA's Specialist Trainee Support Program (STSP) - The RACP is one of 11 non-GP Specialist Medical Colleges that is working with AIDA to support their Specialist Trainee Support Program (STSP). The STSP is funded through the Commonwealth Government's Flexible Approach to Training in Expanded Settings (FATES) and aims to provide a range of culturally safe tailored support options for Aboriginal and Torres Strait Islander medical specialty trainees to support the growth of the Aboriginal and Torres Strait Islander specialist workforce. More details are in Standard 7.

Culturally safe supervision - The College is progressing work to develop resources, in collaboration with stakeholders including AIDA and other medical specialty colleges and members, to support the culturally safe supervision of Aboriginal and Torres Strait Islander trainees. The College received FATES funding for this. The project runs over two years and all resources developed will be shared with participating colleges.

Standard 7.1.3 provides an update on how we are working with Indigenous coaching and mentoring organisations to support Aboriginal and/or Torres Strait Islander, Māori and Pacific Islander trainees.

Indigenous health advocacy and campaigns (1.6.4)

We have led or contributed to a range of advocacy initiatives related to Māori, Aboriginal and Torres Strait Islander health, with some examples provided below.

Aboriginal and Torres Strait Islander health advocacy

The Voice Referendum - On 14 October 2023, the public voted in the referendum to recognise Aboriginal and Torres Strait Islander people in the Australian Constitution through establishing a Indigenous Voice to Parliament (The Voice).

In the lead up to the referendum, the RACP published a public statement (Appendix 1A.62) reiterating its long-standing commitment to addressing Indigenous health inequities in Australia and Aotearoa New Zealand and its position in support of The Voice. It also recognised the importance of listening to the voices of Aboriginal and Torres Strait Islander peoples about the issues and decisions that affect their lives, which is critical to 'closing the gap' in health outcomes between Indigenous and non-Indigenous Australians.

To supplement its public statement supporting The Voice, the RACP undertook a range of activities to inform its members and highlight the importance of listening to Indigenous voices in healthcare. This included:

- the RACP signing of an open letter along with over 125 medical colleges and leading health organisations in support of The Voice (Appendix 1A.63)
- sharing self-recorded videos of RACP members from across Australia explaining the importance of listening to Indigenous voices in healthcare (Appendix 1A.64).

The RACP's members remain unwavering in their commitment to supporting better health outcomes for all Indigenous peoples, regardless of the outcome of The Voice referendum.

RACP President visit to Northern Territory - In early 2023, Indigenous Members were engaged to inform a response from the RACP on alcohol consumption in the Northern Territory. This resulted in a media release (Appendix 1A.65) and submission (Appendix 1A.66) that brought attention to the urgent need for additional community programs to combat the social determinants of alcohol consumption.

As a result of the work in Alice Springs with the Central Australian Aboriginal Congress, the RACP President visited the Northern Territory in June 2023, accompanied by the Manager of Indigenous Strategy, Lee Bradfield and the Senior Executive Officer for the SA/NT Region, Katherine Economides.

The President met with approximately 60 members and stakeholders in Darwin, Katherine, and Alice Springs at both formal meetings and dinners held in each town. The NT currently has 245 RACP members. At these events, the President highlighted the recently approved Rural and Regional Strategy, key policy and advocacy and workforce planning initiatives (Appendix 1A.58).

Māori health advocacy

Support to retain Te Aka Whai Ora - the Māori Health Authority - On November 27, 2023, the RACP released a statement to the incoming government and health minister, urging the government to retain Te Aka Whai Ora – the Māori Health Authority. The RACP has supported the creation of an independent Māori Health Authority as a step towards transformative change in our health system since it was first proposed in 2020.

The statement established: "We recognise our shared responsibility to close the gap in health outcomes for Māori in Aotearoa New Zealand and strongly support a 'by Māori for Māori' approach at every level in healthcare. A commitment to Te Tiriti principles of tino rangatiratanga, active protection, partnership, options and equity in health care has been long overdue, and Te Aka Whai Ora is an opportunity for this to occur."

Smokefree legislation - On 30 November 2023, the RACP released a media statement urging the new coalition Government to abandon its plans to repeal the amendments and regulations of the Smokefree Environments and Regulated Products Act 1990. The regulations in the Act, including de-nicotisation of cigarettes, a reduction in retailers and banning cigarettes for the next generation, were put in place to protect Aotearoa New Zealanders from chronic illness caused by tobacco and smoking. The statement cited the impacts on health for Māori, and that these laws also offered potentially profound health benefits for people of all ages and future generations, especially Māori who continue to face health inequities.

Reconciliation Action Plan (RAP) (1.6.4)

The RACP is currently executing it's second Reflect RAP. This undertaking is led by a Working Group which guides the development, implementation and monitoring of the activities and includes representatives of the each of the RACP teams and departments. The actions in the current RAP are summarised in Table 9 below.

Table 9. RACP Reflect Reconciliation Action Plan 2021-2022

RAP Focus area	Actions
Relationships	• Establish and strengthen mutually beneficial relationships with Aboriginal and Torres Strait Islander stakeholders and organisations • Participate in and celebrate National Reconciliation Week (NRW) • Promote positive race relations through anti-discrimination strategies • Promote reconciliation through our sphere of influence
Respect	• Implement Aboriginal and Torres Strait Islander cultural learning and development • Participate in and celebrate NAIDOC Week • Raise internal understanding of Aboriginal and Torress Strait Islander cultural protocols • Recognise and celebrate Aboriginal and Torres Strait Islander dates of significance • Acknowledge and promote Aboriginal and Torres Strait Islander artwork within our offices
Opportunities	• Increase Aboriginal and Torres Strait Islander employment • Investigate Aboriginal and Torres Strait Islander supplier diversity • Increase Aboriginal and Torres Strait Islander learning and engagement opportunities for members • Support Aboriginal and Torres Strait Islander trainees and Fellows
Governance and tracking progress	• Provide appropriate support for effective RAP commitments implementation of RAP commitments • Build accountability and transparency through reporting RAP achievements, challenges and learnings both internally and externally • Continue our reconciliation journey by developing our next RAP • Establish and maintain an effective RAP Working Group (RWG) to drive governance of the RAP

As we are approaching conclusion of the current two-year Reflect RAP, the RACP has commenced development of the next RAP, which will be an Innovate RAP. The Innovate RAP will be designed to focus on the RACP's actions to develop and strengthen relationships with Aboriginal and Torres Strait Islander peoples, engaging staff and stakeholders in reconciliation, and developing and piloting innovative strategies to empower Aboriginal and Torres Strait Islander peoples.

1.7 Continuous renewal

AMC accreditation standards:

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

As outlined above, our operational plan has established curricula renewal and implementation as a multi-year key strategic priority. As such, this activity is being resourced accordingly. Further details regarding our processes used for the continuous renewal of our education programs are provided in Standard 2 and 3.

As detailed above and in Standard 3, we are making significant investments in education technology to support the implementation of the new programs, in keeping with changing practices and requirements for the delivery of competence-based medical education programs.

Our work to implement our new Cultural Safety domain in the Professional Practice Framework is discussed in Standards 2 and 3.

Our comprehensive review and update of our education governance has been outlined above and demonstrates our commitment to continuous improvement in governance approaches.

We are also undertaking a cross-College review of examinations, commencing in 2024. Further detail on this is provided in Standard 5.

Structures and process to respond to COVID-19

The impacts of the COVID-19 pandemic necessitated the establishment of new arrangements to guide our response and ensure we continued to adapt to changing contexts. We established the following groups to guide our response:

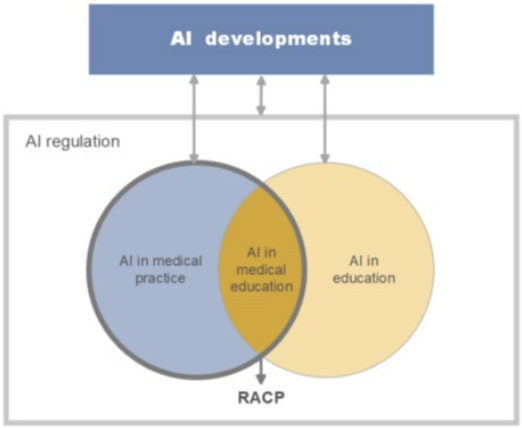
- COVID-19 Expert Reference Group
- COVID-19 Training and Accreditation Advisory Group
- COVID-19 Examinations Advisory Group.

COVID-19 education and training principles and training and accreditation interim program changes were implemented in early 2020. Each training committee developed specialty-specific interim program changes during 2020 and in 2021, in accordance with the education and training principles to try and minimise the disruptions to settings and to progression through training. With the management of COVID-19 continuing into 2022, the CEC approved the continued use of the COVID-19 education and training principles and interim program requirements through 2022. The guidelines continue to be referenced by training committees to guide decision making in consideration of exceptional individual trainee circumstances, through our existing special consideration process.

Responding to the rapid developments of AI technologies on medicine and medical education

Though AI is not a new field, the recent and rapid evolution of the Generative Pre-trained Transformer (ChatGPT) and other large language models has occurred at an unprecedented rate. The RACP recognises the need to respond, delineate, and anticipate the opportunities, challenges, and ethical concerns related to these rapid developments as they continue to change both medical practice and medical education (Figure 19).

Figure 19. Conceptual framework of relationships between AI developments in medicine and education



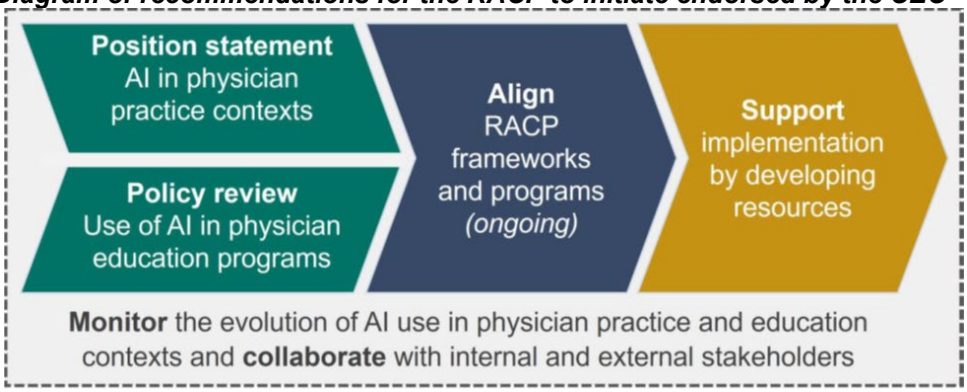
In response to concerr : which AI platforms are developing and the ne n the use of AI in medicine and medical education, the RACP developed a discussion paper (Appendix 1A.67). The discussion paper:

1. Outlined the impacts of the rapid developments of AI technologies on medicine and in response how medical education will need to evolve as education and medical practice continues to change.
2. Systematically catalogued currently available resources related to AI in medicine and medical education.
3. Provided recommendations on how the RACP should respond to AI in medicine and medical education.

The recommendations outlined in the discussion paper were endorsed by the CEC in November 2023. The following activities were endorsed in response to AI's impacts on medical education (Figure 20):

- Development of a position statement about the use of AI in physician practice contexts. This will set the direction for the RACP's organisational stance and inform later activities. The position statement may include promotion of third-party policy and standards, and could be developed as a living document to reflect the rapidly evolving landscape.
- Review policy to identify and address needs for provisions related to use of AI in physician education programs
- Through routinely scheduled review activities, ensure RACP frameworks and programs align with the AI position statement and policy provisions related to AI
- Support implementation of the activities above, by developing associated resources and initiatives for members regarding the effective and ethical use of AI in medical education
- Monitor the evolution of AI use in physician practice and education contexts
- Collaborate with internal and external stakeholders on the above activities, including Australian Alliance for Artificial Intelligence in Healthcare, RACP Digital Health Advisory Group, College Research Committee, RACP Ethics Committee and College Policy and Advocacy Committee.

Figure 20. Diagram of recommendations for the RACP to initiate endorsed by the CEC



Progress towards the implementation of these recommendations

The position statement and policy review will guide how the RACP aligns its frameworks and programs, and which resources need to be developed to support its implementation. The RACP has commenced work on the following activities to progress towards the implementation of the outlined recommendations:

- The discussion paper and recommendations were developed by reviewing the most contemporary resources available on the topic and through two rounds of consultations with RACP staff and the Ethics Committee.
- The RACP provided feedback and participated in a workshop alongside several peak bodies to develop recommendations for a national AI in healthcare policy organised by the Australian Alliance for AI in Healthcare (AAAiH). These contributions led to the national policy roadmap for AI in healthcare (Appendix 1A.68) which was launched at the inaugural AI.Care conference (Appendix 1A.69). The RACP will continue to collaborate with AAAiH and other external stakeholders to support the implementation of the roadmap.
- The RACP has commenced the review of current education policies to assess which need to be modified to consider the impacts of digital health and AI.
- The RACP has convened an AI taskforce consisting of key staff members across the College that contributed towards the development of the discussion paper to determine the next steps for AI and how to commence work on the outlined recommendations, especially the position statement. The taskforce will also consider how to involve Fellows, trainees, and committees throughout this process.

An abstract on this work was accepted for the 2024 Ottawa Conference on the Assessment of Competence in Medicine and the Healthcare Professions, which focusses on sharing the RACP's work on developing a response framework that accepts AI's influence in medical education assessment.

Summary of Standard 1

Strengths and key developments

- well-established organisational direction including defined vision, roles, strategic plan, and values
- robust Strategic Plan (2022-2026) that sets out four strategic priorities and goals for the College
- 2024 Operating Plan that sets out the priority outcomes the College wants to achieve to support the implementation of the Strategic Plan
- new Indigenous Object added to the College's Constitution, reaffirming and embedding the RACP's ongoing commitment to supporting Indigenous aspirations and outcomes in Australia and Aotearoa New Zealand. Strong progress against our Indigenous Strategic Framework. Strong leadership on Indigenous priorities.
- well-established education program management arrangements, with a plan to improve and contemporise these through an education governance review
- enhanced technology leadership and governance, including creation of CIO role, establishment of Technology Committee and improvements to project management processes
- prioritisation, funding and rapid yet robust progress with the TMP, a major new investment in education technology to support implementation of our training programs
- robust processes for approaching education program and policy change, inclusive of stakeholder perspectives
- comprehensive suite of polices, by-laws and terms of reference underpinning our operations
- established relationships across the sector to support collaboration
- effective partnerships between members and College teams for delivering physician training, with an appropriate range of expertise to deliver College functions.

Current and future focus areas

- ensuring financial and human resource sustainability while delivering value to members
- ensuring the RACP's functions are effectively supported through contemporary technologies and systems, and in turn achieving efficiency in processes, robust monitoring and reporting and responsive management of emerging risks
- finalising our Education Governance Review in collaboration with a broad range of stakeholders and implementing the recommendations to ensure that it aligns with College Values, prioritises effective decision-making and timely communication, and improves the member experience
- responding to the opportunities and challenges presented by the impacts of AI in medicine and medical education, through our series of endorsed recommendations.

Standard 2
The outcomes of specialist training and education

Explanatory note on the structure of content provided in response to Standards 2, 3 and 4:

To avoid duplication and to logically sequence content for ease of understanding, some responses to Standards 2, 3 and 4 have been provided out of sequence. At the start of each subsection, the relevant Standards addressed have been identified for ease of reference. For example, one section may address both standards 2.3 Graduate Outcomes *and* 3.2 The content of the curriculum *as these sections refer to the same materials. However, all standards have been specifically addressed across the range of the submission.*

Standard 2 The outcomes of specialist training and education

2.1 Educational purpose

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

Our educational purpose (2.1.1)

Notwithstanding the impact of the RACP's new Indigenous object (refer to Standard 1.1), our educational purpose remains unchanged as set out in the first four objects of the RACP constitution (Appendix 1A.1) to:

- promote the highest quality health care and patient safety through education, training and assessment
- educate and train future generations of physicians
- maintain professional standards and ethics among physicians through continuing professional development and other activities
- promote the study of the science and art of medicine.

Our educational purpose is further articulated in the RACP 2022-2026 Strategic Plan in which we describe our vision, 'World-class specialist physicians creating a healthier and more equitable future', and our core role: to educate, advocate and innovate; while lifting the health outcomes for the Aboriginal and Torres Strait Islander people of Australia and Māori people of Aotearoa New Zealand (Appendix 1A.5).

Our current strategic focus on education, badged as 'Physician and practice of the future', articulates our goal to 'create and support the next generation of physicians for the future of medicine and community health needs.'

How our purpose addresses health issues of Aboriginal and Torres Strait Islander peoples and Māori (2.1.2)

In addition to the new object in the RACP Constitution (see Standard 1.1), lifting the health outcomes for Aboriginal and/or Torres Strait Islander peoples and Māori is a key element of the description of our core role to educate, advocate and innovate.

The College is committed to fostering a culturally safe and competent College and are working to equip and educate the broader physician workforce to improve Indigenous health through the RACP Indigenous Strategic Framework (Appendix 1A.59). Refer to Standard 1.6.4 for details.

Our revised Cultural safety domain

The College is committed to developing training programs that equip our members to provide culturally safe patient care and promote equitable health outcomes for Aboriginal and Torres Strait Islander peoples and Māori. To enable this, a review of the cultural competence domain and standard of our Professional Practice Framework (PPF) (refer to Standard 2.2.1) was undertaken. This will allow us to better articulate what is expected of all graduates of our training programs and of physicians participating in our continuing professional development program.

To ensure a culturally safe revision process, a workshop was held to gain input from people with relevant Indigenous expertise from the outset. We sought involvement from the Leaders in Indigenous Medical Education (LIME) Network who assisted in providing a facilitator and four subject matter experts. The workshop was branded as an RACP and LIME event with two subject matter experts from Aotearoa New Zealand and two from Australia. There was also representation from the RACP's Curriculum Advisory Group, internal College cultural advisors as well as other relevant College staff (Appendix 1A.47).

The workshop agenda was co-developed with the LIME facilitator. It included discussion of cultural competence and cultural safety and a review of the current standard. The outcomes of the workshop included changing the PPF domain name from cultural competence to cultural safety and that College staff who attended the workshop would prepare a draft of a new Cultural safety standard to be supported by the MCNZ's definition of cultural safety. This revision was then consulted on widely and approved by the College Education Committee in July 2022. The new cultural safety standard is set out in Figure 21 below (see also Standard 2.2- Program Outcomes).

Figure 21. The RACP's Cultural safety domain of the Professional Practice Framework, July 2022

Physicians engage in iterative and critical self-reflection of their own cultural identity, power, biases, prejudices and practising behaviours. Self-reflection and an understanding the cultural rights of the community a physician serves brings awareness and accountability for the impact of their own culture on decision-making and healthcare delivery. It also allows for an adaptive practice where power is shared between patients, family, whānau and/or community and the physician, to improve health outcomes.

Physicians recognise the patient and population's rights for culturally safe care, including being an ally for patient, family, whānau and/or community autonomy and agency over their decision-making. This shift in the physician's perspective fosters collaborative and engaged therapeutic relationships, allows for strength-based (or mana-enhanced) decisions, and sharing of power with the recipient of the care to optimise health care outcomes.

Physicians critically analyse their environment to understand how colonialism, systemic racism, social determinants of health and other sources of inequity have and continue to underpin the healthcare context. Consequently, physicians then can recognise their interfacing with, and contribution to, the environment in which they work to advocate for safe, more equitable and decolonised services and create an inclusive and safe workplace for all colleagues and team members of all cultural backgrounds.

Stakeholder input into our purpose (2.1.3)

The development of the RACP Strategic Plan 2022-2026 involved extensive engagement with and opportunities for input from various stakeholders including the RACP Board, Senior Leadership Team, College Council, Divisions, Faculties, Chapters, Regional Committees, other peak Bodies within the College, other members and staff. These stakeholders provided valuable perspectives that contributed towards defining our strategic focus areas, goals and priorities for the College over the coming five years.

Further consultation was also sought form the Aboriginal and Torres Strait Islander Health Committee, Māori Health Committee and our Indigenous staff regarding content relating to Indigenous health, Indigenous knowledge and colonisation.

All RACP members were invited to engage in the consultation process and subsequent member vote to amend the RACP Constitution to include the new Indigenous object, as outlined in Standard 1.6.4.

Introduction to RACP training programs

This next section provides an overview of RACP training programs, in order to provide context for subsequent sections that address the AMC's standards.

Training programs offered by the RACP

There are two basic training and 38 specialty training programs offered by the RACP that are available to eligible applicants (see Figure 22).

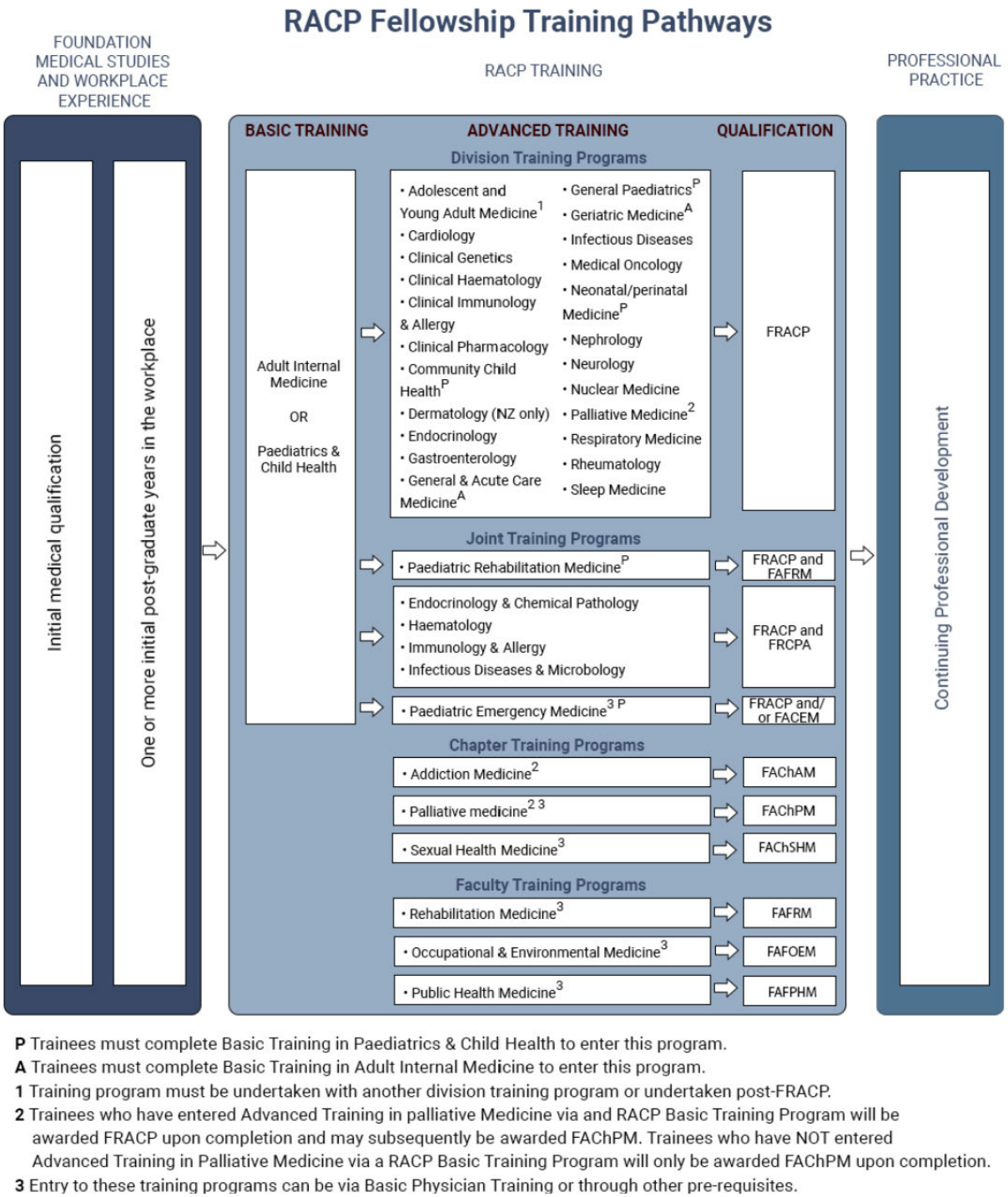
RACP training programs are governed by the College's Divisions, Chapters and Faculties. At the end of specialty training eligible trainees are invited to be admitted to Fellowship of the RACP or relevant Faculty or Chapter. Seven different fellowship qualifications are offered:

- FRACP – Fellowship of the Royal Australasian College of Physicians (awarded to graduates of Adult Medicine or Paediatrics & Child Health Division training programs)
- FAChAM – Fellowship of the Chapter of Addiction Medicine
- FAChPM – Fellowship of the Chapter of Palliative Medicine
- FAChSHM – Fellowship of the Chapter of Sexual Health Medicine
- FAFRM – Fellowship of the Faculty of Rehabilitation Medicine
- FAFOEM – Fellowship of the Faculty of Occupational and Environmental Medicine
- FAFPHM – Fellowship of the Faculty of Public Health Medicine.

The RACP also offers two training programs which don't result in the award of Fellowship or confer eligibility for specialist recognition:

- Clinical Foundations (titled Clinical Diploma prior to 2024) in Palliative Medicine is a six-month course to supplement general practitioners' and physicians' clinical experience in palliative medicine and expand their expertise to manage the palliative care needs of patients.
- Adolescent and Young Adult Medicine is a Division Advanced Training program and is a three-year program that must be undertaken with another specialty. AYAM Advanced Training provides in-depth specialty training in the medicine focused on the health and medical care of adolescents and young people aged 10 to 24 years. Graduates of this training program receive a letter confirming their completion of the program.

Figure 22. RACP Fellowship Training Pathways



P Trainees must complete Basic Training in Paediatrics & Child Health to enter this program.
A Trainees must complete Basic Training in Adult Internal Medicine to enter this program.
1 Training program must be undertaken with another division training program or undertaken post-FRACP.
2 Trainees who have entered Advanced Training in palliative Medicine via and RACP Basic Training Program will be awarded FRACP upon completion and may subsequently be awarded FAChPM. Trainees who have NOT entered Advanced Training in Palliative Medicine via a RACP Basic Training Program will only be awarded FAChPM upon completion.
3 Entry to these training programs can be via Basic Physician Training or through other pre-requisites.

Types of training programs

Most RACP training programs are 'Divisional', under one of the two Divisions of Adult Medicine and Paediatrics & Child Health. Divisional programs result in the award of FRACP. There are 53

Divisional training pathways. Following primary medical program completion and prevocational workplace experience, trainees complete the basic physician training program which includes the RACP Divisional Written and Clinical Examinations, and then go on to complete advanced training in the specialty of their choice.

Basic Training - Divisions

The RACP offers two Basic Training programs, in Adult Internal Medicine and in Paediatrics & Child Health.

The purpose of Basic Training is to:

- contribute to the development of a workforce of physicians who provide safe, high-quality care to meet the needs of the community
- build on trainees' existing knowledge, skills and attitudes to develop competence and confidence, and professional qualities
- ensure clinical exposure to a wide variety of patients and problems across a broad range of medical specialties and settings
- establish a solid foundation for entry into Advanced Training and lifelong learning and practice as a physician
- help trainees make informed decisions about future career paths.

Learning occurs primarily in the workplace, supported and supervised by consultants and peers. This requires a balance of the dual roles of training and service delivery in the workplace. Basic Trainees spend at least 36 months training under supervision in hospital settings, completing short rotations of around two to three months in a variety of subspecialties. The program includes work-based assessments throughout as well as written and clinical examinations in the final year. Further detail on assessment is provided in Standard 5.

Completion of Basic Training results in a completion certificate and is a prerequisite for entry into the majority of the RACP Advanced Training programs. Chapter and Faculty Advanced Training programs have alternative entry criteria, as outlined in Standard 7.

Advanced Training – Divisions, Faculties and Chapters

Advanced Training (Divisions, Faculties or Chapters) builds on and focusses the knowledge and skills gained during previous training to equip trainees to practise as a physician in Australia or Aotearoa New Zealand. Advanced Trainees complete their training in one of 40 diverse training programs (see Figure 22).

The purpose of Advanced Training is to develop a workforce of physicians who:

- have received breadth and depth of focused specialist training, and experience with a wide variety of health problems and contexts;
- are prepared for and committed to independent expert practice, lifelong learning, and continuous improvement;
- provide safe, quality health care that meets the needs of the communities of Australia and Aotearoa New Zealand.

While requirements may vary for each program, generally Advanced Trainees spend three to four years training under supervision in a range of training settings, completing longer rotations of around six to twelve months in a position relevant to their specialty training program.

Assessment in Advanced Training includes a range of work-based assessments focused on trainees' ability to complete relevant tasks in authentic settings. Supervisor reports are regularly submitted with evaluations on a trainee's progress. There are no exit examinations for Divisional

Advanced Training Programs. Some Chapter and Faculty Advanced Training programs include exit examinations, as outlined in Standard 5.

Completion of Advanced Training results in the award of Fellowship of the relevant Division, Faculty or Chapter and allows graduates to register with the Medical Board of Australia or Te Kaunihera Rata o Aotearoa | the Medical Council of New Zealand in the field of specialty practice/vocational scope linked to the program completed.

The Fields of specialty practice and vocational scopes linked to RACP training programs are detailed in the Training Program Details Table, provided in Appendix 2D.1.

Advanced Training - dual training

Dual training is a pathway where trainees complete two or more RACP Advanced Training programs in a reduced amount of time. For example, both Gastroenterology and General Paediatrics are each three year training programs, however it is possible for a dual trainee to complete both programs in a total of four years. Dual training is an option that is available for all Advanced Trainees.

Advanced Training - joint training

The RACP defines a joint training program as a single program of advanced training that results in the award of more than one Fellowship.

We have one internal joint training program in Paediatric Rehabilitation Medicine between the Division of Paediatrics & Child Health and the Australasian Faculty of Rehabilitation Medicine. Completion of this joint program results in the award of both FRACP and FAFRM.

We also have four active joint training programs with another medical college, the Royal College of Pathologists Australia (RCPA). Successful completion of one of these programs results in the award of both FRACP and FRCPA. Each program also has an associated clinical stream which results only in the award of FRACP.

The current state of governance of joint training programs with the RCPA is as follows:

- **Governance.** Committees for Joint College Training (CJCTs), with membership from both RACP, RCPA and Specialty Societies, oversee the Haematology and Immunology/Allergy training programs, including clinical streams. RACP Advanced Training Committees (ATCs) oversee clinical streams for Infectious Diseases and Endocrinology, with separate CJCTs comprising members from RACP and RCPA overseeing joint trainees.
- **Administration.** The CJCTs are administered by RACP Training Services. Both Colleges administer the training programs with pathology components, including pathology exams, administered by RCPA, and clinical components administered by RACP.
- **Curricula.** The RACP has curricula covering only the clinical streams of these programs. RCPA handbooks (Appendix 2A.1) cover the laboratory training aspects. Trainees are referred to both curricula over the course of their training.
- **Training requirements.** The training program requirements for joint trainees are defined in RACP handbooks for endocrinology and chemical pathology, joint haematology, joint immunology/allergy, and infectious diseases and microbiology (Appendix 2A.2-2A.5). There are separate handbooks in place for clinical streams, as well as the separate RCPA handbooks.
- **Fees.** Trainees are required to pay full fees to both RACP and RCPA for each year of training.

Paediatric Emergency Medicine, which is jointly governed with the Australasian College for Emergency Medicine (ACEM); and Nuclear Medicine, which is jointly governed with the Royal Australasian College of Radiologists (RANZCR) via a Committee for Joint College Training, are sometimes referred to as joint training programs, due to the joint college governance and RACP administration of training for the other colleges, however these programs do not result in the award of more than one Fellowship.

Closure of the ACEM stream of the Paediatric Emergency Medicine program

Effective from January 2022, a training stage in the Advanced Training in Paediatric Emergency Medicine (PEM) program was closed. The PEM program has two streams: the RACP stream and the Australasian College of Emergency Medicine (ACEM) stream. Trainees who complete the RACP stream are awarded FRACP and those who complete the ACEM stream are awarded FACEM.

Following completion of one of these streams and admission to Fellowship of either ACEM or the RACP, an additional training stage (Stage 3) was offered which led to dual Fellowship of both colleges. Stage 3 has never been completed by any trainee and there were no trainees registered in 2022.

The rationale for closing Stage 3 was the lack of trainee uptake and absence of any additional specialist registration associated with completing the stage. Steps taken prior to the closure of the Stage 3 pathway included:

- a review of the PEM program conducted by the Committee for Joint College Training (CJCT) in Paediatric Emergency Medicine, which is comprised of both ACEM and RACP representatives
- consultation with ACEM
- implementation of a six-month notice period.

Closure of the Dual Fellowship Training Program in Paediatrics and Child and Adolescent Psychiatry

The Dual Fellowship Training Program (DFTP) in Paediatrics and Child and Adolescent Psychiatry was a joint training program between the RACP and the Royal Australian and New Zealand College of Psychiatrists (RANZCP). The DFTP offered the opportunity to specialise simultaneously and gain Fellowships in Psychiatry (FRANZCP) and Paediatrics (FRACP). The program enabled the requirements of both colleges to be completed in a reduced period of a minimum of seven years full time equivalent. In 2013 the RACP identified several risks with the program, including that it did not adhere to the PREP training framework and that trainees could be awarded FRACP without completing a discrete paediatric RACP Advanced Training program.

In light of changes to both college's training program frameworks, a review of the training program was initiated in 2013. A joint working group between the RACP and RANZCP was established to complete the review and provide recommendations for approval by each college.

As an outcome of the review, in 2014 the colleges agreed to discontinue the DFTP program in its current format and replace it with a clearer guide for trainees regarding reciprocal training arrangements between RACP and RANZCP, i.e., outlining options for recognition of prior learning between psychiatry and paediatrics training programs (Appendix 2A.6).

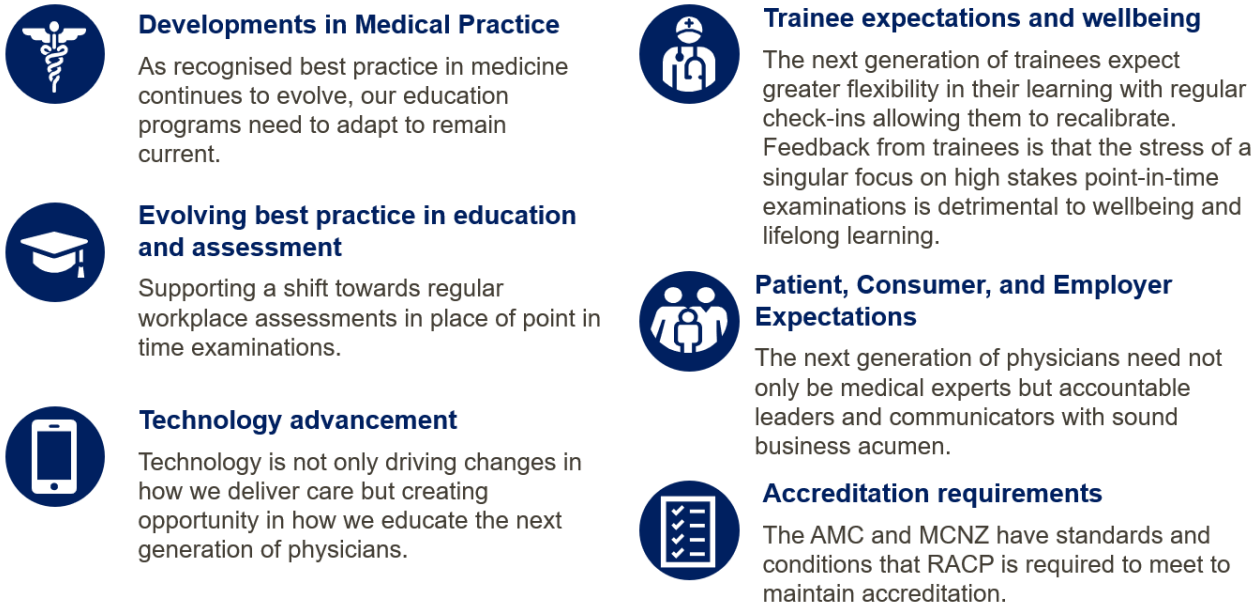
The change did not affect trainees who were enrolled in the DFTP at the time of the review, however the program had been closed to new registrations from 2013. No trainees remain registered in the program.

Significant renewal of PREP training programs underway

The Physician Readiness for Expert Practice, or 'PREP', program framework was introduced in 2008 to guide the design and development of RACP training programs. The PREP programs remain operational in 2024. A major redesign of these programs in progress as part of the RACP's curricula renewal project.

Key drivers for renewal of the RACP's training program curricula are highlighted in Figure 23 below.

Figure 23. Key drivers for RACP curricula renewal



The Curricula Renewal (CR) project aims to:

- transform the 40 Basic (BT) and Advanced Training (AT) programs to a hybrid time- and competency-based approach with programmatic assessment
- align training programs to RACP curricula frameworks and models
- update and rationalise existing curricula content and training requirements in all programs.

Successful completion of the CR project will be the implementation of 40 renewed training programs that feature:

- competency-based learning goals (curricula standards)
- refined learning, teaching, and assessment training requirements, incorporating a programmatic assessment approach, and ensuring alignment with curricula standards
- competency-based progression criteria
- refined governance roles and responsibilities for progression decision-making
- implementation, change management, and transition to business plans and processes.

Overview of curriculum renewal work achieved to date

The first step in the curricula renewal process was the establishment of a Curriculum Advisory Group (Appendix 1A.47), tasked to design the RACP Professional Practice Framework, to define the domains of physician practice. Following approval of the PPF in 2016, the new RACP curriculum model was developed as an organising framework for curricula content.

In 2019 the design of two new Basic Training programs was completed. This was followed by the Common Advanced Training standards and Learning, Teaching and Assessment (LTA) requirements in early 2021.

The first six of 38 Advanced Training specialty curricula (Wave 1) were renewed and approved by the College Education Committee in early 2023. A further 15 (Wave 2) Advanced Training curricula have been renewed in 2023 and are currently out for broad consultation. The remaining 17 curricula will be renewed in 2024.

Refer to Standards 3 and 4 for further details of the College's work in renewing and implementing the new programs.

Reponses to the AMC standards relating to curricula are provided for both our currently operational PREP programs and the new programs which we are preparing to implement.

3.3 Continuum of training, education and practice

As outlined in the disclaimer provided at the start of Standard 2, we are including our response to components of Standard 3 in this location to provide a more logical sequence of information.

AMC accreditation standards:
3.3.1 There is evidence of purposeful curriculum design, which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice.
• Describe processes to articulate the training program with previous and subsequent stages of training.
• Describe how the education provider is kept informed about the requirements of previous stages of medical training.
• Summarise any changes to the specialist medical program *since the last accreditation* because of any changes or feedback.
• Comment on the capacity of the education provider to influence earlier stages of medical training.

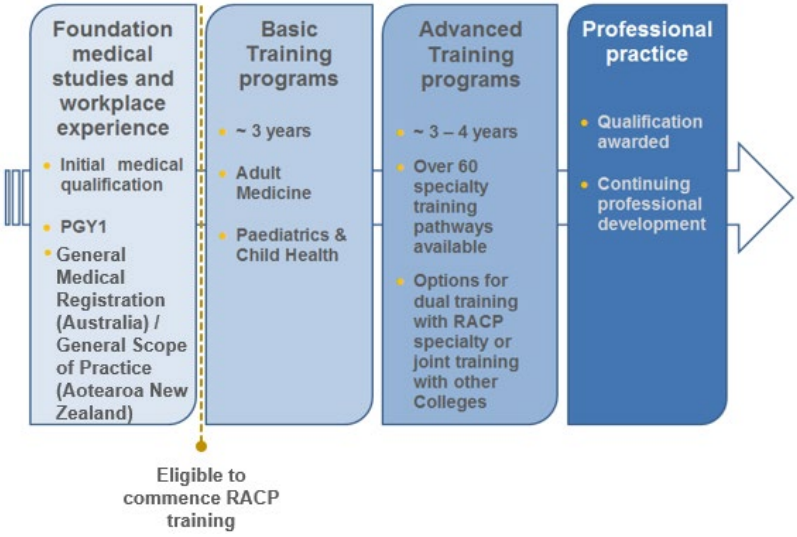
Continuum of training (3.3.1)

The RACP recognises that medical education is a continuum, from medical school, prevocational and vocational training extending through to professional practice and continuing professional development for the wider Fellowship (Figure 24).

RACP training programs sit within the vocational stage of the continuum of medical education, training and practice.

The College continues to foster collaborative relationships with the various organisations responsible for each stage in a doctor's learning pathway. These collaborative relationships help ensure that learning is continuous and incrementally builds knowledge rather than duplicating effort and unnecessarily lengthening training time.

Figure 24. Continuum of medical training



Articulation of RACP training programs with other stages of medical training

Actively interacting with the broader medical education sector for integration

The College maintains a range of relationships contributing to horizontal and vertical integration which are outlined in Standards 1.4 and 1.7. For example, the RACP's Training Services and Accreditation Services operational teams are represented on three key groups at the Health Education and Training Institute (HETI) in New South Wales. These groups are the HETI Physician Training Council, HETI Paediatric Physician State Training Council and HETI Network Directors Group. RACP representatives attend the Council and Network Director meetings to discuss network, training, accreditation and other state related items.

RACP staff members regularly attend the Confederation of Postgraduate Medical Education Council's Annual Prevocational Medical Education Forum which brings together clinicians, medical educators, and junior doctors to share research, educational activities and to discuss current issues and developments in prevocational medical education.

RACP staff regularly present at or participate in the annual conference of the Australian and New Zealand Association for Health Professional Educators with 18 conference presentations and workshops delivered and/or scheduled between 2019 and 2024. In recent years RACP staff have also presented at international conferences such as AMEE and the International Conference on Residency Education. Further details are provided in Standard 6.

Ensuring RACP training program curricula build on skills previously attained

To ensure that curricula are building on skills previously attained, we have undertaken an extensive review of the Basic Training curricula, including development of a standards framework designed to underpin all RACP curricula. Development of our new Basic Training curriculum standards incorporated a review of national prevocational frameworks in both Australia and Aotearoa New Zealand. This informed expected competencies for trainees entering RACP training programs. Consultation on the Basic Training curricula took place at prevocational conferences with a focus on vertical integration. Refer to Standard 3 for more information about this review.

The Australian Medical Council sought consent from the RACP to utilise the structure and content of four of our new Basic Training Entrustable Professional Activities (EPAs) in its development of

the new National Framework for Prevocational Training. We actively engaged in the consultation process reviewing and providing feedback throughout the development of the national framework. As a result of the similarity of structure and content, the new pre-vocational national framework aligns well with the RACP's new Basic Training curricula. This will enable a smooth transition for trainees from pre-vocational training into RACP Basic Training.

Sharing teaching and learning resources developed by the College and other stakeholders across the sectors

The College has developed a number of online modules and learning resources which are available to non-members, including prevocational trainees and allied health professionals. Refer to Standard 3 and 4 for details of these.

Articulation of RACP training programs with professional practice and continuing professional development stage

The RACP's Professional Practice Framework and associated standards underpin both our training programs and continuing professional development program enabling integration and ensuring that learning is continuous and incrementally builds throughout vocational training and into professional practice and the transition to retirement.

Horizontal and vertical integration within RACP training programs

PREP training programs

The Physician Readiness for Expert Practice, or 'PREP' program framework (see Standard 3) provides alignment of the design, development, implementation and evaluation of RACP training programs across the Divisions, Faculties and Chapters.

There are specialty-specific curricula for Basic Training and Advanced Training which are in common templates with common curricula components for learning, teaching and assessment.

These program specific curricula are used in conjunction with the Professional Qualities Curriculum (Appendix 2A.7) which is common to all RACP training programs.

New training programs

In the new training programs, the RACP Professional Practice Framework, common curriculum model (described under Standard 3), the curriculum templates and common content for Advanced Training programs enable both vertical and horizontal alignment within and across RACP training programs.

The new Basic Training is a hybrid time- and competency-based training program. There is a minimum time requirement of three years full-time equivalent professional experience. Progress and completion decisions are based on evidence of trainees' competence, as elaborated on in Standard 5. The Basic Training program may be started in post-graduate year 2 at the earliest, though local factors may mean that the program is started later in some areas of Australia and Aotearoa New Zealand.

The learning, teaching, and assessment (LTA) structure for Basic Training and Advanced Training define clear phases of training (refer to Figures 25 and 26) which are accompanied by progression criteria. The final phase of Advanced Training is "transition to Fellowship" which will then lead into continuing professional development.

Figure 25. Phases of Basic Training

- **Foundation Phase:** orients trainee and confirms their readiness to progress in the Basic Training program.
- **Consolidation Phase:** supports trainees' professional development in the workplace.
- **Completion phase:** confirms trainees' achievement of curriculum standards and completion of Basic Training. Supports trainees' transition to Advanced Training.

There is a selection decision at the beginning of Basic Training, progression decisions between each phase of Basic Training and a completion decision at the end of training resulting in a Completion Certificate.

Figure 26. Phases of Advanced Training

- **Specialty Foundation Phase:** orients trainee and confirms their readiness to progress in the Advanced Training program.
- **Specialty Consolidation Phase:** continues trainees' professional development in the specialty and supports progress towards the learning goals.
- **Transition to Fellowship:** confirms trainees' achievement of curriculum standards and completion of Advanced Training. Supports trainees' transition to unsupervised practice.

There is a selection decision at the beginning of Advanced Training, progression decisions between each phase of Advanced Training and a completion decision at the end of training resulting in award of Fellowship.

The new Advanced Training curricula comprise of a mix of program-specific content and content that is common across all Advanced Training programs (where possible) with common competencies, a mix of common and program-specific Entrustable Professional Activities and program-specific knowledge guides.

The introduction of common content across many curricula is a key aspect of the Advanced Training curricula renewal. In the move toward competency-based training, having common standards for the Advanced Training curricula supports the horizontal integration of learning and vertical integration across dual training programs.

2.2 Program outcomes

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

Definition of a physician or paediatrician

The RACP definition of a physician and paediatrician is publicly available (Appendix 2A.8).

In Australia and Aotearoa New Zealand physicians and paediatricians are medical doctors who have completed Advanced Training in a medical specialty with the RACP to diagnose and manage complex medical conditions.

Physicians treat the medical conditions of adults and paediatricians treat infants, children and adolescents. They're sometimes referred to as specialists, specialist physicians or consultant physicians.

Physicians and paediatricians work in hospitals, private practices and community medical centres and may also focus on research or medical administration. Other physicians work in government, public and private organisations providing public health, occupational and environmental medicine, and rehabilitation services.

Our program outcomes (2.2.1)

The RACP develops and maintains a set of program outcomes for each training program which are publicly available on our website.

Program outcomes – PREP training

Program outcomes for graduates of PREP training programs are defined in the Professional Qualities Curriculum (Appendix 2A.7). Graduates of the program will be equipped to function effectively within the current and emerging professional, medical and societal contexts.

At the completion of their overall training program, it is expected that a new graduate will:

- have demonstrated their knowledge of, and ability to competently utilise the range of common or generic knowledge, skills, attitudes and behaviours required by all physicians/paediatricians, regardless of their area of specialty
- be able to communicate effectively and sensitively with patients and their families, colleagues and other allied health professionals
- understand and acknowledge the importance of the various socio-economic factors that contribute to illness and vulnerability

- be aware of, and sensitive to, the special needs of patients from culturally and linguistically diverse backgrounds
- be able to work within, lead and fully utilise multidisciplinary team-based approaches to the assessment, management and care of their patients
- recognise the need for, develop, and be able to apply appropriate patient advocacy skills
- have the skills required to process new knowledge and the desire to promote and maintain excellence through actively supporting or participating in research and an active program of continuing professional development
- be able to contribute to the education of patients, colleagues, trainees, junior medical officers and other health care workers.

The Professional Qualities Curriculum also sets out the personal and professional behavioural attitudes required of, and commonly utilised by, all consultant physicians and paediatricians in the course of their daily clinical practice and in their relationship with others.

The PREP program outcomes relate to the health care needs of the communities served by RACP members. The nine Domains in the Professional Qualities Curriculum are described in Table 10 below.

Table 10. Domains of the PREP training program Professional Qualities Curriculum

Communication In order to provide high-quality care for patients, it is essential that physicians establish and foster effective relationships with patients and their families, other health care professionals and administrative personnel. To achieve this they must develop and utilise the full range of communication-related skills that will enable them to effectively obtain and synthesise information from, and discuss relevant issues with, patients and their families, professional colleagues, administrative personnel and systems as appropriate. These communication skills will be characterised by understanding, trust, respect, empathy and confidentiality. Effective communication skills will also facilitate their ability to research, evaluate and disseminate information in the broader community. We know that first encounters can have a profound effect on practice; therefore, it is important to develop effective communication strategies early on in training.
Quality and safety Quality and safety guidelines are developed to ensure the safe and quality care of patients. The implementation of these standards is the responsibility of all health care workers. Physicians must consider quality and safety in every aspect of their practice, from their interactions (communication) with patients, to managing and reporting risks and hazards.
Teaching and learning (scholar) Physicians should actively contribute to the further research, development, appraisal, understanding and dissemination of health care knowledge among their professional colleagues, students and patients and within the broader general community. As with any profession, physicians need to model and engage in a process of continuing personal, professional and educational development in order to maintain, further develop and extend their professional knowledge, clinical skills and technical expertise. This is especially important within the current context of an ever increasing, rapid and exponential growth in knowledge and its related applications.
Cultural competency Physicians should display commitment to gaining an understanding of the impact of culture on health outcomes. They must endeavour to become acquainted with the cultural perception of illness, cultural aspects of family, and cultural attitudes toward death and illness held by their patients. Physicians have a responsibility to manage their own development of cultural competency and familiarise themselves with the differing cultures within the community.
Ethics Physicians must adopt an ethical attitude towards the practice of medicine. Ethics pervades every aspect of clinical practice, from communication to critical reflection and professional standards. While it is important to bear in mind

the relationship of health law and practice, it is important also to understand the distinction between law and ethics. Physicians must cultivate ethical reflection and ethical behaviour through an awareness of ethical principles, health law, and the limits of science on behaviour.
Clinical decision-making Physicians have a unique role, with a distinct body of knowledge, skills, attitudes and behaviours which enable them to provide clinical care to the highest standards of excellence. Part of this unique role is the physician's ability to apply effective forms of reasoning to make complex clinical decisions.
Leadership and management The professional physician must have the ability to manage and make decisions about the allocation of personal, professional and organisational resources.
Health advocacy Physicians have an obligation, both as individuals and in their profession, to positively influence the health circumstances of a patient. Opportunities for this may lie outside the immediate clinical context, and the patient may need the physician's support for success. The physician may need to add their voice where the patient is vulnerable due to infirmity, age or commonly stigmatised status (e.g. race, social class or habit). We refer to this process as advocacy. Beyond clinical practice, advocacy has a rich history of success in public health where physicians and others have advocated for, and sustained, favourable change in road safety, immunisation and tobacco control. There is also an opportunity for advocacy for changing the environment or focus of care to improve both the quality and safety of care for others. In the process physicians will proactively identify, analyse, respond to, promote, and be an advocate for, the social, environmental, biological and political factors that determine and impact upon the health and wellbeing of their patients and the broader community.
The broader context of health Physicians have an obligation to think more broadly than the health of the immediate patient. They must consider the effects of societal issues on health, and broader health determinants. They must be aware of the key population and public health principles. Physicians will encourage and educate patients to achieve healthier lifestyles, and prevent injury, ill health and disease. To achieve this, familiarity with risk factors (social, environmental, psychological) affecting specific population subgroups, disease-prevention services and legislation are essential.

The Professional Qualities Curriculum outlines the range of concepts and specific learning objectives required by, and utilised by, all physicians, regardless of their specialty or area of expertise. It spans both the Basic Training and Advanced Training Programs and prior to the development of the Professional Practice Framework in 2016 was utilised as a key component of the Continuing Professional Development Program. Together with the various Basic Training and Advanced Training Curricula, the Professional Qualities Curriculum integrates and fully encompasses the diagnostic, clinical and educative-based aspects of the physician's/ paediatrician's daily practice. All aspects of the Professional Qualities Curriculum are taught, learnt and assessed within the context of everyday clinical practice and, where appropriate, given a subspecialty-specific focus. The PQC is used in conjunction with the program-specific curricula.

Program outcomes - new training programs

The RACP Professional Practice Framework (PPF) (Appendix 2A.9), released in 2016, defines the domains of physician practice and associated standards that apply across all training programs and the Continuing Professional Development program (Figure 27). The centre of the PPF states the role of RACP Members is 'to serve the health of patients, carers, communities, and populations'.

Our PPF provides a comprehensive foundation for physician education across the continuum of practice. The Professional Standards contained in the Framework are public statements of what the communities of Australia and Aotearoa New Zealand can expect of physicians. The Standards form the basis of the new RACP curriculum model but are also broad statements about the expected competencies to be maintained throughout expert professional practice and hence underpin the RACP's MyCPD Program.

The PPF is integrated into the new curriculum model (see Standard 3) and embedded in the templates used to develop competencies and entrustable professional activities. The framework is embedded in all programs that have completed the curriculum renewal process.

Figure 27. RACP Professional Practice Framework (PPF)

Professional Standards

The Professional Standards linked to the Professional Practice Framework are set out in Table 11 below.

Table 11. RACP Professional Practice Framework - Professional Standards

	Medical expertise Physicians apply knowledge and skills informed by best available current evidence in the delivery of high-quality, safe practice to facilitate agreed health outcomes for individual patients and populations.
	Communication Physicians collate information, and share this information clearly, accurately, respectfully, responsibly, empathetically and in a manner that is understandable. Physicians share information responsibly with patients, families, carers, colleagues, community groups, the public, and other stakeholders to facilitate optimal health outcomes.
	Quality and safety Physicians practice in a safe, high-quality manner within the limits of their expertise. Physicians regularly review and evaluate their own practice alongside peers and best practice standards and conduct continuous improvement activities.

	**Teaching and Learning** Physicians demonstrate a lifelong commitment to excellence in practice through continuous learning and evaluating evidence. Physicians foster the learning of others in their profession through a commitment to mentoring, supervising, and teaching.
	**Research** Physicians support creation, dissemination and translation of knowledge and practices applicable to health.1 They do this by engaging with and critically appraising research and applying it in policy and practice to improve the health outcomes of patients and populations.
	**Cultural safety** Physicians engage in iterative and critical self-reflection of their own cultural identity, power, biases, prejudices and practising behaviours. Self-reflection and an understanding the cultural rights of the community a physician serves brings awareness and accountability for the impact of their own culture on decision-making and healthcare delivery. It also allows for an adaptive practice where power is shared between patients, family, whānau and/or community and the physician, to improve health outcomes. Physicians recognise the patient and population's rights for culturally safe care, including being an ally for patient, family, whānau and/or community autonomy and agency over their decision-making. This shift in the physician's perspective fosters collaborative and engaged therapeutic relationships, allows for strength-based (or mana-enhanced) decisions, and sharing of power with the recipient of the care to optimise health care outcomes. Physicians critically analyse their environment to understand how colonialism, systemic racism, social determinants of health and other sources of inequity have and continue to underpin the healthcare context. Consequently, physicians then can recognise their interfacing with, and contribution to, the environment in which they work to advocate for safe, more equitable and decolonised services and create an inclusive and safe workplace for all colleagues and team members of all cultural backgrounds.
	**Ethics and professional behaviour** Physicians' practice is founded upon ethics, and physicians always treat patients and their families in a caring and respectful manner. Physicians demonstrate their commitment and accountability to the health and well-being of individual patients, communities, populations and society through ethical practice. Physicians demonstrate high standards of personal behaviour.
	**Judgement and decision making** Physicians collect and interpret information, and evaluate and synthesise evidence, to make the best possible decisions in their practice. Physicians negotiate, implement, and review their decisions and recommendations with patients, their families and carers, and other healthcare professionals.
	**Leadership, management and teamwork** Physicians recognise, respect, and aim to develop the skills of others, and engage collaboratively to achieve optimal outcomes for patients and populations. Physicians contribute to and make decisions about policy, protocols, and resource allocation at personal, professional, organisational, and societal levels.

Health policy, systems and advocacy

Physicians apply their knowledge of the nature and attributes of local, national, and global health systems to their own practices. They identify, evaluate, and influence health determinants through local, national, and international policy. Physicians deliver and advocate for the best health outcomes for all patients and populations.

Progress with new Cultural Safety Professional Standard

Our work to align curricula content to the new Cultural Safety Professional Standard is progressing. So far, the following work has been completed:

- new Basic and Advanced Training curricula standards addressing cultural safety have been reviewed and updates to the content have been drafted
- new cultural safety content has been drafted for the common competencies for both Basic and Advanced Training
- the new Cultural Safety Professional Standard has been mapped against the revised Basic and Advanced Training competencies to show the progress we intend to see from cultural awareness in Basic Training and cultural safety in Advanced Training
- identification that a number of the behaviours in the existing Advanced Training content adequately reflect a degree of cultural safety.

The updates to the Basic and Advanced Training curricula standards and common competencies are being carried out in tandem with the development of updated content in our Supporting Professionalism in Practice Guide under the cultural safety domain of the RACP PPF (Appendix 2A.10). The purpose of the Guide is to outline the professional attributes and behaviours that the College expects to see in RACP members in terms of cultural safety.

The updates to the curricula standards, common competencies and knowledge guides are being consulted on with Indigenous stakeholders, both internal and external to the College and relevant committees. This includes reviewing Te Kaunihera o Ngā Kāreti Rata of Aotearoa | the Council of Medical Colleges, New Zealand and Te ORA's 'Cultural safety within vocational medical training report' and Cultural Safety Training Plan for Vocational Medicine in Aotearoa and the Australian Health Practitioner Regulation Agency's National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025, to ensure updates to the curricula and competencies are aligned (Appendix 2A.10-2A.13).

We have prioritised seeking appropriate input from Aboriginal and Torres Strait Islander and Māori stakeholders to the 15 Wave 2 Advanced Training specialty curricula that are in the consultation phase (see Standard 3). It is expected the Basic and common Advanced Training curricula content will then be finalised for approval by the College Education Committee.

Specialty overviews – further defining outcomes

The Physician Readiness for Expert Practice PREP Advanced Training curricula (Appendix 2A.14) include a specialty overview section which defines key aspects of the scope of specialty practice and the role of specialists in health care provision (refer to Training Program Details Table in Appendix 2D.1). At the time of the program being developed local and international sources were referred to in developing the specialty overviews.

As part of the curricula renewal process these overviews are being revised and updated in the new program curricula. The six specialty curricula redesigned as part of the Wave 1 Advanced

Training Curricula Renewal (Appendix 2A.15) in 2021-2022 include a revised specialty overview (refer to Training Program Details Table in Appendix 2D.1).

A similar review of the specialty overview and development of curriculum standards integrating the PPF has also been done for the 15 specialty curricula in Wave 2 Advanced Training Curricula Renewal (Appendix 2A.16). The curricula were released for consultation with Members and key external stakeholders including consumer groups until early January 2024. The specialty overview is being revised and confirmed post-consultation in line with the feedback received. Final versions will be confirmed in early May 2024.

The remaining 17 specialty Advanced Training curricula will undertake the renewal process in 2024, with a view to finalising their revised curriculum standards and specialty overview statements (and other curriculum content) by early 2025. At the end of Wave 3, the curriculum redesign work will be complete and the PPF will have been integrated into each training program.

For each specialty, the curricula renewal process has been/will be informed by scoping information, including summarised program and graduate outcomes from comparable specialty training programs internationally.

Specialties involved in curriculum reviews have redeveloped their specialty overviews using a standardised template shown in Table 12.

Table 12. Specialty overview development template prompts

Structure
Section 1: special clinical aspects of the specialty
A broad sentence that encompasses the **breadth and depth of the specialty** and its role in healthcare provision.
A broad sentence that outlines the **philosophy of clinical care** the specialty provides. This section helps trainees to determine whether the specialty is right for them. This could include: • key clinical aspects of care • settings care is undertaken in • special patient groups seen by the specialty.
Further to the above sentence, outline (using bullet points) the specific **nature of care provision** by the specialty. This could include: • the most important specialist clinical skills required. • disease profiles. • important issues that arise in the health care of patient groups. • common settings in which care is provided.
Section 2: professional skills required to be a specialist in the field
A broad statement that outlines the **professional skills** required in the specialty. This section helps trainees determine whether they are right for the specialty. This could include: • important 'soft' skills. • particularly important aspects of the professional practice domains.
Further to the above statement, outline (using bullet points) the **specific professional skills and qualities** that a specialist in this area requires. This could include: • important factors when working with patient groups. • ways that the specialty lead and/or collaborate with their colleagues and other teams involved in healthcare delivery. • personal qualities and values.

An example of a renewed specialty overview is provided in Appendix 2A.17

2.3 Graduate outcomes

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

This standard is addressed along with content related to Standard 3.2, The Content of the Curriculum, from page 110 onwards.

Summary of Standard 2

Strengths and key developments

- RACP Professional Practice Framework finalised following extensive development with members and key stakeholders, which defines the 10 domains of professional practice for all physicians and forms the basis of RACP curricula
- revised Cultural Safety domain of the Professional Practice Framework finalised following comprehensive development process involving key stakeholders
- renewed program and graduate outcomes for Basic Training in Adult Medicine and Paediatrics & Child Health defined in new Basic Training program curricula
- renewed program and graduate outcomes that are common to all RACP specialty training programs defined in Common Standards for Advanced Training
- renewed specialty specific program and graduate outcomes defined in new Advanced Training curricula (6 approved for implementation from 2024, 15 drafted and currently in consultation and 17 to renew in 2024 for implementation from 2025).

Current and future focus areas

- aligning curricula content to the new Cultural Safety Professional Standard
- renewing graduate and program outcomes for specialties in Wave 3 of Advanced Training Curricula Renewal program
- implementing the new graduate and program outcomes.

Standard 3
The specialist medical training and education framework

Explanatory note on the structure of content provided in response to Standards 2, 3 and 4:

To avoid duplication and to logically sequence content for ease of understanding, some responses to Standards 2, 3 and 4 have been provided out of sequence. At the start of each subsection, the relevant Standards addressed have been identified for ease of reference. For example, one section may address both standards 2.3 Graduate Outcomes *and* 3.2 The content of the curriculum *as these sections refer to the same materials. However, all standards have been specifically addressed across the range of the submission.*

Standard 3 The specialist medical training and education framework

3.1 Curriculum framework

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

Curriculum framework (3.1.1)

PREP training programs

The Physician Readiness for Expert Practice, or 'PREP', program framework was introduced in 2008 to guide the design and development of RACP training programs. The PREP programs remain operational in 2024, with a major revision to these programs underway as part of the College's curricula renewal project.

The key principles of the PREP training philosophy are:

- **supportive learning environment** – trainees are provided with a supportive educational framework that will guide them through a defined learning pathway
- **trainee-centred, physician-led approach** – supervisors aim to foster a learning culture within each healthcare setting which allows trainees to tailor learning experiences to meet their individual needs
- **reflective practice** – through enquiry and personal reflection, trainees develop skills for reflective practice necessary for continuous learning and professional practice.

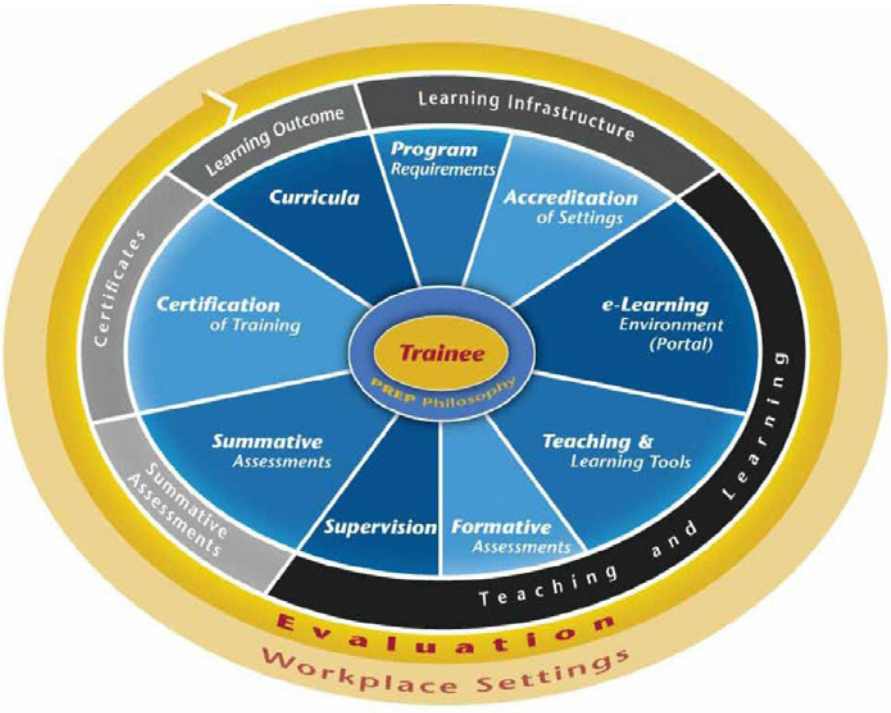
The PREP framework, as illustrated in Figure 28, is made up of various elements of a training program, including:

- **Curricula** – a curriculum specific to each training program outlines the broad concepts and learning objectives related medical expertise in that program, and the Professional Qualities Curriculum explains the non-clinical knowledge, skills, attitudes and behaviours that all trainees need to develop or have as part of their practice.
- **Program requirements** – program requirements, articulated in training program handbooks, are the mandatory components of a training program that a trainee must complete to progress through training. They specify the required formative and summative assessments, teaching and learning activities, type and duration of training rotations, course work, and other requirements such as the minimum duration of training.
- **eLearning environment (Portals)** – both trainees and supervisors are supported by the eLearning environment, which provides access to relevant online learning tools and resources for the PREP program.

- **Teaching and learning tools** – designed to support reflective practice and self-directed learning. These tools cater to a range of learning needs, styles and situations that may arise in workplace training.
- **Assessments** – there are different types of assessments within each program. Some are workplace-based assessments that do not require a pass mark and provide a means for trainees to gain feedback and plan for future learning. Other assessments require trainees to achieve and demonstrate a satisfactory standard to progress. Refer to Standard 5 for details of assessment.
- **Supervision** – supervisors contribute significantly to trainees' learning processes by planning and facilitating trainees' learning path, facilitating effective teaching and learning opportunities, and providing comprehensive and timely feedback on the trainees' progress and achievement of the curricula learning objectives.

All PREP training programs feature these components. The PREP programs introduced new work-based learning and assessment requirements to physician training which enabled increased incidents of self-reflection and assessor feedback into the programs, however the programs remain largely time-based in keeping with historic master-apprentice models in medical training.

Figure 28. PREP framework



New training programs

Following the rollout of the PREP programs, the RACP identified the need to shift the training programs towards a competence-focused model of training.

The first step in this process was the design of the RACP Professional Practice Framework, finalised in 2016, to define the domains of physician practice. Further information on the Professional Practice Framework is available in the Standard 2.

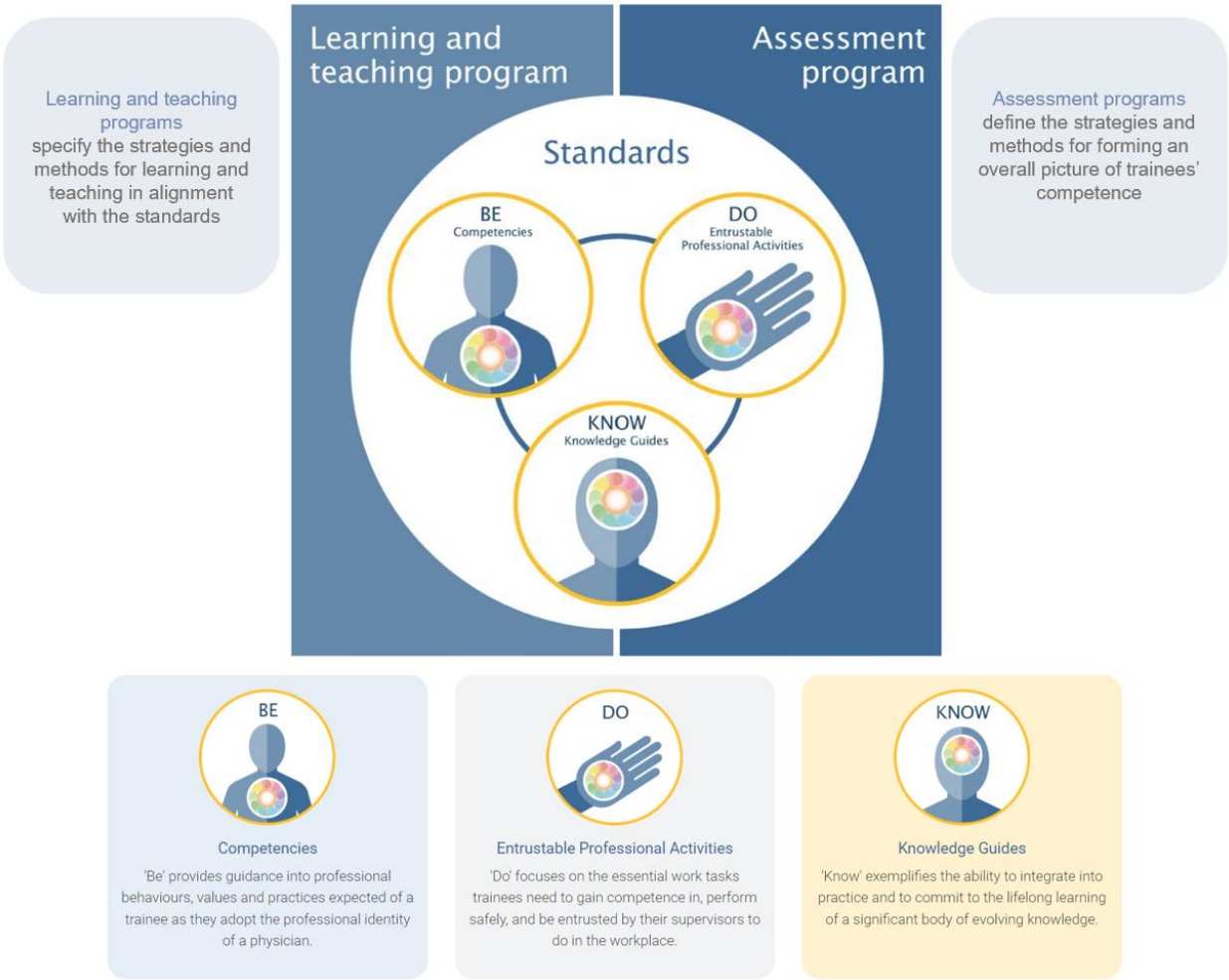
The next step was to establish an overarching organising framework for curriculum objectives to:

- embed consistent expected standards of physician and paediatrician professional practice into the training program curricula
- enable vertical integration of curriculum content between Basic and Advanced Training; and
- align with the expectations for continuing practice.

The RACP Curricula Renewal process was initiated, and a Curriculum Advisory Group (Appendix 1A.47) established to oversee this development work. As mentioned in Standard 1.2, the Curriculum Advisory Group is comprised of individuals with interest and expertise in curricula development. Members include those with professorial, Fellow, senior lecturer and executive roles in medical schools/education institutions, and together hold MDs, PhDs, Masters and Graduate Certificates pertaining to medical education, along with significant practical experience as educators.

Over 2015-2016 the Curriculum Advisory Group refined a model for all College curricula. The curriculum model (Appendix 3A.1) depicts the structure of the curriculum and promotes awareness of its components. The College Education Committee approved the conceptual design of the RACP curriculum model in July 2016, as shown in Figure 29.

Figure 29. RACP curriculum model



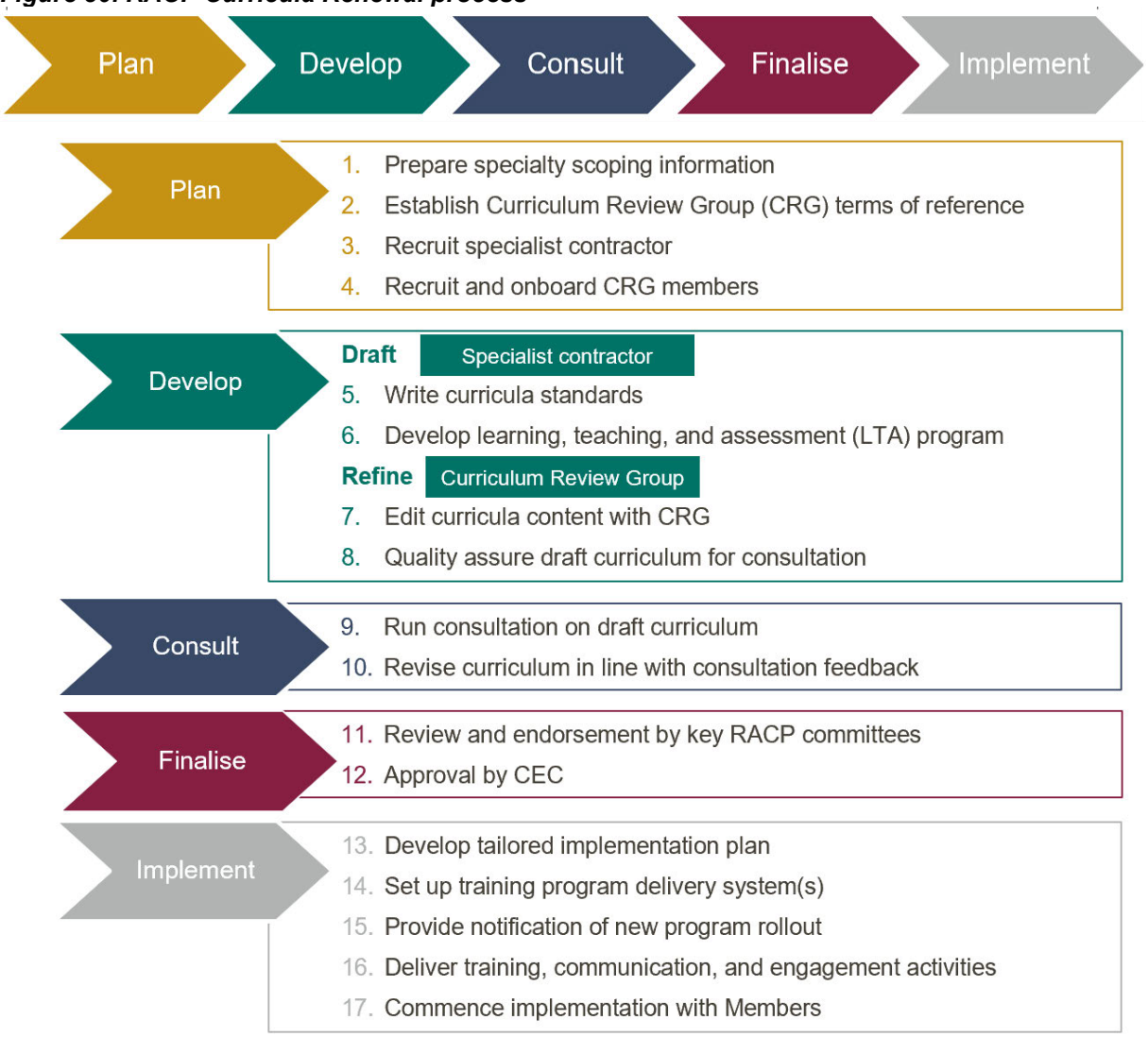
The curriculum model is structured around the concept of what trainees need to **be** (competencies), **do** (entrustable professional activities), and **know** (knowledge guides).

The curriculum model integrates the Professional Practice Framework into the curriculum standards to ensure the ten domains of the framework are embedded in the learning goals of each RACP training program.

Our staged approach to undertaking Curricula Renewal

The RACP Curricula Renewal process involves five development stages, as depicted in Figure 30.

Figure 30. RACP Curricula Renewal process



Through the curricula renewal process, subject matter experts in each training program work with the RACP Curriculum Development team to define the competencies, entrustable professional activities, and knowledge guides for the program using standardised development templates in alignment with the curriculum model.

The set of curriculum standards for each training program form the key learning goals, or graduate outcomes, of the training program, and are the anchors against which the learning, teaching, and assessment programs are designed.

Examples of completed curricula renewed in line with the RACP curriculum model, include:

- New Basic Training programs (Appendix 3A.2)
- Six new Advanced Training programs (from Wave 1 Advanced Training Curricula Renewal) (Appendix 2A.15)

Fifteen renewed Advanced Training programs, developed as part of Wave 2 Advanced Training Curricula Renewal (Appendix 2A.16), were released for consultation in November 2023 with the aim of refining and finalising these curricula by early May 2024.

The remaining 17 Advanced Training programs will be redesigned in line with the RACP curriculum model over 2024, in Wave 3 Advanced Training Curricula Renewal, with a view to finalising these in early 2025.

Specialist expertise contributing to Curricula Renewal

A key feature of the curricula renewal process is the appointment of a specialist contractor and establishment of a Curriculum Review Group (CRG) for each specialty curriculum.

The specialist contractor role was introduced in wave 2 of ATCR in an effort to expedite the process. The specialist contractor is a clinician or expert in the specialty who leads the writing of the first draft of the curriculum in alignment with the project deadlines. They are paid an honorarium for their work.

The specialist contractor is sought through an expression of interest (EOI) process. EOIs are considered by representatives from relevant Advanced Training Committees. The Executive General Manager, Education, Learning and Assessment confirms successful appointees, with consideration of recommendations from the committees. The general expected time commitment from specialist contractors is ~10 hours per week over a six-eight week drafting period.

The CRG is a time-limited working group tasked with refining the new draft curriculum. Each CRG comprises members from the specialty and include representatives from Australia and Aotearoa New Zealand, both Divisions (if appropriate), trainees and specialty societies. CRG members are not required to be members of the Advanced Training Committee (ATC). CRGs have governance reporting lines to the ATCs.

CRG members are sought through an expression of interest (EOI) process. The ATC Chair reviews the EOIs received and appoints members based on merit and overall composition of the group. The general expected time commitment from CRG members is ~20 hours in meetings and out-of-session work over the course of the development process.

Specialist contractors and CRGs are supported and guided through the curricula renewal process by members of the RACP Curriculum Development team with additional expertise and guidance provided by members of the Curriculum Advisory Group.

2.3 Graduate outcomes, 3.2 The content of the curriculum and 3.4 The structure of the curriculum

2.3 Graduate outcomes- the AMC accreditation standards:	
2.3.1	The education provider has defined graduate outcomes for each of its specialist medical programs including any subspecialty programs. These outcomes are based on the field of specialty practice and the specialists' role in the delivery of health care and describe the attributes and competencies required by the specialist in this role. The education provider makes information on graduate outcomes publicly available.
3.2 The content of the curriculum- the AMC accreditation standards:	
3.2.1	The curriculum content aligns with all of the specialist medical program and graduate outcomes.
3.2.2	The curriculum includes the scientific foundations of the specialty to develop skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge.
3.2.3	The curriculum builds on communication, clinical, diagnostic, management and procedural skills to enable safe patient care.
3.2.4	The curriculum prepares specialists to protect and advance the health and wellbeing of individuals through patient-centred and goal-orientated care. This practice advances the wellbeing of communities and populations, and demonstrates recognition of the shared role of the patient/carer in clinical decision-making.
3.2.5	The curriculum prepares specialists for their ongoing roles as professionals and leaders.
3.2.6	The curriculum prepares specialists to contribute to the effectiveness and efficiency of the health care system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of health settings within the Australian and/or New Zealand health systems.
3.2.7	The curriculum prepares specialists for the role of teacher and supervisor of students, junior medical staff, trainees, and other health professionals.
3.2.8	The curriculum includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, so that all trainees are research literate. The program encourages trainees to participate in research. Appropriate candidates can enter research training during specialist medical training and receive appropriate credit towards completion of specialist training.
3.2.9	The curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia, and Māori health, history and cultures in Aotearoa New Zealand as relevant to the specialty(s).
3.2.10	The curriculum develops an understanding of the relationship between cultures and health. Specialists are expected to be aware of their own cultural values and beliefs, and to be able to interact with people in a manner appropriate to that person's culture.

Graduate outcomes (2.3.1)

Graduate outcomes in the PREP training programs

The current PREP Basic (Adult and Paediatrics) and Advanced Training curricula (Appendix 3A.3 - 3A.5), released in 2011, define the expected outcomes at the completion of training for each specialty training program. Learning outcomes are categorised in domains, themes, and learning objectives, and were developed with subject matter experts in consultation with specialty societies, College Members, and other stakeholders.

The PREP curricula are to be used in conjunction with the Professional Qualities Curriculum (last revised 2013).

The combined learning outcomes from the Professional Qualities Curriculum (PQC) and relevant PREP specialty training curriculum form the current graduate outcomes for each RACP training program, reflecting the expected standard for knowledge and skill acquisition and professional behaviours for graduates of the training programs.

Learning objectives of the PQC are categorised with colour codes to provide guidance about levels of learning expected as follows:

> **White - Foundation:** These are the underpinning knowledge and skills, many of which draw on initial medical training. These will be taught and learned and most likely assessed during Basic Training.
>
> **Tan - Higher Order:** These build on Foundation knowledge and skills and may be introduced during Basic Training, although predominantly taught and learned during Advanced Training. These will most likely be assessed during Advanced Training.
>
> **Orange - Extended:** This knowledge and these skills will most likely be further developed within the context of Continuing Professional Development (CPD) but may be introduced during Basic Training or Advanced Training if the opportunity arises.

PREP curricula and the PQC are published on the RACP website and are publicly available. A sample of these graduate outcomes are shown overpage in Tables 13 and 14.

PREP graduate outcomes have remained stable since their release. One minor update was made to the Public Health Medicine learning objectives in April 2022 to increase the expected level of competence that trainees in this program are expected to achieve in relation to the learning outcomes under the Māori and Pacific Islander health domain.

Table 13. Sample of Professional Qualities Curriculum graduate outcomes

Professional Qualities Curriculum graduate outcomes			
Theme		**Learning Objective**	
DOMAIN: MEDICAL EXPERTISE			
See learning outcomes listed in relevant PREP curriculum			
DOMAIN 1: COMMUNICATION			
1.1	Physician–patient communication	1.1.1	Apply communication skills to engage and reassure the patient in specific situations including: first encounters, history taking, counselling and breaking bad news
		1.1.2	Empower patients and be respectful of their rights in all aspects of communication
1.2	Communicating with a patient's family and/or carers	1.2.1	Apply communication skills in encounters with a patient's family (including extended family) and/or carers
1.3	Communicating with colleagues and broader healthcare team	1.3.1	Communicate effectively within multidisciplinary teams
		1.3.2	Communicate effectively with referring doctors and when referring a patient to another specialist
		1.3.3	Facilitate effective clinical handover and transfer of care
		1.3.4	Communicate effectively with health administration
1.4	Communicating with the broader community	1.4.1	Communicate effectively with support organisations, administrative bodies, governments and others in the wider community
		1.4.2	Apply specific medico-legal communication practices
DOMAIN 2: QUALITY AND SAFETY			
2.1	Using evidence and information	2.1.1	Use evidence to inform quality improvement
2.2	Safe practice	2.2.1	Optimise safe work practice, which minimises error
		2.2.2	Facilitate safe prescribing and administration of medication and display an understanding of the associated error types, causes and risks
		2.2.3	Promote safe continuity of care for patients
2.3	Identifying, preventing and managing potential harm	2.3.1	Recognise, report on and manage adverse events and error
		2.3.2	Identify, establish, implement and/or comply with relevant risk-management/minimisation procedures
		2.3.3	Describe the process of managing patient complaints and how to use patient complaints to enhance medical care
DOMAIN 3: TEACHING AND LEARNING			
3.1	Ongoing learning	3.1.1	Participate in effective continuing professional and educational development
3.2	Research	3.2.1	Contribute to the development of new knowledge by active involvement in research
		3.2.2	Describe the principles of evidence-based medicine, the limitations of evidence, and the challenge of applying research in daily clinical practice
		3.2.3	Present research findings in written or oral form
3.3	Educator	3.3.1	Recognise the importance of health education and the role of the physician as a teacher to patients, other physicians and in the wider community, and develop the skills to undertake this role
DOMAIN 4: CULTURAL COMPETENCY			
4.1	Cultural competency	4.1.1	Manage one's own cultural competency development
		4.1.2	Communicate effectively with people from culturally and linguistically diverse backgrounds

Professional Qualities Curriculum graduate outcomes			
Theme		**Learning Objective**	
		4.1.3	Apply specific knowledge of the patient's cultural and religious background, attitudes and beliefs in managing and treating the patient
		4.1.4	Recognise how the special history of Māori and Pacific peoples (NZ) and Aboriginal/Torres Strait Islander peoples (Australia) impacts on their current health status
		4.1.5	Identify and act on cultural bias within health care services and other organisations
		4.1.6	Promote effective cross-cultural partnerships and culturally diverse teams to improve health outcomes
DOMAIN 5: ETHICS			
5.1	Professional ethics	5.1.1	Apply an ethical framework in clinical practice
		5.1.2	Describe and apply ethical principles underpinning the conduct of research
5.2	Personal ethics	5.2.1	Develop a sound professional standard of personal conduct
		5.2.2	Critically reflect on personal beliefs, biases and behaviours, and their alignment with health care policy and impact on interaction with patients
5.3	Ethics and health law	5.3.1	Apply legal and ethical frameworks to physician–patient relationships
		5.3.2	Apply relevant legislation and ethical frameworks to interactions outside the direct physician–patient relationship
DOMAIN 6: CLINICAL DECISION MAKING			
6.1	Clinical decision making	6.1.1	Describe and apply the process of diagnostic reasoning
		6.1.2	Prognosticate and predict risk
		6.1.3	Derive therapeutic decisions which maximise patient benefit and acceptance
		6.1.4	Use evidence effectively and efficiently to inform clinical decision making
DOMAIN 7: LEADERSHIP AND MANAGEMENT			
7.1	Self-management	7.1.1	Implement and model effective self-management practices
7.2	Leadership and managing others	7.2.1	Provide leadership and effectively manage others
DOMAIN 8: HEALTH ADVOCACY			
8.1	Advocacy for the patient	8.1.1	Describe and apply the key principles, processes and limitations of advocacy
8.2	Individual advocacy	8.2.1	Identify and address key issues affecting personal work environment and recognise the role of advocacy
8.3	Group advocacy	8.3.1	Describe and apply the necessary steps required to effect change within the community
DOMAIN 9: THE BROADER CONTEXT OF HEALTH			
9.1	Burden of disease	9.1.1	Recognise health priorities for the local community, and more broadly for Australia and New Zealand
9.2	Determinants of health	9.2.1	Identify and define the determinants of health
9.3	Prevention and control	9.3.1	Adopt a population health approach to the prevention of illness, promotion of health and control of disease
9.4	Priority population groups	9.4.1	Implement strategies to reduce inequities in health status between population groups
9.5	Determinants of health	9.5.1	Describe the societal, political and economic pressures that influence the way funding is provided and used

Table 14. Sample of specialty curricula graduate outcomes- Advanced Training in Clinical Pharmacology (not exhaustive)

Theme 1	Basic Pharmacology
1.1	Evaluate the pharmacology of essential drug groups
1.2	Define the principles of pharmacokinetics and their clinical application
1.3	Define the principles of pharmacodynamics and their clinical application
1.4	Apply the principles of pharmacokinetics and pharmacodynamics in special circumstances in pharmacology: children, geriatrics, pregnancy, lactation, pharmacogenetics, renal disease and hepatic disease
Theme 2	**Drug Research**
2.1	Explain good laboratory practise
2.2	Perform drug related research
2.3	Recognise drug development/s and evaluate efficacy, safety, quality and cost effectiveness
2.4	Explain the ethical aspects of drug related research
Theme 3	**Quality Use of Medicine (QUM)**
3.1	Describe drug safety, including assessment and management of adverse drug reactions (ADRs), adverse drug events (ADEs) and drug error
3.2	Diagnose and manage drug interactions
3.3	Interpret drug concentrations and give advice on dose individualisation
3.4	Access, evaluate and provide drug information
3.5	Develop drug policies and actively contribute to drug-related committee activities
3.6	Describe, practice and advise on Quality Use of Medicines (QUM)
3.7	Assess and manage issues related to compliance/adherence/concordance
3.8	Critically review medications and prescribe rationally
3.9	Explain and critically appraise the use of complementary and alternative medicines (CAMS)
Theme 4	**Addiction and Overdose**
4.1	Recognise clinical and legislative issues relating to drugs of dependence/abuse
4.2	Explain toxicological principles and diagnose and manage poisoning/overdose
Theme 5	**Teaching**
5.1	Teach pharmacology effectively at all levels, including undergraduates and postgraduates across all disciplines

Graduate outcomes in the new training programs

The new training programs, developed through the RACP Curricula Renewal program of work, define the expected competency standards at the completion of training for each specialty training program. There are three types of curriculum standards:

Competencies

These are statements of professional behaviours, values and practices expected of a trainee as they adopt the professional identity of a physician. Competencies are organised by the domains of the Professional Practice Framework (Appendix 2A.9).

Entrustable Professional Activities (EPAs)

EPAs are essential work tasks that can be delegated, observed and assessed.

Knowledge Guides

Knowledge guides will provide detailed guidance to trainees on the important topics and concepts trainees need to understand to become experts in their chosen specialty.

For each training program, the combination of curriculum standards forms the key learning goals that guide learning, teaching, and assessment. These learning goals describe the graduate outcomes for the new training programs, an example is shown in Figure 31. The number of learning goals vary depending on the program.

Figure 31 - Example learning goals (graduate outcomes) for the new Basic Training programs

Graduates of the new RACP Basic Training programs will be able to:		
1.		**Clinical assessment** Clinically assess patients, incorporating interview, examination, and formulation of a differential diagnosis and management plan.
2.		**Communication with patients** Discuss diagnoses and management plans with patients and their families or carers.
3.		**Documentation** Document the progress of patients in multiple settings.
4.		**Prescribing** Prescribe medications tailored to patients' needs and conditions.

Graduates of the new RACP Basic Training programs will be able to:		
5.		**Transfer of care** Transfer care of patients.
6.		**Investigations** Choose, organise, and interpret investigations.
7.		**Acutely unwell patients** Assess and manage acutely unwell patients.
8.		**Procedures** Plan, prepare for, perform, and provide after care for important procedures.
9.		**Professional behaviours** Behave in accordance with the expected professional behaviours, values, and practices.
10.		**Knowledge** Acquire the baseline level of knowledge for Basic Training.

Further examples of curricula standards for the new programs are provided in Appendix 3A.6-3A.11.

The expected standard for completion of learning goals is further described in the progression and completion criteria for each training program, as provided in Standard 4.

Common curriculum content in new Advanced Training programs

A challenge identified with the current PREP training programs was that the large volume of training programs, governed by separate specialty training committees, can lead to a wide array of graduate outcomes and training requirements. This diversity in training requirements and outcomes can cause challenges for trainees when completing dual training, for staff when administering bespoke training requirements for multiple specialties, and for the College when planning for supporting systems and infrastructure.

We have been intentional about enhancing consistency across our 40 training curricula through our curricula renewal process. We chose to establish common content for the revised Advanced Training curricula in order to:

- improve the utility of the work-based curricula and programs
- allow content development processes to be streamlined

- benchmark content across programs to demonstrate equivalency
- better facilitate dual training.

The common Advanced Training curriculum standards (Appendix 3A.12), developed by the RACP Curriculum Advisory Group and Curriculum Development team, comprise a set of competencies aligned with the Professional Practice Framework and 13 Entrustable Professional Activities.

The common standards have undergone extensive consultation with RACP Members, specialty societies, consumer organisations, training settings, and other colleges, to:

- ensure the standards are at an appropriate level for the end of Advanced Training
- ensure the standards are assessable
- elicit feedback from a broad range of stakeholders to refine the standards.

The common standards were finalised by the College Education Committee in early 2020. A similar process was undertaken to develop and finalise the common Advanced Training learning, teaching and assessment program in 2021 (Appendix 3A.13).

There remains more work to be done to ensure the competencies for the Cultural Safety domain are appropriate. Development and consultation will continue in this area. Refer to our updates on the Cultural Safety domain in Standards 2.1.2 and 2.2.1.

The common standards are not an entire curriculum, they are a component. The renewed curricula for Advanced Training will comprise a mix of content that is program-specific and content that is common across Advanced Training programs, as illustrated in Figure 32.

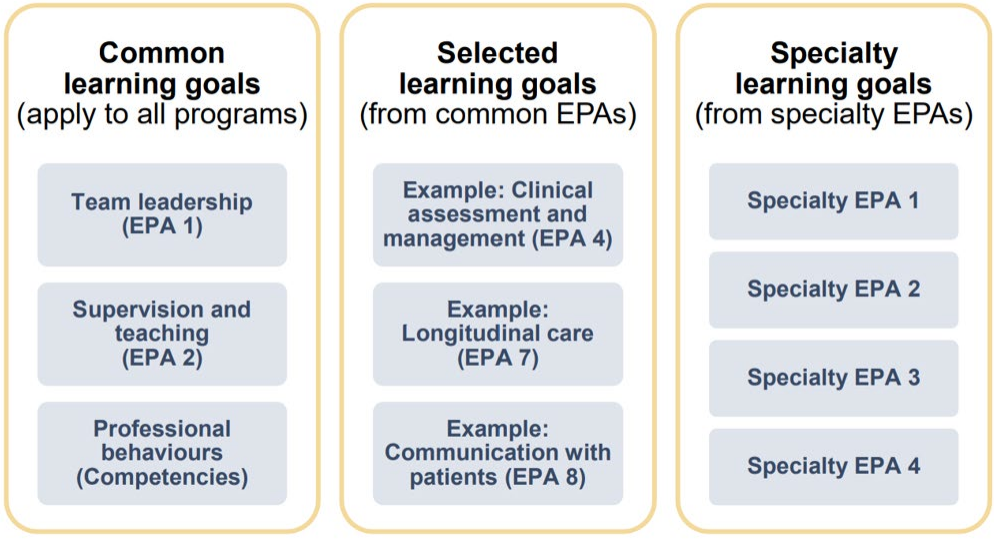
- **Competencies** will be common across Advanced Training programs[4]
- **Entrustable Professional Activities (EPAs)** will be a mix of content that is common and content that is program-specific
- **Knowledge Guides** will be program-specific, although content may be shared between complementary programs.
- The **common Learning, Teaching and Assessment (LTA) programs** will establish a **baseline for learning, teaching and assessment** that will apply to all Advanced Training programs. Specialty groups will be able to tailor these programs by adding elements such as time requirements, learning courses, and entry, progression, and completion criteria, and increasing the numbers of work-based assessments.
  The common LTA programs will apply to all Advanced Training programs, including Faculty training programs, except the Clinical Foundation (Clinical Diploma) in Palliative Medicine.

[4] Some tailoring of Competencies may be necessary for training programs with a less clinical focus.

Figure 32. Mix of common and specialty-specific curriculum content in new AT programs

There are three common **key learning goals** that apply to all Advanced Training programs, as shown in Figure 33. Other common EPAs may be selected for use by Advanced Training programs and/or specialty curriculum content may be developed through the renewal process.

Figure 33. Example of the composition of learning goals in a hypothetical AT program



Curriculum content (3.2)

Alignment of curricula to graduate and program outcomes (3.2.1)

As outlined in 2.3.1, current (PREP) and renewed curricula are built upon graduate and program outcomes, ensuring that curricula content aligns with these outcomes.

Curricula content in training programs (3.2.2-3.2.10)

In the sections below, we first map PREP curricula content in training programs to the AMC's Standards and then in subsequent sections we provide this mapping for our renewed curricula.

Curricula content in PREP training programs (3.2.2-3.2.10)

Figure 34 maps the domains of the PREP Professional Qualities Curriculum to AMC standards 3.2.2 – 3.2.10. For ease of reference, the colours of the PQC domains in Figure 34 translate to the colours of the domains in the new Professional Practice.

Figure 34. Professional Qualities Curriculum domains in reference to AMC standards

Scientific foundations, clinical, diagnostic, management and procedural skills (3.2.2 and 3.2.3)

Physicians have a unique role, with a distinct body of knowledge, skills, attitudes and behaviours which enable them to provide clinical care to the highest standards of excellence. Part of this unique role is the physician's ability to apply effective forms of reasoning to make complex clinical decisions.

To this end, the Professional Qualities Curriculum includes the following learning objectives:

Theme 6.1 Clinical decision making	
6.1.1	Understand and apply the process of diagnostic reasoning
6.1.2	Prognosticate and predict risk
6.1.3	Derive therapeutic decisions which maximise patient benefit and acceptance

6.1.4	Use evidence effectively and efficiently to inform clinical decision making

The curriculum for each PREP training program defines the knowledge, skills, and learning objectives related to medical expertise in the training program.

Time-based professional experience requirements define the expected time. As part of these requirements, many programs specify clinical experiences, such as clinic attendance. The expectations for clinical experiences in 'core' training is often further elaborated on in the criteria for accreditation of training settings, as outlined in Standard 8.

Several RACP training programs require completion of prescribed procedures, and these are typically assessed as completed via a logbook. Refer to Training Program Details Table in Appendix 2D.1. for details of these.

Communication (3.2.3)

In order to provide high-quality care for patients, it is essential that physicians establish and foster effective relationships with patients and their families, other health care professionals and administrative personnel. To achieve this they must develop and utilise the full range of communication-related skills that will enable them to effectively obtain and synthesise information from, and discuss relevant issues with, patients and their families, professional colleagues, administrative personnel and systems as appropriate.

These communication skills will be characterised by understanding, trust, respect, empathy and confidentiality. Effective communication skills will also facilitate their ability to research, evaluate and disseminate information in the broader community. We know that first encounters can have a profound effect on practice; therefore, it is important to develop effective communication strategies early on in training.

The Professional Qualities Curriculum includes the following learning objectives in relation to communication:

Theme 1.1 Physician-patient communication	
1.1.1	Apply communication skills to engage and reassure the patient in specific situations including: first encounters, history taking, counselling and breaking bad news
1.1.2	Empower patients and be respectful of their rights in all aspects of communication
Theme 1.2 Communicating with a patient's family and/or carers	
1.2.1	Apply communication skills in encounters with a patient's family (including extended family) and/or carers
Theme 1.3 Communicating with colleagues and broader health care team	
1.3.1	Communicate effectively with multidisciplinary teams
1.3.2	Communicate effectively with referring doctors, and when referring a patient to another specialist
1.3.3	Apply communication skills to facilitate effective clinical handover and transfer of care
1.3.4	Communicate effectively with health administration
Theme 1.4 Communicating with the broader community	
1.4.1	Communicate effectively with support organisations, administrative bodies, governments and others in the wider community
1.4.2	Demonstrate the ability to apply specific medico-legal communication practices

Shared role of patients in clinical decision-making (3.2.4)

The RACP is committed to supporting effective practice of patient-centred care by trainees and physicians to enable excellent health care experiences and healthier communities.

The Professional Qualities Curriculum describes trainees' expected attitudes and behaviours with patients and families:

- use of a positive, compassionate, caring and empathic attitude towards patients and their families/carers
- involvement of patients as equals in identification of treatment priorities and in the development of the care plan
- ensuring patient confidentiality, particularly where others are involved in the development of a care plan
- imparting of 'bad news' in a compassionate and positive manner
- use of a clinical approach that models and reinforces preventive and prophylactic approaches to health care
- encouragement of patient mastery, including participation in self-awareness and rehabilitation programs
- use of a non-judgemental approach to the assessment of all determinants of illness
- willingness to accede to requests for a second opinion
- provision of constructive and evidence-based advice on complementary and alternative management approaches, when patients wish this.

Further standards relating to shared decision-making with patients are embedded in curricula learning objectives. Examples:

"[Knowledge of patients'] right to be involved in decision making to the extent that the patient feels comfortable"

– Learning objective 1.1.2: empower patients and be respectful of their rights in all aspects of communication. Professional Qualities Curriculum.

"Understand the patient's right to make their own decisions and their rights regarding refusal of treatment / procedures"

– Learning objective 5.3.1: demonstrate the ability to apply legal and ethical frameworks to physician-patient relationships. Professional Qualities Curriculum.

The RACP Framework for improving patient-centred care and consumer engagement (Appendix 3A.14), finalised in October 2016, defines six key principles of patient-centred care [adapted from the Institute of Patient and Family Centred Care (IPFCC) (US)].

Respect and dignity Patient, family and carer knowledge, values, beliefs and cultural backgrounds are respected and incorporated into the planning and delivery of care.	**Indigenous health as a priority** Australia's First Peoples and the Maori of New Zealand experience care which recognises their unique cultural identities and addresses the significant health inequities and lower life expectancy of their peoples.
Shared information Patients, families and carers receive consumer-friendly, timely, and accurate information in order to effectively participate in decision-making and care.	**Collaboration** Consumers and communities are involved at the health system level in policy and program development, delivery and evaluation of services.
Excellent clinical care Patients, families and carers experience safe, effective, timely and co-ordinated care. At a system and population level, this care is informed by innovative evidence-based health policy development and quality improvement activities.	**Participation** Patients, families and carers are encouraged and supported to participate in decision-making and care at the level they choose across the whole continuum of care.

The RACP's Consumer Advisory Group (CAG) is a panel of community members with a background in health consumer affairs, and representing a wide variety of patient and consumer groups across Australia and Aotearoa New Zealand (Appendix 3A.15). The CAG is co-chaired by an RACP Fellow and a community representative. The current community representative co-chair has received Honorary Fellowship of the RACP.

The CAG advise the RACP on how to improve consumer engagement and patient centred care across our professional standards and education approaches, as well as policy and advocacy activities.

Professionalism and leadership (3.2.5)

The expected personal and professional behaviours and attitudes of graduates of RACP PREP training programs are described in the Professional Qualities Curriculum under 'Common attitudes and behaviours' with the following sub-sections describing these in greater detail:

- personal attitudes and behaviours
- attitudes and behaviours with patients and families
- attitudes and behaviours with colleagues.

The professional physician must also be able to manage and make decisions about the allocation of personal, professional and organisational resources.

The Professional Qualities Curriculum includes the following learning objectives related to professionalism and leadership:

Theme 7.1 Self-management	
7.1.1	Implement and model effective self-management practices
Theme 7.2 Leadership and managing others	
7.2.1	Demonstrate ability to provide leadership and effectively manage others
Theme 5.2 Personal ethics	
5.2.1	Develop a sound professional standard of personal conduct

Understanding of health systems (3.2.6)

Physicians have an obligation, both as individuals and in their profession, to positively influence the health circumstances of a patient through advocacy. There is also an opportunity for advocacy for changing the environment or focus of care to improve both the quality and safety of care for others. In the process physicians will proactively identify, analyse, respond to, promote, and be an advocate for, the social, environmental, biological and political factors that determine and impact upon the health and wellbeing of their patients and the broader community.

Physicians must consider the effects of societal issues on health, and broader health determinants. They must be aware of the key population and public health principles, risk factors (social, environmental, psychological) affecting specific population subgroups, and disease-prevention services and legislation.

The Professional Qualities Curriculum includes the following learning objectives related to understanding health systems:

Theme 8.2 Individual advocacy	
8.2.1	Identify and address key issues affecting personal work environment and recognise the role of advocacy
Theme 9.5 Economics of health	
9.5.1	Demonstrate a basic understanding of the societal, political and economic pressures that influence the way funding is provided and used

Teaching and supervision (3.2.7)

Physicians have an important role as teacher and supervisor of students, junior medical staff, trainees, and other health professionals.

The RACP Supervisor Professional Development Program (SPDP) is open to Advanced Trainees to help prepare them for the role of teacher and supervisor. Trainees are encouraged to participate to develop their teaching and supervision skills (Appendix 3A.16). In the new programs Advanced Trainees will be required to complete the SPDP as a requirement of their training program. Further detail on this change is provided in Standard 8.

The Professional Qualities Curriculum includes the following learning objectives regarding teaching and supervision:

Theme 3.1 Ongoing learning	
3.1.1	Participate in effective continuing professional and educational development
Theme 3.2 Research	
3.2.1	Contribute to the development of new knowledge by active involvement in research
3.2.2	Demonstrate understanding of the principles of evidence-based medicine, the limitations of evidence and the challenge of applying research in daily clinical practice
3.2.3	Demonstrate the ability to present research findings in a written or oral form
Theme 3.3 Educator	
3.3.1	Recognise the importance of health education and the role of the physician as teacher to patients, other physicians and the wider community, and develop the skills to undertake this role

Skills expected to be developed under the Educator learning objective in the PQC include:

- Facilitates learning of patients especially regarding self-management, community services and liaison.
- Understands the most effective methods of delivery of health education.
- Facilitates learning of colleagues and students.
- Recognises and maximises learning opportunities.
- Applies knowledge of different learning styles to teaching/learning activities.
- Plans and implements teaching/learning activities with colleagues and other people in the health care team.
- Uses available information and develops new information to inform patients and deliver health education.

Research (3.2.8)

Physicians should actively contribute to the further research, development, appraisal, understanding and dissemination of health care knowledge among their professional colleagues, students and patients and within the broader general community.

The Professional Qualities Curriculum includes the following learning objectives:

Theme 3.2 Research	
3.2.1	Contribute to the development of new knowledge by active involvement in research
3.2.2	Demonstrate understanding of the principles of evidence-based medicine, the limitations of evidence and the challenge of applying research in daily clinical practice
3.2.3	Demonstrate the ability to present research findings in a written or oral form

All trainees are required to complete a research project during Advanced Training. The Advanced Training Research Project (ATRP), introduced to most trainees who commenced after 2017,

addresses previously wide variations in purpose, type, quantity and assessment criteria across the RACP Training Programs. An ATRP submission provides evidence of the skills of:

- considering and defining research problems
- the systematic acquisition, analysis, synthesis and interpretation of data
- effective written communication

The ATRP is a report on a project that the trainee has had significant involvement in designing, conducting of research and analysis of data. ATRPs are not required to be specialty-specific but must be broadly relevant to the chosen area of specialty. 'Broadly relevant' is defined as topics that can enhance, complement and inform the trainee's practice in the chosen specialty. The Research Projects | RACP Online Learning is a self-directed resource covering the process of conducting RACP research projects (Appendix 3A.17). The resource includes interviews with six trainees, exploring their journey completing one of the acceptable types of RACP research projects: research in human subjects, populations and communities or laboratory research; audit; and systematic review. Further detail on the Advanced Training Research Project requirement implementation and improvements is provided in Standards 5.4.1-5.4.2.

Health of Aboriginal and Torres Strait Islander peoples and Māori (3.2.9) and Relationship between culture and health (3.2.10)

Physician training requires trainees to:

- examine their own implicit biases
- be mindful of power differentials
- develop reflective practice
- undertake 'transformative' unlearning
- contribute to a decolonisation of health services for Indigenous peoples.

The Professional Qualities Curriculum includes the following learning objectives of relevance:

Theme 4.1 Cultural competency	
4.1.1	Manage one's own cultural competency development
4.1.2	Demonstrate the ability to communicate effectively with people from culturally and linguistically diverse backgrounds
4.1.3	Apply special knowledge of the patient's cultural and religious background, attitudes and beliefs in managing and treating the patient
4.1.4	Understand how the special history of Māori and Pacific peoples (NZ) and Aboriginal/Torres Strait Islander peoples (Australia) impacts on their current health status
4.1.5	Identify and act on cultural bias within health care services and other organisations
4.1.6	Demonstrate the ability to promote effective cross-cultural partnerships and culturally diverse teams to improve health outcomes
Theme 5.2 Personal ethics	
5.2.2	Demonstrate the ability to critically reflect on personal beliefs, biases and behaviours, their alignment with health care policy and impact on interaction with patients

The Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence and Cultural Safety online course teaches best practice medicine for patients through reflection by a trainee on their own cultural values and recognition of their influence on professional practice (Appendix 3A.18).

This online module has been a mandatory training program requirement for trainees commencing Basic Training from 2022 onwards. It is recommended for those who commenced before 2022. It is also a mandatory training program requirement in all Advanced Training programs for trainees who commenced in 2023 onwards (if they have not completed the course in Basic Training).

The RACP Cultural Safety Curated Collection has been designed to support physicians and trainee physicians in Australia and Aotearoa New Zealand to provide more impactful, meaningful, culturally safe care for Indigenous patients, their families, whānau and communities. The Collection, available to all RACP members, presents a detailed library of resources that can help members understand and implement culturally safe practices in their workplace. The resources cover six themes (see Figure 35) that are central to cultural safety and that have been drawn from the RACP's Statement on Indigenous Child Health in Australia and Aotearoa New Zealand (Appendix 3A.19).

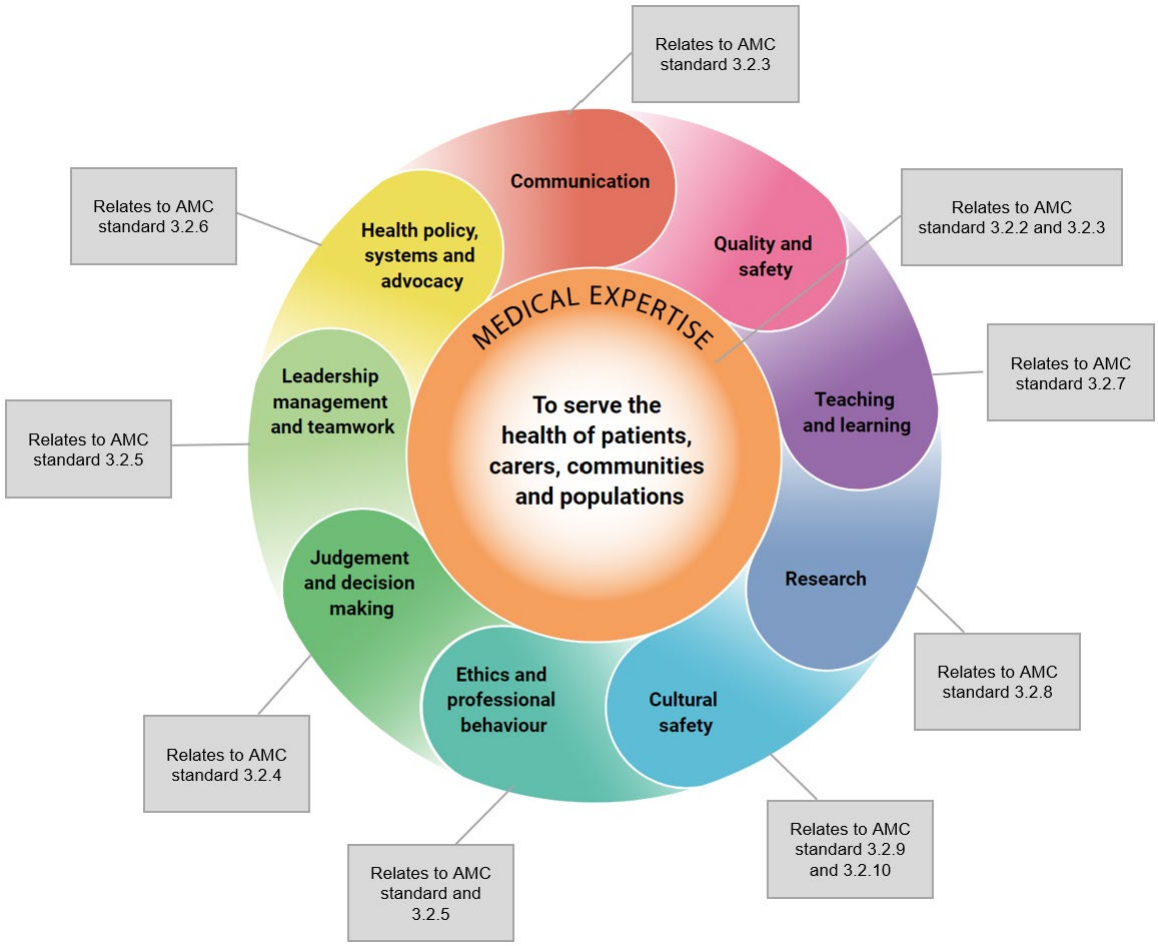
Figure 35. Themes and learning objectives of the RACP Cultural Safety Curated Collection

Theme	Learning Objective
 Unconscious bias	Improve physicians' understanding of how their own unconscious biases can influence their practice.
 Institutional racism	Provide an opportunity for physicians to look to their workplace and acknowledge systems and values that may disadvantage minority cultures and understand changes they can make at both individual and organisational levels.
 Privilege	Provide an opportunity for physicians to reflect on and acknowledge privilege that impacts on their attitudes and approaches to caring for Indigenous patients.
 Colonisation and decolonisation	Encourage physicians to educate themselves on the continued impact of colonisation on Indigenous peoples, and to undertake a process of decolonisation.
 Intergenerational trauma	Improve physicians' understanding of intergenerational trauma and trauma-informed models of care.
 Culture and healthcare	Provide an opportunity for physicians to explore ways that they can embed Indigenous models of healthcare into their practice, and to recognise how their own culture influences the interactions they have with those around them.

Curricula content in the new training programs

Figure 36 maps the domains of the RACP Professional Practice Framework to AMC standards 3.2.2 – 3.2.10.

Figure 36. Professional Practice Framework domains in reference to AMC standards



Scientific foundations, clinical, diagnostic, management and procedural skills (3.2.2 and 3.2.3)

Scientific foundations of the specialty are included in all current Advanced Training curricula; and in the knowledge guide (Appendix 3A.20) component of the new Basic Training curricula standards.

Communication, clinical, diagnostic, management skills are embedded in the RACP professional standards and the competencies (Appendix 3A.21) component of the new Basic Training curricula standards. Procedural skills are covered in the EPA (Appendix 3A.22) components of the new Basic Training (BT) programs and common curricula standards (Appendix 3A.23) for Advanced Training (AT), however inclusion of these types of skills will not be applicable to all RACP training programs. Additionally, the Professional Practice Framework contains a domain dedicated to Quality and Safety. The new BT curricula and the common curricula standards for AT contain competencies in the Quality and Safety domain, and there is a Professional Standard for this

domain. For the existing programs, these skills are embedded in the program curricula and/or the Professional Qualities Curriculum.

The Professional Practice Framework articulates the professional standard in the domain of medical expertise: Physicians apply knowledge and skills informed by best available current evidence in the delivery of high-quality, safe practice to facilitate agreed health outcomes for individual patients and populations.

Figures 37 and 38 illustrate the Basic Training and common Advanced Training competencies relating to the PPF domain of medical expertise.

Figure 37. Basic Training competencies – Medical expertise

THEME	COMPETENCY By the completion of Basic Training, a trainee will be able to:
Knowledge	Develop knowledge of the scientific basis of health and disease and apply this to the management of patients (*see knowledge guides*).
Acute management	Recognise critically unwell patients, initiate management, and escalate as appropriate.
Synthesis	Gather relevant data via age- and context-appropriate means to develop reasonable differential diagnoses, recognising and considering interactions and impacts of comorbidities.
Management	Formulate management plans in partnership with patients, families, or carers[1] and in collaboration with the health care team.
Broader considerations	Develop diagnoses and management plans that integrate an understanding of individual patients' circumstances, including psychosocial factors and specific vulnerabilities, epidemiology, and population health factors (*see knowledge guides*).

Figure 38. Common Advanced Training competencies – Medical expertise

Medical expertise

Professional standard: Physicians apply knowledge and skills informed by best available current evidence in the delivery of high-quality, safe practice to facilitate agreed health outcomes for individual patients and populations.

Knowledge: Apply knowledge of the scientific basis of health and disease to the diagnosis and management of patients.

Synthesis: Gather relevant data via age- and context- appropriate means to develop reasonable differential diagnoses, recognising and considering interactions and impacts of comorbidities.

Diagnosis and management: Develop diagnostic and management plans that integrate an understanding of individual patient circumstances, including psychosocial factors and specific vulnerabilities, epidemiology, and population health factors in partnership with patients, families, or carers[2], and in collaboration with the health care team.

Communication (3.2.3)

Communication is embedded in the RACP professional standards and the competencies component of the new Basic Training curricula standards. Communication skills are covered in

the EPA components of the new Basic Training (BT) programs and common curricula standards for Advanced Training (AT).

There are several online resources available to support trainees to develop their communication skills (Appendix 3A.24). These include: Communication Skills; Communication Essentials; Communication Curated Collection. There are also several resources on communication on RACP Medflix, an educational video library available on the RACP's online learning platform. These are available to trainees in PREP and new programs.

In the new programs the Communication Skills online module is a training program requirement of Basic Training. The Basic Training and Common competencies for Advanced Training that relate to the PPF domain Communication are illustrated in Figures 39 and 40.

Figure 39. Basic Training competencies – Communication

Effective communication skills	Use effective and appropriate verbal, non-verbal, and written communication skills.
Communication with patients, families, and carers	Demonstrate collaborative, effective, and empathetic communication with patients, families, and carers.
Communication with professionals and professional bodies	Demonstrate collaborative, respectful, and empathetic clinical communication with juniors, peers, senior colleagues, and other health professionals and agencies.
	Demonstrate collaborative and effective communication regarding training with supervisors and professional bodies.

Figure 40. Common Advanced Training competencies – Communication

Communication

Professional standard: Physicians collate information, and share this information clearly, accurately, respectfully, responsibly, empathetically, and in a manner that is understandable.

Physicians share information responsibly with patients, families, carers, colleagues, community groups, the public, and other stakeholders to facilitate optimal health outcomes.

Effective communication: Use a range of effective and appropriate verbal, nonverbal, written and other communication techniques, including active listening.

Communication with patients, families, and carers: Use collaborative, effective, and empathetic communication with patients, families, and carers.

Communication with professionals and professional bodies: Use collaborative, respectful, and empathetic clinical communication with colleagues, other health professionals, professional bodies, and agencies.

Written communication: Document and share information about patients to optimise patient care and safety.

Privacy and confidentiality: Maintain appropriate privacy and confidentiality, and share information responsibly.

Shared role of patients in clinical decision-making (3.2.4)

The professional standard for the Judgement and decision making domain states *"Physicians collect and interpret information, and evaluate and synthesise evidence, to make the best possible decisions in their practice. Physicians negotiate, implement, and review their decisions and recommendations with patients, their families and carers, and other healthcare professionals".*

The new Basic Training curricula standards and new common curricula standards for Advanced Training emphasise the importance of formulating management plans in partnership with patients, families, or carers and in collaboration with the health care team (see Medical Expertise competencies [BT and AT]). The explanatory text in the RACP professional standards explains the RACP principles of patient-centred care (as already described on page 113).

The Basic Training and Common competencies for Advanced Training that relate to the PPF domain Judgement and decision making are illustrated in Figures 41 and 42.

Figure 41. Basic Training competencies – Judgement and decision making

	Diagnostic reasoning	Apply sound diagnostic reasoning to clinical problems, to make logical and safe clinical decisions.
		Apply judicious and cost-effective use of health resources to their practice.
	Task delegation	Recognise their own limitations and seek help when required.
		Apply good judgement and decision making to the delegation of tasks.

Figure 42. Common Advanced Training competencies – Judgement and decision making

Judgement and decision making

Professional standard: Physicians collect and interpret information, and evaluate and synthesise evidence, to make the best possible decisions in their practice.

Physicians negotiate, implement, and review their decisions and recommendations with patients, their families and carers, and other health professionals.

Diagnostic reasoning: Apply sound diagnostic reasoning to clinical problems to make logical and safe clinical decisions.

Resource allocation: Apply judicious and cost-effective use of health resources to their practice.

Task delegation: Apply good judgement and decision making to the delegation of tasks.

Limits of practice: Recognise their own scope of practice and consult others when required.

Shared decision-making: Contribute effectively to team-based decision-making processes.

Professionalism and leadership (3.2.5)

The Professional Practice Framework includes a domain for Leadership, Management and Teamwork, and this will be embedded in all renewed curricula. The competencies component of the new Basic Training curricula standards and common curricula standards for Advanced Training include specific competencies for Leadership, management and teamwork (see Figures 43 and 44).

Figure 43. Basic Training competencies – Leadership, Management and Teamwork

Managing others and providing leadership	Develop leadership and management skills to enable them to become a role model and leader in professional practice.
Teamwork	Work effectively in multidisciplinary teams.
Wellbeing	Maintain personal health and wellbeing and consider the health and safety of juniors, peers, senior colleagues, and other health professionals.

Figure 44. Common Advanced Training competencies – Leadership, Management and Teamwork

Leadership, management, and teamwork

Professional standard: Physicians recognise, respect, and aim to develop the skills of others, and engage collaboratively to achieve optimal outcomes for patients and populations.

Physicians contribute to and make decisions about policy, protocols, and resource allocation at personal, professional, organisational, and societal levels.

Physicians work effectively in diverse multidisciplinary teams and promote a safe, productive, and respectful work environment that is free from discrimination, bullying, and harassment.

Managing others: Lead teams, including setting directions, resolving conflicts, and managing individuals.

Wellbeing: Consider and work to ensure the health and safety of colleagues and other health professionals.

Leadership: Act as a role model and leader in professional practice.

Teamwork: Negotiate responsibilities within the healthcare team and function as an effective team member.

Developed in 2020, the RACP online learning module, Introduction to Leadership, Management and Teamwork (Appendix 3A.25) is a compulsory training program requirement of the new Basic Training program to support trainees to develop these competencies during training.

Understanding of health systems (3.2.6)

The Professional Practice Framework includes a domain for Health Policy, Systems, and Advocacy, and this will be embedded in all renewed curricula. See competencies component of the new Basic Training curricula standards and common curricula standards for Advanced Training. Relevant competencies from the curricula relating to understanding of health systems are highlighted below in Figures 45 and 46.

Figure 45. Basic Training competencies – Health policy, systems and advocacy

	The broader context of health	Understand the health needs of the local community and the broader health needs of the people of Australia and New Zealand.
		Understand the population health approach to the prevention of illness, promotion of health, and control of disease.
		Understand current strategies to reduce inequities in health status.
	Health systems, economics, and policy	Demonstrate a basic understanding of health funding and the influence of societal, political, and economic pressures.
	Advocacy	Respond to individual patients' health needs by advocating for them within and outside the clinical environment.

Figure 46. Common Advanced Training competencies – Health policy, systems and advocacy

Health policy, systems, and advocacy

Professional standard: Physicians apply their knowledge of the nature and attributes of local, national, and global health systems to their own practices. They identify, evaluate, and influence health determinants through local, national, and international policy.

Physicians deliver and advocate for the best health outcomes for all patients and populations.

Health needs: Respond to the health needs of the local community and the broader health needs of the people of Australia and New Zealand.

Prevention and promotion: Incorporate disease prevention, health promotion, and health surveillance into interactions with individual patients and their social support networks.

Equity and access: Work with patients and social support networks to address determinants of health that affect them and their access to needed health services or resources.

Stakeholder engagement: Involve communities and patient groups in decisions that affect them to identify priority problems and solutions.

Advocacy: Advocate for prevention, promotion, equity, and access to support patient and population health needs within and outside the clinical environment.

Resource allocation: Understand the factors influencing resource allocation, promote efficiencies, and advocate to reduce inequities.

Sustainability. Manage the use of healthcare resources responsibly in everyday practice.

Teaching and supervision (3.2.7)

The Professional Practice Framework includes a domain for Teaching and Learning and this will be embedded in all renewed curricula. See competencies component of the new Basic Training curricula standards and common curricula standards for Advanced Training (see Figures 47 and Figure 48).

There is a common EPA in all Advanced Training programs on Teaching and Supervision, as shown in Figure 49.

Following consultation with the Curriculum Advisory Group, in July 2022 the College Education Committee approved the inclusion of Supervisor Professional Development Program (SPDP)

completion in the Common learning, teaching and assessment programs for Advanced Training. Refer to Standard 8 for more detail on this change.

Figure 47. Basic Training competencies – Leadership, Management and Teamwork

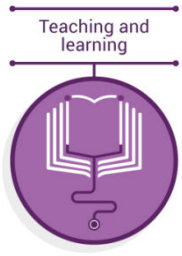
	Lifelong learning	Undertake effective self-education and continuing professional development.
	Teaching and supervising others	Use appropriate educational techniques to promote understanding of health and disease amongst patients.
		Use appropriate educational techniques to facilitate the learning of peers, junior colleagues, and other health professionals.
		Provide supervision for junior colleagues.

Figure 48. Common Advanced Training competencies – Teaching and Learning

Teaching and learning

Professional standard: Physicians demonstrate a lifelong commitment to excellence in practice through continuous learning and evaluating evidence.

Physicians foster the learning of others in their profession through a commitment to mentoring, supsupervising, and teaching.[3]

Lifelong learning: Undertake effective self-education and continuing professional development.

Self-evaluation: Evaluate and reflect on gaps in own knowledge and skills to inform self-directed learning.

Supervision: Provide supervision for junior colleagues and/or team members.

Teaching: Apply appropriate educational techniques to facilitate the learning of colleagues and other health professionals.

Patient education: Apply appropriate educational techniques to promote understanding of health and disease amongst patients and populations.

Figure 49. Common EPA in all Advanced Training programs on Teaching and Supervision

EPA 2: Supervision and teaching

Theme	**Supervision and teaching**	**AT-EPA-02**
Title	**Supervise and teach professional colleagues**	
Description	This activity requires the ability to: • provide work-based teaching in a variety of settings • teach professional skills • create a safe and supportive learning environment • plan, deliver, and provide work-based assessments • encourage learners to be self-directed and identify learning experiences • supervise learners in day-to-day work, and provide feedback • support learners to prepare for assessments.	

Research (3.2.8)

The Professional Practice Framework includes a domain for Research and this will be embedded in all renewed curricula. See competencies component of the new Basic Training curricula standards and common curricula standards for Advanced Training (see Figures 50 and 51).

All Advanced Trainees are required to complete the RACP Advanced Training research project before the end of training., as previously summarised on page 115 and further outlined in Standard 5. For an example of the Advanced Training research project requirements, refer to the Clinical Pharmacology page and Endocrinology page (Appendices 3A.26 and 3A.27, navigate to the Training Requirements tab and scroll to the Advanced Training Research Project section).

Figure 50. Basic Training competencies – Research

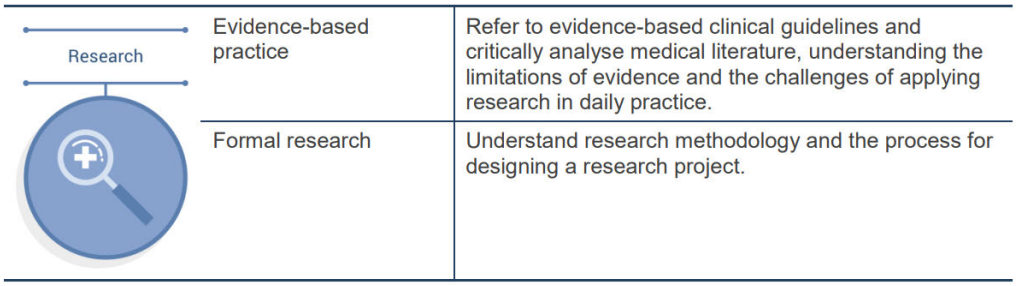
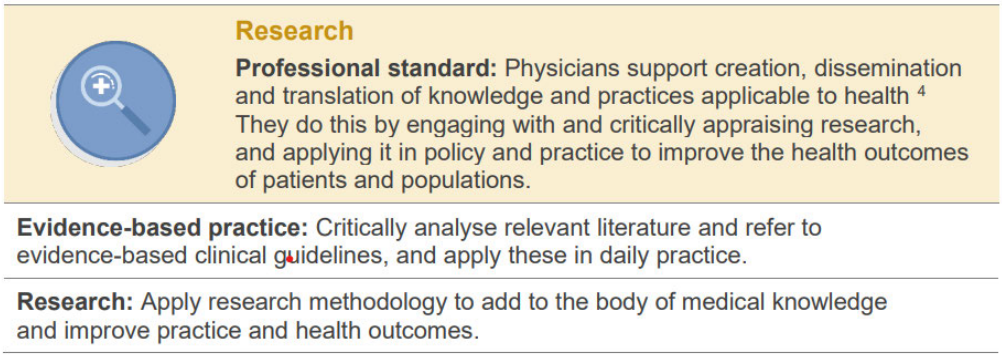


Figure 51. Common Advanced Training competencies – Research



Health of Aboriginal and Torres Strait Islander peoples and Māori (3.2.9) and Relationship between culture and health (3.2.10)

The Professional Practice Framework includes a domain for Cultural Safety, and this will be embedded in all renewed curricula. See competencies component of the new Basic Training curricula standards. Further work will be done on the Advanced Training common curricula standards for Cultural Safety in partnership with the Aboriginal and Torres Strait Islander Health Committee and Māori Health Committee. More detail on this work is provided in Standard 2.

The Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence and Cultural Safety online course (Appendix 3A.28) teaches best practice medicine for patients through reflection by a trainee on their own cultural values and recognition of their influence on professional practice.

This online module has been a mandatory training program requirement for trainees commencing Basic Training from 2022 onwards. It is recommended for those who commenced before 2022. It is also a mandatory training program requirement in all Advanced Training programs for trainees who commenced in 2023 onwards (if they have not completed the course in Basic Training). It is a training program requirement of the new programs.

Other online resources available to trainees to help them develop competencies in cultural safety have been described previously.

Implementation of our new training programs

2021-2023 Basic Training early adopter rollout

Implementation of the new Basic Training programs commenced at the beginning of the second training rotation in 2021 with nine early adopter settings across Australia and Aotearoa New Zealand, including 108 first year (Foundation phase) Basic Trainees.

Useability issues with the Minimum Viable Product version of Tracc, the program's original supporting technology, were identified throughout the early adoption period. These issues stemmed from continued delayed enhancements to functionality of the technology platform. The RACP worked closely with the technology provider to deliver enhancements while maintaining manual workarounds to support the training process for early adopters.

Significant delays in the readiness of the enabling technology have affected our ability to progress to full implementation of the new program with the RACP initiating disengagement with the vendor in March 2023.

Due to discontinuation of the Tracc platform, the College rolled back delivery of the new BT programs pending the availability of suitable technology to enable a well-supported program delivery experience. Over the course of 2023, 247 trainees were rolled back to the PREP program with four trainees at Townsville Base Hospital staying on the new program, completing their Basic Training program at the end of the 2023 clinical year (see Table 15).

Table 15. Early adopter setting participation 2021 - 2023

Lead setting	Time as early adopter setting	Reason for withdrawing as an early adopter
Box Hill Hospital *Adult Internal Medicine*	April 2021 – May 2023	Withdrew due to delays in development of enabling technology, and associated ongoing impacts to user experience
Dunedin Hospital *Paediatrics & Child Health*	May 2021 – May 2023	Withdrawal due to Tracc discontinuation
Gold Coast University Hospital *Adult Internal Medicine*	April 2021 – June 2023	Withdrawal due to Tracc discontinuation
Queensland Paediatric Network *Paediatrics & Child Health*	January 2022 – January 2023	Withdrew due to delays in development of enabling technology, and associated ongoing impacts to user experience
Royal Hobart Hospital *Paediatrics & Child Health*	April 2021 – June 2023	Withdrawal due to Tracc discontinuation
Starship Children's Hospital *Paediatrics & Child Health*	April 2021 – April 2023	Withdrew due to delays in development of enabling technology, and associated ongoing impacts to user experience
Sunshine and Footscray Hospitals *Adult Internal Medicine*	May 2021 – July 2022	Withdrew due to COVID 19 impacts
Taranaki Base Hospital *Paediatrics & Child Health*	January 2022 - April 2023	Withdrawal due to Tracc discontinuation
Townsville University Hospital *Adult Internal Medicine*	April 2021 – August 2023	Withdrawal due to Tracc discontinuation

Lead setting	Time as early adopter setting	Reason for withdrawing as an early adopter
Waikato Hospital *Adult Internal Medicine*	April 2021 - July 2023	Partially withdrew in Dec 2022 due to delays in development of Tracc, the new program's enabling technology, and associated ongoing impacts to user experience
Women's and Children's Hospital, Adelaide *Paediatrics & Child Health*	May 2021 – May 2023	Withdrawal due to Tracc discontinuation

A program evaluation looking at the first year of the new BT program was conducted in late 2021. Details of the evaluation and its findings are provided in Standard 6. Participants in the evaluation endorsed the new curriculum as valuable and representative of physician practice, however issues with implementation, in particular the useability of the supporting technology impeded ability to engage fully with the learning teaching and assessment program. Draft recommendations from the evaluation are being further explored and refined in conjunction with key stakeholders and will inform a review to determine if any changes are required to the program or implementation approaches ahead of further rollout.

The evaluative feedback received from our early adopters has been invaluable in confirming the appropriateness of the design of the new program and what is needed from supporting technology to make implementation as easy as possible for DPEs, trainees and supervisors.

New program rollout plans

Planning for the implementation of the new BT and AT programs is progressing well with full implementation of programs to commence in 2025. All programs are scheduled to commence full implementation by the beginning of the 2026 clinical year. Figure 52 illustrates the staged rollout of renewed curricula for specialties in Basic Training and Advanced Training Waves 1, 2, and 3, with first-year trainees.

Figure 52. schedule of implementation of new training programs

Training management platform

The implementation planning and schedule will be reviewed in line with confirmation of, and subsequent changes to, the schedule for delivery of supporting technology, the Training Management Platform (TMP). The TMP is managed as a separate project and is a key dependency for Curricula Renewal implementation of the redesigned training programs as planned.

Curricula Renewal and TMP projects will work collaboratively and share resources to achieve deliverables. The member-facing aspects of TMP implementation will be managed through the Curricula Renewal project as part of the broader rollout of the new programs.

Please see Standard 1.1 for further information on TMP development.

Wave 1 interim implementation

In lieu of TMP availability, an interim implementation approach for the six Advanced Training Curricula Renewal (ATCR) Wave 1 specialties will commence in 2024 as a transition year. This will involve first year advanced trainees in those programs undertaking a hybrid of the new and PREP program elements (as shown in Figure 53). The transition year will include a strong focus on change management and preparation for full rollout in 2025.

Approximately 400 trainees will be included in the transition year. Training program handbooks for the transition year have been published and support activities are currently underway.

Figure 53. Transition year program elements

New program component	Included in 2024 transition year	Included in 2025 full rollout
Curriculum standards (competency-based learning goals)	☑	☑
Entry criteria	☑	☑
Learning program		
Learning plan	→	☑
Professional experience	☑	☑
Learning courses	→	☑
Teaching program	☑	☑
Assessment program		
New assessment tools	☒	☑
Programmatic assessment	☒	☑
Examinations	→	☑
Progression and completion		
Progression criteria	→	☑
Progress Review Panels	→	☑

☑ delivered → partially delivered ☒ not delivered

Full implementation

Planning is underway and on track to commence full implementation from 2025. Full implementation will be staggered across two years, with six Wave 1 Advanced Training programs for first and second-year cohorts in 2025; two Basic Training programs and 15 Wave 2 Advanced Training programs for first-year cohorts in 2025; and 17 Wave 3 Advanced Training programs for first year cohorts in 2026.

Our implementation support plans include:

- Onboarding activities including online self-service orientation and training resources and orientation and training sessions run via change champion models of training to ensure local and specialty context is considered as a part of delivery.
- Establishment of Progress Review Panels (PRPs) - see Standard 4 for a description of the role of PRPs in our new programs. The established PRPs will sit within the current education governance structure, reporting to the existing training committees that oversee each program, as outlined in Standard 1.2. Delegation of the monitoring and progression of trainees will be provided to PRPs from the Training Committees as the PRPs are established and when the new education technology is available to enable appropriate access to trainee information in order to support reviews.

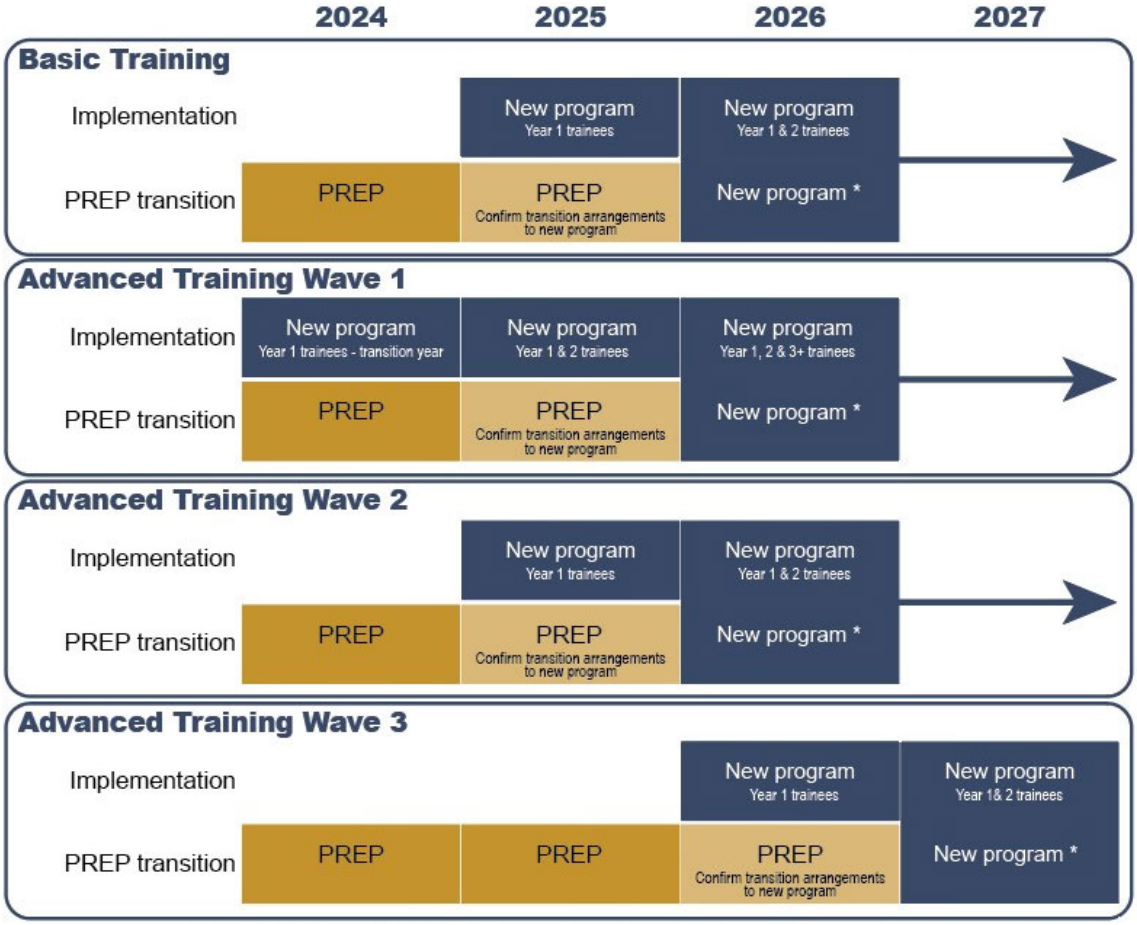
Transition of existing PREP trainees to the new programs

We are developing arrangements for trainees who started training in a PREP program prior to full implementation of the relevant new program to transition to the new programs. These trainees will continue training in the PREP program until full implementation is complete. Implementation of transition arrangements will commence in the year following full implementation of the relevant program.

Transition arrangements will be determined for each training program, guided by standard principles to ensure trainees are well supported throughout the transition period and are not disadvantaged by requirement changes. Training Committees will be supported via existing and new technologies leading up to transition with all trainees to move to the new TMP platform at the time of transition to the new programs.

Implementation and transition to new programs is scheduled to be finalised for 2027 at which point all training settings will be delivering the new training programs, all trainees will be enrolled in the new programs, and the PREP programs and systems may be retired (See Figure 54).

Figure 54. Implementation and transition schedule for new programs



*Trainees enrolled in PREP who are due to complete their training early within the new program transition year will be advised of arrangements in the transition preparation year and supported on a case by case basis.

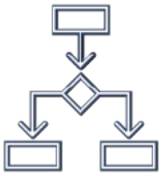
Contingency plans for new program implementation

Detailed project plans, schedules, and risk registers are in place for the Curricula Renewal and Training Management Platform projects to guide the successful delivery of the new curricula and supporting technology.

Contingency plans are in place to ensure the College is ready to address situations and issues if/when they arise during the curriculum design or implementation stages.

Contingency plans for implementation issues have been developed in line with the following principles:

Protect trainees. Trainees must not be disadvantaged by the rollout of the new training programs and will not be penalised for any shortfalls in the RACP or local settings' ability to implement the program.



Streamline contingency enactment. In recognition that training settings may be disrupted at any point during the rollout of the new programs due to COVID-19, a flexible and streamlined process is needed to fast-track approval of temporary amended training requirements and communicate changes as soon as possible to impacted trainees and supervisors.

Respect local advice. Local Directors of Physician/Paediatric Education (DPEs), Supervisors and other training setting leads are the experts in understanding their local capacity constraints and what is / is not feasible in their training setting.

Maintain baseline standard. The new training programs are designed to generate, and base important progression decisions on, lots of day-to-day assessment feedback. The required number of work-based assessments should be upheld where possible with an option to temporarily lower the number of required assessments to match the PREP programs if necessary.

Detailed contingency plans are in place should issues arise during the implementation phase including technology not being fully or partially available for implementation, staff resourcing impacts and stakeholders' reluctance or inability to adopt changes. Monitoring of implementation readiness is ongoing and assessed against implementation readiness criteria.

Contingency plans may be enacted for one or multiple programs. As a part of these contingency plans, mitigations held in reserve prior to full implementation commencing include:

- **Reduced settings** - held in reserve in case of partial completeness of supporting technology and implementation readiness criteria. Contingency plan will amend the schedule to allow a selected number of settings to implement to ensure appropriate support is provided for onboarding and training operations support.
- **Defer implementation** - held in reserve in case it is determined that implementation of the new training program/s cannot go ahead as planned. Contingency plan will amend the schedule to defer the rollout of the new program/s and/or amend the scope.
- **Reduced/revised program scope**- held in reserve in case it is determined that implementation of the new training programs cannot go ahead as planned. Contingency plan will amend the scope of the rollout of the new programs to be supported by existing technology or partially delivered new technology.

3.3 Continuum of training, education and practice

AMC accreditation standards:	
3.3.1	There is evidence of purposeful curriculum design, which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice. *This standard has been addressed earlier in association with Standard 2. Refer to page 82.*
3.3.2	The specialist medical program allows for recognition of prior learning and appropriate credit towards completion of the program.

Recognising the value of prior learning (3.3.2)

Recognition of Prior Learning Policy

A key tenet of RACP education is that all training should be prospectively approved. This is based on the educational rationale that learning should be planned in advance in order to ensure it is educationally robust and meets RACP standards. However, the RACP recognises that there are circumstances where prospective approval of training is not possible, and gives trainees the opportunity to apply for RPL in order to avoid unnecessary duplication of learning. The RACP's Recognition of Prior Learning (RPL) Policy (Appendix 1A.28), provides a mechanism for the formal recognition of experience obtained prior to entry to an RACP training program.

The purpose of the RPL Policy is to ensure a rigorous and adequately documented process is followed in the application for, and granting of, RPL. The policy defines who may apply for RPL as well as possible outcomes after assessment of an application. The policy applies to all trainees, including post-Fellowship trainees, of RACP training programs (Division, Faculty and Chapter) in Australia and New Zealand.

The policy introduces nine principles of RPL to be addressed when making an application for RPL and in assessing applications for RPL: validity, authenticity, currency, reliability, comparability, continuity, timeliness, evidence-based and maximum time.

The policy also outlines four categories of learning which may be eligible for RPL: RACP training programs; non-RACP specialty training programs; relevant post-graduate coursework and research; experience undertaken outside a formal specialty training program.

In most circumstances, RPL will be granted for no more than 12 months of training time. Up to 24 months of RPL may be granted for experience undertaken as part of a specialty training program.

All applications must be received within 3 months of commencing the training program. In early 2024, a change to this aspect of the policy will be implemented, allowing trainees longer (6 months) to apply for RPL for Advanced Training Research Project Requirements.

As outlined in Standard 5.4.1-5.4.2, other changes will be made to the RPL Policy in early 2024 to better align the policy provisions with the Advanced Training Research Project Requirements.

To support the implementation of the RPL Policy several resources are shared on the RACP website (Appendix 3A.29):

- Frequently Ask Questions (Appendix 1A.29)
- Guide for Applicants (Appendix 1A.30)
- Application Form (Appendix 3A.30)
- Application Sample Learning Portfolio (Appendix 3A.31)– a de-identified excerpt from an application for which RPL was fully granted

Data on applications for recognition of prior learning

Table 16 summarises data on applications received for recognition of prior learning over the past three years, including application outcomes. Appendix 3D.1 provides a more detailed breakdown of this data by each specialty.

Table 16. Requests for recognition of prior learning, 2020-2022

Year	# requests received	# granted	% granted	# rejected	% rejected
2020	204	173	85%	31	15%
2021	236	210	89%	26	11%
2022	180	153	85%	27	15%

Recognition of Prior Learning (RPL) applications are most commonly rejected on the grounds that they do not meet the RPL Principles of Validity and Comparability. Broadly, most of the rejected requests are for experiences outside of a training program, which the relevant Training Committee has deemed ineligible for RPL.

In Basic Training, this is most commonly periods completed outside of a formal program at a local level, e.g. it is not at an accredited or appropriate setting with appropriate supervision (Comparability).

In Advanced Training, periods completed outside of a training program are often rejected on the basis that the learning experience does not sufficiently demonstrate relevance to the training program (Validity) and is not comparable in terms of breadth of experience, level of responsibility, rigour of training requirements, assessment process, supervision and training setting (Comparability). Training not being at an equivalent or higher level of responsibility to that of an RACP trainee in the relevant training program is a common reason that Advanced Training RPL applications are rejected.

3.4 Structure of the curriculum

AMC accreditation standards	
3.4.1	The curriculum articulates what is expected of trainees at each stage of the specialist medical program.
3.4.2	The duration of the specialist medical program relates to the optimal time required to achieve the program and graduate outcomes. The duration is able to be altered in a flexible manner according to the trainee's ability to achieve those outcomes. *This Standard is addressed in Standard 4. Refer to page 138.*
3.4.3	The specialist medical program allows for part-time, interrupted and other flexible forms of training.
3.4.4	The specialist medical program provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes.

Description of the programs (3.4.1)

Programs structures have been described throughout earlier sections of Standards 2 and 3, and further details provided in upcoming sections in Standards 4 and 5. A comprehensive summary of the features of each PREP and new RACP training program is provided in the Training Program Details Table in Appendix 2D.1 including:

- duration of training
- experiential requirements

- assessments, teaching and learning activities, inclusive of procedural/other skills requirements
- plans for program review.

Supporting flexible training pathways (3.4.3)

Policies to support flexibility in training

In late 2022, the RACP made significant changes to the Flexible Training and Progression Through Training policies to improve flexibility, equity, wellbeing and inclusion in training, while ensuring a focus on educational outcomes is maintained. The revision of the policies, due in 2023, was expedited in response to the 2021 Gender Equity in Medicine report (Appendix 3A.32). This report highlighted policy barriers, such as caps on leave from training, to achieving gender equity in training. In addition, the policy review also considered the policies from a broader equity, wellbeing and inclusion lens and identified that the policies could impede people with health and wellbeing issues from participating in training.

Following consultation with members including key committees and trainees, the CEC approved four primary changes to the Flexible Training policy:

1. Removal of the 24-month cap on Interrupted Training, taken due to parental leave, that can be excluded from accruing towards the time limit to complete training
2. Periods of Interrupted Training taken due to certified medical leave are now excluded from accruing towards the time limit to complete training
3. The standard minimum full-time equivalent (FTE) considered eligible for part-time training has been reduced from 0.4FTE to 0.2FTE
4. Introduction of 'return to training plan' concept, required for trainees who interrupt training for 24 continuous months or more.

To ensure alignment between policies, associated amendments to the Progression Through Training policy were approved by the CEC, effective from the 2023 training year. The two key amendments are:

1. Time limits to complete training do not include approved full-time parental leave and medical leave.
2. Irrespective of whether certification decisions are made in units of weeks or months, training periods undertaken will be recognised in one-week increments.

Existing time limits to complete training were retained, following the inclusion of additional allowances in response to the impacts of the COVID-19 pandemic. In March 2020, the College Education Committee approved a 12-month extension to the time limit to complete training for all trainees who started training in 2020 or earlier, in recognition of the exceptional circumstances due to COVID-19. This extension applies to the training program(s) that the trainee was registered in for the 2020 training year.

Training programs must be completed within the time limit for the length of the program as set out in Table 17. Basic and Advanced Training are considered distinct training programs and the time limit applies separately to each program.

Table 17. Time limits to complete training based on minimum length of program

Minimum length of program	6 months	2 years	3 years	4 years	5 years
Time limit	15 months	6 years	8 years	10 years	12 years

If a trainee is undertaking dual or conjoint training the time limits for each RACP program will be adjusted. Typically, one additional year will be added to each program's time limit, which may be further extended upon consideration of outstanding training requirements and consideration of periods where training in one program inhibited training in the other.

The updated Flexible Training and Progression Through Training policies (Appendices 1A.25 and 1A.27) came into effect on 1 January 2023 and available on the RACP website (Appendix 3A.33).

We have completed our initial phase of implementation activity, communicating these changes to all members along with FAQs (Appendix 1A.26). The College also hosted a webinar for trainees in April within which flexible training was a topic and we are developing additional resources to support trainees, training settings, supervisors and committees. In early 2024, following one year of these changes being in effect, we will extract and review monitoring data, to identify any variations in application and access to the new provisions.

We were pleased to hear in the latest Medical Training Survey that RACP there was a 5% increase in the proportion of RACP trainees who agree that the College supports flexible training (49% in 2023) and look forward to increasing this with further implementation supports.

Additionally, other groups are aligning their initiatives with these changes. For example, the RACP Research Grants Advisory Committee recently agreed to align grant processes with the standards established in the revised Flexible Training Policy. Grant recipients are eligible to receive their grant funds provided they retain a minimum 0.2FTE at their respective research institution, whereas this threshold was previously set at 0.6FTE.

Interruptions to training and Continuing Professional Development (CPD) requirements

To comply with the new Medical Board of Australia CPD registration standard, in effect from 1 January 2024, trainees that interrupt their training program will need to select a CPD Home and complete CPD requirements if:

- they are not eligible for a CPD exemption according to the CPD Participation Policy, e.g. parental or carers leave and
- they continue to maintain their medical registration in Australia
- they interrupt their training program for more than six months in a calendar year.

In September 2023, the Board approved a new CPD option for RACP trainees that interrupt their training and have a CPD requirement under the new regulatory requirements in Australia. This CPD option is only available to this category of membership for an annual fee of $530 AUD (plus GST).

We have implemented a communications plan and associated processes to support relevant trainees to comply with the new registration standard, with the option to nominate the RACP as their CPD home.

Data on flexible training arrangements

Table 18 summarises data on flexible training arrangements over the past three years. Appendix 3D.1 provides more detailed breakdowns of this data by each specialty, location and gender.

Table 18. Summary of requests for part-time training, 2020-2022

	Number requested	Number granted	% granted
Basic Training	973	797	82%
Advanced Training	2,421	2,005	83%

Allowing for breadth and diversity in training experiences (3.4.4)

Physician and paediatrician training is by nature broad and diverse in the range of fields of practice offered and in the variety of patient types, condition types, and types of training locations that trainees can experience across the course of their Basic and Advanced Training.

Each training program has a set of associated training requirements, which define the types of learning experiences that can be counted towards training, as outlined in Appendix 2D.1 Training Program Details Table. The majority of RACP training programs include provision for some form of elective, or “non-core”, training time in which trainees can gain professional experience in a range of roles to supplement the outcomes of their chosen training program. Many training programs offer flexible methods for completing other prescribed training requirements,

This allowance for diversity and breadth in training accommodates dual training pathways (refer to Standard 2), development of clinician researchers and educators through participation in higher degrees and overseas fellowships, and training in non-traditional settings (refer to Standard 8.2.2 for how we are expanding this), where these activities align with the specified program outcomes and requirements. Our recognition of prior learning policy (refer to Standard 3.3.2) provides for retrospective recognition of relevant training, which allows trainees to account for breadth and diversity in a range of non-linear training journeys.

We are looking at ways to increase this type of flexibility as we shift towards competency-based training models and implement our Accreditation Renewal Program (refer to Standard 8.2). Further information on flexibility in learning experiences and requirements is outlined in Standard 3.4.3.

Summary of Standard 3

Strengths and key developments

- continued use of the PREP program across 40 Basic and Advanced training Programs, inclusive of specialty specific curricula and the Professional Qualities Curriculum.
- commencement and strong progress with education renewal, inclusive of Curricula Renewal to transform 40 training programs
- development of the RACP curriculum model that integrates the Professional Practice Framework into the curriculum standards to ensure the ten domains of the framework are embedded in the learning goals of each RACP training program
- design and approval of new Basic Training programs, with insights gained and actioned from early adoption implementation
- design and approval of six new Advanced Training programs, 15 further programs to be finalised by May 2024 and a model for the renewal of the remaining 17 programs by early 2025
- robust development approach for curricula renewal which has been refined and expedited whilst still allowing for extensive stakeholder input
- comprehensive plans for implementation of the new programs, with a transition year in 2024 and full implementation commencing from 2025, supported by education technology.
- robust assessment processes in place for trainees to seek recognition of their prior learning, with improvements related to recognition of research activities
- revision and implementation of a new Flexible Training Policy, to support improved gender equity, wellbeing and inclusion in training.

Current and future focus areas

- continued progress with Curricula Renewal to finalise renewal of remaining Advanced Training programs
- implementing the renewed programs in partnership with training settings and committees and supported by education technology
- continued implementation, monitoring and review of initiatives, policies and processes to enable flexibility in training in alignment with program and graduate outcomes.

Standard 4 **Teaching and learning**

Explanatory note on the structure of content provided in response to Standards 2, 3 and 4:

To avoid duplication and to logically sequence content for ease of understanding, some responses to Standards 2, 3 and 4 have been provided out of sequence. At the start of each subsection, the relevant Standards addressed have been identified for ease of reference. For example, one section may address both standards 2.3 Graduate Outcomes *and* 3.2 The content of the curriculum *as these sections refer to the same materials. However, all standards have been specifically addressed across the range of the submission.*

Standard 4 Teaching and learning

4.1 Teaching and learning approach

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

4.2 Teaching and learning methods

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

This section also addresses one substandard of Standard 3:

3.4 Structure of the curriculum

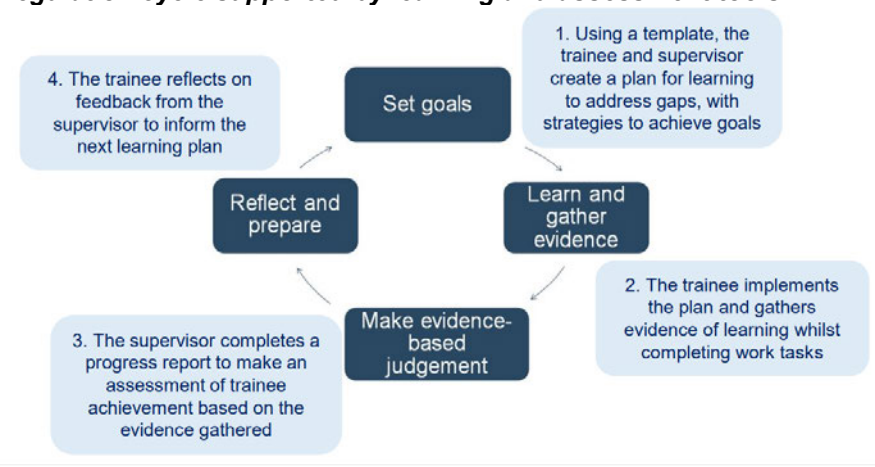
AMC accreditation standards	
3.4.2	The duration of the specialist medical program relates to the optimal time required to achieve the program and graduate outcomes. The duration is able to be altered in a flexible manner according to the trainee's ability to achieve those outcomes.

A comprehensive summary of the features of each PREP and new RACP training program is provided in Appendix 2D.1, including a description of the specific teaching and learning methods and requirements of each program.

Teaching and learning principles

Physician and paediatrician training is primarily work-based in training settings across Australia and Aotearoa New Zealand. RACP training programs embed principles of self-directed learning (Appendix 4A.1) and reflection to promote professional growth, lifelong learning, and self-regulation (See Figure 55).

Figure 55. Self-regulation cycle supported by learning and assessment tools

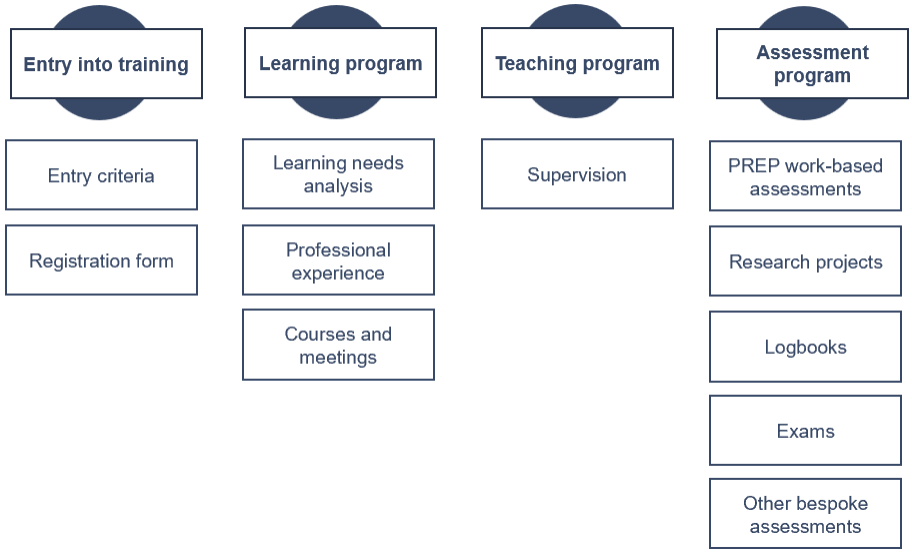


While learning and assessment tools may vary between the PREP and renewed training programs, the underpinning principles of work-based learning and self-regulation apply.

PREP and new program teaching and learning methods

The PREP training programs include a mix of learning, teaching, and assessment tools and requirements (See Figure 56).

Figure 56. PREP learning, teaching, and assessment toolkit overview



Planning and appraising learning

Planning and appraising learning in alignment with the curricula is a core feature of both the PREP and renewed programs.

Current state (PREP): Learning Needs Analysis

The Learning Needs Analysis (LNA) helps trainees to set training goals and track their achievements. It includes a two-part process:

Part 1: Learning Plan

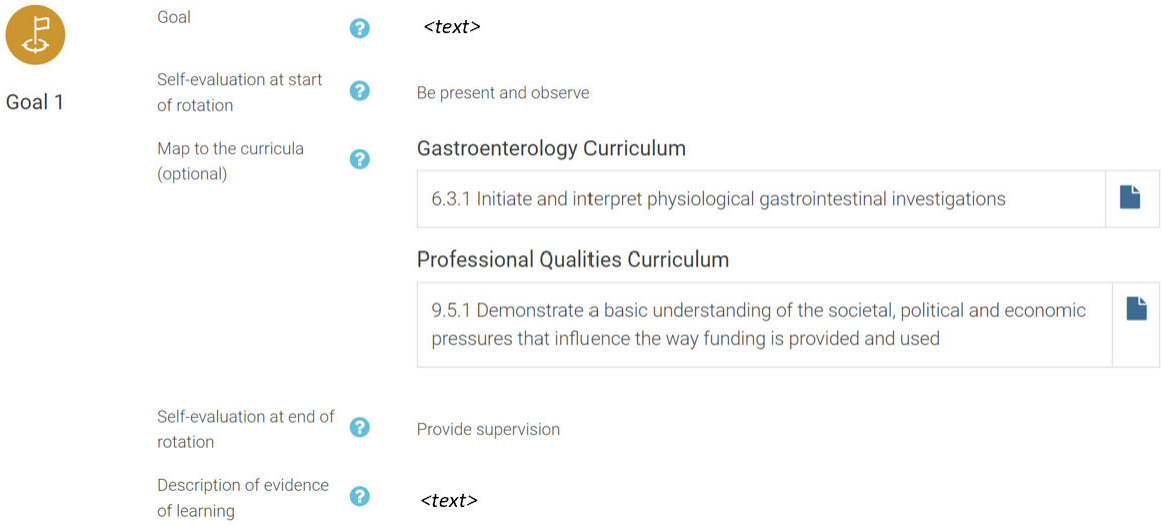
As trainees begin their training, they are prompted to think about their current skills, what they would like to achieve, and strategies for success. Trainees are encouraged to discuss their learning plans with supervisors.

Part 2: Self-Evaluation

At the end of the training period, trainees are asked to review their learning goals and reflect on their progress. After they complete their self-evaluation, they are encouraged to discuss it with their supervisor, reflect on their achievements and gaps and plan for the next rotation.

The Learning Needs Analysis is accessed via the Training Portals. Figure 57 provides an example of an LNA.

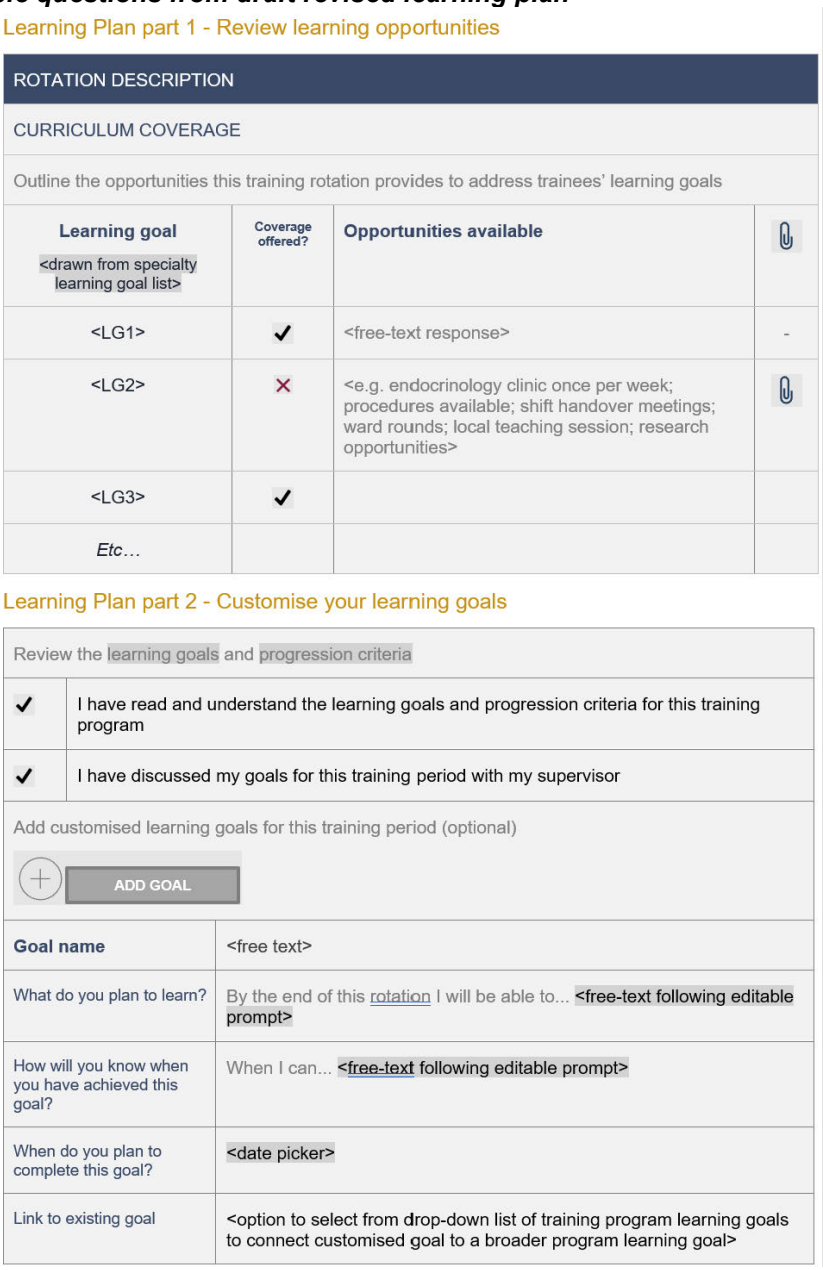
Figure 57. Example: setting learning goals in the LNA



Future state (renewed programs): Learning Plan

The learning plan tool will be refined as part of the renewed training program delivery, to reflect the preset nature of the new programs' learning goals. Figure 58 provides an example of how the revised learning plan may ask trainees to link learning opportunities to their program learning goals, and provide similar options for custom learning goals as provided in the current LNA. The final design of the new learning plan is dependent on the configuration options of the supporting technology.

Figure 58. Example questions from draft revised learning plan



Learning Plan part 1 - Review learning opportunities

ROTATION DESCRIPTION			
CURRICULUM COVERAGE			
Outline the opportunities this training rotation provides to address trainees' learning goals			
Learning goal <drawn from specialty learning goal list>	Coverage offered?	**Opportunities available**	
<LG1>	✓	<free-text response>	-
<LG2>	✗	<e.g. endocrinology clinic once per week; procedures available; shift handover meetings; ward rounds; local teaching session; research opportunities>	
<LG3>	✓		
Etc…			

Learning Plan part 2 - Customise your learning goals

Review the learning goals and progression criteria	
✓	I have read and understand the learning goals and progression criteria for this training program
✓	I have discussed my goals for this training period with my supervisor
Add customised learning goals for this training period (optional) ADD GOAL	
Goal name	<free text>
What do you plan to learn?	By the end of this rotation I will be able to... <free-text following editable prompt>
How will you know when you have achieved this goal?	When I can... <free-text following editable prompt>
When do you plan to complete this goal?	<date picker>
Link to existing goal	<option to select from drop-down list of training program learning goals to connect customised goal to a broader program learning goal>

Professional experience (also addresses Standard 3.4.2)

Both PREP and renewed RACP training programs are vocational programs, drawing on the strengths of work-based learning opportunities garnered from professional experiences.

Current state (PREP): Professional experience

The purpose of time-based professional experience requirements is to ensure that trainees receive breadth and depth of focused physician or paediatrician training, and experience with a wide variety of health problems and contexts.

The majority of RACP training programs require 36 months of professional experience, with some variations (see Training Program Details Table, Appendix 2D.1, for specifics).

Professional experience requirements include training rotations or work placement arrangements to ensure that trainees learn from their work. “Core” learning occurs in accredited training settings, and accreditation standards assure appropriate case mix, educational supervision arrangements, and appropriate physical environments to foster effective work-based learning. Specified learning experiences can vary between training programs, though frequently include aspects of physician practice such as inpatient care, ambulatory care, acute care, and the provision of consultative services within hospitals. Non-hospital-based training programs require different appropriate learning experiences. (see Training Program Details Table for details)

Most RACP training programs have a provision for “non-core” professional experiences, which serve as a flexible way in which trainees can supplement their core learning in accredited settings with other work-based learning experiences.

Learning opportunities vary between training settings and training programs, however training settings often provide local access to resources such as lectures, tutorials, grand rounds presentations, journal clubs, and examination preparatory sessions.

Learning in the workplace is supplemented by work-based learning and assessment tools to ensure trainees reflect on their progress, and are observed and provided with feedback to inform their learning. See Standard 5 for further description of work-based assessment tools.

Trainees’ professional experience plans are reviewed and approved individually each year via annual training application/registration forms.

Future state (new programs): Professional experience

The new training programs are a hybrid of time- and competency-based training and as such will retain minimum time-based professional experience requirements. This is to ensure trainees have minimum expected exposure to important learning experiences and takes into consideration potential disruptions to the health system if all time-based requirements were removed from physician training.

Professional experience requirements will be reviewed and refined to consider alignment to renewed training program learning goals, and to seek justifications for educational rationale, consistency and fairness, and feasibility and sustainability.

As the new competency-focused training programs are rolled out, and progression criteria are implemented, monitored and evaluated, the dependence on time-based professional experience requirements may be able to ease in favour of greater flexibility for trainees to demonstrate how a range of professional experience options may contribute to their learning and achievement of training program learning goals.

Learning courses and meetings

In addition to work-based professional experience requirements, trainees’ learning is supplemented by formal learning experiences.

Current state (PREP): Learning courses and meetings

Depending on the program and it’s learning outcomes, trainees in each program are required to complete formal learning activities such as completion of online modules, participation in learning courses, attendance at scientific or academic meetings and events, and access to online learning resources.

All trainees are required to complete the RACP's Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence and Cultural Safety online course before the end of training. This course is available to trainees for free via the RACP Online Learning site.

Several training programs require trainees to undertake mandatory skills courses as part of their program requirements. For example, all Basic Trainees are required to complete an Advanced Life Support or Advanced Paediatric Life Support course, or equivalent. The College does not typically endorse specific providers of external learning courses, though there are some exceptions to this.

Some training programs require trainees to complete university courses, either prior to or during training. For example, the Sexual Health Medicine Advanced Training Program requires trainees to complete formal units of study in the following areas: fertility regulation; epidemiology; HIV medicine; and laboratory methods. Completion of these units is generally acquired through a Masters level course in Public Health or Sexual Health.

Several programs require trainees to attend annual scientific meetings and conferences, with a view to encouraging trainees to participate in professional development in their chosen specialty and engage in networking with peers.

External learning courses and meeting attendance requirements are typically self-funded by trainees.

Learning course and meeting requirements are outlined in Training Program Requirement Handbooks. See Training Requirements Details Table in Appendix 2D.1 for details.

Future state (new programs): Learning courses and meetings

The renewed training programs will include requirements for trainees to complete an expanded list of standardised, free online courses aligned with the Professional Practice Framework and accessible via RACP Online Learning (See Figure 59).

Figure 59. Required RACP learning courses in renewed curricula

Learning program requirements

Required learning courses
RACP Orientation to Basic Training resource**
RACP Communication skills resource**
RACP Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence and Cultural Safety resource**
RACP Ethics and Professional Behaviour resource**
RACP Leadership, Management, and Teamwork resource**
RACP Orientation to Advanced Training resource*
RACP Health Policy, Systems and Advocacy resource*
RACP Supervisor Professional Development Program
*Resource in development
**Required in the new Basic Training programs. Not required to be repeated if already completed in BT.

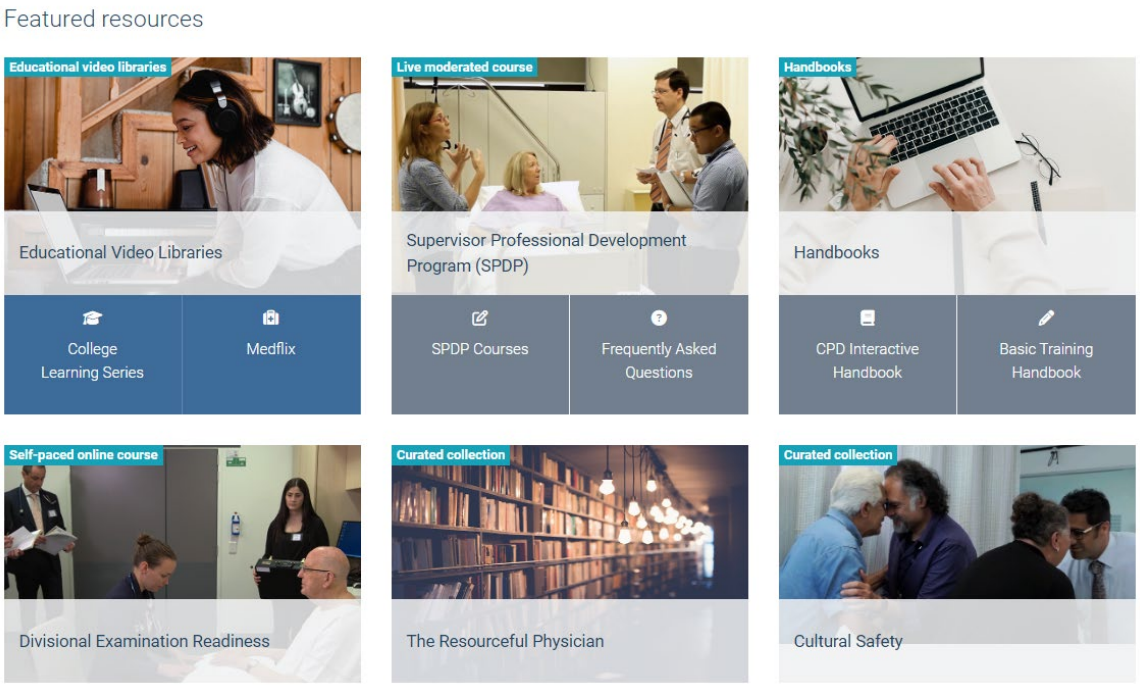
Existing requirements for external courses, study, and/or meeting attendance in PREP programs will be reviewed through the curricula renewal process, to ensure requirements have clear educational rationale and are aligned with revised training program learning goals, are feasible, sustainable, and don't pose unnecessary barriers for trainees to progress and complete their training.

Supplementary learning resources

In addition to required formal learning requirements, we provide a range of resources for self-directed learners to access to address their learning goals.

RACP Online Learning (Appendix 4A.2) is home to all online learning opportunities for trainees, overseas trained physicians, and Fellows' continuing professional development. It hosts a range of online learning courses, resources, curated collections and podcasts (See Figure 60).

Figure 60. Example of RACP Online Learning resource collections



Online Learning Resources cover a wide range of topics, including:

- Aboriginal, Torres Strait Islander and Māori Cultural Competence and Cultural Safety
- Adolescent & Young Adult Medicine
- Addiction Medicine
- Communication, Leadership and Management
- Clinical audit
- Critical Care
- Ethics
- Indigenous Health
- Overseas Trained Physicians (OTP)
- Quality and Safety
- Research
- Rural Health
- Palliative Medicine
- Sexual Health Medicine
- Supervisor Professional Development

Resources are developed by expert RACP Members in collaboration with College staff.

College Learning Series

RACP Online Learning also hosts the College Learning Series (Appendix 4A.3), a growing and interactive resource of online lectures, mapped to the College curricula and specifically targeted to the needs of Basic Trainees.

The College Learning Series (CLS), launched in early 2018, delivers a comprehensive online lecture program with more than 450 recorded lectures available. The first annual program for Paediatrics and Child Health (PCH) commenced on 30 June 2021. Supplementary lectures were added to the series in 2022, bringing the total to 106 lectures. In 2023, the first full calendar year program for PCH was launched, delivering 131 lectures.

The Adult Medicine program has been running every year since its launch in 2018. The 2023 program delivered 147 lectures. Twenty-one of these lectures have been identified as covering acute presentations that are particularly valuable for first year basic trainees, and they have been promoted in this manner. The 2023 series also delivered the following five Hot Topics lectures:

- cardiology: Heart failure, cardiac structural intervention, and electrophysiology
- transoesophageal Echocardiogram (TOE)
- infectious diseases: Monkey pox, Japanese encephalitis, tuberculosis guidelines, the Anchor study
- immunotherapy related endocrinopathies
- immunotherapies in haematology.

The CLS produced five dedicated COVID-19 lectures to date:

- 2021 AMD series
    - hot topics for infectious diseases: COVID-19 (3-part lecture)
- 2022 AMD series
    - coronavirus clinical features; and
    - COVID-19 Vaccination and therapeutics.
- 2023 AMD series
    - COVID-19 update
- 2023 PCH series
    - COVID-19 in children: Acute and long-term consequences.

Member enrolment in the CLS continues to increase, with 90% of Adult Medicine basic trainees, 98% of Advanced Trainees and 35% of Fellows enrolled in the CLS as of January 2024.

Over 6,000 RACP members clicked play on a CLS Adult Medicine lecture in 2023, with more than 100,000 views in total.

PCH basic trainee enrolment has increased from 57% in February 2023 to 68% in January 2024. Forty-one per-cent of Advanced Trainees and 17% of Fellows are also enrolled. Over 1,000 RACP members clicked play on a CLS Paediatrics & Child Health lecture in 2023, with over 13,500 views in total.

In April 2022, the RACP began adding pop-up surveys at the end of its previous lecture videos to provide a more comprehensive and responsive review process for content, and better feedback for lecturers. As of 8 January 2023, 131 viewers had responded to the following four

statements (Table 19). Of the respondents, 81% were basic trainees, 86% were from Adult Medicine and the geographic distribution was evenly split across all Australian states and Aotearoa New Zealand.

Table 19. Survey responses from CLS viewers

Extent to which the lecture viewed:	Average star rating out of 5
Covered what you [the viewer] need to know about the topic	4.3
Was pitched at the right level of training (not too advanced, not too basic)	4.3
Was well presented	4.3
Had good quality audio/video	4.4

Supervision and feedback

Trainees learn and develop through feedback and guidance from their training supervisors and other colleagues and role models in the workplace.

Feedback plays a key role in moving trainees towards their goals and provides opportunities to clarify expectations and adjust learning goals. Giving feedback to trainees, whether it is about a particular task or their overall performance, is an essential part of facilitating their progress towards expert performance.

Feedback to trainees is prompted by RACP work-based learning and assessment tools, which are designed to supplement the process of observation, reflection, and feedback to trainees from a range of assessors and supervisors. See Standard 5 for further description of work-based assessment tools.

Supervisors receive training for their roles through completion of the RACP Supervisor Professional Development Program (SPDP) (Appendix 3A.16). SPDP includes three training modules (Appendices 4A.4-4A.6):

SPDP 1 | Educational Leadership and Management

Educational and leadership management incorporates the overarching themes of developing trainee expertise and using coaching techniques to improve feedback practice.

This workshop focuses on delivering feedback using 2 frameworks, the GROW model and the four areas of feedback. By using these models, supervisors can facilitate change and growth in trainees towards expert performance.

Objectives

- Demonstrate strong educational leadership.
- Plan and manage for effective supervision.
- Advocate for enhanced support for trainees.
- Self-reflect on supervisory performance.

SPDP 1 booklet

SPDP 2 | Learning Environment and Culture

Learning environment and culture provides a range of teaching strategies to manage and overcome challenges supervisors face in a complex healthcare setting. These strategies include planning for learning, differentiated instructions for multi-level groups, and using teaching techniques such as questioning.

This workshop explores some cultural aspects that may impact on learning, including the hidden curriculum, tribalism and the need for effective role modelling.

Objectives

- Understand how to establish an effective learning environment.
- Recognise the importance of planning for learning.
- Define and model professional behaviour.
- Optimise opportunities for learning.

SPDP 2 booklet

SPDP 3 | Teaching and Facilitating Learning for Safe Practice

Teaching and facilitating learning for safe practice is a complex and necessary part of physician training. The challenges of undertaking work-based learning and assessment along with the complexities of the healthcare environment are many and varied.

This workshop offers techniques and solutions to these challenges that will help supervisors in their vital role.

Objectives

- Use safe and effective work-based assessments/activities to guide learning.
- Make evidence-based assessment on trainee performance.
- Use evidence-based tools to improve supervisory practice.

SPDP 3 booklet

Further details regarding our support for supervisors are provided in Standard 8.

Current state (PREP): Supervision and feedback

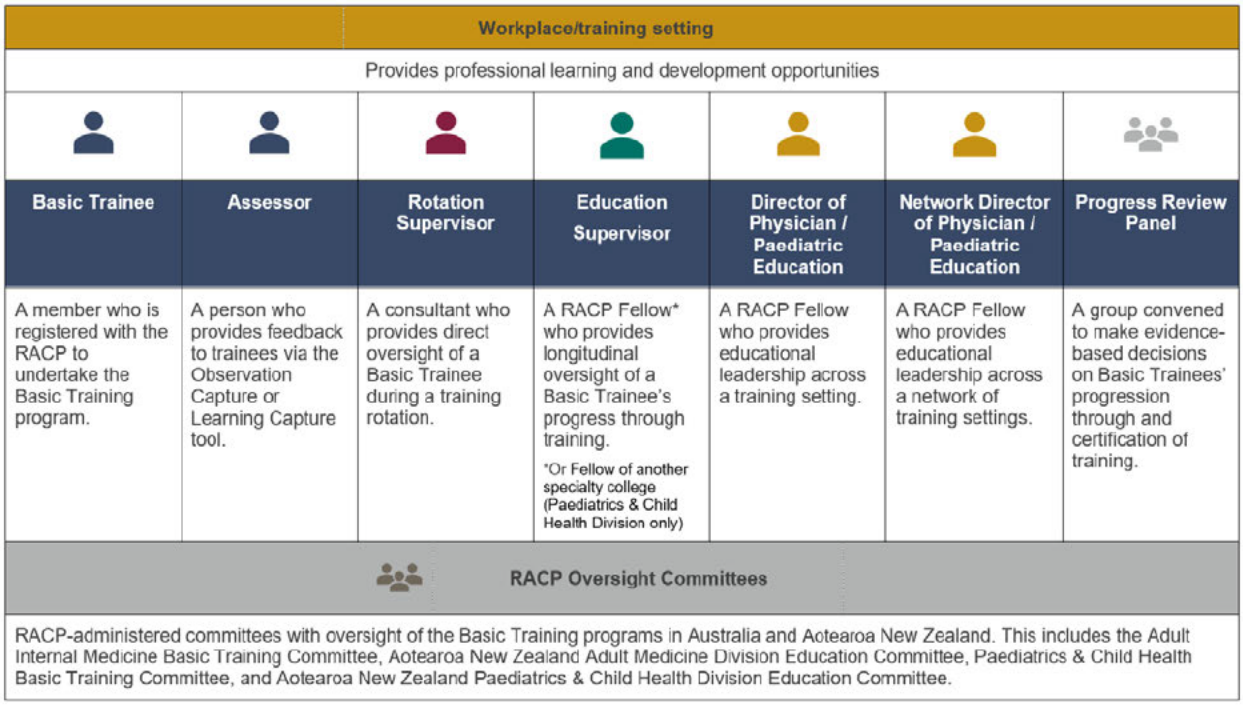
PREP trainees are typically required to nominate two supervisors for each period of training. Specific supervision requirements are detailed in the Training Program Handbooks.

Future state (new programs): Supervision and feedback

The design of the renewed training programs will build on the strong trainee/supervisor relationships that form a foundation of the PREP programs, and seek to enhance the provision of feedback and guidance to trainees through clearer learning goals and evidence of progress drawn from increased work-based assessments.

The training program handbook (Appendix 4A.7) for the new Basic Training programs outlines the roles and responsibilities for trainees, assessors, and supervisors in the context of the new training programs (See Figure 61).

Figure 61. Overview of new BT program roles and responsibilities



Advanced Training supervision roles have some differences compared to Basic Training due to the structure and nature of Advanced Training positions (See Figure 62).

Figure 62. Supervision requirements in new AT programs

Advanced Training teaching program requirements

Name **2 eligible individuals for the role of Education Supervisor:**

- Minimum of 1 supervisor per rotation, who is a Fellow of the RACP in <specialty>

Recommended: wherever possible, trainees should maintain the same Education Supervisors throughout a phase of training.

Identify **1 RACP training committee or group to act as a Progress Review Panel**

Name **1 individual for the role of Research Project Supervisor** (may or may not be the Education Supervisor).

The renewed training programs will introduce Progress Review Panels to oversee and form decisions on trainees' progression through training. Progress Review Panels will be centrally- or locally-based panels made up of supervisors and other representatives involved in the associated training program.

The panels' goal is to review the evidence of trainees' progress, performance, and abilities in the associated training program and provide input to decision making. Regular review of trainees' progress facilitates a developmental approach, supporting trainee learning over time.

The shared decision-making, based on evidence of trainees' performance, aims to enable a better overview of changes in trainee performance over time and therefore better decision making. Group discussion also aims to increase detection of trainees' problematic performance and patterns of performance, assist in addressing some 'failure to fail' issues, and support

decision makers in cases of appeal and trainees in cases of perceived supervisor bias (see Figure 63).

Figure 63. Progress Review Panel responsibilities

Review and assess trainees' progress

- Synthesise pieces of evidence to make informed decisions about trainees' completion of requirements and eligibility for phase progression.
- Recommend modifications to trainees' learning plans and activities to aid growth and development.
- Flag issues or concerns with progress.

Monitor delivery of the local training program

- Track the longitudinal progression of all trainees based in the setting.
- Benchmark trainee progress in each phase.
- Identify training needs for trainees and supervisors.
- Identify opportunities for improvement of local training delivery.

Communicate and report on progression decisions

- Communicate progression decisions and guidance on further learning to supervisors and trainees.
- Report to RACP oversight committees where required.

Ensure compliance to regulatory, policy and ethical matters

- Adhere to RACP training requirements and education policies.
- Participate in the RACP Reconsideration Review and Appeals process as required.
- Adhere to the RACP Code of Conduct.
- Comply with workplace policies and procedures as it relates to trainee progression.

Consideration of challenges

Current state challenges

A 2023 internal audit of PREP training program requirements found that there are commonalities in types of training program requirements in the PREP programs. However, the detail of the requirements includes a wide variety of partially or completely customised training requirements.

The audit found that improvements could be made to clearly articulate the educational rationale behind training requirements, and ensure greater consistency, feasibility and sustainability across training programs.

There is a general gap in standardisation of learning and assessment tools and requirements, which contributes to operational complexity and challenges with identifying priority requirements for supporting technology.

Future state focus areas

Through curricula renewal, training programs will define their customised curriculum standards within the parameters of the RACP curriculum model. Learning, teaching and assessment programs will be formed from a standardised learning and assessment toolkit, embedding competency-based, programmatic assessment approaches. Learning and assessment requirements will be blueprinted to curricula standards.

Bespoke PREP training requirements will be reviewed in the context of their alignment with new program learning goals. They will also be considered in terms of their educational rationale, consistency and fairness, and feasibility and sustainability. This will determine if the requirements need to be phased out, adapted to align with new criteria, or continue to be useful for learning in the new training programs.

Draft criteria for the review of renewed RACP training programs was refined over 2023 by the Curriculum Advisory Group and College Education Committee, as shown in Figure 64. These criteria will continue to be refined and used in the review of curricula developed through the renewal process, and are intended to be used as a guide, it is not expected that all requirements will satisfy all criteria.

Figure 64. Draft RACP training program requirement principles

 **VALUE AND EDUCATIONAL IMPACT**	**The educational purpose and impact of the requirement is clearly justified**. i.e., the requirement: • has a clear learning rationale • is clearly aligned with curricula standards • is demonstrably valid (measures what it intends to measure) • optimises reliability (results can be consistently reproduced) • includes clear definition on the expected level of performance • will provide value to Members
 **CONSISTENT AND FAIR**	**The requirement is fair, equitable and allows for flexible completion**. i.e., the requirement: • is compliant with College policies and other regulatory standards • is consistent with requirements across other training programs • is flexible in the way it can be accessed or completed • does not cause unnecessary strain on trainees' wellbeing
 **FEASIBLE AND SUSTAINABLE**	**The requirement can be sustainably delivered**. i.e., the requirement: • can be maintained with existing people and infrastructure resources, including assessors, staff, and technologies • can be delivered in all relevant Australian and Aotearoa New Zealand training settings • can be delivered with standardised RACP operating and support models • is not impacted by access issues which may limit trainees' progression through training • can be adapted to respond to challenging circumstances • may be completed by trainees/supervisors without additional administrative support • does not incur costs beyond standard training and examination fees • is viable for long-term delivery

Increasing degree of independent responsibility (4.2.4)

Current state (PREP)

The PREP training programs have an emphasis on time-based professional experience requirements. Curricula learning objectives define the expected level of knowledge and skill acquisition by the end of the training program. Trainees work towards these objectives over the course of their training program.

A challenge with the PREP training programs is that it can be difficult for trainees to understand the expected milestones for progression within the training programs.

Future state (new programs)

The competency-based focus of the new training programs allows for further definition of the level of competence that trainees are expected to achieve at key stages of the training program.

Learning goals articulate what trainees need to be, do, and know, and are assessed throughout training on a five-point scale (See Figure 65).

Figure 65. RACP learning goal rating scales

Levels	1	2	3	4	5
Be: Competencies (professional behaviours)	Needs to work on behaviour in **more than 5 domains** of professional practice	Needs to work on behaviour in **4 or 5 domains** of professional practice	Needs to work on behaviour in **2 or 3 domains** of professional practice	Needs to work on behaviour in **1 or 2 domains** of professional practice	Consistently behaves in line with **all 10 domains** of professional practice
Do: Entrustable Professional Activities (EPAs)	Is able to **be present and observe**	Is able to **act with direct supervision**	Is able to **act with indirect supervision** (e.g. supervisor is physically located within the training setting)	Is able to **act with supervision at a distance** (e.g. supervisor available to assist via phone)	Is able to **provide supervision**
Know: Knowledge guides	Has **heard of** some of the topics in this knowledge guide that underpin specialty practice *(heard of)*	**Knows** the topics and concepts in this knowledge guide that underpin specialty practice *(knows)*	**Knows how** to apply the knowledge in this knowledge guide to specialty practice *(knows how)*	**Frequently shows** they can apply knowledge in this knowledge guide to specialty practice *(shows how)*	**Consistently applies** sound knowledge in this knowledge guide to specialty practice *(does)*

Progression and completion criteria are defined for each learning goal and anchored to the phases of training outlined in the learning, teaching, and assessment structure (see Figure 66).

Figure 66. Example progression and completion criteria (AT in Cardiology)

		Progression criteria		Completion criteria
	Learning goals	Specialty foundation* *By the end of this phase, trainees will:*	Specialty consolidation *By the end of this phase, trainees will:*	Transition to fellowship *By the end of training, trainees will:*
Be	**1. Professional behaviours**	**Level 5** consistently behaves in line with **all 10 domains** of professional practice	**Level 5** consistently behaves in line with **all 10 domains** of professional practice	**Level 5** consistently behaves in line with **all 10 domains** of professional practice
Do	**2. Team leadership:** Lead a team of health professionals	**Level 2** be able to act with direct supervision	**Level 4** be able to act with supervision at a distance	**Level 5** be able to provide supervision
	3. Supervision and teaching: Supervise and teach professional colleagues	**Level 2** be able to act with direct supervision	**Level 4** be able to act with supervision at a distance	**Level 5** be able to provide supervision
	4. Quality improvement: Identify and address failures in health care delivery	**Level 2** be able to act with direct supervision	**Level 3** be able to act with indirect supervision	**Level 5** be able to provide supervision
	5. Clinical assessment and management: Clinically assess and manage the ongoing care of patients	**Level 2** be able to act with direct supervision	**Level 4** be able to act with supervision at a distance	**Level 5** be able to provide supervision
	6. Management of transitions in care: Manage the transition of patient care between health care professionals, providers, and contexts	**Level 2** be able to act with direct supervision	**Level 4** be able to act with supervision at a distance	**Level 5** be able to provide supervision
	7. **Acute care:** Manage the early care of acutely unwell patients	**Level 2** be able to act with direct supervision	**Level 4** be able to act with supervision at a distance	**Level 5** be able to provide supervision
	8. Communication with patients: Discuss diagnoses and management plans with patients	**Level 2** be able to act with direct supervision	**Level 4** be able to act with supervision at a distance	**Level 5** be able to provide supervision
	9. Procedures: Plan, prepare for, perform, and provide aftercare for important practical procedures and investigations	**Level 2** be able to act with direct supervision	**Level 3** be able to act with indirect supervision	**Level 4** be able to act with supervision at a distance
	10. Clinic management: Manage an outpatient clinic	**Level 2** be able to act with direct supervision	**Level 4** be able to act with supervision at a distance	**Level 5** be able to provide supervision
	11. Manage patients with untreatable, life-limiting cardiac conditions: Manage the care of patients with untreatable, life-limiting cardiac conditions	**Level 2** be able to act with direct supervision	**Level 3** be able to act with indirect supervision	**Level 5** be able to provide supervision

		Progression criteria		Completion criteria
	Learning goals	Specialty foundation* *By the end of this phase, trainees will:*	Specialty consolidation *By the end of this phase, trainees will:*	Transition to fellowship *By the end of training, trainees will:*
Know	**12. Scientific foundations of cardiology**	**Level 3** know how to apply the knowledge in this knowledge guide to specialty practice (knows how)	**Level 4** frequently show they can apply the knowledge in this knowledge guide to patient care (shows how)	**Level 5** consistently apply sound knowledge in this knowledge guide to patient care (does)
	13. Management of the acutely unwell (shocked) cardiac patient	**Level 2** know the topics and concepts in this knowledge guide that underpin specialty practice *(knows)*	**Level 4** frequently show they can apply knowledge in this knowledge guide to specialty practice *(shows how)*	**Level 5** consistently apply sound knowledge in this knowledge guide to specialty practice *(does)*
	14. Coronary artery disease	**Level 3** know how to apply the knowledge in this knowledge guide to specialty practice (knows how)	**Level 4** frequently show they can apply knowledge in this knowledge guide to specialty practice *(shows how)*	**Level 5** consistently apply sound knowledge in this knowledge guide to specialty practice *(does)*
	15. Conditions affecting the circulation	**Level 3** know how to apply the knowledge in this knowledge guide to specialty practice (knows how)	**Level 4** frequently show they can apply knowledge in this knowledge guide to specialty practice *(shows how)*	**Level 5** consistently apply sound knowledge in this knowledge guide to specialty practice *(does)*
	16. Structural heart disease, including valvular and congenital heart disease	**Level 2** know the topics and concepts in this knowledge guide that underpin specialty practice *(knows)*	**Level 3** know how to apply the knowledge in this knowledge guide to specialty practice (knows how)	**Level 4** frequently show they can apply knowledge in this knowledge guide to specialty practice *(shows how)*
	17. Rhythm disorders	**Level 2** know the topics and concepts in this knowledge guide that underpin specialty practice *(knows)*	**Level 4** frequently show they can apply knowledge in this knowledge guide to specialty practice *(shows how)*	**Level 5** consistently apply sound knowledge in this knowledge guide to specialty practice *(does)*
	18. Heart failure	**Level 3** know how to apply the knowledge in this knowledge guide to specialty practice (knows how)	**Level 4** frequently show they can apply knowledge in this knowledge guide to specialty practice *(shows how)*	**Level 5** consistently apply sound knowledge in this knowledge guide to specialty practice *(does)*
	19. Interactions with other specialties and systems	**Level 2** know the topics and concepts in this knowledge guide that underpin specialty practice *(knows)*	**Level 4** frequently show they can apply knowledge in this knowledge guide to specialty practice *(shows how)*	**Level 5** consistently apply sound knowledge in this knowledge guide to specialty practice *(does)*

Through frequent collection of work-based learning and assessment tools, aligned with learning goals, trainees will build a body of evidence to demonstrate their increasing degree of competence and readiness for unsupervised practice.

Progress Review Panels will form decisions on trainees' progression based on the evidence provided and the expected standards outlined in the progression and completion criteria for each training program. As we implement the new programs, we will work closely with Progress Review Panels to support calibration and consistency in decision-making. We will do this through training, resources, monitoring and evaluation. Standard 6.2 provides an update on our evaluation of the implementation of Progress Review Panels.

Summary of Standard 4

Strengths and key developments

- continued delivery of Physician Readiness for Expert Practice (PREP) program teaching and learning activities
- development of Learning, Teaching and Assessment Programs for the renewed Basic and Advanced Training programs
- development and review of a large catalogue of learning resources as part of RACP Online Learning
- delivery, expansion and review of the high-regarded College Learning Series
- continued delivery of a robust Supervisor Professional Development Program
- successful development and pilot of Progress Review Panels through the early adoption of the new Basic Training programs, in alignment with competency based medical education design principles
- comprehensive audit of PREP training program requirements.

Current and future focus areas

- continued review and development of RACP Online Learning to support trainee learning needs in alignment with curricula
- implementing Progress Review Panels for the renewed training programs to oversee and form decisions on trainees' progression through training and ensuring that they are effectively supported in this function through suitable education technology
- ensuring greater consistency, feasibility, and sustainability of training requirements across training programs through addressing the findings of the audit of the PREP training program requirements, via Curricula Renewal
- continued development of the Learning, Teaching and Assessment programs for remaining Advanced Training programs
- implementation of the renewed Learning, Teaching and Assessment programs via implementation of the renewed Basic and Advanced Training programs.

Standard 5 **Assessment of learning**

Standard 5 Assessment of learning

5.1 Assessment approach

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

The purpose of assessment in RACP training programs (5.1.1)

Overall, the purpose of the College assessment programs, now and into the future, is to facilitate learning by guiding the development of trainees towards the achievement of competence and readiness for expert practice.

The goals of assessment at the College are to:

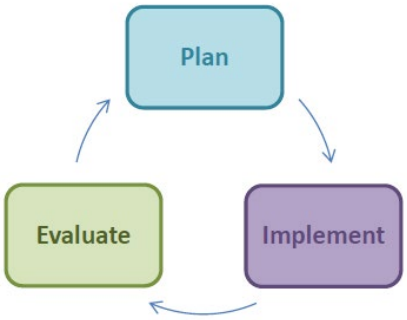
- Support trainees to learn and become the best physician they can be in the field of their choosing. Assessment systems of the training programs do this by providing progressive and constructive feedback on individual learner progress towards the achievement of competence and readiness for expert practice.
- Engage in an accurate, timely and fair process to generate robust evidence of trainee competence for the individual, for their supervisor, and for the College and the broader community.
- Maintain professional standards to promote the highest quality patient care.

Overview of assessment of learning at the RACP (5.1.1)

To support achievement of the above purpose and goals, each RACP training program has formalised structures for the assessment of learning aligned to the curriculum. The strategic and operational approaches to assessment are consistent across training programs and well established in terms of purpose, structures, governance, policies and standards. There are documented procedures for implementing the policies and standards, including assessment development, administration, reporting, and evaluation. Assessment activities are supported by both member and staff resources, all of which hold specialist expertise in assessment relevant to their roles in delivering assessments.

The overall framework that guides assessment practices within College training programs is outlined in the Assessment Policy (Appendix 1A.21) and Standards for Assessment Programs (Appendix 1A22). Together, these document the three principles (Figure 67) and related nine standards for assessment applied across the lifecycle of assessments in the College context.

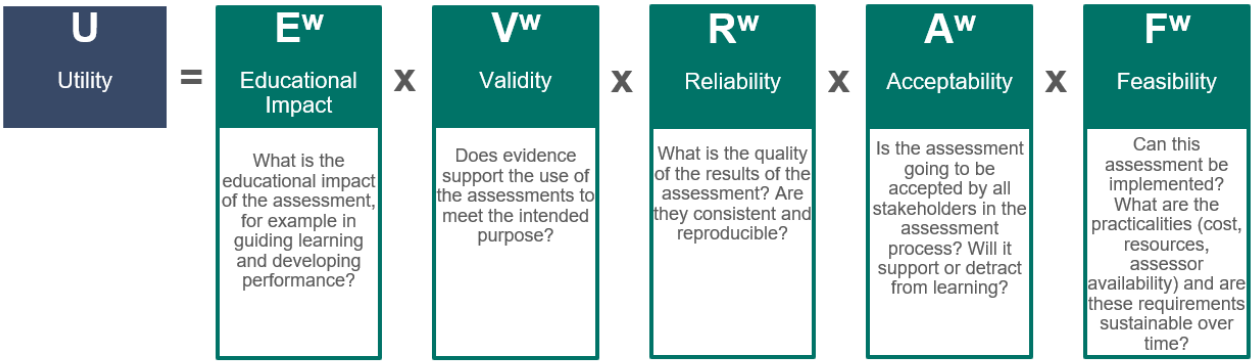
Figure 67. Framework for the RACP's Assessment Standards



The three assessment principles are:

1. **Plan:** this principle details the standards for the development of assessments, including determining the educational value and rationale of assessments, developing programs of assessment, ensuring that assessments are fit for purpose and that the development of assessments is informed by evidence and the context in which it will be used.
2. **Implement:** this principle details the standards for the implementation of assessments, including fairness and transparency, sustainability of assessments, the provision of feedback, and implementation using appropriate methods of communication and training where necessary.
3. **Evaluate:** this principle details the standards for the evaluation and continuous quality improvement of assessments. It outlines how the College applies a "Utility Index"[5] heuristic to guide the evaluation the quality of assessment strategies to fit the context and purpose of assessment across a range of factors as outlined in Figure 68.

Figure 68. Utility Index[5] heuristic as used to evaluate the quality of RACP assessment strategies



[w]= infers a weighting on the factor according to the stakes and context of the assessment

Our embedded programs of assessment (5.1.1)

The College delivers an embedded program of assessment for each of its 40 training programs. Each assessment program is designed to support learning and provide evidence that trainees have met program requirements. The RACP's suite of assessments across training programs

[5] van der Vleuten, C. P., & Schuwirth, L. W. (2005). Assessing professional competence: from methods to programmes. Medical education, 39(3), 309–317. https://doi.org/10.1111/j.1365-2929.2005.02094.x

includes a range of in-training assessment components as well as bi-national written and clinical examinations. Annually, across all training programs this equates to the coordination of thirteen examinations as well as the collection and review of work-based assessments, in-training supervision reports and Advanced Training Research Projects.

The College system of assessment supports the horizontal integration of training program curricula through a suite of standardised work-based assessment tools that are incorporated into each training program in support of relevant graduate outcomes.

Assessment supports vertical integration of curricula by clearly articulating the required standards of performance at each level of training. As trainees move towards and through Advanced Training programs, the increasingly specialised focus of training results in specialty specific goals for assessment along the transition points in training. However, the use of standardised work-based assessment tools is maintained. The Advanced Training assessment programs are currently being renewed using the common templates for learning, teaching and assessment programs, as previously described in Standards 2 and 3.

Factoring for context in assessment (5.1.1)

As highlighted in the Utility Heuristic[5] discussed earlier, quality assessment programs account for a range of factors that can be dependent on the specific context and are informed by the educational paradigm in which the assessment program is designed and implemented. Across the RACP's 40 training programs, and over time, the context for assessment has and will continue to vary. In the following sections, we discuss these contextual factors and identify how we are accounting for them in our assessment programs.

Internal factors impacting RACP assessment programs

The number of trainees within training programs

As detailed in Standards 1 and 7, the number of trainees within each RACP training program greatly varies, ranging from nearly 4000 Adult Medicine Basic Trainees in 2023 to much smaller volumes in Advanced Training programs, such as Sexual Health Medicine, which had 38 trainees in 2023. The volume of trainees determines the number of candidates presenting for barrier examinations, which subsequently impacts the choice of assessment format, administration and standard-setting approaches that can be feasibly applied to support robust decision-making of assessment outcomes. The approaches used for the context of each assessment in the current programs are detailed in Section 5.2 Assessment Methods.

Education Renewal

Like many medical training programs and as described throughout this submission, the training programs of the RACP are engaged in a program of education renewal. As described in detail in Standards 2 to 4, the RACP's education renewal includes a paradigm shift to the principles and practices of competency-based medical education, incorporating programmatic approaches to assessment. Subsequent sections in this Standard outline how the College is approaching the incorporation of programmatic assessment principles through innovations in training and work-based assessment strategies as well as a holistic Cross College Review of Examinations as part of the renewal process.

Evolving assessment towards competency-based medical education (CBME)

Maintaining a robust system of assessment while incorporating change and implementation of new assessment paradigms presents significant challenges to specialist training programs, not least of all because there is no opportunity to 'pause' assessment.

Recognising that this change would be best approached as an evolution, not revolution, the College strategically decided to first design and implement the new curriculum objectives, graduate outcomes and common curricula standards, then the learning, teaching and assessment programs for new curricula. Emphasis was placed on quality improvements to examinations before making significant changes to the role of high-stakes point-in-time assessments in the new programs. The Cross College Review of Examinations (more detail below in Standard 5.1.1), which will take place in 2024, is a key step in establishing what role each assessment type, in particular high stakes single point in time examinations, will have in the renewed curricula.

Evolving concepts and terminology in programmatic assessment

CBME programs that incorporate programmatic assessment principles and systems include a shift in how information from assessment activities is used to support learning and decision-making about progression and certification. Consequently, there have been changes to the terminology and language used to describe types and functions of assessments, and the RACP is in the process of evolving the terminology used to describe new assessment formats in the new curricula. We are shifting away from using language such as 'formative' and 'summative', because in a programmatic assessment paradigm, assessment data is not considered as binary formative/summative data; all data is used to both support learning and inform progression decisions. Instead, our evolving terminology considers the continuum of 'stakes' of assessment related to purpose and how various assessments have low or high stakes implications on training progression.

In this report, we describe high-stakes point-in-time assessments that must be 'passed' to continue progression in training as barrier examinations. In the PREP program these have been characterised as summative assessments. Similarly, in the PREP program, progress reports from supervisors are also considered summative assessments whereas other work-based assessments have been referred to as formative assessments, because their primary purpose is feedback for learning.

The College acknowledges that embedding a change to the way members and stakeholders perceive and define assessment activities requires a significant investment in uplifting assessment literacy about programmatic assessment for all users of assessment and across all programs, and this is likely to be a process that occurs over time.

External factors impacting RACP assessment programs

The College's response to the impact of the COVID-19 pandemic demonstrates the extent of the adaptive strength necessary to achieve change and maintain integrity of the assessment program in the context of factors beyond the control of the College. The pandemic had immediate and ongoing direct and indirect effects on the health workforce, medical education systems and experiences and in particular, our examinations. We detail these impacts throughout the relevant sections of this Standard.

Oversight of assessment (5.1.1)

Since the last accreditation decision, the College has progressed a robust system of governance for examinations, with roles and responsibilities clearly documented for each function.

College Assessment Committee and College Censor

The College Assessment Committee (CAC) was established in 2016 as a key education committee reporting to the College Education Committee. The CAC oversees assessment quality

and improvement across all College training programs, in accordance with the RACP Assessment Policy, Standards for Assessment and other RACP education policies relevant to the conduct of assessment and progression through training. Terms of reference for the CAC are provided in Appendix 5A.1.

The CAC is Chaired by the College Censor. As touched on in Standard 1.2, the College Censor is the custodian of standards for assessment across the College, with the support of the CAC. They are a senior College Fellow with credentials and/or significant experience in assessment and appointed on merit through an expression of interest process. Dr Mike Tweed took up this position in 2023, bringing his expertise in assessment practice and research. He extends upon the pioneering work of Professor Tim Wilkinson, who was the inaugural incumbent in this position.

The Education Governance Review (as outlined in Standard 1.2) aims to strengthen the ability of the CAC and Censor, and in turn College Education Committee, to discharge their responsibilities for quality assurance of assessment across all training programs.

Other key authorities and roles

The RACP has a range of additional accountable authorities for the various responsibilities associated with the design, delivery and monitoring of our programs of assessment. These range from governing committees, operational committees, item writing panels, staff including academic, psychometric and operational leaders, lead examiners and assessors. These roles and responsibilities are summarised in Table 20.

Table 20. Assessment authorities and roles

Role	Responsibilities	Links
Committees	The College has established Examination Committees in each training program that include examinations in assessment programs. These committees apply relevant policies and procedures to oversee the design, development and conduct of assessments including the approval of the results.	
Divisional Assessment Committees (DAC), one per Division	Oversee Divisional examinations. Report to Division Education Committee, with dotted line reporting to CAC.	• Adult Medicine DAC Terms of Reference (Appendix 5A.2) • Paediatrics and Child Health DAC Terms of Reference (Appendix 5A.3) • Adult Medicine DAC Operational Procedures and Delegations (Appendix 5A.4) • Paediatrics and Child Health DAC Operational Procedures and Delegations (Appendix 5A.5)

Role	Responsibilities	Links
Divisional Clinical Examination Committees (DCEC), one per Division per country	Oversee the Divisional Clinical Examinations	• Adult Medicine DCEC Terms of Reference (Appendix 5A.6) • Paediatrics and Child Health DCEC Terms of Reference (Appendix 5A.7) • Adult Medicine DCE Subcommittee - Aotearoa New Zealand Terms of Reference (Appendix 5A.8) • Paediatrics and Child Health DCE Subcommittee - Aotearoa New Zealand Terms of Reference (Appendix 5A.9) • Adult Medicine DWEC Operational Procedures (Appendix 5A.12)
Divisional Written Examination Committees (DWEC), one per Division	Oversee the Divisional Written Examination	• Adult Medicine DWEC Terms of Reference (Appendix 5A.10) • Paediatrics and Child Health DWEC Terms of Reference (Appendix 5A.11) • Paediatrics and Child Health DWEC Operational Procedures (Appendix 5A.13)
3 x Faculty Assessment Committees (FAC), one per Faculty	Oversees Faculty barrier assessments. Reports to Faculty Education Committee, with dotted line reporting to CAC. Working groups are established to develop examination material. The Chair of each FAC is responsible for the final review and approval of assessments. The FACs also confirm blueprints and participate in policy and procedure development as well as results meetings and planning.	• Public Health FAC Terms of Reference (Appendix 5A.14) • Occupational and Environmental Medicine FAC Terms of Reference (Appendix 5A.15) • Rehabilitation Medicine FAC Terms of Reference (Appendix 5A.16) • Paediatric Rehabilitation Medicine FAC Terms of Reference (Appendix 5A.17)
Item Writing Panels	Coordinates the creation, review, and adaption of all RACP Divisional Written examinations items. Each author is a Fellow of their chosen specialty and is required to write examination questions to be presented to their peers at the IWP meetings for discussion and approval. Convened	Item Writer- Overview of role in Appendix 5A.18

Role	Responsibilities	Links
	from members of the relevant Divisional Written Examination Committee.	
Results Committee	Convened from members of the relevant Divisional Written Examination Committee. See DWE Committees above	
Decision Panels	Make decisions to activate contingency plans	
Assessors and Examiners		
Regional Examiners	Fellows from each hospital who are the initial contact in relation to locally hosting the Examination for that cycle. The Regional Examiner appoints and assists the Local Examination Organiser (previously known as Organising Registrar) and nominates Local and Provisional Examiners.	Example provided for Divisional Clinical Examination in Appendix 5A.19
National Examining Panel (NEP)	The members of NEP and Senior Examining Panel (SEP) travel to the cities and hospitals where the Examination is being held and lead the Examining Teams.	Example provided for Divisional Clinical Examination in Appendix 5A.20
Local Examination Organiser (LEO)	The LEO is the hospital contact who is nominated to oversee the administrative processes involved in the hospital's organisation of the Examination. They work directly with the Regional Examiner and the RACP Examination Coordinators throughout the examination cycle.	Example provided for Divisional Clinical Examination in Appendix 5A.21
Local examiner	Local and Provisional Examiners are Fellows who form part of the Examining Team for their local hospital or a nearby hospital.	Example provided for Divisional Clinical Examination in Appendix 5A.22
Chief Examiner	Member of NEP and is responsible for decisions regarding any misadventure/changes to the schedule that may affect the examination at that hospital.	Example provided for Divisional Clinical Examination in Appendix 5A.23
Work-based assessment assessors	Complete work-based assessments. Training for this is delivered via SPDP (refer to Standard 8.1)	
Supervisors	Complete in-training reports. Training for this is delivered via SPDP (refer to Standard 8.1)	
Staff	A range of staff with operational and specialist assessment skills	
Operations	Teams have been assigned to work on the Divisional Clinical Examinations, another group to the Divisional Written Examinations and a third group allocated to Faculty/Chapter examinations and assessments. Work-based assessments are monitored by staff in Training Services teams in conjunction with other progression monitoring activities.	
Psychometrics and Quality Assurance	A psychometrician is employed who is an assessment academic with expertise in assessment quality assurance. The psychometrician works closely with key assessment committees, including the examination committees and CAC.	

Planning RACP assessment programs (5.1.1)

Conceptualising constructive alignment in RACP programs

Constructive alignment is a key tenet considered in our assessment design and refers to the process of ensuring that there is a clear link between the competencies trainees are expected to develop, the learning and teaching activities trainees participate in to facilitate this development, and the assessments the RACP's uses to guide learning and provide evidence that trainees have achieved competency outcomes. The term "constructive" is used because it is based on the theory of constructivism, which posits that learners construct new knowledge based on their experiences and prior knowledge.

Constructive alignment of the RACP's current and new curricula helps to ensure trainees have access to relevant learning experiences, appropriate support in training and the assessments used to make decisions about their level of competence of readiness to progress are directly related to those activities and stated program outcomes.

Table 21 shows the RACP Standards for assessment planning and implementation that relate to constructive alignment and transparency of RACP assessment programs, in particular for barrier (ie progression-decision related) assessment events.

Table 21. RACP Standards for Assessment relating to constructive alignment and transparency

Planning- Standards A program of assessment includes a mix of assessment activities, with methods that are matched to the required purpose or intent of the assessment, and implemented at an appropriate stage of training. Integrated assessment programs, aligned to desired curriculum standards, are important to gain a more complete picture of competence.	
1. Clear educational value and purpose	
1.1	The purpose of the proposed assessment program at each progression decision point is clearly stated and readily available, including how it relates to the learning required to progress through the next stage of training or practice.
1.2	The progression decisions, that will be made based on the assessment results, are clearly stated and readily available.
2. Programmatic assessment and blueprinting	
2.1	The assessment methods are chosen in order to promote learning across the whole program.
2.2	A range of assessment methods are selected and blueprinted to ensure coverage of the depth and breadth of curriculum standards that are contained within the curriculum framework for each RACP training program.
2.3	The intended curriculum standards that may be sampled by each assessment method are identified and readily available.
Implementation – Standards A number of supporting structures should be put in place when implementing a high quality program of assessment. This includes: the use of fair and transparent assessment processes and fair and transparent decision making; sustainability of assessments and assessment processes; the provision of feedback to trainees as a result of assessments; and the development of communication and training resources to engage stakeholders. The process of implementing assessments also includes consideration of how changes will affect stakeholders and how assessments will be consulted on, implemented and evaluated, including process, educational rationale, examination construction, psychometric properties and examination outcomes.	
3. Fair and transparent processes and decision making	
3.4	Program level blueprints, policies and criteria for progression through training are publicly available.
3.5	Trainees are provided with clear and accessible information about the purpose and processes of assessments.

Constructive alignment and blueprinting in the current PREP programs

Exam blueprints are used for all written examinations across RACP programs. These specify the curricula topics that are sampled and their relative weighting in each assessment, for example the proportion of questions in an exam that address the topic. The blueprints are provided to candidates on the RACP website and are provided in Appendices 5A.24 and 5A.25.

For clinical examinations, domains of the curriculum that are covered in the examination are provided for each examination on the RACP website page, along with detailed information about the scoring rubrics. More detail on the scoring rubrics is provided in Standard 5.2.

Each of these examinations has dedicated workflows to ensure constructive alignment to curriculum outcomes in the development of items and collation of examinations for written examinations and the preparation of case material for performance-based examinations, as outlined in Standard 5.1.3.

Work based assessments in the PREP program including the rubrics used in assessing performance are aligned to the domains of the Professional Qualities Curriculum (Appendix 2A.7) described in detail in Standard 2 of this document, in the context of the rotation a trainee is currently working in.

Constructive alignment and blueprinting in the renewed curricula

Through Curricula Renewal, as detailed in Standards 2-4, the College has undertaken a review of Basic Training and Advanced Training curricula. The scope of that review includes design of a robust and contemporary system of assessment that focuses on the evolving needs of the physician of the future, through strengthening the alignment of supervision and workplace based assessment with curricula standards.

The set of curriculum standards for each training program form the key learning goals, or graduate outcomes, of the training program, and are the anchors against which the learning, teaching, and assessment programs are designed. These provide a structure that allows trainees to demonstrate an increasing degree of specialty practice and progression through training with increasing independence of practice.

Figures 69 and 70 below illustrate the alignment of the assessment program for each training program to learning goals and progression criteria, including the work-based assessments. Each assessment activity type is blueprinted to one or more learning goal, including how and how often within training phases assessment data will be collected for each learning goal and progression point. The trainee can assign the assessment to one or more learning goal based on the specific instance of the assessment activity.

Figure 69. graphic representation of continuous assessment of learning goals using a range of assessment methods

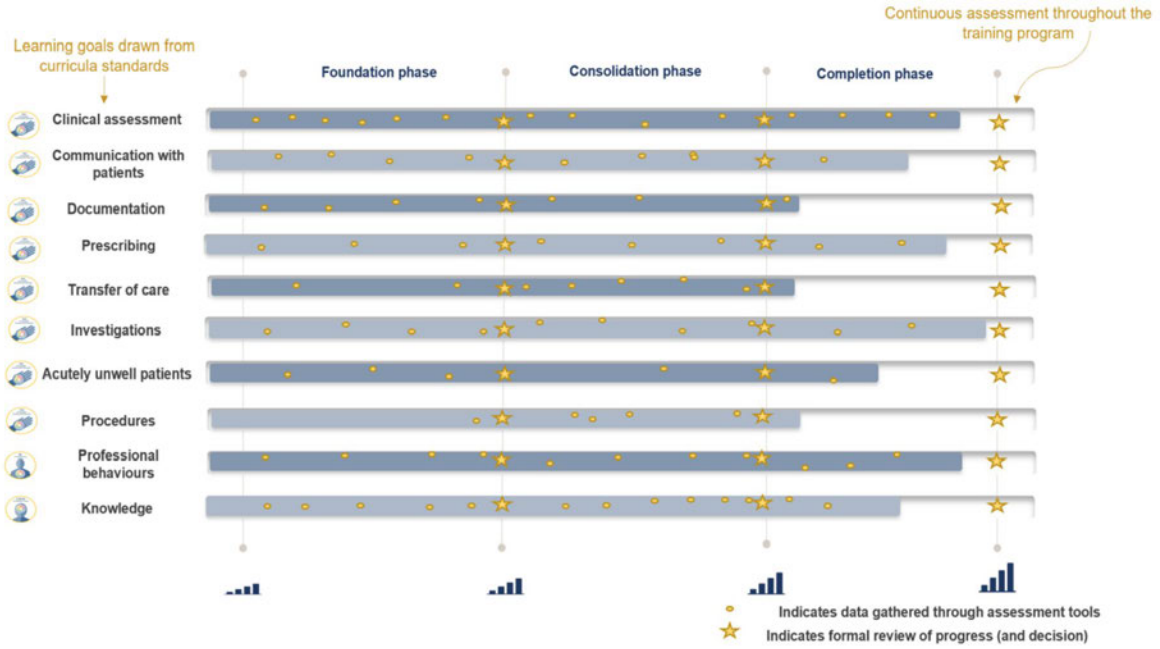


Figure 70. Assessment blueprint in the new Basic Training Program

Assessment blueprint

This high-level assessment program blueprint outlines which of your learning goals *could be* and *will be* covered by the assessment tools.

Learning goals	Assessment tools						
	Registration form	Learning Capture	Observation Capture	Rotation Plan and Progress Report	Phase Plan and Progress Report	Written Examination	Clinical Examination
1. Clinical assessment	×	Could assess	Could assess	Will assess	Will assess	×	Will assess
2. Communication with patients	×	Could assess	Could assess	Will assess	Will assess	×	Could assess
3. Documentation	×	Could assess	Could assess	Will assess	Will assess	×	×
4. Prescribing	×	Could assess	Could assess	Will assess	Will assess	Could assess	Could assess
5. Transfer of care	×	Could assess	Could assess	Will assess	Will assess	×	×
6. Investigations	×	Could assess	Could assess	Will assess	Will assess	Could assess	Could assess
7. Acutely unwell patients	×	Could assess	Could assess	Will assess	Will assess	×	×
8. Procedures	×	Could assess	Could assess	Will assess	Will assess	×	×
9. Professional behaviours	×	Could assess	Could assess	Will assess	Will assess	×	Could assess
10. Knowledge	×	Could assess	Could assess	Will assess	Will assess	Will assess	×

Since 2020, the Divisional Written and Clinical Examinations in the Basic Training Programs have been aligned to aspects of the new Basic Training curricula standards. For example:

- The Divisional Written Examinations blueprints include alignment to the Knowledge Guides (refer to Appendix 5A.24 for Adult Medicine and Appendix 5A.25 for Paediatrics and Child Health)
- The Long and Short Case components of the Divisional Clinical Examinations are aligned to competencies and learning goals of the new curricula standards. This is not

the sole assessment of these competencies and learning goals in the program, but one source of assessment data. For example, the Divisional Clinical Examination Long and Short Cases gather some assessment data regarding a candidate's ability to, in part, demonstrate performance for EPA 1:

- EPA 1 - Clinical assessment: Clinically assess patients, incorporating interview, examination, and formulation of a differential diagnosis and management plan.

Beyond examinations, the learning goals (EPAs) will be assessed through a variety of work-based assessments indicated in Figure 70 above. In these assessments trainees and assessors will be able to specify the specific learning goal and objectives the activity is targeting and apply the relevant scale for that assessment (e.g. supervision scale for EPAs, behaviourally anchored scale for competencies including professional qualities and demonstration of knowledge).

Cross College review of examinations, 2024 (5.1.1)

The role of high stakes point-in-time barrier examinations and assessments in the new training curricula is the subject of a recently initiated major review, referred to as the Cross College Review of Examinations. Sponsored by the RACP Board and CEC, the review is partially in response to the computer-based testing failure of 2022 and resultant KPMG report (refer to Standard 5.4.1-5.4.2). Instead of focussing solely on a review of the exam delivery modality, the RACP is first conducting a holistic review of all examinations and examination processes.

The review will commence in early 2024, with a Project Lead having commenced in December 2023. This review will consider the purpose and place of each assessment within each program, the required changes based on curricula renewal and adjustments to adapting to a new programmatic assessment paradigm as well as candidate and member feedback and contemporary developments in health professions education research on assessment of competence.

Communicating assessment and completion requirements with program participants (5.1.2)

Comprehensive details of the current and renewed assessment requirements for each training program are outlined on the College website, with links and summary details provided in Appendix 2D.1, Training Program Details Table.

Information provided about each barrier examination also includes details about how to apply to sit examinations, how to prepare for the examination, including practice papers for all item types and information about exam day requirements and results processing.

For clinical barrier examinations, domains of the curriculum that are covered in the examination are provided for each examination on the relevant RACP website page, along with detailed information about the format, timing and scoring rubrics and links to support and preparation materials.

Supporting preparation for high-stakes point-in-time assessments

We provide trainees with a range of materials for use throughout training, which are particularly relevant as they approach high-stakes point-in-time assessments.

A key learning resource related to clinical practice, and hence relevant in preparing for the Divisional Clinical Examination, is the College Learning Series, which is detailed in Standard 4. We also provide a suite of resources including (Appendix 5A.26):

- fireside chat webinar series, including a webinar on performing under pressure and an interview with a trainee, examiner and a Director of Physician Education on how to use daily work opportunities to prepare for exams
- Divisional Examination Readiness (Appendix 5A.27) learning course- information, resources and study tools to assist them in preparing for the Divisional Written and Clinical Exams
- preparation tips
- practice examination questions and answers for written examinations and sample papers.

We also provide resources for Occupational and Environmental Medicine and Public Health Medicine and Rehabilitation Medicine trainees and supervisors that are relevant to examination preparation, including webinars, preparation guides and example questions and answers (Appendices 5A.28-5A.30).

Special consideration for assessment (5.1.3)

The College's Special Consideration for Assessments Policy (Appendix 1A.32) (first introduced in 2010 and last reviewed in 2022) sets out the process of considering particular circumstances affecting a trainee and the special provisions or arrangements available to alleviate the impact of those circumstances. Special consideration does not excuse a trainee from meeting a requirement, or performance standard for examinations or work-based assessments. The policy applies to all assessments, inclusive of examinations, conducted by the College.

Circumstances that may require special consideration covered by the policy are:

a) permanent and longstanding impairment,
b) temporary impairment – medical grounds,
c) non-medical compassionate grounds or serious disruption,
d) essential commitments (religious, cultural, societal or legal),
e) or technical problems during an examination.

In relation to barrier examinations, options for special consideration fall into three categories:

1. Pre-examination considerations- an incident or issue that occurs prior to commencement of the examination. Outcomes for these requests may be approved/partially approved and specify particular provisions (extra time or aids, rescheduling/supplementary assessment), allocations to particular exam locations or withdrawal without financial penalty.
2. Consideration of technical or procedural issues encountered during an examination- the candidate must make the examiner or local examination organiser (LEO) aware as immediately as possible. Outcomes include resolution of the issue and/or compensation for this during the assessment.
3. Post-examination considerations- an incident/issue that occurs once the examination has commenced where resolution and/or compensation for this during the assessment is not possible. Outcomes include potential redesignation of exam status (such as exam not counting as an attempt) and/or refund. A supplementary exam attempt is only an option

for Divisional Clinical Examinations where significant technical or procedural issues occurred.

Pre-examination requests are determined by staff, as delegated by the relevant committee. Post examination consideration requests are determined by the relevant committee. The applicant's personal details are removed when requests are considered by committees.

For work-based assessments, considerations refer to an incident/issue which could lead to the trainee being unable to satisfactorily complete or submit all requirements for a prospectively approved training period. Outcomes will specify a time extension or other appropriate consideration to enable completion and/or submission of the requirement. Work-based assessment special consideration requests are considered by the relevant training committee.

The largest volumes of special consideration requests are received for the Divisional examinations, as outlined in Table 22.

Table 22. Special consideration requests and outcomes for Divisional examinations, 2023

	Divisional Clinical Examination		Divisional Written Examination	
	Received	**Outcome**	**Received**	**Outcome**
Paediatrics & Child Health				
Pre-Exam	34	29 Approved 4 Partially approved 1 Not approved	18	16 Approved 2 Partially approved
Post-Exam	17	12 Passed 4 Failed 1 Supplementary Exam	1	Not approved
Adult Medicine				
Pre-Exam	30	26 Approved 4 Partially approved 0 Not approved	33	28 Approved 4 Partially approved 1 Not approved
Post-Exam	48	32 Passed 14 Failed 2 Supplementary Exam	10	4 Approved 6 Not approved

5.2 Assessment methods

AMC accreditation standards	
5.2.1	The assessment program contains a range of methods that are fit for purpose and include assessment of trainee performance in the workplace.
5.2.2	The education provider has a blueprint to guide assessment through each stage of the specialist medical program. *(Discussed in conjunction with Standard 5.1)*
5.2.3	The education provider uses valid methods of standard setting for determining passing scores.

Overview of assessment methods (5.2.1)

The RACP's suite of assessments includes a variety of in-training assessment components as well as high stakes written and clinical barrier examinations. These assessments include:

- satisfactory in-training reports from supervisors
- demonstration of satisfactory completion of the work-based assessment program (such as Mini CEX, Case-based Discussions)
- barrier examinations that trainees must pass to continue or complete their stage of training (such as written examinations, vivas, OSCEs etc)

- satisfactory completion of research activities, such as the Advanced Training Research Project.

Each assessment includes a set of business rules that accompany the roles and responsibilities of individuals and groups involved in developing and administering the assessment. The business rules describe the format, criteria for the pass standard, how assessment content is created, collated and reviewed prior to and after each examination or at the end of a training year for in-training assessments. These systems and procedures ensure assessment quality including monitoring of parameters such as reproducibility indices, construct and content validity (constructive alignment to learning outcomes and sampling) incorporated in the Utility Index described in Standard 5.1.1.

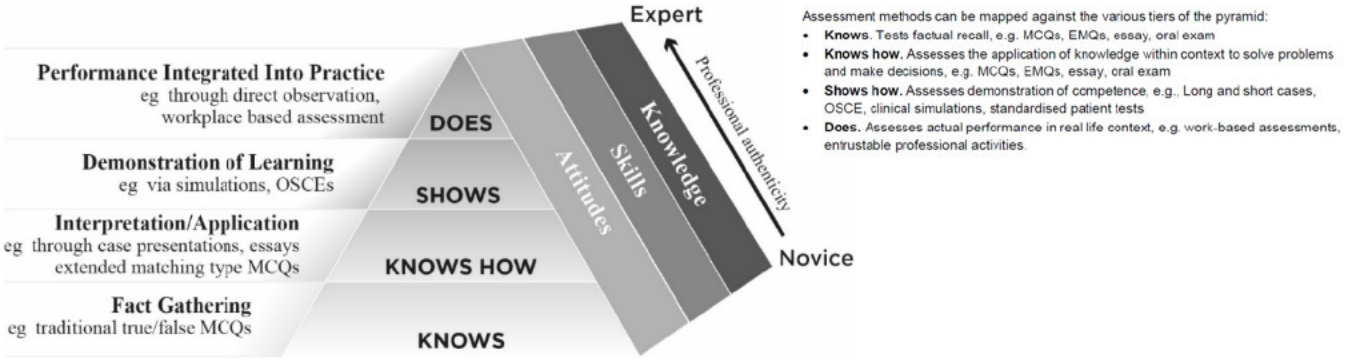
Fit for purpose assessment methods

Assessment methods are aligned to the learning outcomes being measured using frameworks such as Miller's Pyramid of increasing clinical competence. Figure 71 below illustrates an adaptation[6] of this well-known conceptual framework, which describes the developmental hierarchy of components of competence and related assessment objectives suited to each component.

Vertical integration of the components of clinical competence are represented as tiers in the below image from foundational knowledge at the "knows" level through to work-based assessment of performance at the "Does" level in terms of performance integrated into practice. "Attitudes" and "Skills" are incorporated into this adaptation to recognise the development of professional behaviours and other domains of professional practice beyond medical expertise and the inclusion of those domains in assessment programs. All of these domains are incorporated into the RACP assessment strategies across a range of methods and approaches.

In both the PREP and renewed programs, a range of assessment methods are used to provide a comprehensive view of trainee progress across the tiers of developing clinical competence with an emphasis on work-based assessment as appropriate for the experiential nature of physician training.

Figure 71. Miller's Pyramid, as adapted by Mehay[6]



The assessment methods used in RACP training programs are categorised in Table 23 in relation to Miller's Pyramid. For each assessment method, the table also outlines the assessment composition, and standard setting approach.

[6] Mehay RB, R. Chapter 29: Assessment and Competence. In: Mehay R, editor. The Essential Handbook for GP Training and Education. London: Radcliffe; 2012

Table 23. Categories of RACP assessments per Miller's Pyramid

Assessment Method	Miller's Pyramid tier	Composition	Standard setting approach	Typical n candidates
Divisional Basic Training Programs				
DWEs* (AIM and PCH)	Knows/ Knows how	170 multiple-choice questions (with 12 Extended Matching Questions): • 100-item Clinical Applications paper • 70 item Medical Sciences paper	Modified Angoff with Rasch anchoring on 'marker' items to stabilise exam difficulty between administrations	~1400, with approx. 1100 for Adult Medicine and 300-350 for Paediatrics and Child Health
DCEs*	Shows how	Each candidate sees 2 long cases and 4 short cases	Rubric: the "CLEAR" framework establishing the performance levels on domains within case types. The passing standard is combined across the 2 Long Cases and 4 short cases. A score combination grid weights performance on long and short cases to establish the passing standard. Refer to Standard 5.2.3 for details	~1200, with approx. 900 for Adult Medicine and 300 for Paediatrics and Child Health
Rehabilitation Medicine				
AFRM Entry Phase Examination** *(New program)*	To be determined as part of curriculum renewal process. Exam will be delivered from 2025 and will replace the Module 2 Clinical Assessment.			Unknown, 2025 will be first year of exam.
Module 1 Assessment *	Knows/ Knows how	MCQ :100 items.	Modified Angoff	50 (final assessment delivered in 2023)
Module 2 Clinical Assessment * OSCE		7 station OSCE mix of: • 'live' with patient role player • 'static' – written Rest stations included	Borderline regression method on live stations, modified Angoff on static stations. Cut score is rounded down 0.5% after calculation to lowest whole number.	60
Fellowship Written Examination MCQ* and MEQ Papers*	Knows/ Knows how	• MCQ :130 items • MEQ: 10 scenarios with short answer questions building on each case	Modified Angoff	MCQ – 35 MEQ - 40
Fellowship Clinical Examination OSCE*	Shows how	10 station OSCE mix of: • 'live' with patient role player • 'static' – written Rest stations included	Borderline regression method on live stations, modified Angoff on static stations. Cut score is rounded down 0.5% after calculation to lowest whole number.	60

Assessment Method	Miller's Pyramid tier	Composition	Standard setting approach	Typical n candidates
Rehabilitation Medicine (Paeds)				
Fellowship Written Examination MCQ and SAQ Papers*	Knows/ Knows how	• MCQ: 130 items • SAQ: 10 scenarios with short answer questions building on each case	Modified Angoff	MCQ – 3 SAQ – 3
Fellowship Clinical Examination OSCE*	Shows how	10 station OSCE mix of: • 'live' with patient role player • 'static' – written Rest stations included	A very small cohort of candidates annually so regression and other methods not possible. Minimal score for pass set at 6/10 based on a standardised rubric. With assessment of Professional Qualities ratings.	Less than 5
Public Health Medicine				
Oral Assessment*	Knows / Knows how	Oral presentation knowledge and understanding examination. 8 questions/scenario, with one or two parts in each scenario. Sat across x2 30-minute interviews, with 1 hour preparation time. 3 examiners in each interview panel.	Content and competency framework with a standard set for each scenario, examiners are calibrated to the framework and standard prior to the exam. Individual examiners mark candidates out of 10. A candidate passes the question if at least 2 of the 3 examiners award a score of 5 or more and the average score awarded by the three examiners is 5 or more. A total score will be calculated for each candidate by summing the examiner scores from all eight questions. Total scores will be rounded to the nearest whole number before applying the following rules. To pass the exam a candidate must score 60 or above and pass 6 or more questions. Candidates who pass 6 or 7 questions with a total score of 58 to 59 are deemed borderline. Candidates with borderline performance are discussed during a moderation meeting for final determination.	25
Occupational and Environmental Medicine				
AFOEM Stage A Written MCQ *	Knows/ Knows how	MCQ 120 items	Modified Angoff process per exam. Small cohort of candidates annually so item analysis anchor statistics are not produced.	10-15

Assessment Method	Miller's Pyramid tier	Composition	Standard setting approach	Typical n candidates
AFOEM Stage B Written*	Knows/ Knows how	Two papers (Paper 1 and Paper 2) sat across two days. Each paper contains 5 short answer response questions. One or two scenarios per question.	Modified Angoff	10-15
AFOEM Stage B Practical * Examination	Shows/ Shows how	OSCE 'like' examination mix of: • 2 exhibit based stations • 2 OSCE format stations • 2 clinical long cases	Exhibit and OSCE stations are set using a modified Angoff process. Pass score for clinical long case component is rubric based and set qt 12/20 marks.	10-15
Sexual Health Medicine				
Exit Examination *	Knows /Knows how	Structured Interview knowledge examination. 2 x 30 minute sessions each with: • 4 scenario-based questions • 2 examiners each per scenario Each question consists of a clinical scenario and a number of sub-questions. Candidates receive 5 minutes of reading time before each session. Total of 8 questions in overall exam.	Content and competency framework with a standard set for each scenario, examiners are calibrated to the framework and standard. Individual examiners mark candidates as 'pass' or 'fail' or if necessary 'borderline' on each station. Examiner pairs discuss and agree on result for each station and candidates with failing or borderline performance on their scenarios are discussed during a moderation meeting for final determination. The consensus scores which must be either Pass or Fail will be transcribed onto a separate sheet.	Less than 10
Divisional Advanced Training Programs				
Research Project	Knows/ Knows how	At least one standardised research project.	As per the rubric associated with the type of project submitted.	NA
All training programs: work based and in-training assessments				
Work-based assessments. See Table 24 and Figures 72 and 73 below for further information on WBAs	Does	Set numbers of WBAs per training year within each program.	Minimum number of submissions at expected standard specified for level of training – see Standards 3 and 4.	NA
Progress Reports	Does	Periodic progress reports scheduled within each program	Progress reports include rating scales that are aligned to the domains of the Professional Qualities Curriculum. Educators receive training in their use through the SPDP (refer to	NA

Assessment Method	Miller's Pyramid tier	Composition	Standard setting approach	Typical n candidates
			Standard 8.1). Low ratings are explored as part of oversight by committees/DPEs.	

**Denotes high-stakes point-in-time barrier assessment*
*** Assessment is new and in development as part of curriculum renewal for General Rehabilitation Medicine. Replaces two prior assessments Module 1 written assessment and Module 2 OSCE assessment.*

Figures 72 and 73 show the overall program requirements and assessments planned in the new Basic and Advanced Training curricula respectively. As discussed in Standard 5.1.1. the role of the high stakes single point in time examinations in the new programs will be a focus of the Cross College Review of Examinations.

Figure 72. Assessment program requirements in the new Basic Training programs

Assessment tools	Frequency
Basic Training registration form - checks that you meet the entry criteria and enrols you into training. The form includes a step for your Director of Physician / Paediatric Education to endorse your registration	1 per year
Learning Plans	
Phase Learning Plan - helps you plan your learning over a phase of training and each training rotation.	1 per phase
Rotation Learning Plan - helps you plan your learning opportunities for each training rotation.	1 per rotation
Learning Captures prompt you to enter evidence of work-based learning linked to learning goals.	12 per phase
The **Observation Capture** is a supervised observation of your work-based performance linked to learning goals.	12 per phase
Progress Reports	
Rotation Progress Report - assesses your progress over a training rotation.	1 per rotation
Mid-phase Progress Report - check-in on your progress mid-way through a phase of training.	1 per phase
Phase Progress Report - assesses your progress over a phase of training.	1 per phase
Examinations	
Each year the RACP run **written and clinical examinations.** These exams are typically taken by trainees in the Completion phase of training.	
Written examination assesses your applied knowledge.	1 each for the Basic Training program
Clinical examination assesses your ability to perform clinical assessment of patients.	

Further details on assessments in the new Basic Training program are available in the Learning and Assessment Interim Guide, provided in Appendix 4A.7.

Figure 73. Assessment program requirements in the new Advanced Training programs, as drawn from Advanced Training Common Learning, Teaching and Assessment programs

What do trainees need to do? *Assessment program requirements*	When do trainees need to do it?	Applicability
	Each phase of training (each year)	
1 Registration form	• At the start of each phase	Applicable to **all curricula**
12-24 Learning capture^, across the range of learning goals	• Minimum of ~1 per month ^The frequency of this assessment may be revised upon evaluation of its use in the new Basic Training programs, at early adopter settings throughout 2021.	Applicable to **all curricula**
12-24 Observation capture^, across the range of learning goals	• Minimum of ~1 per month ^The frequency of this assessment may be revised upon evaluation of its use in the new Basic Training programs, at early adopter settings throughout 2021.	Applicable to **all curricula**
1 Learning plan	• At the start of each phase of training, and reviewed every three months	Applicable to **all curricula**
4 Progress report	• Minimum of one every three months Note: fourth progress report includes end-of-phase review	Applicable to **all curricula**
	Once over the course of training (if passed)	
1 Research project	• Submitted for marking before the start of the **Transition to Fellowship** phase[8].	Applicable to **all curricula**
Additional tools under review for inclusion in the assessment toolkit		
Case report	• To be determined	Applicable to **some curricula**
Logbook	• To be determined	Applicable to **some curricula**

Further details on the assessments in the new Advanced Training programs can be obtained in the Advanced Training Common Learning, Teaching and Assessment programs (Appendix 3A.13).

In-training work-based assessments (WBAs)

Formal in-training WBAs support learning through feedback and guidance, supplementing everyday instances of informal feedback. They are conducted in the workplace through trainee,

supervisor, interprofessional and healthcare consumer interactions and documented through structured assessment forms submitted online.

WBAs are a significant opportunity for trainees to receive feedback for learning. A minimum number of WBAS of each type listed in the Table 24 (current programs) and Figures 73 and 74 (renewed programs) are required to be completed each training year and the assessment report of each to be submitted to the trainee's supervisor for discussion with the trainee at their progress meeting with their supervisor. Each individual WBA activity is designed to provide the trainee with a rich opportunity to receive feedback from an assessor to support and guide their learning. The combined data from submitted WBAs is used in the end of rotation discussion between the trainee and supervisor and contributes to progression decision making through the supervisor report.

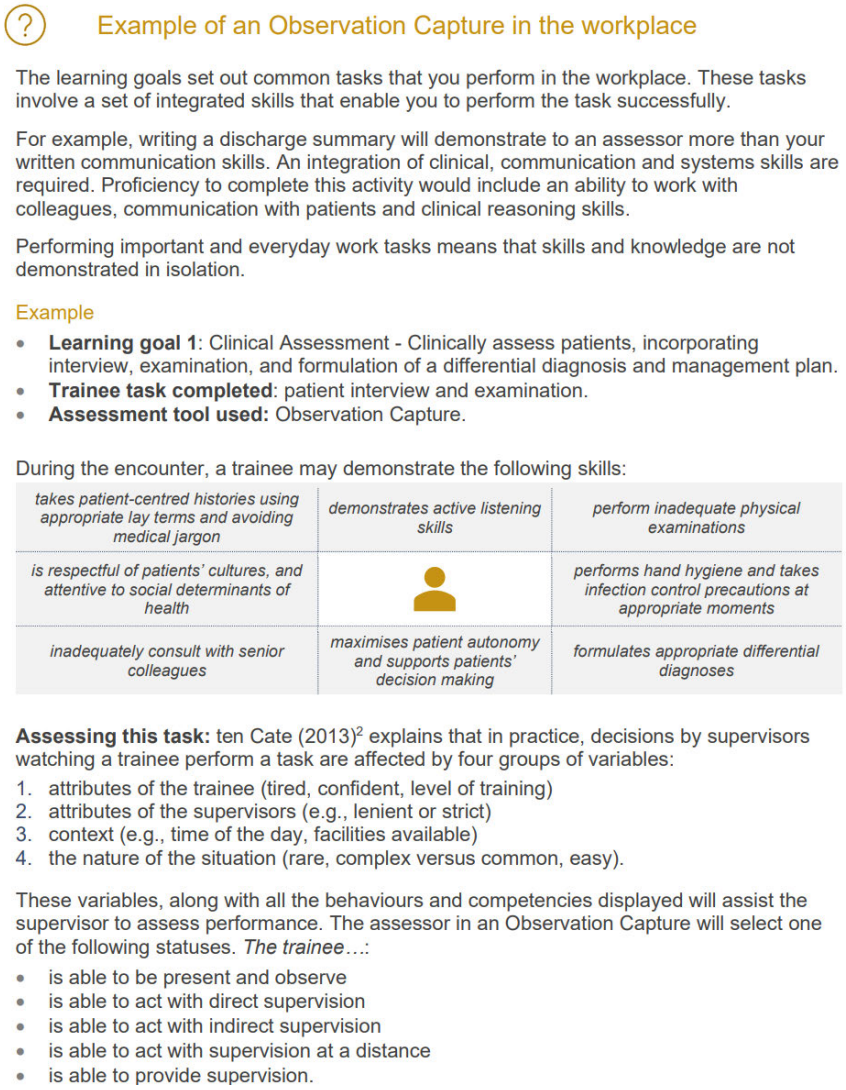
The number of required WBAs per year in each training program is specified in Appendix 2D.1, Training Program Details Table.

Table 24. Description of work-based assessment methods

Assessment	Details
Observation of Performance	
Mini-Clinical Evaluation Exercise (mini-CEX)	A mini-CEX encounter evaluates the trainee in real life settings and assesses aspects of clinical performance. A mini-CEX is designed to guide the trainee's learning through structured feedback; help improve communication and professional practice; provide the trainee with an opportunity to identify strategies to improve their practice; and be a teaching opportunity enabling the assessor to share their professional knowledge and experience. The following areas are assessed: 1. Medical interviewing skills 2. Physical examination skills 3. Professional qualities 4. Counselling skills 5. Clinical judgement 6. Organisation and efficiency
New: Observation Capture	'Observation Captures' will replace Mini CEX encounters in the new curricula as the focus of providing feedback moves to include the 'entrustability' concept and the use of a scale indicating the level of supervision required for the trainee in completing the clinical task as opposed to a performance scale from poor – excellent. Like Mini CEX's Observation Captures consist of an observed assessment of a trainee completing a work task that is directly aligned to one of the Learning Goals in the new Curricula. Further detail about the Observation Captures is shown in the example in Figure 74 below and in the handbooks for the new programs (refer to Appendices 3A.2 and 3A.3).
Direct Observation of Procedural Skills (or variations) (DOPS)	DOPS is an evidence-based assessment that aims to guide trainee learning and achievement of competency. The trainee performs a procedure on a patient and is observed by an experienced assessor. Performance is reviewed against a structured checklist which allowed feedback to be focused on the various composite parts of a procedure. Of the Advanced Training Committees who have adopted DOPS, a specialty-specific list of procedures drawn from the curriculum is available for each. Specialty-specific Assessment Guides have been developed by each Advanced Training Committee and are intended to be used on conjunction with the DOPS rating form.

Assessment	Details
Direct Observation of Field Skills (DOFS) **(AFOEM program)**	DOFS is a work-based assessment that has been adopted by the AFOEM. DOFS assesses a trainee's competency in purposeful evaluation of a workplace or environmental setting. A Direct Observation of Field Skills encounter involves a trainee being observed while conducting a workplace visit with a defined purpose, e.g. the assessment of modified duties to assist a worker's return to work. The trainee is offered feedback from the assessor across a range of areas related to technical ability and professionalism.
Direct Observation of Professional Practical Skills (DOPPS)	DOPPS is a work-based assessment that has been adopted by the AFPHM. A DOPPS encounter aims to guide trainee learning and achievement of competency in professional skills such as communication, leadership, management and teamwork. The trainee performs a practical professional activity in the workplace and is observed by an experienced and knowledgeable assessor who reviews the trainee's performance against a structured checklist.
Discussion	
Case-based Discussions (CbD)	A CbD encounter evaluates the level of professional expertise and judgement exercised in clinical cases by a trainee. The CbD is designed to guide the trainee's learning through structured feedback; help improve clinical decision making, clinical knowledge and patient management; provide the trainee with an opportunity to discuss their approach to the case and identify strategies to improve their practice; and be a teaching opportunity enabling the assessor to share their professional knowledge and experience. The following areas are assessed: 1. Record keeping 2. History taking 3. Clinical findings and interpretation 4. Management plan 5. Follow-up and future planning 6. Professional qualities
Written Reflection	
Professional Qualities Reflection (PQR)	The purpose of the PQR is for the trainee to articulate and formalise ideas and insights about their professional development through the process of reflection. The PQR is designed to encourage critical thinking and reflection about learning experiences, facilitate the development of the trainee's ethical attitudes and behaviours, and help the trainee identify the link between their everyday experiences and the domains of the Professional Qualities Curriculum. A PQR involves the trainee revisiting and reflecting on an event or series of events that have impacted on their professional practice. Through analysis of the event(s), the trainee is able to identify and consolidate good practices leading to improved performance.
New programs: Learning Capture	The Learning Capture assessment tool facilitates trainees' practice of reflection, improving learning and showing outcomes of learning and promoting lifelong learning. Trainees will log evidence of their learning experience and document their reflective commentary on the experience. Feedback from an assessor is optional for trainees. Further information is available in the handbooks for the new programs (refer to Appendix 2D.1, Training Program Details Table).

Figure 74. Example of the Observation Capture process in the new RACP curricula



Example of an Observation Capture in the workplace

The learning goals set out common tasks that you perform in the workplace. These tasks involve a set of integrated skills that enable you to perform the task successfully.

For example, writing a discharge summary will demonstrate to an assessor more than your written communication skills. An integration of clinical, communication and systems skills are required. Proficiency to complete this activity would include an ability to work with colleagues, communication with patients and clinical reasoning skills.

Performing important and everyday work tasks means that skills and knowledge are not demonstrated in isolation.

Example

- **Learning goal 1**: Clinical Assessment - Clinically assess patients, incorporating interview, examination, and formulation of a differential diagnosis and management plan.
- **Trainee task completed**: patient interview and examination.
- **Assessment tool used:** Observation Capture.

During the encounter, a trainee may demonstrate the following skills:

takes patient-centred histories using appropriate lay terms and avoiding medical jargon	*demonstrates active listening skills*	*perform inadequate physical examinations*
is respectful of patients' cultures, and attentive to social determinants of health		*performs hand hygiene and takes infection control precautions at appropriate moments*
inadequately consult with senior colleagues	*maximises patient autonomy and supports patients' decision making*	*formulates appropriate differential diagnoses*

Assessing this task: ten Cate (2013)[2] explains that in practice, decisions by supervisors watching a trainee perform a task are affected by four groups of variables:

1. attributes of the trainee (tired, confident, level of training)
2. attributes of the supervisors (e.g., lenient or strict)
3. context (e.g., time of the day, facilities available)
4. the nature of the situation (rare, complex versus common, easy).

These variables, along with all the behaviours and competencies displayed will assist the supervisor to assess performance. The assessor in an Observation Capture will select one of the following statuses. *The trainee…*:

- is able to be present and observe
- is able to act with direct supervision
- is able to act with indirect supervision
- is able to act with supervision at a distance
- is able to provide supervision.

Progress reports

PREP program progress reports provide a comprehensive overview of trainees' progress and achievement during a training period from supervisors' perspectives, informed by multiple sources of information. The purpose of the progress report is to provide trainees with structured feedback on their performance and inform overseeing RACP committees' decisions on the certification of training periods.

Trainees are encouraged to meet with their supervisors, reflect on and discuss their learning and progress over the training period, and identify areas of focus to guide their learning plan for the next training period.

Progress reports are required to be submitted to the College annually at a minimum, or at the end of a training period. Mid-year training reports are also required for many training programs.

In the renewed programs, the rotation and phase progress reports have been/will be blueprinted to the learning goals as illustrated in Figure 70 provided previously.

Three types of progress reports will be used in the new programs. Rotation progress reports are primarily to be used in Basic Training due to the short training periods involved.

	Requirement	Completed with	Purpose
Rotation Progress Report	1 per rotation	Rotation Supervisor	Assesses trainee progress over a training rotation.
Mid-phase Progress Report	1 per phase	Education Supervisor	Check-in on trainee progress mid-way through a phase of training.
Phase Progress Report	1 per phase	Education Supervisor	Assesses trainee progress over a phase of training.

The revised progress reports will formalise the opportunity for trainees to reflect on their progress against their learning goals and planned activities through a discrete trainee reflection and self-rating step.

Supervisors will rate trainees' progress against each of their learning goals and provide feedback to trainees and make recommendations on their progress to inform Progress Review Panels' decision-making.

The progress report process will ask trainees and supervisors to:

- Reflect on current skill level – i.e., trainees consider where they sit against the expected standard for each learning goal at their current stage of training
- Reflect on progress – i.e., what evidence of progress has been observed or documented throughout the phase rotation, what learning has occurred
- Assess progress – supervisors select the most appropriate rating for each learning goal, as supported by the evidence of learning, and provide focused feedback to trainees for ongoing professional development.

Three new rating scales will be used in the renewed curricula to monitor and provide feedback to trainees on their progress towards the required level of competency for each Learning Goal at the end of each phase of training. These rating scales are described in detail in the example shown in Figure 65, *RACP learning goal rating scales*, in Standard 4.2.4. The rating scale for most learning goals will indicate the level of supervision with which the trainee is entrusted for each core activity. This rating data adds to the body of evidence drawn from various assessment methods to inform training progression and completion decisions.

At the end of each phase, a Progress Review Panel will review trainees' assessment records, including their phase progress report. The Progress Review Panel is responsible for making evidence-based progression decisions for each trainee, and also to provide feedback and recommendations to individual trainees for additional work-based activities to submit if required levels of competence have not yet been attained.

Through our Training Management Platform (discussed in Standard 1.1), we are working to establish technology support to enable trainees, supervisors, and Progress Review Panel members to easily access logged assessment data to inform their reflection, assessment, and decision-making.

Preparation of barrier assessments

The RACP's suite of centrally administered barrier assessments is a significant practical undertaking each year, involving a substantial contribution of staff and Member time to the development, editing and quality assurance of items and papers. This section outlines the approach to this activity.

Our Standards for Assessment guide our approach to preparation of assessments, with relevant standards summarised in Table 25.

Table 25. Assessment Standards relevant to preparation of assessments

Implementation – Standards	
3. Fair and transparent processes and decision making	
3.1	The required level of performance for each assessment is determined according to the standards contained within each curriculum.
3.2	Pass thresholds for examinations are criterion referenced where appropriate, or developed using recognised methodologies for standard setting
3.3	A process of quality assurance is in place for all stages of the examination process, including the development of questions, construction of the examination, maintenance of security, data gathering, data collation and validation, and dissemination of results
3.4	Program level blueprints, policies and criteria for progression through training are publicly available.
3.5	Trainees are provided with clear and accessible information about the purpose and processes of assessments
3.6	Trainees and assessors are informed to whom assessment information will be provided and how it will be used.
3.7	Resources to support trainees and assessors are readily available prior to the implementation of new assessments or significantly revised assessments.
3.8	The process for Reconsideration, Review and Appeals is readily available
3.9	Each training program documents its implementation of the College Special Consideration for Assessments Policy.
3.10	The College Impact Assessment Guidelines are used to determine the impact of any changes to assessments and the period of notice given prior to implementation
3.11	High stakes decisions for trainees are made by an appropriately constituted panel of decision makers drawing on sufficient relevant information
4. Sustainability	
4.1	Logistical support for developing and maintaining assessments is appropriately resourced and managed
6. Appropriate Support	
	Assessors are appropriately selected, trained and supported, and their roles are clearly defined.

Item development

Item development for examinations is an ongoing process and challenge for the College, as it is for most institutions that rely on member interest and goodwill to produce assessment materials. For RACP training programs item writing panels are convened for each assessment and their roles and responsibilities are described in the business rules for each assessment and in individual role description agreements, as referenced in Standard 5.1.

To support members as subject matter experts in the development of new assessment material the College has produced a suite of faculty development and support materials that are freely

available online (including to trainees). The College also hosts item writing workshops and calibration sessions with examiners to facilitate consistency both in items produced and examiner judgments in performance-based examinations. Online item writing support materials are available here: Examination development resources (Appendix 5A.31).

In 2023, we increased the examination item bank by taking the following steps:

[redacted]

From 2024, the RACP will be introducing a mentoring approach for new IWP members, wherein individuals stepping down will guide and mentor incoming members. To support this initiative, the Adult Medicine group has chosen to retain a cadre of experienced writers who will remain on the panel as mentors. Their role includes elucidating the question writing process during meetings and providing examples of crafting effective questions. Members who are stepping down have also committed to extended mentoring periods for new members, fostering collaboration and offline question review before formal presentation at the IWP.

Similarly, the Paediatrics and Child Health group seeks to establish small 'buddy' groups within their specialty, allowing colleagues to collaborate and share ideas. These collaborative efforts would be presented to the IWP meetings by experienced members.

Tagging questions with metadata is an important part of managing and utilising the item bank. Going forward, the College will be expanding its use of tagging within ExamDeveloper, the College's exam question software. To accomplish this, the College will be working with Pearson Vue in 2024 to tag questions with additional metadata. Tagging refers to associating questions with descriptive labels or tags that provide information about the characteristics of the question. The purpose of tagging is to allow for improved organisation, retrieval, and analysis of the questions within the bank, this aids quality improvement in blueprinting and feedback reporting. Metadata is already a feature in ExamDeveloper, however the goal of comprehensive tagging will enhance the exam development and management process.

Maintaining security of examination item banks

Exam and item bank security is maintained through confidentiality agreements, access control, encryption, secure transfer practices, and staff procedures for any physical materials.

[redacted]

[redacted]

Construction of papers

Item Writing Panels (IWP) are convened three times a year for Adult Medicine (AM) and twice for Paediatrics & Child Health (PCH) Divisional Written Examinations to write and review potential exam questions. This process helps ensure the exam questions accurately test the knowledge and skills required for each medical specialty.

The exam question review process involves the following:

[redacted]

The application of business rules for the development and administration of DWEs are demonstrated in the Assessment Summary Report provided in 5A.33. Similar processes are used for other written examinations.

Divisional Clinical Examinations (DCE)

As the DCE is conducted with real patients in clinical settings, assessment preparation significantly focuses on the identification and recruitment of suitable patients (in alignment with the blueprint as discussed in Standard 5.1) at clinical settings as well as the training, calibration and co-ordination of large numbers of volunteer members who participate as examiners.

In terms of curriculum alignment, the focus for this type of examination is ensuring examiners and candidates are knowledgeable about the marking criteria for the Long and Short Case components of the examination.

The application of business rules for the development and administration of DCEs are demonstrated in the Assessment Summary Report provided in 5A.34. Similar processes are used for other clinical examinations.

Methodologies for standard setting (5.2.3)

Summary descriptions of standard setting for examinations were provided earlier in Table 23. This section provides further detail and rationale for the approaches used for major standard setting calibration exercises.

Standard setting approaches for barrier examinations are guided by the following RACP Assessment Standards aimed at achieving fair and transparent processes and decision making:

Implementation – Standards	
3. Fair and transparent processes and decision making	
3.1	The required level of performance for each assessment is determined according to the standards contained within each curriculum.
3.2	Pass thresholds for examinations are criterion referenced where appropriate, or developed using recognised methodologies for standard setting

Standards of expected performance on all assessments in the RACP training programs are criterion-referenced to relevant training outcomes. Pass thresholds, i.e. cut scores, are established using recognised methodologies that are appropriate for the format of each assessment. The size of the training cohort, and therefore the expected number of candidates does impact the choice of psychometric approaches that can be applied to cut score calculations for individual assessments so for each assessment the methodology applied to passing score threshold calculation is selected based on parameters of feasibility and maximisation of fair and accurate outcomes for candidates.

Standard setting for performance examinations

For the large-scale Divisional Clinical Examination, the long and short case components are combined in considering candidate performance. The examination is criterion-referenced; the marking criteria are accompanied by detailed scoring rubrics with six level performance rating scales and a combined case-type scoring grid. The scoring grid identifies the possible performance rating combinations that can achieve a minimum passing standard across the 2 Long Cases and 4 short cases. The score combination grid and detailed rubric were introduced in 2019 to improve the accuracy of examiner ratings and set a passing standard that can compensate for outlier performance on long and short cases. The development and review of this new approach is detailed below. The rubrics and passing standard are available to trainees, and examiners

undergo calibration exercises using the rubric as part of their commitment to examining in the DCE.

For Observed Structured Clinical Examination (OSCE) based examinations with sufficient numbers of candidates, an examinee-centred approach using the "Borderline Regression" method is used to set cut scores. Where there are static (written) stations included, a modified Angoff approach is used to set the score on each station.

As noted in Standard 5.1, some performance assessments have small numbers of candidates, and psychometric approaches to setting cut scores are not possible due to insufficient data. In these cases, pass standards are criterion referenced and set through review of the rubric for each station/item applying subject matter expert professional judgement. The rubric and published score requirements are available to candidates.

Standard setting for written examinations

The standard is set predominantly using the Modified Angoff approach.

For written examinations that contain less items and much smaller candidate cohorts than for the Divisional examinations, Modified Angoff standard setting approaches are applied at each administration.

For the Divisional Adult Medicine and Paediatrics Written Examinations, a Modified Angoff scoring process takes place once every five years on a full paper calibration. The most recent calibration took place in 2019 (refer to further detail below).

Psychometric analysis using the Rasch model, an item response theory model, stabilises the cut score on subsequent administrations of the written examinations that are constructed of new items and a set of previously used marker items included in the exam development process as link items. (See 'stage 2' below).

2019 major standard-setting exercise for the Divisional Written Examinations

As part of a five-yearly cycle, in 2019, College staff and examination committees conducted a major standard-setting exercise for the Divisional Written Examinations. The purpose of the exercise was to develop a stable, criterion referenced standard that, through item anchoring methods and statistical analysis, can be translated into an equivalent cut score at each examination administration, thus ensuring accuracy and fairness in making examination pass/fail decisions for successive cohorts of candidates. The process followed a two-stage process:

1. Standard setting using the Modified Angoff process.
2. Test equating at the level of the passing standard

The sections below describe each of these stages in more detail.

Stage one: Standard setting using the Modified Angoff process

This stage is based on the concept of a "minimally competent" candidate.

The panel (subject matter experts), through a calibration process exercise, rate the difficulty of each item in the examination using the following framework:

1. What is the purpose of the Exam? What candidates are taking this exam?
2. Discuss concept of borderline/minimally competent candidate for this assessment. What is important at this level?
3. The panel then rate difficulty of each item considering:
   "Imagine 100 borderline candidates in a room – how many will get this answer correct?"

OR

What proportion of minimally competent candidates would answer this question correctly?"

4. Often, panel members provide scores that are too high resulting in too many candidates failing, so after the initial scoring and discussion of outlier ratings item difficulty statistics from a subset of items are provided to show the actual degree of difficulty based on prior use.
5. The final standard score used is the average of multiple panel members' opinions, and established as a defensible and criterion referenced approach to standard setting on written examinations.

Stage two: Test equating at the level of the passing standard

1. A pool of items from the full Angoff exercise that perform well psychometrically are indicated as 'marker items' and included, in different subsets, in subset examinations.
2. Rasch analysis was applied to the first administration of the Angoff'ed examination items to identify the 'ability estimate' (a statistical output of the Rasch analysis) that provides an index in log logit units, as per Rasch analysis output, of the ability of the candidates who achieved the score at the passing standard set by the Angoff method. This logit estimate is the reference point for the passing cut score at future administrations of the examination.
3. Rasch analysis simultaneously provides 'item difficulty' estimates for each item in the examination, theoretically independent of the ability levels of the candidates who completed the examination, but in the same measurement frame of reference.
4. The item difficulty estimates of marker items are then prepopulated into Rasch analysis of subsequent examination data, and these values as 'anchors' enable a calculation of relative difficulty of the examination overall to the original standard. The raw score for the passing standard on subsequent examinations can then be identified as the value at the reference logit estimate for the original, criterion referenced standard.

The full Modified Angoff standard setting is scheduled for approximately every 5 years to accommodate any changes in content and blueprinting and as marker items are retired for a variety of reasons, including exposure.

Review of the Divisional Clinical Examination scoring rubric (CLEAR rubric)

The scoring rubrics for the Divisional Clinical Examination were significantly revised in 2018 after extensive review of the domains and behavioural descriptions at each level of performance on a progressive scale.

This revision involved a review of international and best practice and subsequent development of a new banded approach to determining examination outcomes was developed, referred to as a Score Combination Grid, as shown in Figure 75. This risk matrix-style grid moves away from weighting item scores to instead allow a compensatory approach to combining item scores. This design was proposed to remove the skew applied through item weighting and aims to redress the confounding impact of false-negative low performance and false-positive high performance that may occur due to variations in examiner leniency or other sources of measurement error that may occur in the assessment context.

On the Score Combination Grid, long cases are shown on the axes. Each long and short case is scored out of 6, with candidates attempting two long cases and four short cases. The grid has a diagonal progression of 'bands' depicting differing requirements of short case performance based on long case performance. Low scores on long cases can be partially compensated by high

scores on short cases and vice versa. The bands are consistent except for long case scores of 3 and 3 as both long cases have not met the minimum standard.

Figure 75. Score Combination Grid, Divisional Clinical Examination

Long Case #2 Score \ Long Case #1 Score	1	2	3	4	5	6
1	0	0	0	0	1	2
2	0	0	0	1	2	3
3	0	0	0	2	3	4
4	0	1	2	3	4	4
5	1	2	3	4	4	5
6	2	3	4	4	5	5

0	Band 0: Does not meet Standard
1	Band 1: SC Passed ≥3 AND SC Aggregate Score ≥19
2	Band 2: SC Passed ≥2 AND SC Aggregate Score ≥15
3	Band 3: SC Passed ≥2 AND SC Aggregate Score ≥13
4	Band 4: SC Passed ≥1 AND SC Aggregate Score ≥13
5	Band 5: SC Passed ≥1 AND SC Aggregate Score ≥12

The Score Combination Grid was validated by modelling on past results, trialling on new results and running parallel systems for a complete examination. Simulation of the Score Combination Grid using historical data suggested a high level of agreement of pass rate compared to the traditional model (89%, K 0.7), with a small pass rate change (1.6%) using the new approach. Expert group outcome validation strongly indicated that if the outcomes differed, the new approach would produce more robust evidence of candidate ability. The College adopted the new approach from 2019.

Examiners continue to assess if the candidate displays the required skills in the time allowed, based on criteria for assessment of performance. Criteria for assessment of performance in the Long and Short Case are provided in Appendix 5A.35 and available online. The Score Combination Grid is provided in Appendix 5A.36 and an explanation provided to candidates online (Appendix 5A.37).

Quality assurance measures for assessment (5.1.3)

Examinations

All examinations are supported by a considered set of business rules that are designed to suit the purpose, format and relevant risk areas for each examination. Given the number of programs and formats of summative assessments across training programs, a summarised version of the features of business rules are provided below. Examples of the application of these business rules for the two largest scale examinations (DWE and DCEs) are demonstrated in the Assessment Summary Reports provided in Appendix 5A.33 and 5A.34. These demonstrate the

processes and checks included to ensure fair and accurate results are provided to candidates of barrier examinations. Business rules for other examinations follow this model and are available on request.

Business rules cover the key stages of each examination including:

- planning – work with relevant committee
- blueprinting
- creation and collation of items – item writing, review by technical editor
- recruitment and calibration of examiners (practical examinations)
- conduct of all examinations
- item analysis (written assessments), scoring reviews (practical assessments)
- checks and balances of data accuracy (all examinations)
- standard setting
- results meetings and ratification (Including discussion of borderline candidates or examination events that may impact on candidate results or examination integrity
- communications with candidates and other stakeholders about results and feedback
- collection and utilisation of feedback from candidates about each examination administration
- review of assessment material (items) for item banking and use in future assessments.

Clinical Examinations: calibration of examiners and inter-rater reliability evaluation

Calibration sessions are held prior to clinical examinations, including the Occupational and Environmental Medicine practical examinations, to improve inter-rater reliability and ensure that the standard of each examination is consistently maintained from year-to-year. Examiners consistently provide positive feedback about the usefulness of these calibration sessions (for example, 95% agreement from examiners in 2023 on the usefulness of the session).

Divisional Clinical Examinations

In addition to calibration, an evaluation of the National Examining Panel (NEP) inter-rater scores is undertaken post exam using the Hawk/Dove Index. This provides monitoring data and allows for management of any identified risks associated with potential outlier behaviours.

The Index is constructed by collecting all the marks the NEP gave in the clinical examination and obtaining an arithmetic mean of these. The marks used are the consensus marks. The NEP members' ratings are then placed in an array for analysis.

In-training, work-based assessments

The utility of work-based assessment (WBA) including the accuracy of interpretations made about trainee competence on the basis of these tools is largely determined by adequate sampling from a pre-determined blueprint[7]. Sampling needs to consider both breadth and depth of relevant work-based experience. Minimum numbers of required WBA submissions specified in the RACP assessment programs also consider the feasibility of undertaking the assessments in the context of health service delivery roles.

[7] Wilkinson T.J., Tweed M.J. (2018). Deconstructing programmatic assessment. *Advances in Medical Education Practice*, 9, 191–7.

As detailed in previous reports to the AMC, to support construct and content validity of assessment outcomes, we have blueprinted assessments to the curriculum standards. To achieve improved reliability, we have increased the number and frequency of work-based assessment episodes. Details regarding the evidence base for our programmatic approach to assessment are available in our Programmatic assessment at-a-glance guide (refer to Appendix 5A.38), which is relevant to both Basic and Advanced Training programs.

As described in Standard 5.1.1., assessments in the new curricula including WBAs as well as rotation and phase progress reports are blueprinted to the curricula standards, which are summarised as learning goals, relevant to the phase of training. The planned number of work-based assessment episodes is a minimum of 24 per Basic Training phase at full implementation. Similar models are used for the renewed Advanced Training programs. The required number of WBAs for making robust decisions about trainee progress will be monitored in the early stages of implementation of the new curricula.

5.3 Performance feedback

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

Our commitment to quality feedback

Our Assessment Standards document our commitment to providing constructive feedback through assessment, with Standard 5 being *Quality feedback*. Our Assessment Standards articulate:

"The provision of feedback is an important aspect of … assessments and should be provided according to performance on the task at hand, as well as overall progress through the curriculum and training program. Feedback should be used by trainees and their supervisors to plan for future learning and amend their practice accordingly. Trainees should also have the opportunity to provide feedback about their assessment experiences." (page 14)

More specifically, the Assessment Standards then specify the implementation criteria outlined in Table 26, articulating the RACP's commitment to providing useful feedback to learners.

Table 26. RACP Assessment Standards implementation criteria for quality feedback

Implementation – Standards	
5. Quality feedback	
5.1	Individual assessments generate feedback for trainees on their performance and progress in the particular areas being assessed in order for them to plan future learning.
5.2	Programs of assessment generate feedback for trainees on their performance and progress through the curriculum overall in order for them to plan future learning.
5.3	Feedback is provided by those who have undertaken appropriate training.

Work-based performance feedback to guide learning (5.3.1)

Trainees are required to meet with their supervisor early in their training rotation to develop a learning plan, and also at other points during the training rotation to provide feedback on performance, and to complete in-training assessments with their supervisor. The College's work-based assessment tools are designed to facilitate the continuous provision of feedback to the trainee about their performance in order to guide learning throughout each period of training. These supplement the day-to-day informal feedback offered by the supervisor.

At the completion of a training rotation the supervisor formalises this feedback by completing a report about the trainee's performance during the rotation relative to their stage of training. This report highlights specific aspects of the trainee's performance which were satisfactory or more than satisfactory, and also where the trainee could improve or needs to improve performance. Supervisors are required to meet with the trainee at the end of the term of training to discuss their assessment of the trainee's performance and provide feedback directly to the trainee.

The Medical Training Survey results from RACP trainees in 2023 indicate the RACP performs comparably against the national average for the usefulness and frequency of formal and informal feedback from clinical supervisors.[8]

Performance feedback following examination attempts (5.3.1-5.3.2)

This section first outlines the overall principles and processes for performance feedback following examinations within RACP training programs, including strengths and challenges. This overview is followed by performance feedback strategies for specific high-stakes examinations, as the context and format of assessments may vary.

Notwithstanding the role of barrier examinations in determining readiness for progression or certification, the College recognises that all trainees are on a continuum to expert performance and thus performance feedback is a feature of all examinations. Detailed feedback can assist candidates in identifying the topic areas in which the candidate is excelling or requiring improvement and guide self-reflection on areas of strength and areas requiring development. Supporting documentation for this reflective process is included in the Divisional Clinical Examination. Performance feedback is also provided to supervisors and Directors of Physician/Paediatric Education to assist in supporting trainees in future attempts for examinations if necessary and also to monitor areas of strength and need for improvement in local education programs.

In addition, and in accordance with RACP Assessment Standard 3 concerning transparency in decision-making, detailed feedback supports candidates in understanding how their performance was assessed and ensures that there is transparency in the examination process by aligning feedback to published blueprints for assessments to curriculum topics and objectives (as described in Standard 5.2).

The Medical Training Survey results[6] from RACP trainees in 2023 indicate the RACP performs slightly better than the national average for the question "I received useful feedback about my performance in the exam(s)", with 47% agreement, as compared to 38% in the national average.

---

[8] Medical Training Survey RACP College Report, 2023, 2023 MTS Report for RACP.pdf

Likewise, the RACP's results for the question "The feedback [about exam performance] is timely" were slightly higher; 47% agreement, than the national average of 43%.

Our use of a digital score sheet system has, in part, empowered our ability to provide prompt and quality feedback following examinations. See Standard 5.4 for details of this innovation.

General performance feedback process

After each examination, performance feedback data is prepared for candidates at the individualised level. For some assessments, reports of cohort performance are also prepared by examiners. These describe the characteristics of poor and strong responses to examination questions. Performance data by topic level is prepared for supervisors and benchmarked against overall performance averages and other cohort stratifications where appropriate (see details for each assessment below).

Members of the Assessment Services team are responsible for collating and preparing performance feedback correspondence to candidates and faculty. The examinations data analyst and examinations coordinator complete these processes with the oversight of the Assessment Services Manager and College Psychometrician.

Feedback to candidates: written examinations

For examinations comprised of multiple-choice questions, candidates are provided with an individual results letter that provides at a minimum, the outcome of their performance (pass/fail), their performance score as a raw score and percentage as well as the score required to pass the examination (pass mark).

For the Divisional Written Examination (DWE) MCQ assessments and AFRM short answer question/modified essay question (SAQ/MEQ) format exams, candidate feedback results are broken down to performance per topic area and/or linked to curriculum learning objectives.

Feedback to candidates: clinical examinations

Preparing individualised candidate feedback reports is a highly resource intensive process even with systems to support the collation and merging of data to individualised letters. Numerous quality assurance checks are required to ensure accurate reporting and this can create a waiting time for candidates to receive results of up to four weeks. For written assessments that require human raters and feedback commentary, results processing and compilation of data can take up to six weeks. The College acknowledges these waiting times are stressful for candidates and has worked hard to implement improvements, as evidenced by our improved trainee feedback in the 2023 Medical Training Survey results outlined in the sections above.

As noted throughout this report, the COVID-19 pandemic created significant assessment challenges including the provision of candidate results. For example, examination adjustments to the Divisional Clinical Examination in 2020-2022 extended the time frame between result release and candidates receiving feedback to four weeks. This delay resulted in a significant number of candidates expressing their dissatisfaction with the delay in receiving their feedback. In addition, between 2020-2022 examinations were held over several months which meant there were multiple result release dates and multiple deadlines to provide feedback to candidates. In 2023, the Divisional Clinical Examination administration returned to business-as-usual timeframes and candidate feedback was sent out within two weeks of results release.

Feedback following Divisional Written Examinations

Feedback to candidates

Each exam question is categorised by a topic area linked to the curriculum. Each candidate receives a report showing the number of items in each topic area and the number of questions per area they answered correctly. The feedback is sent to each candidate within four weeks of receiving their DWE results.

Feedback to Supervisors

A report is made with a table that shows how many questions candidates got correct per topic area and is displayed by; Training Setting average, State/Territory average, and overall exam average.

A Training hospital summary is created for all training settings and sent out to the Directors of Physician/Paediatric Education (DPEs) of each training setting. Summaries are also sent out 4 weeks after candidates receive their results.

Plans for Development

The Assessment Services team is reviewing ways to streamline the feedback process to provide candidates with this information sooner than four weeks post examinations. Better technology systems are needed to effectively streamline this process.

Based on items that all candidates perform poorly on, a generic report outlining the detail of difficult questions is under development. This report may also report on items or topics where candidates show consistent strengths.

Measures will be put in place to look at improving the feedback cycle. Plans are also underway to collect feedback from candidates on the usefulness of the feedback they receive.

Feedback following Divisional Clinical Examinations

Feedback to candidates

Candidates receive a feedback document which includes their individual scores for each long and short case, along with the examiners' comments/feedback on the assessment criteria for each case. This information is generated from the Digital Score Sheet (DSS) software that examiners use to record the patients' case summaries, candidates' assessments, and scores. The exported information is then mail-merged into a document for each candidate and proofread to ensure the quality of the documents and all patients' names are removed due to patient confidentiality. The review also ensures that the comments/feedback provided by the examiners are appropriate.

All candidates are provided with a reflection sheet to guide their self-assessment of their examination performance.

Candidates who pass the examination are provided with their documentation as soon as the feedback is made available. Candidates who pass receive a Results Letter, a Feedback Document and a reflection sheet. If candidates wish to have a feedback session after receiving the relevant documentation, they can contact RACP staff who will then allocate a National Examining Panel (NEP) member to provide feedback.

Failing candidate's documentation is sent to a member of the National Examining Panel (NEP) to provide personalised face-to-face feedback with an experienced examiner at a meeting of the NEP member, the candidate and their supervisor if desired. The NEP member is provided with the candidate's feedback summary, a summary of the cases the candidate was given and a feedback document.

NEPs provide personal feedback individually to improve the candidate's progression based on exam performance. NEP members are contacted to ensure they are available and willing to provide feedback to the failed candidates, so that there is no delay in candidates receiving feedback. NEPs are allocated with geographical location in mind so that candidates have the opportunity to have the feedback session in person. The NEP allocation is also performed to ensure there is no conflict of interest, either at their site or a nearby site.

For privacy, security and confidentiality reasons, feedback documents are password protected and the password is provided in a separate email. During the session, the NEP is required to provide the candidate with a copy of their feedback document for discussion. The candidate is then able to keep a copy of this document.

The NEP is advised that the Case Summaries are for discussion purposes only as these contain confidential patient information. Case Summaries are also examination material and should not be provided to the candidate to keep, copy, or photograph. They are required to securely destroy the Case Summaries once they have discussed them with the candidate.

Candidates are advised that should they require further support, their DPE is able to join their feedback session to guide them through the process and help determine where they can improve for future attempts (where applicable). For candidates who are not successful in meeting the required standard in the DCE, supplying the feedback data to the DPEs allows them to support their candidates and assist with training for future attempts.

Feedback to Directors of Physician/Paediatric Education (DPEs)

Summaries are created with the results for each candidate within a Country/State/Territory and sent to the DPEs. The documents are password protected and the password is sent in a separate email.

Strengths

The strengths of this feedback system for candidates who do not pass the DCE include the transparency of information provided and the available support mechanisms. For example, supplying the feedback data to the DPEs allows them to support their candidates and assist with training for future attempts and the flexible options for seeking further feedback. In particular, this is empowered by NEP members providing feedback individually suited for improving the candidate's progression based on their exam performance.

Feedback following Faculty multiple choice question format exams

Both Occupational and Environmental Medicine and Rehabilitation Medicine use this format of examination with the process outlined below.

Feedback to Trainees

Trainees receive their score out of the total amount of answers, and the overall percent this mark indicates. The feedback letter includes the pass mark for the assessment to indicate how well or poorly they performed relative to the pass mark on the Multiple-Choice Question (MCQ) Exam.

Feedback to Supervisors

Supervisors do not receive direct feedback for their trainees. Trainees are empowered to share their results with their supervisor.

Plans for Development

As part of Curriculum Renewal, the exam blueprint and feedback tables will be updated to match the new Knowledge Guides (as per the Divisional Written Examinations). Feedback may become based on dimensions beyond the content topic areas as outlined in the new curriculum design.

Feedback following Short Answer Question/Modified Essay Question format exams

Rehabilitation Medicine uses these format examinations and the processes outlined below.

Feedback to Trainees

Each question is categorised by a topic area according to the curriculum. A spreadsheet is created with a table that shows how many questions candidates were successful or unsuccessful in. This table is then used to mail merge the final results letter which breaks down topic areas and the final result for the trainee.

Candidates can see the areas where they exceeded or met the current standard or those areas where they should improve their knowledge or practice.

In addition, examiners who mark the candidate papers provide comments and feedback during the marking process.

Candidates also receive generalised feedback from the examiners. This is a summary and overview of the exam and addresses each topic area by breaking it down into three sections: the areas the candidate performed well in, the areas candidate performed poorly in, and other comments section.

All candidates of the MEQ/SAQ receive a copy of this feedback regardless of their examination outcome. This general feedback report is then published to the Exams webpage.

Feedback to Supervisors

Advanced Training (AT) Supervisors do not receive direct feedback for their trainees. Trainees are empowered to share their results with their AT Supervisor.

The generic feedback report is available to the Supervisors via the Examinations webpage with a 2023 example of the feedback report available here.

Challenges

Trainees who do not pass the examination may wish for further breakdown of marks on topics failed. This format does not provide the pass mark, or the candidates overall mark reflected as a total mark or percent.

There is a five to six week window between the exam day and the results release. This is to allow for the processes that take place to ensure accurate results are published. However, it is acknowledged that this processing time can be stressful for candidates.

Feedback following Faculty and Chapter Clinical Exams

Faculty Exams are held for all three Faculty programs and the Australasian Chapter of Sexual Health Medicine training program. Each Chapter/Faculty has various ways of providing feedback to trainees and supervisors.

Planning is underway to review all feedback formats to ensure candidates receive robust feedback that aligns with the RACP's Assessment Policy principle of 'transparency' and ensures that the feedback is useful for performance and practice improvement.

Feedback to Candidates

During the examinations, examiners note down feedback for each candidate per station. This information is collated and sent to the candidates.

The generalised feedback from the examiners is sent with the results letter and a summary of feedback on overall exam performance is published on the Exams webpage. This feedback includes general areas of strength and areas that need improvement overall.

The Public Health Medicine Oral Examination provides individualised feedback to each candidate who fails overall. This feedback is provided by the examiners who examined the trainee. The feedback is summarised per topic/question and provides overall strengths, weaknesses and an overall comment on performance.

Feedback to Supervisors

Occupational and Environmental Medicine supervisors are provided with copies of the relevant candidate's results letter. Candidates are made aware that their results will be shared with their supervisor, however they are able to opt out of this feedback process if desired.

All other Faculties do not provide feedback in writing to the candidates' supervisor.

Strengths

All candidates, regardless of their final outcome, receive general feedback on the candidate cohort. Feedback is linked to the curriculum, reinforcing the learning objectives assessed in the exam.

Challenges and Plans for development

Feedback as a whole is being reviewed within the Faculty Exams team to be able to provide candidates with a robust breakdown of their performance when requested.

Early identification of trainees in need of enhanced support (5.3.3 and 5.3.4)

Trainees can experience varying degrees of difficulty in meeting the challenges of RACP training. These difficulties can become apparent throughout the course of assessment but also at other times. The RACP has a Trainee in Difficulty Policy and Training Support Pathway and Process which together form our framework for offering enhanced support to trainees in these situations.

Trainee in Difficulty Policy

The Trainee in Difficulty Policy (Appendix 1A.33) provides the underpinning provisions for defining a trainee in difficulty, principles used to support a trainee, roles and responsibilities of trainees, supervisors and educational leaders, employers and the RACP and committees. The policy acknowledges that training difficulties can arise from factors that may not relate to the individual capability of the trainee and instead relate to the training setting or the trainee/supervisor relationship.

The policies eight underpinning principles are:

1. Patient and trainee safety as a priority

2. Centred on educational progress and professional development
3. Early intervention wherever possible
4. Local remediation wherever possible
5. Fair and transparent processes early accessible by all parties
6. Transfer of important educational information
7. Support focussed
8. Centred on solutions.

The policy introduces the Training Support Process and Pathway, including the Improving Performance Action Plan, as further outlined below. The policy is currently undergoing a minor revision to align it with the goals, roles and responsibilities of our renewed programs, provide clearer guidance for resolution of training supervisor/setting issues, and to contemporise the language.

Training Support Pathway and Process

The Training Support Pathway (TSP) (Appendix 1A.36) has been available to trainees since 2012. The pathway has three stages, covering multiple levels and reasons for enhanced support. The overall aim of the pathway is to provide individually tailored assistance to trainees to support them to progress through training.

The TSP Process (Appendix 1A.35) provides a transparent and formally defined process to facilitate this activity. Our TSP policy and process are on our website.

Improving Performance Action Plan

Throughout each stage of the TSP, the Improving Performance Action Plan (IPAP) (template provided in Appendix 3A.39) is used to provide a framework to help trainees, supervisors and the College outline and monitor:

- learning strategies to be implemented to improve performance in areas where performance is below the expected standard
- expected outcomes from these actions and strategies
- dates on which the trainee and their supervisor will meet to review progress.

Stage 1- Local support

The first stage of support has a strong emphasis on local resolution of the difficulty including involvement of the Director of Physician/Paediatric Education (DPE) or supervisor where appropriate. During the first stage of the support, the College may have little to no interaction with the trainee.

During this stage, the initial IPAP is developed by the trainee and supervisor and a review is conducted at the end of the three-to-six month period. If the remediation was successful and performance is at the level expected, the supervisor will recommend the trainee is exited from the TSP. If further remediation support is required, the trainee will progress to Stage 2 of the Training Support Pathway.

Trainees who are approaching their last eligible examination attempt are placed on the local level of the TSP. The RACP works with DPEs to facilitate this.

Stage 2- College support

If training difficulties are not resolved at the end of a period of local support, the DPE or supervisor will notify the College by submitting their supervisor assessment report at the end of the training period. The Training Support Unit at the College will then get in touch with the trainee and supervisor to arrange additional support. The Training Support Unit brings the case to the relevant Training Committee to formally refer the trainee to the second stage of the TSP. This stage of the pathway enables support and progression to be monitored by the appropriate College body, with further remedial action being taken as needed.

Stage 3- Comprehensive Review of Training

A Comprehensive Review of Training (CRT) is the final stage of the Training Support Pathway. A referral is made for a CRT when the relevant training committee believe that all support options in previous stages of the pathway have been exhausted. When a trainee is referred for a CRT, the training committee can make a decision to withdraw the trainee from that specific training program if they believe that the trainee is not suitable for training. If the decision is made not to withdraw a trainee, the training committee is able to monitor the trainee's progress for a further 12 months. At the conclusion of the 12-month monitoring period, the training committee must decide whether the trainee is suitable for ongoing training or whether they should be withdrawn.

Data on use of the Training Support Pathway

Table 27 provides a summary of the volumes of trainees on the Training Support Pathway Stage 2 and 3 in the past four years. It is not possible to report on the volumes of trainees on Stage 1 as that data is only locally maintained. We are working to improve our technology to enable efficient collection and reporting of all TSP related data, including that related to Stage 1.

As can be seen in the Table 27, volumes of trainees on the TSP have increased over time. The RACP interprets this as a positive outcome as it indicates enhanced support needs are being identified and delivered as required. The proportion of trainees with successful remediation outcomes (i.e. the volumes of trainees exited from the TSP) decreased in 2021 and 2022, due to increased complexity of cases and challenges associated with COVID-19. In 2023 we have been pleased to observe an increase in the proportion of trainees with successful remediation outcomes.

Table 27. TSP outcomes, Stages 2 and 3

Year	# trainees on TSP	# exited from TSP (ie successful remediation)	% exited from TSP (ie successful remediation)	# Involuntarily withdrawn from training
2020	[redacted]	[redacted]	[redacted]	[redacted]
2021	[redacted]	[redacted]	[redacted]	[redacted]
2022	[redacted]	[redacted]	[redacted]	[redacted]
2023	[redacted]	[redacted]	[redacted]	[redacted]

Involuntary withdrawal (dismissal) from training (5.3.3)

As outlined above, failure to progress in training following Stage 3 of the Training Support Pathway can result in the trainee being involuntarily withdrawn from training.

As outlined in the Progression through Training Policy (Appendix 1A.27), trainees will be ineligible to continue in training if they:

- fail to complete examinations within the relevant exam attempt limits (either number of attempts or time limit to use attempts)
- are unable to complete the program's requirements within the specified time limit.

In each of these situations, the trainee is provided with multiple written notifications of the impending requirement and offered tailored support.

As outlined in the Academic Integrity in Training Policy and Process, (Appendix 1A.19 and 1A.20) the outcome of an enquiry into a suspected case of academic misconduct can include suspension from a training program for a certain period of time or dismissal from the training program, depending on the nature and severity of the misconduct.

The enquiry is a formal process, with the trainee provided a written allegation to respond to in writing. The relevant training committee convenes to review the report of the alleged misconduct with additional information, the trainee's training record, the trainee response and any additional information provided by the trainee. The committee may also seek additional information. The committee will consider the information including aggravating or mitigating factors including the nature of the offence, the character of the trainee and general deterrence.

Provisions for special consideration of exceptional circumstances are set out in the Special Consideration for Assessment Policy (Appendix 1A.32). Rights of reconsideration, review and appeal are set out in the Reconsideration, Review and Appeals Process By-Law (Appendix 1A.45).

A trainee who is exited from training may apply for an alternative RACP training program. Applications to commence in an alternative RACP training program will be considered by the relevant training committee on a case-by-case basis with reference to the applicant's RACP training history (see Table 28).

Table 28. Involuntary discontinuations from training*

Year	Exhausted examinations attempts	Failure to complete in time limit	Exited via Stage 3 TSP-CRT	Academic Integrity breach
2020	3	9	0	0
2021	15	14	[redacted]	0
2022	13	43^	[redacted]	0

**note that counts in this table are involuntary discontinuations from training per program. A trainee may be undertaking two programs and if they were involuntarily discontinued from both programs, they would contribute to two counts in the table.*
^ The CEC granted an additional 12 months time to complete training in 2020 due to the impact of COVID-19. This accounts for the small number of exits due to exhausted time limits in 2020 and 2021 and a delayed peak in exits in 2022.

Table 29 also provides a summary of the reasons for voluntary trainee withdrawals from programs. We note that trainees commonly withdraw from one Advanced Training program to focus on pursuing training in another. More detailed data is provided in Appendix 7D.

Table 29. Voluntary withdrawal from training

Year	Personal/ family reasons	Pursuing another RACP specialty	Pursuing non-RACP training	Unknown
2020	7.8%	22.9%	19.9%	49.4%
2021	7.4%	13.1%	15.2%	64.2%
2022	10.6%	20.0%	19.4%	50.0%

Informing regulators of patient safety concerns (5.3.4)

The Trainee in Difficulty Policy establishes that patient and trainee safety is a priority and outlines the mandatory notification obligations of employers and clinicians as per the Medical Board of Australia and Te Kaunihera Rata o Aotearoa | The Medical Council of New Zealand (per AMC Standard 5.3.4). The College routinely reminds relevant training settings of their obligations in respect to mandatory reporting to regulatory authorities. The College does not make these reports directly.

Further to this, Standard 6.4 of the RACP Assessment Standards establishes that supervisors, and where appropriate, regulators will be informed where patient or public safety concerns arise in assessment. Disciplinary action in respect to employment or medical registration is a matter for the employer and/or regulator as appropriate if there is evidence of serious breaches of care. Assessors are bound by mandatory notification requirements to the relevant regulator.

No reports to regulators have been made directly by the RACP regarding patient safety concerns since the last reaccreditation decision.

5.4 Assessment quality

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

Monitoring the integrity of assessment processes and outcomes (5.4.1-5.4.2)

The RACP has undertaken considerable work in defining standards for assessment quality over the last ten years. The aforementioned Standards for Assessment (Appendix 1A.22) have a central role in providing criteria for ensuring the integrity of assessments in terms of their purpose, their use within a training program, and how information from the assessments is translated into defensible decisions. We have detailed this work in previous standards. Standard 8.1 further discusses the purpose of the Supervisor Professional Development Program in supporting educators in their roles as work-based assessors.

The previously mentioned business rules for each assessment include principles and procedures for maintaining the integrity of each assessment over time, including:

- development and review of examination items and construction of papers
- the use of internal and external checks on assessment data
- standard setting and results review
- the storage and security of assessment items– including secure item banks
- measures to ensure the confidentiality and privacy of candidate and where appropriate, patient information.

After each barrier examination, a results meeting is convened with members of the relevant Examination Committee to review the results of assessment data analysis, any issues arising through the conduct of the examination included in invigilators' reports, the calculation of the cut score for the examination (written examinations) the pass rate and candidate performance. Once the committee members confirm the outcome of the assessment, the process is also reviewed and signed off by senior RACP Staff, including the Executive General Manager of Education, Learning and Assessment and the RACP Risk and Compliance Manager.

In acknowledging these strengths, we also must acknowledge that the RACP has encountered several recent set-backs to the feasibility of delivering examinations in recent years, and several of these initiatives have been instigated in response to lessons learned. We have provided an update on computer-based delivery of examinations below.

Maintaining the integrity of assessments during disruption (5.4.1- 5.4.2)

The RACP's centrally administered barrier assessments can be vulnerable to location-specific or wide-scale disruption from a range of sources. This can range from technical issues, extreme weather events, pandemics and health emergencies, affecting the ability of candidates and/or examiners/invigilators to prepare and even move between locations. Maintaining the integrity of assessment standards while mitigating for potential and responding to actual events is a key component of the RACP's assessment delivery program, with consideration given to the health, safety and wellbeing of all stakeholders.

Risk management and contingency planning for assessment

The College has a well-established risk management and contingency planning framework in place for examinations. This was refined and enhanced throughout the COVID-19 pandemic with lessons learned applied for continued quality improvements.

Comprehensive Risk Management Plans are in place to manage any situations impacting the delivery of exams. These are supported by:

1. **Situation Management Plans** guide the management of external events impacting exam delivery and are complemented by a Crisis Communications Plan.
2. **Contingency Plans** have been developed as part of the overall Risk Management approach for all exams. These plans are published on the website and focus on deferring exam delivery or implementing an alternative form of delivery. They are reviewed in advance of each examination to ensure that Situation Management Plans address emerging issues.
3. Implementation of a dedicated **Divisional Clinical Examination Support model** is in place with College staff and external suppliers providing support on all exam days.
   Support includes:
   a. An internal Help Desk providing general support for the Digital Scoresheet and assistance with technology queries and issues.
   b. A comprehensive suite of support resources for examiners, candidates, and hospitals.

Contingency plans are developed and communicated to examination stakeholders using the RACP website (see AM and PCH DCE webpage and DWE webpage for examples – Appendices 5A.40 and 5A.41) and in outgoing examination related communications.

Contingency plans are enacted by the Decision Panel who are a combination of Committee Chairs, Chief Censor of the College, Dean of the College, and RACP management. The Decision Panel is provided with all the information related to the issue/risk and they will decide at their meeting on the outcome to follow. The situation management plan sets out each contingency and other situations that could occur with a step-by-step guide of who is responsible and accountable for carrying out the tasks to manage the issue/risk. Available contingency options may be applied to an individual exam site or multiple impacted sites.

When the Decision Panel is convened, College staff will prepare notes and meeting summaries, capturing discussions, decisions, and ensuing actions. The Decision Panel is obligated to report its findings to the College Assessment Committee (CAC) and the College Education Committee (CEC), with college staff delivering comprehensive reports to the RACP Senior Leadership team.

Depending on the nature of the significant event, the following consistent, overarching key actions are undertaken, with the designated individuals or groups responsible:

1. Call a Decision Panel Meeting
   Responsible: Assessment Services Manager.
2. Gather Information on the Situation
   Responsible: Divisional Examinations staff (for information updates), IT (for IT-related issues, e.g., outages), Marketing and Communication (to manage communications and questions).
3. Convene Decision Panel to assess the situation and determine appropriate action.
   Responsible: Decision Panel
4. Enact recommended action
   Responsible: EGM ELA (to update RACP Senior Leadership on the Decision Panel's outcome), Examination Staff (provide instructions, assist in developing communications, and enact a reserve examination if needed), IT (implement website changes) and Marketing and Communication (execute crisis communication, inform candidates of examination changes).

COVID-19 pandemic

In 2020, the impacts of the COVID-19 pandemic on our ability to prepare for and deliver our examinations presented an unprecedented challenge, particularly for clinical examinations. It was necessary for the RACP to creatively and strategically problem solve with a range of stakeholders, looking to technology for solutions and opportunities in an environment requiring social distancing, and limiting travel and face to face interactions.

The RACP liaised closely with educational leaders and state and territory Health Departments and District Health Boards (now Te Whatu Ora) regarding approaches to examination delivery and formats.

The College had to postpone the majority of 2020 examinations and some in 2021 due to the impact of COVID-19, as summarised in Table 30. As we previously reported, the 2020 Divisional Clinical Examinations were delivered in a modular format, whereby short cases and long cases were delivered separately.

In February 2021, the College Education Committee approved a 2+2 Short Case format for use as an emergency measure to enable significantly COVID-19 impacted exam sites to deliver the

Short Case component of the 2020 Divisional Clinical Examination (DCE). It allowed clinical exams to be offered in situations where hospitals do not have the capacity to run all four Short Cases.

In the 2+2 Short Case format all candidates undertook two Short Cases initially. The Score Combination Grid (without the aggregate score requirement) was applied to the candidate's Long Case band and initial two Short Case scores to determine if their exam outcome can be determined. If yes, the candidate's exam was complete. If no, the candidate was asked back for two further Short Cases to determine their exam result. This format was designed to reduce the overall number of Short Cases required (in the 2020 DCE for Adult Medicine in Australia only 28% of candidates needed a further two Short Cases).

Modelling undertaken by the Australian Council for Educational Research using the Australian Adult Medicine 2019 exam data set, indicated the 2+2 model produced outcomes of similar reliability to the traditional model. Later analysis based on the 2020 Adult Medicine exam data set confirmed the findings. For the 2020 DCE 18 Adult Medicine exam sites (largely in Victoria and New South Wales) needed to use this emergency measure delivery format. For the 2021 DCE, some exam sites again needed to use the 2+2 Short Case format due to COVID-19 impacts. The currently preferred format continues to be four Short Cases.

From 2023 onwards, the College returned to our business-as-usual model for exam delivery, with added COVID-safe precautions.

Collectively, these adaptations required an immense amount of Member and training setting effort, collaboration and communication. Through the height of the COVID-19 impacts, the RACP appointed a dedicated Program Lead to spearhead these efforts across the College and health settings. It was a significant shared achievement to continue delivery of examinations, maintain the integrity of these assessments and provide trainees opportunities to continue to progress in their training.

Table 30. Summary of examination delivery through 2020-2023

	2020	2021	2022	2023
Basic Training				
Divisional Written Examinations				
Adult Medicine	Delivered in February 2020 as planned	Delivered in February and March 2021 as planned First introduction of October Exam, 258 candidates sat exam	Delivered in February, 762 candidates, computer-based exam Delivered in March, 222 candidates, paper-based exam Delivered in October, 86 candidates, paper-based exam	Delivered in February and March (Auckland only), 752 candidates, paper-based exam October 2023, paper-based exam
Paediatrics and Child Health	Delivered in February 2020 as planned	Delivered in February and March 2021 as planned First introduction of October Exam, 52 candidates sat exam	Delivered in February, 225 candidates, computer-based exam Delivered in March, 60 candidates, paper-based exam Delivered in October, 22 candidates, paper-based exam	Delivered in February and March (Auckland only), 205 candidates, paper-based exam October 2023, paper-based exam

	2020	2021	2022	2023
Divisional Clinical Examinations				
Adult Medicine	Aotearoa NZ- Long Cases delivered November 2020. Short cases delivered February 2021.	Aotearoa NZ – traditional format exam (face-to-face Long and Short Cases on the same day) delivered as scheduled June 2021	Face- to- Face traditional exam for all candidates except those in Western Australia who sat the modular exam due to COVID restrictions.	Delivered as planned in June
	AUS- Long Cases delivered via teleconference November 2020- March 2021. Short Cases delivered face-to-face March- May 2021.	AUS - Delivery commenced July 2021 as scheduled. Traditional format delivery in QLD, SA, TAS, NT, and WA, and modular format delivery (teleconference Long Cases and face-to-face locally delivered Short Cases) in VIC, NSW, and ACT due to COVID-19 impacts	Total of 933 candidates AU: 3 June to 17 September	
			Aotearoa NZ: 2 to 11 September	
Paediatrics and Child Health	Aotearoa NZ - traditional format exam delivered Oct-Nov 2020 AUS- Long Cases delivered via videoconference December 2020- March 2021. Short Cases delivered face-to-face March- April 2021.	Aotearoa NZ – traditional format exam delivered as scheduled May 2021 AUS – modular format exam delivered from 1 September 2021. Short Case delivery in NSW and ACT postponed to March 2022.	Face to Face – some delay of examination in Western Australia due to COVID restrictions, 257 candidates AU: 13 May to 12 June 2022 & 3-6 September 2022 Aotearoa NZ 28 to 30 October 2022	Delivered as planned in May-June
Australasian Chapter of Sexual Health Medicine				
Exit Examination				
	Delivered in August 2020 via videoconference platform. This was the first RACP exam to be delivered virtually and was successful.	Delivered in August 2021 via videoconference platform.	Video-delivery of examination in August. Examiners meeting in Sydney and candidates meeting via videoconference, 13 candidates	Face to Face Oral Examination, 21 July 2023.10 candidates completed the exam.
Australasian Faculty of Rehabilitation Medicine				
Written Examinations				
Module 1 Assessment	Postponed from May 2020 to May 2021.	Delivered in May 2021 via computer- based testing	Delivered in July, 59 candidates, paper-based exam	Paper-based exam, 11 July 2023
Fellowship Written Examination - Multiple Choice Exam	Postponed from May 2020 to February 2021.	Delivered in February 2021 for both 2020 and 2021 cohorts at multiple exam venues.	Delivered in March, 35 candidates, paper-based exam	Delivered as planned via paper-based exam in March
Fellowship Written Examination - Modified Essay			Delivered in March, 41 candidates, paper-based exam	

	2020	2021	2022	2023
Question exam				
Fellowship Written Examination (Paediatrics) - Multiple Choice Examination			Delivered in March, 3 candidates, paper-based exam	
Fellowship Written Examination (Paediatrics) - Short Answer Question Examination			Delivered in March, 3 candidates, paper-based exam	
Clinical and Practical Examinations				
Module 2 Assessment	Postponed from June 2020 to June 2021.	Delivered as scheduled in June 2021. Candidates attended 3 hospitals across Australia and Aotearoa New Zealand. Victorian candidates were unable to attend due to Melbourne lockdown and were rescheduled to October 2021.	Delivered in August, 56 candidates, face-to-face OSCE	Face-to-face OSCE, 27 August 2023
Fellowship Clinical Examination - General Rehabilitation	Postponed from August 2020 to May 2021.	Delivered as scheduled in May 2021. Majority of candidates undertook exam face to face at 3 hospitals, small number of candidates undertook exam via videoconference platform.	Delivered in May, 67 candidates, face-to-face OSCE	Face-to-face OSCE, 13 May 2023
Fellowship Clinical Examination (Paediatrics)	Postponed from September 2020 to May 2021.	Delivered via videoconference at candidates local hospital or RACP state office, Held on 29 May, 2021.	Delivered in June, 2 candidates, face-to-face OSCE	Face-to-face OSCE, 25 June 2023
Australasian Faculty of Public Health Medicine				
Oral Examination				
	Postponed from October 2020 to March 2021.	Delivered in March and October 2021 via videoconference platform.	Delivered in October, 26 candidates, video-delivery of examination with examiners meeting in Sydney and candidates meeting via videoconference.	Face-to-face oral examination, 17-18 October 2023
Australasian Faculty of Occupational and Environmental Medicine				
Written Examinations				
AFOEM Stage A	Postponed from September 2020 to September 2021.	Delivered in exam venues across Australia and	Delivered in September, 15 candidates, paper-based exam	COVID safe written MCQ examination, 9 September 2023

	2020	2021	2022	2023
Written Examination		Aotearoa New Zealand in September 2021.		
AFOEM Stage B Written Examination	Postponed from September 2020 to September 2021.		Delivered in September, 17 candidates, paper-based exam	COVID safe written Short-answer examination, 9-10 September 2023
Clinical and Practical Examinations				
AFOEM Stage B Practical Examination	Postponed from November 2020 to November 2021.	Delivered in November 2021 for both 2020 and 2021 cohorts. The exam was delivered using a hybrid model, candidates undertook some stations face to face at the hospital venue and some stations via videoconference platform.	Delivered in November, 14 candidates, face-to-face OSCE	Face-to-face OSCE, 18-19 October 2023

Other disruptions

We enacted a contingency plan for the Divisional Written Examinations in response to the 2023 Cyclone Gabrielle in Auckland, which involved the use of a reserve examination. We monitored and adjusted supports in response to the March 2022 floods in Queensland and 2022 Cyclone Dovi in Aotearoa New Zealand however each of these examinations was able to go ahead on the originally planned date.

Computer-based testing

In 2018, the RACP had to cancel its first computer-based Divisional Written Examination due to a technical error. Exam provider Pearson VUE acknowledged fault for the examination failure. An independent enquiry was commissioned and conducted by Ferrier Hodgson, which covered implementation of the computer-based examination and events on and preceding the examination date and recommendations for improving examination processes. The report of the enquiry was shared with all RACP Members and is provided in Appendix 5A.42.

The inquiry findings were used to inform future implementation of computer-based testing (CBT). They were also used to guide improvements to governance, culture, contracting procedures, examination testing and validation, communication strategies and project management frameworks.

The RACP again attempted to transition written examinations to computer-based testing (CBT) in 2022 to modernise the exams and align with international best practices. This followed an extensive program of system testing implemented by our exam provider and College staff, and computer-based testing pilots for the Australasian Faculty of Rehabilitation Medicine Module 1 Assessment and Divisional Written Examination.

We delivered the computer-based Divisional Written Examinations in February 2022 to 1,150 candidates. Regrettably, around 100 candidates across Auckland, Melbourne, Brisbane and Perth experienced a combination of technical and process issues with delivery of their computer-based test and were unable to complete a session in the allocated time. Six candidates in Western Australia were affected with incomplete exam data.

In the following days, we learned that other candidates had unsatisfactory exam experiences due to delays with logins, slow downloads, pausing, and or pop up of error messages on the screen.

Management of these issues disrupted the examination environment for other indirectly affected candidates.

We apologised and issued refunds to those who sat and did not pass the computer-based examination. A back up, paper-based examination was delivered on 8 March 2022. Methods were implemented to allow scores to be combined from papers completed across the February and March DWEs. Prior to the examination, it had been determined that both the February and March Divisional Written Examinations (DWEs) would not count as an official exam attempt for unsuccessful candidates. Future Divisional Written Examinations will return to the paper-based format until further investigation and consultation can occur.

In response to the issues encountered with the computer-based delivery of the Divisional Written Examination in February 2022, the College contracted KPMG to undertake an investigation. The College received the KPMG Report in October 2022. The KPMG Report (Appendix 5A.43) set out eight recommendations to be considered prior to the College planning a future move to computer-based testing for examinations:

1. Request Contractor A to:
    - undertake a comprehensive technical investigation to determine the reasons for the high and prolonged server CPU utilisation experienced during the DWEs
    - define a comprehensive testing plan that accurately models server CPU usage in a live exam scenario
    - ensure that server CPU resource allocations are set with a sufficient margin of comfort when conducting any future exams.
2. Undertake a detailed assessment of the merits and drawbacks of online CBT vs offline CBT.
3. Supplement the expertise of the RACP Project Team with additional technical expertise to mitigate key person risk.
4. Require an increased level of specialist technical support with working knowledge of the software on the day of the exam.
5. Require the vendor to develop a post-exam checklist to assist with preventing data loss.
6. Require the vendor to provide “hands on” training of the software to invigilators, so they are familiar with its functionality.
7. Establish more effective two-way communication channels for managing major incidents.
8. Improve communication around the Observer role.

The RACP has accepted the recommendations of the KPMG report. Through a Cross College Review of Examinations we are exploring our priorities related to examination design, delivery, quality assurance and quality improvement to align with our new curricula prior to offering any future computer-based examinations. An update on this activity is provided in Standard 5.1.1.

Evaluating and improving the quality of assessments (5.4.1-5.4.2)

The College has a number of strategies aimed at improving the quality of its current assessment methods. As noted in Standard 5.1, the College designs and evaluates the quality of its

assessments with reference to van der Vleuten's Utility Index heuristic[9], which proposes that the utility of an educational intervention can be assessed in terms of its validity, reliability, acceptability, educational impact and feasibility. In addition to our extensive activities working with a large range of stakeholders to undertake Curricula Renewal, we have completed several significant reviews aimed at evaluating assessment quality as highlighted below.

Cross College Review of Examinations

Refer to Standard 5.1.1 for a discussion of this significant review activity occurring in 2024.

Monitoring the stability of examination difficulty and pass rates

The College employs a range of strategies to monitor the stability of examination difficulty and pass rates across the life cycle of each assessment and over time. These activities have been described in detail in previous sections, and include preparation of assessments such as examination blueprinting, item writing panel training (written examinations), examiner calibration sessions (clinical examinations and work-based assessments) and criterion referenced standard setting approaches support the consistency of examination difficulty across administrations.

Annual psychometric reports are developed and considered by the College Assessment Committee, along with feedback reports developed from post-examination candidate and examiner surveys.

Examination Difficulty

For the larger cohorts of written examinations, examination difficulty is monitored over time using the Rasch based standard setting approach including statistical monitoring of any item 'drift' in item difficulty of anchor items.

Statistical analyses of examination difficulty over time is more challenging for practical examinations when cohort numbers are small. As part of quality assurance activities for these assessments, the scores from all the examiners are collated and discrepancies between examiners are checked by the station supervisors. The scores are collated to support comparisons between examiners in concurrent groups of candidates or different venues and across previous years' examinations.

Examination pass rates

All RACP assessments including barrier examinations are criterion referenced so all candidates who meet the required standard will achieve a passing result. There is no set pass rate; all candidates who achieve the pass standard will receive a satisfactory result. The committee for each examination reviews the pass rate at each administration in the context of previous pass rates, and the number of candidates sitting the examination, noting that pass rate information as a quality assurance monitoring strategy only provides significant value with larger numbers of candidates. Some variation in passing rates is anticipated, however large variations in pass rates are investigated through additional quality assurance checks of assessment data and processes, before confirmation of results. The most significant trend in terms of systematic differences in pass rate has been observed as a downward trend in pass rates as the number of attempts increases in the Divisional Written Examination, which was taken into account when considering the cap on the allowable number of attempts for this assessment.

[9] van der Vleuten, C. P., & Schuwirth, L. W. (2005). Assessing professional competence: from methods to programmes. *Medical Education*, 39(3), 309–317. https://doi.org/10.1111/j.1365-2929.2005.02094.x

Incorporating examiner and candidate feedback into assessment improvements

After each barrier examination, candidates and examiners, as relevant, are invited to complete a post examination feedback survey. The details of these monitoring mechanisms are described in Standard 6.1, and there have been a number of subsequent improvements to examination processes as a result of this feedback. For example:

- **Introduction of mindfulness activities during OSCE examinations**- Previously, the rest stations within the Rehabilitation Medicine OSCEs did not include any activity options and recently several options were trialed upon the suggestion of trainee representatives. After analysis of candidate feedback, we have now identified and will continue to offer preferred mindfulness activities in this examination.
- **Accommodating small numbers of DWE candidates through provision of network-level results-** Previously, we were unable to share aggregate results data for small settings with educational leaders (Network DPEs and DPEs) due to risk of candidate identification. We are now using Microsoft PowerBI to manage our examination results, and as a result, can efficiently produce aggregated reports at Network level, allowing greater access to results data for quality improvement yet still maintaining confidentiality obligations.
- **Provision of more detail in DWE results feedback, in response to candidate requests**- In response to candidate feedback, from October 2023 onwards, individual results sheets for candidates now include the number of items in the examinations at the component level, i.e. candidates can now see their proportional number of items correct from the subtotals per the two different papers included in the examinations.

Improvements to the Advanced Training Research Project requirement

As outlined in Standard 3.2.8 and Table 23 in Standard 5.2.1, all Advanced Trainees are required to satisfy the Advanced Training Research Project Requirement (ATRP). These projects are reviewed by College Fellows to ensure that they meet the expected standard.

In 2022, feedback from Advanced Training Committees and trainees indicated a need to provide alternative methods to meet the requirements of the ATRP. The initial scoping of the purpose of the assessment, current issues, their impacts and alternative assessment methods was undertaken at the Advanced Training Forum in October 2022.

Two key issues were identified as priorities to address:

- Delays with processing and results. Trainees frequently wait a long time for their ATRP to be processed, assessed, and have the result communicated to them.
- Value and flexibility. There was a perception that the ATRP lacks value for non-career researchers and should be able to be achieved in more flexible ways.

Immediate steps were taken to increase the reviewer pool to include over 800 new reviewers across all specialties. This has reduced the burden on reviewers and contributed to improved average results timeframes for trainees.

Additionally, the College Education Committee identified several research project-related optimisation initiatives which were discussed with the College Trainees' Committee and Advanced Training Committees at the Advanced Training Forum in July and August 2023. The following changes have been approved for implementation from 1 January 2024.

- Three submission dates for Advanced Training Research Projects across all programs. Historically, trainees could submit at any point throughout the year which resulted in a high

volume of submissions at the end of each year and contributed to a bottleneck for confirming completion of training requirements and admission to Fellowship. The new submission dates will support consistency across programs, more efficient management of reviewer allocation and processing to further improve results timeframes.

- Revisions to the Recognition of Prior Learning Policy to expand the application timeframe and eligibility criteria related to research, and the accepted research categories. This will increase flexibility for trainees to address the issue of value and flexibility.
- A new exemption process for Advanced Trainees undertaking research activities during training. The purpose of the exemption process is to recognise research requirements completed during Advanced Training outside of the ATRP. The exemption process will mirror the College's RPL process and be managed by Training Services along with the Advanced Training Committees for complex applications. This will address the issue of flexibility, as well as reducing the number of projects requiring review.

Evaluation of the new Basic Training Program, inclusive of assessments

A program evaluation of the 2021/2022 Early Adopter Program of the new Basic Training Program provided an in-depth exploration of the new WBAs designed for the program. The evaluation findings are discussed in Standard 6.3, and the full report is included in Appendix 6A.11. A program evaluation of the process and outcomes of implementing Progress Review Panels for trainee progression as part of the Early Adopter Program is currently underway. Findings and recommendations from both evaluations will inform the full implementation of new training curricula planned for 2025.

Research reports on existing work-based assessments

Throughout 2016 and 2018, we undertook several in-depth evaluations of specific work-based assessments. Results from these evaluations fed into the BT and AT curricula renewal work, along with informing improvements to the design and implementation of the PREP program and were shared in presentations at medical education conferences.

We took stratified samples of 400 Case-based Discussions (CbD), Mini-CEX and Final Supervisor's Reports (FSR) (Appendices 5A.44-5A.46), respectively, and combined these with other training data. We then analysed the data to explore how the assessments were engaged with and how they relate to other features of the training program.

The results revealed that:

- both trainees and assessors were reasonably satisfied with using the Mini-CEX and CbD
- work-based assessment encounters took, reportedly, slightly longer than as suggested by the literature
- work-based assessments tended to be completed towards the end of training periods, reducing their utility for guiding learning
- assessment ratings tended to be very positive, however, assessors who participated in the SPDP program tended to provide a broader range of assessment ratings
- multi-dimensional rating scales were often engaged with uni-dimensionally, or, in the case of the Final Supervisor's Report, three-dimensionally
- majority of comments provided in both open-ended response fields were of moderate quality or above
- slight tendency for trainees with fewer written exam attempts and fewer clinical exam attempts to receive higher FSR rating scores. There was also a slight tendency for FSR rating scores to increase with higher written exam and clinical exam pass marks. These

correlations suggested that the exams were a reasonable measure of a trainee's later performance in Advanced Training.

Digital scoring in Divisional Clinical Examinations

In 2020, the RACP introduced a Digital Score Sheet (DSS) system for the DCE which was found to significantly increase the quality, timeliness, and legibility of the score sheets. The DSS mimics the information previously captured in the paper-based scoring sheets. A major improvement of the introduction of the DSS has been the quality and quantity of feedback reported to candidates as this is transposed directly into candidate feedback reports from examiners' typed responses (rather than images of potentially handwritten feedback with variable legibility).

Strengthening training for examiners in performance assessments: reducing unconscious bias

The College is developing a new training module for examiners involved in performance assessments such as clinical examinations. This module will focus on supporting self-reflection to identify possible unconscious biases and how to mitigate for these in assessment processes.

Additional opportunities to undertake the DWE each year

From 2023 onwards, the RACP is offering two Divisional Written Examinations (DWE) per annum. The usual February sitting will continue and we will be offering a second sitting in October.

We piloted the second sitting in 2022, with all pilot candidates provided with a bonus opportunity to undertake the examination that did not use one of their allowable examination attempts.

A total of 235 candidates attempted the October 2023 DWE, which is about a quarter of the size of the cohort undertaking the February DWE. We anticipate that the cohort sitting the examination at this time will continue to be smaller, although we are carefully monitoring the reasons candidates are undertaking the examination at this time to better understand their needs and impacts on service delivery and psychometrics. In 2023, for some it was their first attempt as they were not available in the previous February, others used it as their second attempt following a failure the previous February and others used it as an early first attempt and reserved February as their second opportunity to pass.

Increasing the number of attempts allowed for DWEs

Effective from 1 January 2024, trainees are permitted an increased number of attempts at the Divisional Written Examination, increasing from three to four attempts. The College Education Committee made this decision in September 2023, recognising that the limited number of allowable examination attempts placed a significant wellbeing strain on those approaching their final attempt and the introduction of an additional DWE each year allowed further opportunity for trainees to attempt the examination without prolonging their training for further years.

Trainees who had their third attempt at the DWE in October 2023 and were unsuccessful were extended an additional DWE attempt, assuming they met all other eligibility criteria for sitting the examination.

Examination data

Tabulated information for the last five years for each examination offered is provided in Appendix 5D. For each examination, we have provided the number and percentage of trainees who passed the various summative assessments at their first, second and any subsequent attempts. As requested by the AMC, this has been broken down by sex or gender and location.

Summary of Standard 5

Strengths and key developments

- a well-established assessment program, with improved candidate flexibility (increased annual sittings, increased allowable attempts) and evidence of adaptiveness to changing circumstances (COVID adaptations) while maintaining assessment integrity
- improved assessment governance and operations, as part of the implementation of the Standards for Assessment and renewed Assessment Policy
- development and partial implementation of new work-based assessment program, incorporating contemporary 'entrustment' based decisions
- robust marking and standard-setting approaches have been implemented for barrier assessments
- initiation of a Cross College Review of Examinations, in alignment with Curricula Renewal, to establish the role and place of examinations in our contemporised training programs.

Current and future focus areas

- implementation of the principles of programmatic assessment, as supported through technology and shifting paradigms through faculty development and building trainee assessment literacy
- examining the role of examinations in our new programs, which we are addressing through the Cross College Review of Examinations
- quality assurance of programmatic assessment- guaranteeing the reliability, validity, and fairness of the programmatic assessments is a complex process requiring robust systems and procedures
- balancing the use of existing and new assessments in a manner that assures quality but does not increase burden is a high priority challenge for the College's holistic review of examinations in 2024
- expanding the item banks for written examinations and increasing the use of meta tagging of examination items for quality improvement purposes
- efficient and sustainable delivery of centralised and clinical examinations with a health and medical education workforce that is strained and vulnerable to disruption
- ensuring that assessment does not unduly detrimentally affect trainee and assessor wellbeing
- examining the role of Artificial Intelligence, especially Large Language Models, in assessment.

Standard 6
Monitoring

Standard 6 Monitoring and evaluation

Overview of our program monitoring and evaluation activities

Program monitoring and evaluation play integral roles in the RACP's educational strategy. Monitoring and evaluation activities form complementary streams of strategic effort, are embedded in education renewal initiatives, and support the effectiveness and continuous improvement of the RACP's educational programs overall.

Our monitoring activities focus on the ongoing collection and analysis of data to track members' current experience of training delivery as well as progress on the implementation of educational innovations. We draw upon cross-cutting insights from a suite of monitoring systems to identify opportunities for improvement and design solutions to potential issues. Standard 6.1 focusses on describing these monitoring systems, highlights how insights are used in reviews and how trainees and supervisors, along with other stakeholders contribute to these systems and reviews.

Beyond monitoring, our program evaluation strategy for the current suite of education renewal initiatives includes a series of interrelated formal program evaluations with consistent activities aligned to each stage of program implementation, from program design, to implementation, to outcomes evaluation. Standard 6.2 describes this strategy and our recent and current program evaluations.

6.1 Monitoring

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

Regular review of training and education programs, with trainee and supervisor input (6.1.1-6.1.3)

Curricula Renewal

The Basic and Advanced Training Curricula Renewal work is advancing through cyclical stages of planning, development, consultation, implementation, and evaluation. These curricula renewal (review) processes, including stakeholder involvement, are described in full detail in Standards 2, 3 and 4, including the outcomes of stakeholder involvement. The process addresses curriculum content, teaching and learning, supervision, assessment and trainee progress. We provide an update on our evaluation of this activity in Standard 6.2.

Accreditation Renewal

We are in the process of implementing the outcomes of a large program of development and review related to training settings as part of Accreditation Renewal. This work is a result of many years of development and stakeholder consultations. Standard 8 provides a comprehensive update on this activity, our progress with implementation and continual renewal. We provide an update on the evaluation of this activity in Standard 6.2.

Reviews of Examinations

As outlined in Standard 5, in 2024, the RACP is undertaking a Cross College Review of Examinations. This will examine the role and place of examinations in RACP training programs.

We regularly seek and action feedback from trainees and examiners through our post-examination surveys and have provided an update on this activity in Standard 6.2.

Following the computer-based testing issues with the Divisional Written Examination in February of 2022, we appointed KPMG to examine our Divisional Written Computer Based Testing function. Refer to Standard 5 for details of that review and our response.

Changes to training program requirements and education policies

As outlined in Standard 1.2, we have established processes for regular reviews of training program requirements and education policies. These processes feature member and stakeholder review and consultation. Updates on education policies, including stakeholder involvement, have been provided throughout the respective Standards in this submission.

Supervisor professional development program

We are in the midst of a program evaluation of our Supervisor Professional Development Program (SPDP). An update on this is provided in Standard 6.2 below.

Our systematic suite of monitoring mechanisms (6.1.2-6.1.3)

The College uses a range of mechanisms to systematically monitor education quality and contextual changes that are likely to impact the delivery of the education and training programs. All monitoring activities include structured opportunities for trainees, supervisors and other stakeholders of physician training to provide feedback. In recent years, several new monitoring mechanisms (surveys) have been established to gather perspectives at key thresholds in training, including selection into training, training experiences, educator experiences and in the early years of Fellowship. Table 31 provides a summary of these mechanisms, with subsequent sections of text describing them further.

Table 31. Summary of surveys initiated to monitor and improve training experience

Name	Target Group	Purpose	Frequency
Survey of trainees' experiences of selection into training	Registered trainees who have participated in a selection process in the previous round	Quality assurance and improvement of selection into training processes	Approximately biennial • 2019 • 2021 • 2024 (planned)
Physician Training Survey (PTS), administered by Big Village Australia, now IPSOS International, on behalf of the RACP	Trainees and educators in all RACP training programs	Quality assurance and improvement of learning environment and training experiences	Biennial • 2021 • 2023
Medical Training Survey (MTS) (not administered by the RACP)	All doctors in training in Australia	Quality assurance and improvement of learning environment and training experiences	Annual
Post examination surveys including: • Post Examination Candidate Surveys (PECS) • Post Examination Examiner	Each group involved in all each examination: • Candidates • Examiners • Exam organisers	Quality assurance and improvement of examination experiences	After every examination, including backup examinations in the case of adverse events.

Name	Target Group	Purpose	Frequency
Surveys (PEES) • Exam Organiser Surveys.			
New Fellow Survey	Members who completed a training program in the past 1-2 years	Quality assurance of experiences of Advanced Training, monitoring of preparedness for unsupervised practice and experiences of transition to unsupervised practice	Biennial since 2021
Member Satisfaction Survey (Appendix 6A.1), administered by EY Sweeney on behalf of the RACP	All college members and overseas trained physicians being assessed by the RACP	Longitudinal study to measure satisfaction with specific activities, online resources and other areas of interest, including: • overall satisfaction • communication • policy and advocacy • representation • value for money	2015 2016 Annual since 2019
Training Support Exit Survey	Trainees undergoing remediation via the Training Support Pathway and their supervisors	Experiences of trainees undergoing remediation and their supervisors to determine the effectiveness of the Training Support program and make improvements.	In development. First administration planned for Q2 2024.

In addition to these routine survey-based mechanisms for gathering monitoring data, we also gather pre and post-engagement data from users of specific educational products and services, such as:

- pre and post completion surveys embedded in our online learning courses
- pre and post participation surveys of those undertaking each module in the SPDP
- satisfaction scales embedded in work-based assessment/learning tools capturing trainee and assessor satisfaction
- feedback surveys completed by stakeholders involved in accreditation, including measures of satisfaction
- satisfaction survey embedded in College Learning Series lectures (refer to Standard 4)
- website analytics.

The College also leverages a wide array of program data to inform our monitoring. In 2022-23, we constructed and launched business intelligence dashboards that collate and summarise data drawn from our existing technology systems. These dashboards are used by service delivery teams to monitor and report on key service delivery metrics. The data models underpinning these also have secondary applications, as they provide a rich source of program data for using in program evaluations. Other sources of program data we use for monitoring include accreditation reports, work-based asessment data and examination psychometric data. When requesting access to these data sources, we go through a robust data governance and ethical review process (refer to Standard 6.2).

The following sections describe each key survey from Table 31 in more detail.

Trainee experiences of selection into training

Background and Methodology

In 2019 and 2021 all registered trainees were invited to complete surveys on their experiences of selection into training. The purpose of the surveys was to obtain a better understanding of trainee experiences during the annual recruitment campaigns (April – October) and provide data for the College to better understand the challenges for trainees in selection and recruitment. A comparative report of the results of these pulse surveys is included in Appendix 6A.2.

The surveys were also introduced to monitor the introduction of increased guidelines and communication with local selection committees to support selection processes. In 2021, the survey was expanded to explore non-discriminatory practice in interviews in detail and further explore the prevalence of 'pre interview' meetings. The surveys were a combination of demographic, Likert scale and open-ended response questions. The survey targeted registered trainees through the College's membership communications; therefore the majority of respondents were Basic Trainees applying to Advanced Training positions. See Standard 6.2 "Evaluation of a pilot to implement a Situational Judgment Test (SJT) for entry into Basic Training" for recent work completed in the context of pre-membership selection into Basic Training programs.

A total of 512 responses and 160 responses were received in 2019 and 2021 respectively. Response rates are difficult to establish as many local selection committees operate the administration of selection processes within each health jurisdiction and these are external to College data systems.

Survey data from each administration was analysed separately and then in comparison to explore changes between administrations and in light of updated guides for local selection committees to refer to and incorporate expected standards in selection processes.

Key Findings

In both years, approximately 75% of respondents applied to Advanced Training positions and most of the remainder to Basic Training programs with some representation of applicants to Faculty or Chapter programs. In 2021, female applicants to Advanced Training positions were slightly overrepresented in the survey responses. Key themes are summarised below.

Transparency of application information and decision-making criteria- In 2019: 73% (n=371) found the application information easily accessible. Most (85%, n=428) were able to access a copy of the position description for the training position before they applied. In 2021, the proportion of applicants who found the application information easily accessible increased to 82% (n=161). However, respondents indicated poor transparency about factors that contribute to selection decision making was a concern, particularly for selection into Advanced Training positions.

"Pre-interview meetings"- Across both survey administrations, a similar proportion of respondents indicated they attended a "pre-interview" meeting (2019: 37%; 2021: 39%), although respondents were not certain of the role of these meetings in the selection process and such meetings were rarely documented as part of the selection process.

Interviews- Most respondents across survey administrations felt they were not asked inappropriate questions during their selection interview (2019:91%; 2021: 89%). For both survey years, the areas respondents felt that they were asked inappropriate questions related to pregnancy and then family planning for female applicants as well as plans for extended leave for both female and male applicants.

For both survey years, most respondents felt the interview panel was representative. Respondents who disagreed felt panels were not representative because:

- lack of demographic diversity e.g., male and white dominated
- there are few representatives from the networks/regions/a wide variety of hospitals
- panels consist of doctors only and no other healthcare staff.

In summary, the findings from the surveys into selection into training experiences identified that while some areas have improved since 2019, in 2021 there were still areas that remain of concern, particularly regarding Advanced Training selection practices, i.e.:

- programs provided more information about **what information to include** in applications than **how the information is used** to make decisions
- analysis of free text comments indicates that participants had concerns about **transparency in the formal and unofficial components of the selection process**
- greater standardisation of selection processes across jurisdictions and Specialty groups would improve the consistency and efficiency of the selection into training experience.

Actions arising from findings

Findings from both survey administrations were communicated with stakeholders, including the College Trainees Committee (CTC), the College Education Committee (CEC), and the Advanced Training Committees. The findings have also been used to support the in-progress review of the Selection into Training policy and inform other activities to improve local selection practices, including initiatives to improve the experience of selection into Basic Training programs. These initiatives are described in detail in Standard 7.1.

Physician Training Survey (PTS)

Background and Methodology

Established in 2018, the Physician Training Survey (PTS) is used to collect feedback from RACP trainees and educators to understand how we can best support and improve workplace training and supervisory experiences. The survey items directly address the new Standards implemented as part of the new Training Provider Accreditation Program, specifically key topics such as workload, wellbeing, supervision, workplace culture, access to learning opportunities, and flexible work, amongst others.

The survey is administered biennially and serves as an important source of longitudinal data and results are used to inform quality improvement activities at both a College-wide level and within specific training settings and programs. A report of the results of the most recent PTS is provided in Appendix 6A.3 and available to members in a password protected area on the College website.

Eligible survey participants include:

1. Educators at an accredited training setting across Australia or Aotearoa New Zealand, including rotation supervisors, education supervisors, Advanced Training Supervisors, and Directors of Physician/Paediatric Education (DPEs).
2. Trainees in Aotearoa New Zealand registered in an RACP training program and working at an accredited training setting. From 2022 onwards, trainees in Australia are not eligible to complete the survey as they are encouraged to complete the Medical Training Survey (MTS) instead.

Likert scale survey questions in the PTS are analysed using descriptive and inferential statistics. Significance testing is used to determine differences in responses across variables such as survey year, country, region, training level (Basic Training/Advanced Training), and Division. Free text responses are thematically analysed and compared against applicable quantitative survey results.

Key findings

The most recent iteration of the PTS ran in 2022. Eighteen percent of eligible trainees (n=203) and 13% of eligible educators (n=803) responded to the survey. The findings pointed towards a challenging year for both trainees and educators. While the majority of educators across both countries remained satisfied with their overall supervisory experience, trainees in Aotearoa New Zealand reported a marked drop in their overall satisfaction with training. In comparison to the 2020 results, both trainees and educators reported significant increases in workload, burnout and adverse effects of COVID-19. Further, concerningly high rates of bullying, harassment and/or discrimination held steady from previous years.

Although service provision took priority over training to a greater extent than in previous years, high quality clinical and educational supervision were maintained. While some of the troubling findings may be attributed to the ongoing impacts of COVID-19 during the survey period, the results signal persistent systemic issues that the College will continue to work to address alongside other key stakeholders in the health sector.

Actions arising from findings

In response to findings from the PTS analysis, the following actions have been initiated:

Contributed to the development of RACP-wide areas of focus and strategic initiatives- The PTS results have contributed directly to the new Member Health and Wellbeing Strategic Plan 2023-2026, discussed in Standard 8, and the Safe Training Environments Action Plan.

Encourage quality improvement in training settings and training programs- Health service and education leaders have been provided with setting-specific survey results. Training-program specific summary reports are provided to RACP Training and Accreditation Committees. These reports enable training committees to explore and address program strengths and areas for improvement, while accreditation teams review survey results ahead of accreditation visits to guide potential areas of investigation. The College encourages DPEs to use survey findings to advocate for support for training, and from 2024, high-performing training settings will be formally notified of areas of excellence to highlight successes and encourage the ongoing delivery of high-quality training.

In addition, targeted results have been used to **identify and address potential areas of concern** relating to trainee or educator wellbeing, workload or safety. Where results point to potential concerns, the RACP shares the results with training setting leaders and accreditors. This process is described in detail in our response to how we use the results of the MTS, as the results of both surveys are used to identify and address local-level concerns at training settings.

Medical Training Survey (MTS)

Standard 6.3 provides an update on this.

Post Examination Surveys

Background and Methodology

After every Divisional, Chapter and Faculty assessment the College administers anonymous, routine post-examination surveys to capture member experiences and satisfaction. The surveys have been routinely conducted after each examination since 2019. The survey instrument contains a mix of select response agreement scales and open-ended comments. Respondents remain anonymous.

The instruments explore:

- experiences prior to the examination
- experiences on examination day
- examination venue, format,
- experiences with exam preparation
- perspectives on content difficulty and curriculum alignment
- experiences with computer-based testing (if required)
- impact of COVID-19 (from 2020)
- overall satisfaction with the examination process.

Post-examination surveys have also been used to explore proposed changes to assessments such as scheduling during the year, the use of computer-based testing and digital score sheets for examiners in clinical assessments.

Most administrations of post-examination surveys solicit a response rate in the range 20% to 60%.

Key findings

Two examples of reports from data from post examination surveys are included in Appendices 6A.4 and 6A.5. One provides a summary of the overarching themes from the surveys in recent years and the other is a specific example of the report from the February 2023 Divisional Written Examination.

Overarching themes that have emerged across all post-examination surveys in recent years include:

Examination communication and organisation- Candidate and examiner feedback in 2023 has highlighted high satisfaction (range 70–100%) with College communication in the lead-up to the examinations, examination venues and organisation on exam days, which demonstrates an improvement in satisfaction over the last four years.

Impacts of COVID-19- Since 2020, most respondents for all examinations indicated that COVID-19 not only adversely impacted their learning opportunities and preparation but also changed the way they prepared for the examination. Since 2022, the impact of COVID-19 on learning opportunities and preparation has reduced, and in 2023 agreement about the adverse impact of COVID-19 was 20–60% across all examinations, with candidates sitting examinations held earlier in the year generally reporting higher levels of agreement than those who sat examinations later in the year.

Adaptations in response to COVID- Candidate and examiner feedback was mostly positive regarding the acceptability of our local-level approach to contingency planning for examination delivery in light of COVID-19. There was less positive perception regarding the virtual delivery of the long case component of the Divisional Clinical Examination.

Computer-based Testing- Survey respondents for the 2021 AFRM Module 1 Assessment and October 2021 Divisional Written Examination in general perceived the computer-based delivery of their examinations in positive terms. Greater than 85% of respondents felt that the system was easy to navigate, answer sections were easy to use, and the systems were sufficiently responsive to user commands. This was not the case for the February 2022 cohort, due to the technical difficulties, delays and disruptions experienced by a proportion of candidates.

Other cohorts who sat paper-based Advanced Training examinations across 2019–2023 expressed mixed preference (30–70% agreement) for the written examinations to be delivered electronically.

Examiners surveyed about the use of digital score sheets for Divisional Clinical Examinations run between 2021 and 2023 expressed high levels of agreement (70–90%) that they preferred a digital score sheet to using pen/pencil and paper.

Exploring examination initiatives in assessment-

Wellbeing support during examinations- During the rest stations at the 2023 AFRM Module 2 Assessment, candidates were given the choice to engage in mindfulness activities (colouring, stretching or Rubik's cube). Candidate feedback rated colouring as the most helpful activity. Almost all respondents preferred having mindfulness activities in rest stations to not having them. All respondents would like to see mindfulness activities in future clinical assessments. These findings will inform the provision of mindfulness activities at the 2024 AFRM Fellowship Clinical Examination and subsequent OSCEs.

Delivery format- In terms of the examination format, survey insights informed the decision to hold the 2023 AFPHM Oral Examination in person after two years of hybrid delivery, based on candidate and examiner preference for this format. However, candidate feedback in 2023 was more supportive of future examinations being delivered online utilising videoconferencing technology.

Actions arising from findings

The survey results are regularly reviewed by the Assessment Services team as part of the continuous improvement cycle of examination delivery. This cycle is further described in Standard 5.

Candidate feedback regarding the February 2022 examination delivered via computer-based testing was used to further understand the nature, extent and impacts of the technical and process issues experienced and inform the next steps.

New Fellow Survey

Background and Methodology

First implemented in 2021, the New Fellow Survey assesses short-term graduate outcomes of RACP training programs to identify opportunities for improvements. The survey also explores member experiences of the transition from trainee to specialist physician and opportunities for improved training and support.

All new Fellows who completed RACP Advanced, Faculty or Chapter training between 2 Oct 2020 and 31 March 2022, were eligible to participate (ie new Fellows one-two years post completion of any training program).

The survey explores:

- new Fellows' preparedness for unsupervised practice
- the difficulty of the transition from training
- desired supports for the transition, including perceived usefulness and awareness of existing resources available to new Fellows.

In 2023 the survey was extended to cover new questions regarding Advanced Training Research Projects.

The response rate for the survey was 10% (n=160) in 2023 and 13% (n=117) in 2021. The report of the results of the 2023 New Fellow Survey is available on the RACP website (Appendix 6A.6).

Key findings

Preparedness for practice with reference to Advanced Training common competencies- Most respondents indicated that in general they felt prepared or very prepared for unsupervised practice. A high proportion of participants felt their training prepared them for the unsupervised practice with reference to the Advanced Training competencies of communication, judgement and decision making, and medical expertise. Respondents felt their training prepared them least for unsupervised practice with reference to the Advanced Training competencies of health policy systems and advocacy, and research.

Transition to unsupervised practice- Respondents reported experiencing challenges during their transition to unsupervised practice which included balancing new workload expectations, transitioning to a less supported environment, navigating private practice, feeling confident making unsupervised decisions, and finding consistent employment.

New Fellows are taking longer to find employment as Consultants/Specialists after completing their training and a higher proportion are working part-time compared to 2021.

Approximately one fifth of respondents indicated that transition from Advanced Training to unsupervised professional practice was difficult and approximately two thirds of respondents indicated further College support on managing the transition from trainee to consultant/specialist would be helpful.

New Fellows' awareness and use of some of the existing College resources to support the transition including the New Fellows page on the RACP website, the New Fellows Forum, RACP Online Wellbeing Guides, and the RACP Support Program (Converge International) is declining further over time.

Advanced Training feedback- Completing the research project requirements is a particularly challenging component of training, especially finding sufficient time to devote to work on them. In addition, work/life balance during training is increasingly problematic. High workload (especially during the COVID-19 pandemic), inflexible nature of training (availability of part-time and leave opportunities) and completing training requirements (such as rural placements and research projects) were contributors to work/life balance challenges.

Actions arising from findings

Findings from both surveys have been used to create activities to support New Fellows, and also to inform curriculum renewal and support resources as part of the curriculum renewal projects for Advanced Training programs. For example:

Transition to unsupervised practice

- new Health Policy, Systems and Advocacy online course under development
- Mentor Match program, ROC community's supervisory training/requirements are now in effect
- findings are used to inform planning for new online resources and CPD offerings.

Advanced Training feedback

- findings are being used to inform the development of the new Advanced Training Curricula and have been included in the scoping data for renewed program requirements and learning, teaching and assessment programs
- findings are being used to inform improvements to Advanced Training Research Projects. Refer to Standard 5 for an update.

Member Satisfaction Survey (MSS)

Background and Methodology

The MSS is a longitudinal study that enables the College to measure changes in key member satisfaction and engagement metrics. The College has previously undertaken an MSS in 2015, 2016, 2019, 2021 and 2022, with the latest survey conducted in July/August 2023.

The MSS is a short online survey, with members emailed a unique link and is conducted by an independent third party. The surveys in 2021, 2022 and 2023 were conducted by EY Sweeney.

Survey data is weighted by country, membership status, gender and age to be representative of the RACP membership. In 2023, the MSS was conducted from 10 July to 11 August, with 2,426 members responding. The maximum margin of error of +/- 1.99% at the 85% confidence level, meaning we are 95% confident that survey estimates are reflective of the real world within +/- 1.99%.

Key findings

The 2023 MSS results showed either little change in satisfaction levels or a slight softening from 2022. Satisfaction differed significantly depending on membership type, with Fellows more satisfied than Basic and Advanced trainees.

The top drivers of “overall satisfaction” are Value for Money, Communication and Activities related to Physician training.

A summary of the results is provided in Appendix 6A.7.

Actions arising from findings

A process is underway to develop a detailed action plan to respond to the 2023 MSS results which will be brought to the RACP Board in March 2024. This work is founded on the development of a Member Value Proposition, which was discussed in Standard 1.1.

Demonstrating to stakeholders the impact of their feedback (6.1.2 -6.1.3)

The College uses a range of communication mechanisms to disseminate findings and actions arising from findings of monitoring and evaluation activities. Some mechanisms follow the standardised College communications channels to committees and other bodies in the education and stakeholder governance structures. These include:

- communication briefs and presentations to committee meetings
- the President’s Message emailed to all members

- the RACP Online Community (ROC)
- the RACP Weekly
- summary reports on the public RACP website.

For outcomes relating to Advanced Training programs, summaries of findings are also provided to Specialty Societies.

For some initiatives, such as the Physician Training Survey (PTS), with outcomes that have direct relevance to specific training settings and programs, additional mechanisms have been developed for stakeholders to access information. For the PTS data an interactive results dashboard has been developed. Members can use the dashboard to view stratified and benchmark results of their own setting (where sufficient data is available to protect confidentiality of individual respondents) on key metrics included in the survey. The dashboard is promoted to members through direct emails, eBulletins and newsletters.

Other mechanisms for regular consultation with specific groups

To assist the AMC to plan its approach to collecting feedback, we have indicated below, processes used for regular consultation with the following specific groups:

- **Trainees**- primarily via the College Trainees' Committee, Aotearoa New Zealand Trainees' Committee and state/territory-based trainees committees in Australia. The Trainee Community on the ROC is another forum for dialogue.
- **Supervisors of training**- primarily via our education and training committees, through discussions with DPEs and topic-specific consultations. The Educator Community on the ROC is another forum for dialogue.
- **Health departments**- work closely with Directors of Physician/Paediatric Education (DPEs) and Network DPEs, and host regular fora with them to seek their perspectives. Each year we host state-based meetings of DPEs, a meeting of DPEs in Aotearoa New Zealand and a meeting of Directors of Paediatric Education.
- **Other providers of specialist medical programs**- the President of the RACP (PRACP) and key SLT members participate in the Council of Presidents of Medical Colleges (CPMC) meetings. Managers participate in a range of cross-College networks, although some of these groups have been less active lately.
- **Consumer groups**- primarily use the College Consumer Advisory Group for this function, however, where specific input is required we approach relevant consumer representative groups.
- **Deans of medical schools**- beyond the links we use through CPMC and Medical Deans Australia and New Zealand, we do not have an active consultation relationship with medical deans.

6.2 Evaluation

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

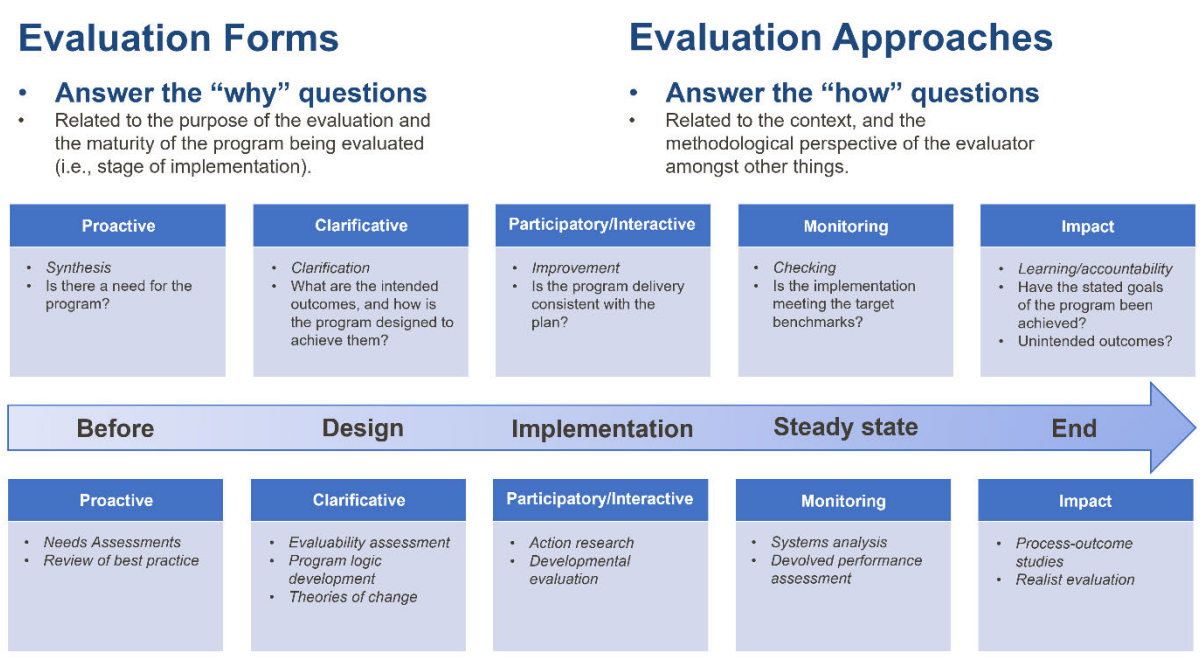
Evaluation and research strategy for education renewal (6.2.1)

Our current evaluation strategy for education renewal is summarised on the College website and provided in Appendix 6A.8. As noted in the introductory text to Standard 6, the College is in the process of refreshing the Evaluation and Research Strategy for education. We anticipate that the refreshed strategy, which builds on the current version, will be available for sharing with the Assessment Team in May 2024.

A key focus of the strategy as well as recent and current evaluations is the program of education renewal. Each project in this wider program has its own timeline, although they are sequenced within the program as far as possible. Accounting for different states of program maturity is important to effective evaluation practice. We are approaching this by adopting Owen's[10] concepts of 'forms' (purpose of evaluation) and 'approaches' to guide appropriate evaluation goals and approaches at various stages in the life cycle of program implementation. Figure 76 illustrates the concept of evaluation forms and approaches that guide program evaluation projects *underway.*

All evaluations of educational programs of the College are included in the work plan of the College Education Committee (CEC) and accompanied by a documented evaluation plan developed with stakeholders in the evaluation. An example of a program evaluation plan prepared for the evaluation of the "Early Adopter" phase of the new Basic Training program is included as Appendix 6A.9.

Figure 76. Example of different forms and approaches for program evaluations at various life stages



Context appropriate approaches to program evaluation

Our evaluation strategy also incorporates approaches to evaluation, including methodological choices, that are appropriate to the context of medical education in a postgraduate context. We recognise that specialist physician training occurs in an open, recursive complex system that supports the qualification and professionalisation of junior doctors on a lifelong learning journey. As such, our research and evaluation approaches foreground the role of context in our program evaluations. We apply a range of theoretical frameworks, in particular underpinning educational theories, to program design (e.g. adult learning, self-regulated and directed learning, growth mindset) and incorporate 'realist'[11] approaches and mixed methods to produce evidence that can

[10] Owen, J.M. (2006) *Program Evaluation: Forms and approaches*, Routledge, London.
[11] Pawson R. & Tilley N. (1997). *Realistic evaluation*. Sage.

be translated into fit-for-purpose interventions to continuously improve the physician lifelong education journey.

Theory-based evaluation

Evaluation plans that are prepared for evaluation projects as part of education renewal all consider the current development stage of a new or revised program. If a program is already in operation but is not accompanied by an explicit problem statement, theory of change and program logic (theory of action) the evaluation team collaborate with the business unit responsible for the program to develop these elements as part of the evaluation. See the Evaluation Plan for Accreditation Renewal 2022-2024 in Appendix 6A.10 as an example.

Utilisation-focussed evaluation

The primary goal of program evaluation in the education renewal context is to provide robust evidence that can support the College and its members in realising the full potential of the training programs. As such forming actionable recommendations from program evaluation and research findings are a fundamental component of these activities. Recommendations are formed through stakeholder engagement and discussion. We use the 'three phases of evaluative thinking' proposed by Davidson[12] as shown in Figure 77 below.

Figure 77. Three phases of evaluative thinking

Robust research and evaluation governance

All significant education research and evaluation activities have project plans developed prior to commencement of the activity. These comprehensively detail the background, rationale, theoretical framework, methods and proposed protocol and are developed in consultation with relevant stakeholders. These plans are approved by the College Education Committee, as the body accountable for oversight of educational research and evaluation.

All research and evaluation projects conducted at the College undergo ethical review in alignment with the National Statement on Ethical Conduct in Human Research[13]. Prior to undertaking any research or evaluation project, the research team assesses the level of risk associated with the research methodology, design and participant population.

As per the National Statement, any research that involves the risk or likelihood of harm is reviewed by a Human Research Ethics Committee (HREC). The College has a Memorandum of Understanding with Sydney Local Health District, enabling it to submit applications for ethical review to the Concord General Hospital Research Office. Projects that pose only the risk of inconvenience or discomfort (low or negligible risk) are reviewed by the College Research Committee (CRC). Through this process, the research team submits an application to the CRC detailing the project's aim, participants, method, potential risks, information protection, consent, and data storage and security. Research and evaluation activities only commence after ethical approval is granted by a HREC or the CRC.

Access and use of College data for monitoring, evaluation and research purposes is managed through the College's overarching Data Governance Framework (refer to Figure 78 below). The framework defines the policies, processes, business rules and guidelines for how data is managed, and includes the College's Survey Governance Framework. The RACP has a Data Governance

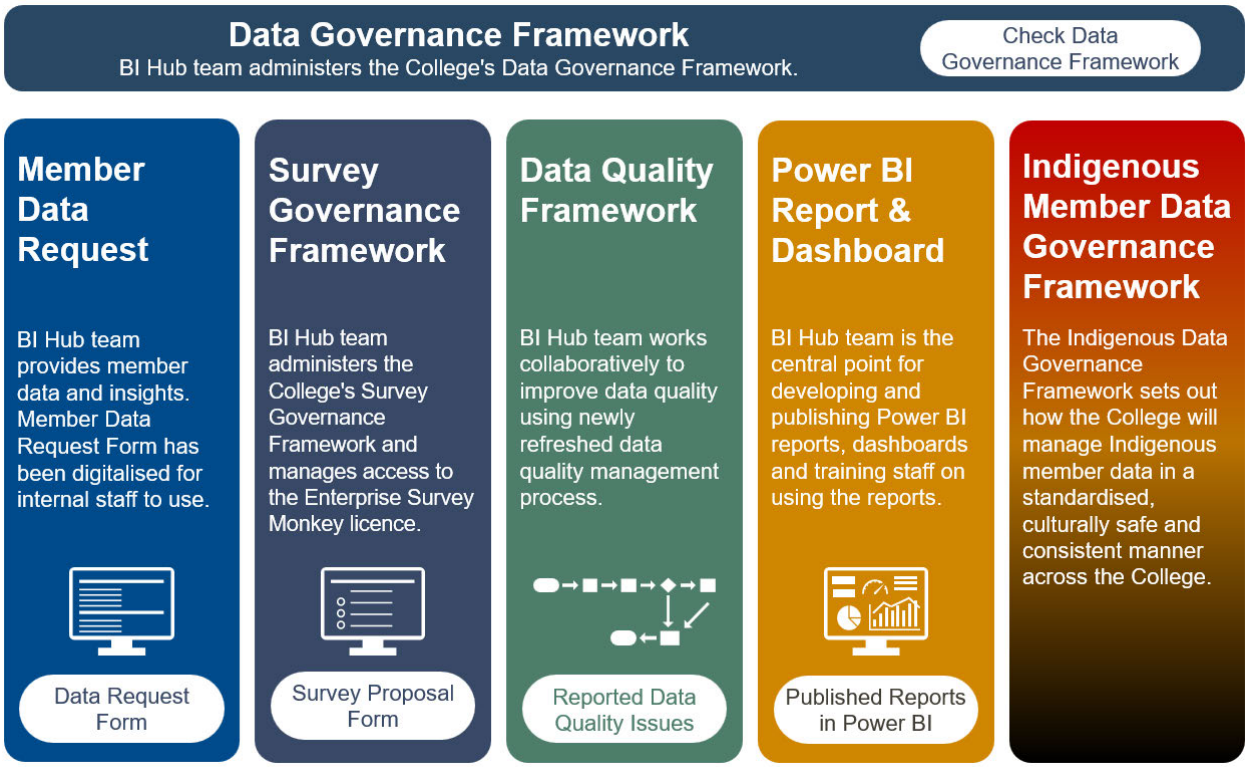
---

[12] Davidson EJ. (2012) *Actionable Evaluation Basics: Getting Succinct Answers to the Most Important Questions.* CreateSpace Independent Publishing Platform

[13] National Health and Medical Research Council, Australian Research Council and Universities Australia (2023). *National Statement on Ethical Conduct in Human Research*. Canberra: National Health and Medical Research Council.

Group that leads this activity. The Data Governance Group reports to the Senior Leadership Team and includes staff with strong interest and experience in data management, Data Owners and Primary Data Stewards for each College data asset, Data Custodians (responsible for the technical management of data assets) and Indigenous Data Guardians (refer to details below). All requests for access to College data sets are managed by the College's Business Intelligence (BI) Hub and the relevant Data Owner must approve provision of the requested data.

Figure 78. Data Governance Framework and associated initiatives



The Survey Governance Framework ensures that all surveys, including those used for research and evaluation purposes, represent best practice, are applied strategically, effectively communicated, acted upon, and aim to minimise survey fatigue. The framework applies to any survey data request or survey proposal from RACP staff, Members, College bodies, or external organisations.

Refer to Standard 6.3.1 for a discussion on how we report monitoring and evaluation results through governance and administration structures.

RACP's Indigenous Data Governance Policy

The RACP's Indigenous Data Governance Policy was developed throughout 2022-2023 and is currently being implemented. It supports:

- the standard collection and quality of Indigenous identity data
- the Indigenous Health Committees to exercise good governance over their respective Member data
- more accurate data to inform progress against the priorities of the Indigenous Strategic Framework.

The Policy defines the role of the College's Indigenous Data Guardians (who approve the use of Indigenous data) and outlines processes for managing Indigenous member data in a culturally safe manner. The Policy will also give members that identify as Aboriginal and / or Torres Strait Islander Peoples the opportunity to choose to share their information with Australian Indigenous Doctors Association.

Considering graduate and program outcomes in evaluation (6.2.1)

Through application of the above approaches, we ensure that our program evaluations reference our program and graduate outcomes and incorporate the needs of both graduates and stakeholders, and reflect community needs, and medical and health practice.

Specifically, we do this by:

- using appropriate evaluation forms and approaches to support robust educational interventions at all stages of the lifecycle, with reference to needs assessment, design, improvement, monitoring and outcomes evaluations of graduate and program outcomes
- accounting for how context impacts the interventions and program and graduate outcomes through appropriate evaluation methodologies
- using theory-based evaluation approaches to develop theories of change that explicitly link and explore interventions with the intended and observed (graduate and program) outcomes
- using a utilisation-focussed evaluation framework to ensure that relevant stakeholder voices are appropriately prioritised throughout the evaluation process, including in forming recommendations in response to evaluation findings.

Use of suitable data for program evaluations (6.2.2)

As detailed in Standard 6.1, we have developed a suite of data for use in a range of monitoring and evaluation activities. We also draw upon program data and where warranted, collect evaluation specific data in accordance with approved evaluation plans, governed by our ethics and data management frameworks.

Where possible, we seek to reduce research participation fatigue amongst RACP members, acknowledging that doctors are an over-surveyed cohort.

Data types are determined according to each evaluation's questions, and we have collected and used numerous data types, triangulating these where possible, including:

- surveys
- semi-structured interviews
- focus groups
- written submissions
- program materials
- program participation data
- web and educational analytics.

Standard 6.2.3 provides specific details of various data sources used in our program evaluations.

Recent and in-progress program evaluations (6.2.3)

Table 32 below lists program evaluation activities completed in the last three years or continuing. Subsequent sections of this standard provide further details on the program evaluations, including how stakeholders have contributed to these.

Table 32. Program evaluation activities completed in the last three years or continuing

Evaluation activity	Context	Evaluation form
Curriculum Renewal Program evaluation	Curriculum Renewal	• Needs assessment • Impact (Process/ outcomes)
Program evaluation of the new Training Provider Accreditation Program	Accreditation Renewal	• Clarificative • Impact (Process/outcomes)

Evaluation activity	Context	Evaluation form
Evaluation of the Supervisor Professional Development Program	Professional development for supervisors	• Impact (process/outcome)
Evaluation of a pilot project to implement a situational judgement test as part of selection into Basic Training programs	Entry into Training	• Impact: (process/ outcome), incorporating validation study

Curricula Renewal program evaluation

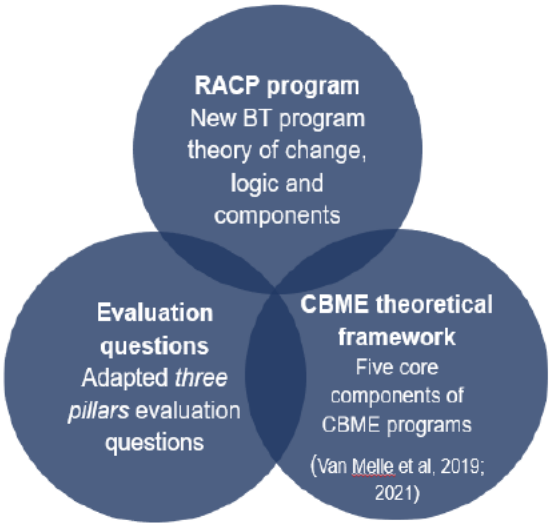
Evaluation activities for Curricula Renewal have followed the phased trajectory of development and implementation of the new curricula. As such our evaluation activities followed the experience of the Early Adopters of the new Basic Training program in 2021, including a project specifically designed to look at the functions and outcomes of Progress Review Panels.

With the current work in developing and implementing three waves of new Advanced Training programs we are refining and expanding our evaluation plans to provide feedback on development and implementation that can be applied across the phased implementation waves of curricula. Specifically, our evaluation activities for curricula renewal currently completed or underway include:

1. Program evaluation of the Early Adopters experience of a renewed Basic Training program. This is completed.
2. Evaluation of the Early Adopter experience of Progress Review Panels for progress decision making. This is underway.
3. Curricula Renewal Program evaluation: full implementation Basic and Advanced Training. This is in development.

Each of these program evaluation components follows our overarching conceptual framework for curriculum renewal evaluation. This framework provides an overall picture of the evaluation context that guides the data collection and analysis to the overall objectives of the evaluation. The conceptual framework connects the curricular objectives and program theory to the theoretical framework of competency-based medical education (CBME) via major evaluation questions. The evaluation of forms and approaches guides the specific evaluation questions activities and data collection for each phase of program development and maturity. Figure 79 illustrates an overview of how the conceptual framework was applied in the Basic Training "Early Adopter" program evaluation.

Figure 79. The conceptual framework for curricula renewal program evaluation as applied to the "Early Adopter" program evaluation 2021-2022

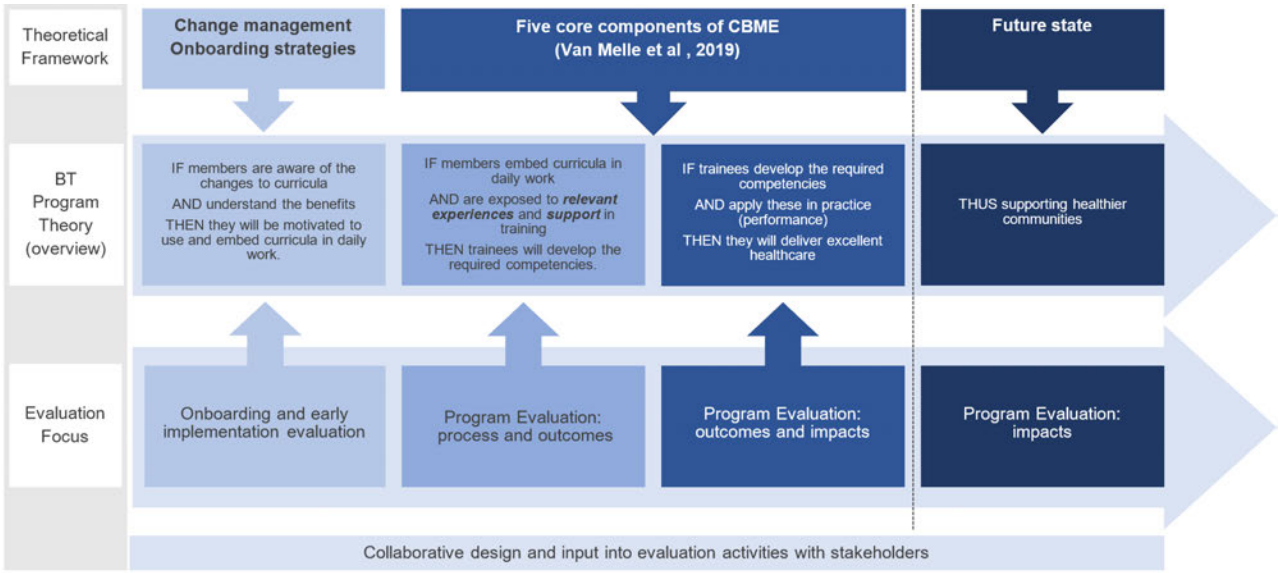


Conceptual framework components

- RACP program theory of change- *How* the activities of the program produce outcomes
- CBME Theoretical framework- "Five core components of competency based medical education (CBME) programs."[14]
- "Three Pillars" Major Evaluation Questions[15], which are:
    1. *Fidelity of implementation* - To what extent are the critical components of the program in place?
    2. *Integrity of implementation* - To what extent do the program activities embody the key qualities of the five core components of CBME?
    3. *Program outcomes (intended and unintended)* - What are the intended and unintended outcomes of the program implementation?
        - Outcomes measured a result of implementation factors?
        - Outcomes measured a result of program theory, or inadequacies of program theory?
- *Realist Evaluation: "What works for whom, why, and under which conditions"* [16]

Figure 80 below shows the relationship between the phased implementation, scope of the evaluation and longitudinal evaluation activities over time developed for the evaluation of the new Basic Training Curriculum. This approach has been expanded to incorporate the development and implementation of new Advanced Training Curricula from 2024.

Figure 80. Implementation framework for evaluating the new Basic Training program



Methodology: Mixed methods approaches

- surveys: scale and qualitative
- program data (outputs and qualitative feedback)
- interviews: realist techniques: ***"teacher-learner", "conceptual focusing".***[17]

Data analysis

Triangulation of survey, interview, and program data to explore participants perceptions.

---

[14] Van Melle, E, Frank JR, Holmboe ES, Dagnone, D, Stockley D, Sherbino J. (2019). A Core Components Framework for Evaluating Implementation of Competency-Based Medical Education Programs. *Academic Medicine* 94 (7).
[15] Pawson R. & Tilley N. (1997). *Realistic evaluation*. Sage.
[16] Is competence by design working? Accessed September 21, 2023. https://www.royalcollege.ca/ca/en/cbd/understanding-cbd/cbd-program-evaluation.html
[17] Manzano, A. (2016). The craft of interviewing in realist evaluation. *Evaluation.* 22 (3).

Component one of the Curricula Renewal program evaluation: Early Adopter experience of the renewed Basic Training program

Following the evaluation methodology described above, we completed the Early Adopter evaluation *from late 2021-2022.*

Key findings

A report of the results of the evaluation is included as Appendix 6A.11.

New curricula standards are well received

The program goals and curricula standards are mostly well received and relevant, even if the underlying theories of CBME and Programmatic Assessment were not well understood by many of the participants. For instance, both trainees and educators supported the increased focus on competencies and Entrustable Professional Activities (EPAs), and the learning goals were thought to align with the expectations of a competent physician.

For trainees, there was no relationship between their self-assessed knowledge of CBME and their perceived clarity of the knowledge guides. Although most trainees found the progression criteria related to the knowledge guides clear, there was a sense of information overload within the guides.

Learning teaching and assessment program

Findings revealed varying levels of satisfaction with the new learning and assessment tools. Trainees expressed several concerns regarding learning plans, including a perceived lack of clarity in terminology, challenges with the layout, and difficulties identifying relevant learning goals without a clear understanding of what to expect during a rotation. Trainees also experienced challenges rating their progress against learning goals due to the perceived unidimensional nature of the rating scales, which were considered inadequate to account for variation in competence in different contexts. Positively, trainees considered receiving feedback from their supervisor on their learning plan as the most valuable aspect for guiding their learning.

Observation and learning captures, the new work-based assessment tools, were generally well received. Compared to learning captures, observation captures were considered more difficult to set up and complete; however, trainees considered observation captures as the most valuable activity for learning due to the direct feedback received on their observed performance. Despite most trainees struggling to compete the required number of observation captures, performance was almost always recorded at expected phase level. Findings also highlighted areas of opportunity in the way trainees and supervisors engaged with these tools. For instance, evidence indicated trainees took a more opportunistic approach to undertaking these activities rather than mapping out activities at the beginning of a training rotation that align with their learning plan. Additionally, an analysis of supervisor written feedback revealed a notable proportion of comments lacking the rich and specific feedback necessary for trainees to plan for their ongoing learning, indicating an opportunity for further development in supervisor skills.

Challenges

Opportunity to tailor learning experiences to curriculum learning goals- Due to variations in the learning opportunities available across different rotations, not all trainees had consistent opportunity to undertake learning and teaching activities across their rotations.

Faculty development and CBME "literacy"- Trainees and assessors may not possess depth of knowledge or skill in reflective practice and providing feedback for learning to maximise value of learning and teaching activities for trainee development.

Difficulty using educational technology- Delays in the development and implementation of the supporting educational technology program created significant challenges for trainees in contacting and engaging assessors. Supervisors, assessors, and trainees found the processes for completing records of feedback complex which led to delayed entry and superficial recording of feedback for learning and progress reporting.

Contextual factors- Contextual factors in training affected the manner and level that trainees and educators were able to engage with the new curriculum philosophy and activities. These contextual factors included trainees preparing for various upcoming milestones, such as the divisional

examinations, moving into a registrar role, and entry into their preferred Advanced Training speciality. Further, workforce capacity issues, compounded by COVID-19 staffing impacts, severely impacted supervision, access to educational activities, and supervisor knowledge of the new program.

Opportunities and recommendations

Key recommendations from the Early Adopter program evaluation focus on the implementation aspects of the program to support transformational change in the way trainees and educators view progress towards competency based training outcomes, for example adopting a growth mindset to learning opportunities (rather than performance mindset) and encouraging detailed feedback aligned with the principles of programmatic assessment, i.e multiple instances of low stakes assessments on a broad range of learning goals accompanied by assessor feedback for learning. Recommendations include:

1. Explore methods to simplify and “chunk” information for Directors of Physician/Paediatric Education (DPEs) and supervisors such as quick start guides for settings implementing the new training program
2. Prioritise advice for training settings to set up and activate program elements over the first year
3. Explore strategies that promote the understanding of lifelong learning by trainees and emphasise the contextual and developing nature of expertise in competencies over the continuum of medical training
4. Consult with trainees and supervisors on learning plans and work-based assessment forms to ensure usability and suitability
5. Provide increased guidance on how to identify relevant learning opportunities suitable for observation and/or learning captures, within the context of each rotation
6. Encourage use of observation captures as a discussion tool in specialty (core) rotations as a mechanism to relate learning goals to educational activities
7. Provide training for supervisors on how to provide specific, meaningful feedback to guide trainee learning
8. Explore mechanisms to make assessor completion of observation capture forms more viable at the time of assessment to promote recording of meaningful feedback.

These evaluation findings and recommendations are being used to inform a program review and aid in implementation planning, as discussed in Standard 3.

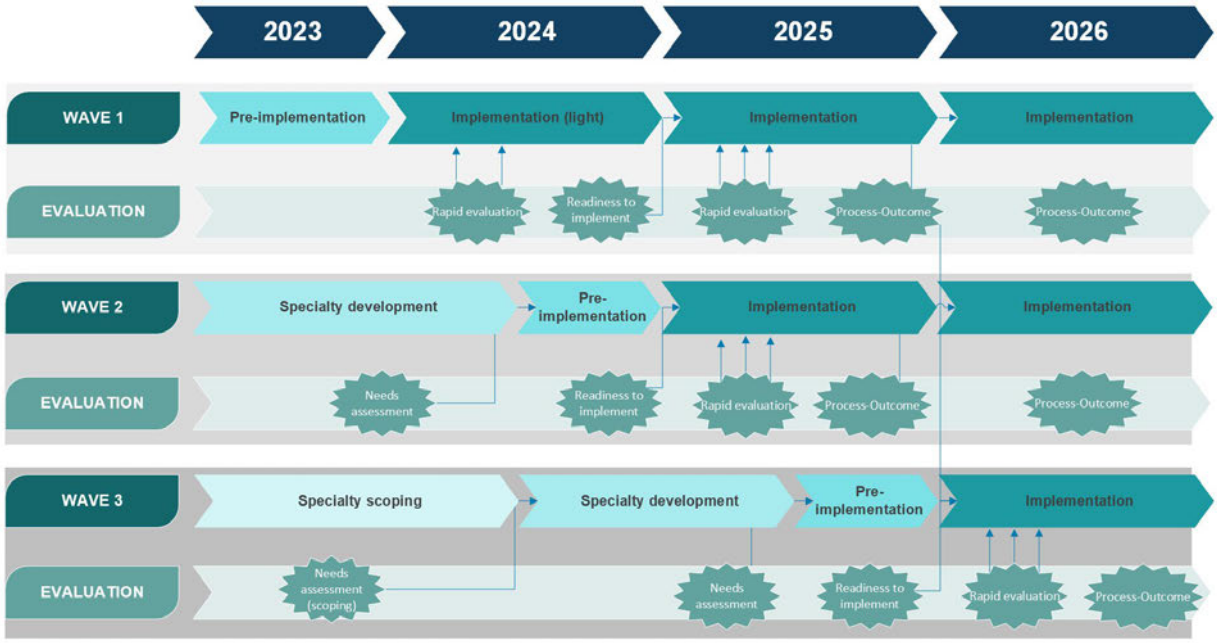
Component two of the Curricula Renewal program evaluation: Evaluation of the Early Adopter experience of Progress Review Panels for progress decision making

In depth exploration of the Early Adopter experience of preparing, implementing and progress review panels for progression decision making for trainees completing the Foundation phase of the revised Basic Training curriculum is underway. Representatives from most early adopter settings (n=5, 71% participation rate) who used Progress Review Panels have been interviewed and data analysis is underway. This evaluation has been prioritised to support the introduction of Progress Review Panels. Initial findings revealed widespread support for the introduction and principles of the panels. Participants highlighted the opportunities the PRPs presented for diverse panel membership and robust group decision making processes regarding trainees’ readiness to progress to the next phase of training. Panel members highlighted various PRP benefits, including improved longitudinal oversight of trainees, decreased likelihood of ‘failure-to-fail’, and early identification and support for trainees in need of enhanced support and remediation. Challenges experienced by the panels highlighted the importance of effective technological systems to support data representation of trainee performance against program requirements and the need for local administrative support.

Component three of the Curricula Renewal program evaluation: program evaluation of full implementation of the renewed Basic and Advanced Training programs

Figure 81 below provides a high-level overview of the integration of program evaluation through the development and implementation stages of Curricula Renewal. As described in Standard 3, the curriculum development and implementation teams have project plans and activities for full implementation of Curricula Renewal from 2024 – 2026. The overall Curriculum Renewal Program evaluation strategy follows the same framework as described in the 'Early Adopter' example but with an expanded focus to support pre-implementation (curricula development and implementation strategy) as well as rapid cycles of implementation feedback and a comprehensive process outcome evaluation post implementation. The program evaluation team are supporting curriculum development and implementation activities applying a needs assessment approach; developing and analysing survey instruments being distributed to specialties in Wave 2 and 3 currently in the 'scoping' and 'consultation' phases, and triangulating survey findings with contextual data from training settings for program readiness to implement and other College monitoring and evaluation activities, e.g. the New Fellows survey findings as described in Standard 6.1.

Figure 81. High level overview of integration of program evaluation through the development and implementation stages of curricula renewal



Training Provider Accreditation Program (TPAP) Evaluation

Evaluation Framework

The overall purpose of the evaluation is to explore how and to what degree the Training Provider Accreditation Program (TPAP) (refer to Standard 8.2) promotes the delivery of high-quality training.

A program evaluation conceptual framework has been developed to guide the formation of evaluation questions. This framework consists of the following:

1. the objectives of the accreditation program
2. the ten Principles for Accreditation (as outlined in the Training Provider Accreditation Program – Appendix 6A.12)
3. the role the Program plays in emerging trends and tensions within accreditation and physician training, including quality assurance versus quality improvement and equitable access to high quality training across a broad range of contexts.

Evaluation and Accreditation Phases

The new TPAP is described in Standard 8.2 of this report. Implementation of the TPAP is accompanied by evaluation activities developed collaboratively by the Accreditation Services and the Education Policy, Research and Evaluation (EPRE) teams. These evaluation activities included initial and ongoing evaluation of Phase 1 implementation (Basic Training settings), the evaluation of Phase 2 (Network Accreditation) implementation, and a blueprint for evaluation of the short-,

medium- and long-term outcomes of the full accreditation program. An evaluation of the initial implementation of Phase 1 program and setting accreditations has been completed. Key findings of the Phase 1 evaluation are described below. The findings from the Phase 1 evaluation are also reflected in the design and focus of some Phase 2 evaluation activities, in particular the inclusion of a 'clarificative evaluation' to support stakeholders' understanding and engagement with the rationale for program changes and how the activities they have been asked to complete will lead to program outcomes such as increased visibility of training processes that are working well and targeting of areas that require support and improvement.

Ker findings: Phase 1

Encouraging findings from the Phase 1 evaluation included stakeholders':

- general acceptance of the new program
- favourable perceptions of training session pace and organisation
- positive perception of visit organisation
- confidence navigating and applying the new standards and requirements.

Challenges with the Program included stakeholders':

- lack of understanding of the rationale behind program changes
- unfamiliarity with the new standards and requirements
- dissatisfaction with the time-consuming nature of the new program forms
- desire for training sessions to include guidance on how to interpret and apply the standards and requirements.

Program evaluation: Phase 2 and beyond.

Table 33 outlines the activities underway and planned for the evaluation of the renewed Accreditation Program. The evaluation activities span several stages of program implementation, including the continuation of Phase 1 implementation as more settings undergo the accreditation process, pre-implementation activities of Phase 2, to post-implementation of Phase 2 in 2024.

Table 33. Program evaluation purpose and questions applied to the phases of the Training Provider Accreditation Program: 2022 – 2024

Stage of Program Implementation	Evaluation questions	Evaluation Form and purpose
Pre-implementation	What are the mechanisms through which the tools and processes of the Program work to meet the program objectives and create outcomes? (What is the program theory of change?)	**Clarificative:** To clarify with program stakeholders the program rationale and the mechanisms by which accreditation activities lead to accreditation outcomes.
Implementation	How and to what degree does the implementation of the Program align with the ten Principles for Accreditation?	**Implementation/process:** To check whether program implementation is occurring as intended and adjust processes if necessary.
Post-implementation (short, medium, and long term)	To what degree does the Program meets its ***objectives*** by delivering these as **outcomes** of the accreditation process? What, if any, are the unintended outcomes of the Program?	**Outcome/Impact Evaluation:** To examine program outcomes and impacts.
Post-implementation (medium to long term)	What evidence is there that the Program has a role in driving quality assurance and improvement from operational and strategic perspectives?	

Stage of Program Implementation	Evaluation questions	Evaluation Form and purpose
	What evidence is there that the Program drives equitable access to high quality physician training in all Australian and Aotearoa New Zealand training contexts?	

Methodology

Multiple methods were used for the Clarificative aspect of the evaluation, to develop the program theory:

- document analysis of TPAP documentation
- interviews with stakeholders
- workshop with RACP Training Accreditation Services team.

Surveys with Training Providers and accreditors were conducted as part of the Implementation evaluation to determine whether program implementation is occurring as intended:

- training session surveys, distributed after live training sessions (Training Providers and accreditors)
- Training Provider post-review survey, distributed to key hospital staff involved in the review
- accreditor calibration day survey, distributed to all attendees at the accreditor calibration day.

Key findings (to date)

A summary report of key findings to date is included in Appendix 6A.13.

Program theory developed

A program theory, depicting how and why the program's activities lead to its outcomes, was initially developed by the EPRE team. This initial program theory was further refined through discussion with the Training Accreditation Services staff during a program theory workshop, resulting in a program theory that includes four key "pillars" in the new program that help achieve the accreditation outcomes. These pillars are:

1. quality assurance
2. quality improvement
3. integrated training program
4. equity of access to healthcare.

Over the next several months, the program theory will be adapted to use as a communication tool with the aim of improving stakeholder understanding and engagement with the new program.

Training provider feedback

Key successes in the program to date include DPEs expressing confidence in assessing against the standards and requirements; agreement that the program meets its objectives; and general satisfaction with external assessment instructions and organisation.

Areas identified for improvement include improving usability of the Self-assessment Form; increasing awareness of the online training modules; and providing assistance in effectively utilising the Capacity to Train Guidance documentation.

Accreditor & committee member feedback

Positively, survey findings highlighted a group of accreditors that feel well supported and prepared to complete accreditation visits. Accreditors felt positively about the collaborative nature of the accreditation process and the coverage and flexibility of the new standards. Committee members reported confidence in their decisions and integrity in the decision-making process.

Areas identified for improvement include: improving the usability of the Self-assessment and Accreditation Findings Forms; improving accreditors' confidence in documenting their true opinion on the Self-assessment Form.

While *network accreditation* has commenced there is limited feedback available about experiences with this. It is anticipated that more feedback will be available in 2024 when network accreditation expands.

Program Evaluation of the Supervisor Professional Development Program

Evaluation of the Supervisor Professional Development Program

Business units with the Directorates of Professional Practice and Education Learning and Assessment are collaborating on the program evaluation of the Supervisor Professional Development Program (SPDP). The SPDP is an established program that has been operating for ten years and is described in Standard 8.1. Previous evaluations of the SPDP focused on analysing the results of participant evaluation questionnaires and a review of content sequencing. This program evaluation will build on previous work to identify and focus on how and to what extent the program achieves its stated outcomes, and the relevance of the educational theories and tools used in the SPDP to the College's education programs, foreshadowing the incoming changes to the learning teaching and assessment programs through Curricula Renewal.

In keeping with the College's Education Evaluation and Research framework the evaluation approach incorporates a description of the program objectives and how the program is intended to achieve this (the program theory), and a mixed methods approach to data collection and analysis to promote triangulation of evidence and consider the different contexts for supervision, for example, in terms of the type of clinical settings training occurs in.

Also in keeping with the framework, the goal of this evaluation is to provide actionable feedback for program improvement for the large numbers of members who undertake the program and facilitators who volunteer their time to run the courses. As at December 2023, the evaluation is underway; data is being analysed from end of course surveys for the last three years, 18 facilitators and 11 past participants have been interviewed about their experiences in the program, and a short survey is open to the RACP membership to collect insights into how and to what extend course participants are using skills and knowledge gained from the workshops in practice.

Two reports of the evaluation are planned for submission to the College Education Committee in the first half 2024, focussing on program delivery and outcomes.

Evaluation of a pilot project to implement a Situational Judgment Test (SJT) in the selection processes for entry into Basic Physician Training

Please refer to Standard 7.1.1 for information about this pilot evaluation.

6.3 Feedback, reporting and action

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

Reporting monitoring and evaluation results through governance and administration structures (6.3.1)

As discussed in Standard 6.2, the College has a robust internal process for governance of monitoring, evaluation and research activity. As part of this framework and in alignment with our commitment to utilisation focussed evaluation, at the commencement of each activity, we appraise key stakeholders and identify their roles as relevant throughout the lifecycle of the activities, adjusting this as contexts change. Stakeholder roles can range from design input, negotiation of results findings and recommendations, to more simple updates on results.

As the key College body responsible for oversight of education research and evaluation, we report to the College Education Committee at key points in our activities, including when proposing a new activity, providing status updates on progress, comprehensive reports on conclusion of the activity and then reporting back following wider consultation on findings and proposed actions.

We use a range of channels to report on our results, dependent on the communication and engagement goals. These include briefs and presentations to key committees and at College team meetings, website updates, content in eBulletins and President's Messages, direct email campaigns, updates in committee communiques and posts on The ROC. Where there is a need to communicate with the membership on results, we develop a Communications Plan in collaboration with the College Marketing and Communications team.

Reporting and exploring Medical Training Survey data

The Medical Training Survey (MTS) was developed by the MBA and the Australian Health Practitioner Regulation Agency (Ahpra). The AMC previously signalled to Colleges that the results of the MTS may be used in accreditation and monitoring processes. The AMC has asked the College to comment on how it has used, or has plans to use the results from the MTS, in particular, how it has explored results with internal and external stakeholders and how it has investigated results, or is planning to investigate the MTS results, and is making changes based on these investigations. The sections below provide comments in response to these requests. The RACP is happy for the AMC to share these comments with the MBA and Ahpra.

Exploring results with internal and external stakeholders

Following each iteration of the MTS, the RACP shares the results with key stakeholders.

The RACP conducts an analysis of the MTS results, comparing them against the findings of our own Physician Training Survey (PTS), identifying areas in which RACP trainees responded considerably less favourably than the national response, and monitoring progress against past results. The analysis also summarises current and planned RACP initiatives linked to key areas of improvement identified in the survey results. The analysis is shared with key RACP training and education committees, as well as the Board, the College Trainees' Committee and the Member Health and Wellbeing Committee. Region-specific MTS results are also shared with our Regional Committees to help identify strengths and areas of improvement in various states and territories. These committees are tasked with examining the survey results in conjunction with existing and upcoming projects to identify specific areas within their scope that may require enhanced or new initiatives.

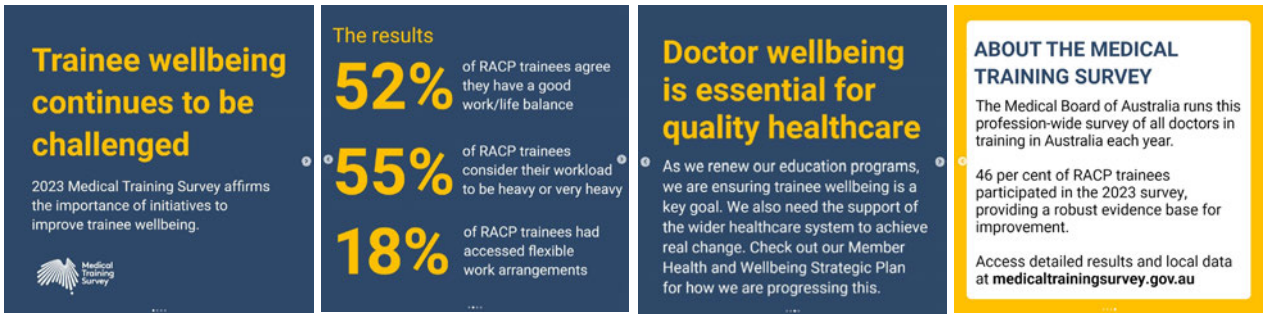
The RACP shares MTS findings with all staff via the MTS RACP Summary Report and encourages further exploration via the interactive reporting dashboard. Presentations are provided at staff meetings.

Further, the College promotes the MTS results by sharing key findings through a comprehensive communication campaign which includes:

- summaries on the trainee and educator-specific pages on the RACP Online Community (ROC)
- direct emails to Directors of Physician/Paediatric Education (DPEs) encouraging local-level exploration of results
- videos and articles in eBulletins
- awareness and advocacy based social media campaign.

An example post from our social media campaign regarding the 2023 MTS results is provided in Figure 82.

Figure 82. Example social medical post from 2023 Medical Training Survey results campaign



The College explores MTS results with training settings via its annual survey follow up process, the details of which are outlined below.

Investigation of results and changes based on these investigations

Since 2021, the College has used the MTS results in conjunction with results from our own PTS in its survey follow-up process. This process identifies settings that score one standard deviation above the mean setting score on questions related to trainee wellbeing, workload, and/or patient/doctor safety. We then discuss these results with the setting DPE and integrate concerns management into accreditation processes where possible. Results are also escalated to the setting's executive where appropriate. As of 2023, the RACP's Breach of Training Provider Standards Process has been used to investigate potentially severe concerns at a Training Setting that does not have an upcoming accreditation activity.

Processes used in the past to manage concerns have successfully raised training settings' awareness of potential areas of concern, prompting local exploration of concerns and providing a strong evidence base for educational leaders to seek resources and support for training from setting executives. From 2023, survey results will also be used to identify high-performing training settings who score one standard deviation more favourably than the mean score across all settings in particular areas, such as quality of clinical supervision, overall. A snapshot of the results of the 2023 MTS for the RACP is included at Appendix 6A.14.

Sharing and disseminating activities in research and evaluation (6.3.2)

In addition to the activities described in Standard 6.3.1, we have a range of established approaches to disseminating our activities in research and evaluation with stakeholders that have an interest in program and graduate outcomes.

We describe our approaches to responding to stakeholder views regarding research and evaluation findings throughout this submission in conjunction with the sections that describe each respective renewal activity.

Publications on the RACP website

A range of our research and evaluation activities are published to members on the RACP website (Appendix 6A.15). Results from the PTS dashboard are provided on the website (Appendix 6A.16) in summary reports and via the interactive Member and training settings (setting-specific login) dashboards. Where there is a risk of individuals or training settings being identified, we apply data suppression methods to maintain anonymity.

Conference presentations

College staff and members regularly present at local and international conferences on the range of the RACP's education, research and evaluation initiatives, promoting collaboration across the sector.

A summary of conference presentations, posters, seminars, workshops and symposia delivered in the past five years and coming up in 2024 is provided in Table 34 below and a full list provided in Appendix 6D.1.

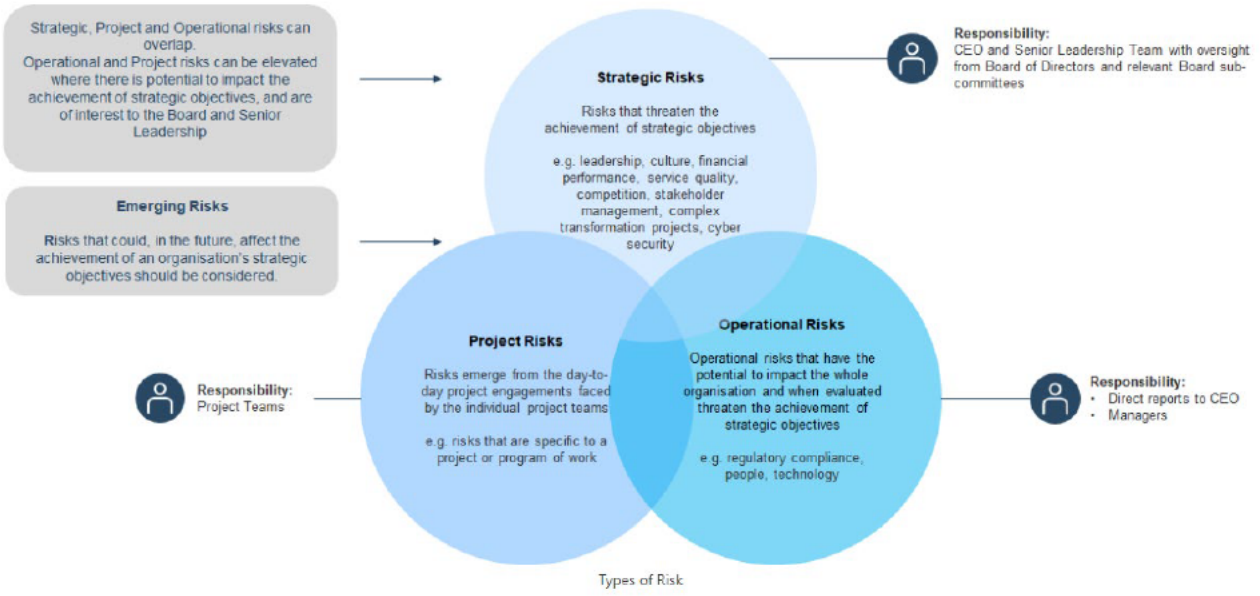
Table 34. Summary of conference presentations delivered regarding RACP education, research and evaluation initiatives

Year	Count of activities
2019	6
2020	5 (note: additional were accepted but not delivered due to COVID-19 impacts)
2021	15
2022	25
2023	20
2024	6 (accepted to-date)
Total	**77**

Managing risks about the quality of RACP programs (6.3.3)

The College has a comprehensive risk management framework and policy. These manage risk at three levels: Strategic, Operational and Projects, as shown in Figure 83.

Figure 83. Risk management levels used at the College



The RACP's Risk Management Policy (Appendix 6A.17) describes the behaviours expected of those involved in the governance of the College, and the roles and responsibilities of the various parties involved.

The Risk Management Framework (Appendix 6A.18) document fleshes out how the Board, the Finance and Risk Management Committee, and College teams manage risk. It includes the agreed definitions of levels of consequence and likelihood, the risk matrix, the control effectiveness ratings and the residual action matrix.

We use a Balanced Scorecard process to report key performance indicators to management (monthly), our Finance and Risk Management Committee and the Board (quarterly). The Balanced Scorecard includes, amongst others, longitudinally tracked KPIs for:

- percentage of trainees that agree RACP clearly communicates training program requirements (data drawn from Medical Training Survey)
- percentage of trainees that agree they receive support from the RACP [regarding assessment] when needed (data drawn from Medical Training Survey)

- percentage of trainees that agree the quality of supervision they receive is excellent or good (data drawn from Medical Training Survey).

Reporting and management of risks and issues regarding the quality of training and education programs are discussed in various sections of this submission, including in Standard 1.1 in relation to delivery of College projects, Standard 1.2 in relation to reporting via our education governance structures, Standard 6.3.1 in relation to monitoring and evaluation findings and in Standard 8.2 in relation to Training Providers.

Achieving timely and effective responses to identified risks to the quality of RACP training and education programs is challenged by the scope of the College's educational programs, complexity of education governance, breadth of stakeholders engaged in these functions and the devolved nature of physician training implementation. Our review of education governance structures and reporting mechanisms (Standard 1.2) is intended to ensure that "emerging risks and issues are efficiently escalated and visible to the peak education committee and Board and there is effective performance monitoring of all our education programs".

Summary of Standard 6

Strengths and key developments

- the use of rigorous, theory-based approaches to evaluate program success from program implementation through to identification of program outcomes and metrics
- evidence-informed approaches of the review of education programs and policies
- regular design and application of cutting-edge research methodologies to inform the development of projects
- comprehensive approach to the inclusion of stakeholder contributions at each stage of a project's life cycle and communicating the impact of their contributions
- best practice and processes shared nationally and globally with a proven track record of conference presentations
- introduction of a range of monitoring surveys that track training experience from selection through to the experience of new Fellows and educators
- enhanced evaluation and research strategy
- a comprehensive risk management framework, policy and processes.

Current and future focus areas

- continuing to gather cross-sectional and longitudinal feedback from trainees and educators in a context where engaging members in survey activities is challenging
- developing new mechanisms for collecting trainee and educator insights such as through leveraging existing datasets both internally and externally
- adapting approaches to evolving program design and the influences of external factors
- engaging and tracking change in response to recommendations emerging from research, evaluation and monitoring activities and finding a balance in specificity and generality in these calls to action across the RACP’s 40 training programs.

Standard 7
Trainees

Standard 7 Trainees

7.1 Admission policy and selection

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

Selection into training policies and principles (7.1.1)

The context of selection into physician training

The College's primary role in selection into training at the institutional level is to set and monitor standards for selection and provide advice on the selection and recruitment of trainee physicians.

The context in which candidates are selected into RACP training is complex and involves many different entities. Physician trainees are concurrently postgraduate learners and employees of health services that are accredited to provide physician training. As a result, recruitment and selection decisions are interlinked in the employment process. Employment decisions rest solely with the employing body, however, as accredited Training Providers, employers must also comply with the RACP's Selection into Training policy.

The RACP Selection into Training Policy and Standards

The RACP's Selection into Training policy (Appendix 1A.31) has been in effect since 2017. The policy was developed by a working group who undertook extensive consultation with stakeholders, including jurisdictions and health service representatives. It was informed by a review conducted for the RACP by leading academics in medical education selection.

The policy sets out the principles that underpin selection into all RACP training programs. It outlines criteria for eligibility and selection into RACP training programs, and standards for the process of selection into training at RACP accredited training settings. The RACP's Selection into Training policy is standards-based and intended to be adaptable to allow for defensible variations in diverse local and program contexts.

The policy sets out the four principles of selection into RACP training:

1. **Selecting for excellence**- to identify candidates with the capabilities and attributes required to successfully complete the training program and progress to competent independent practice as defined in the RACP Standards Framework
2. **Rigour and Fairness**- to use criteria and a process that is evidence-based, merit-based, transparent, current, sustainable, objective, equitable and procedurally fair

3. **Embracing Diversity**- to support a diverse range of candidates to apply for and progress through training
4. **Continuity**- to advocate for the continued recognition of trainees who are progressing satisfactorily and support them to complete training.

The policy defines the roles and responsibilities in selection of trainees as follows.

- **The RACP** is responsible for identifying doctors who are eligible to participate in its training programs by:
    - defining the principles and standards for selection into training
    - determining the eligibility criteria and the selection criteria
    - developing resources to support implementation of the process and provide guidance.
- **Training settings accredited by the RACP** are required to either conduct its own selection into training process or participate in a coordinated selection into training process for example as part of a local or regional training network, a state, or whole of specialty group. The selection process must comply with the standards for selection into training at RACP accredited training settings.
- **Health service jurisdictions and employing institutions** provide employment and infrastructure for training. They are solely responsible for making employment decisions. Their responsibility is to provide adequate service to meet the needs of the population.

Eligibility criteria for selection

To be eligible for selection into training, candidates must meet the published eligibility criteria for the training program as set out in the relevant RACP training program handbook. A summary of this criteria is provided in Appendix 2D.1, Training Program Details Table.

For all programs, applicants must be appropriately registered medical practitioners with the relevant authority. For Divisional Advanced Training programs, applicants must have completed, or be due to complete, all requirements of Basic Training prior to commencement of the program. Eligibility criteria for Chapter and Faculty training programs varies and can include course completion requirements and/or Fellowship of other Colleges.

Selection criteria

The policy specifies that selection criteria for each program includes:

- the candidate demonstrates a commitment to pursuing career as a physician
- the candidate demonstrates the appropriate level of ability, and willingness to progress toward competence, in each domain of the Professional Practice Framework.

For Basic Training, relevant attributes associated with domains of the Professional Practice Framework have been identified as important to assess in the process of identifying applicants who a suitable for training at the entry into Basic Training level. The role of these attributes in selection is further described in the evaluation report of the Situational Judgement Test (SJT) pilot.

Standards for Selection into training at RACP accredited settings

The policy is accompanied by the Standards for Selection. The process for selection into training must comply with the standards set out below.

- **Valid:** The selection methods used are fit for purpose and effectively predict which candidates will successfully complete the training program and progress to competent independent practice.
- **Reliable:** The selection process is based on rigorous selection methods and is designed to produce consistent outcomes.
- **Transparent:** The selection process is clear. Eligibility and selection criteria are publicly available. There is national awareness of training opportunities through clear advertising including the number of training positions available. Information provided to candidates is

sufficient to allow informed decisions. All candidates are advised of the outcome of the selection process and offered feedback.

- **Procedurally fair:** The selection process is fair and impartial with defensible, merit-based outcomes. Selection panels operate without prejudice. Any conflict of interest is declared. Selection panels consider only matters that are pertinent to the selection process, in accordance with anti-discrimination legislation. There is a process for formal review of decisions which is outlined to candidates prior to the selection into training process.
- **Evidence-based:** Selection processes are based on current evidence-based practice aimed to select the highest quality of candidate. The process is the subject of regular review and evaluation for continual quality improvement.
- **Sustainable:** The selection process is sustainable for trainees, the College, and the employing institutions. The requirements are reasonable for candidates.
- **Collaborative:** Selection into training is interlinked with the process of recruitment for employment wherever possible. Selection panels include a Fellow of the relevant training program chosen to represent the interests of the RACP in assessing the candidate's suitability for the training program wherever possible**.**
- **Accountable:** The selection process is conducted in accordance with the RACP principles for selection into physician training and there is clear responsibility and rationale for decisions.

Approaches to recruitment and selection

As allowable under the policy and standards, approaches to recruitment for employment and selection for training are permitted to vary across settings and programs. Some specialty groups are involved in centralised application processes such as preferencing 'matches', while Basic Training recruitment is typically undertaken by regional networks or consortia and may involve a component of 'selection' either before, during or after recruitment. The duration of employment contracts varies across jurisdictions and programs, with some health services offering 'length of training contracts' while others offer only single year contracts. This means that selection/ recruitment activities may occur at different points and frequencies throughout training.

Basic Training

For Basic Training, health service employers play a role by determining the number of training positions available at their site. They can recruit to positions directly through the local health service or by participating in a network/consortia recruitment campaign.

Most applications for selection into Basic Training are assessed as part of the annual recruitment campaigns within each jurisdiction. A small number may be advertised through jurisdiction health services at other times throughout the year. Workforce managers and hospital executives work with Directors of Physician/Paediatric Education and others in the design and administration of the recruitment process. Health Services manage recruitment and employment contracts.

Advanced Training

Trainees can apply to employment positions that are individually accredited as Advanced Training positions within an RACP specialty. These positions are advertised and recruited to through a variety of channels depending on the jurisdiction and training program.

Centralised selection processes exist for some specialties/jurisdictions, independent of the RACP. Some of these centralised selection processes are conducted by specialty societies and some by other groups. Irrespective of the host body, all centralised selection processes are expected to be conducted in accordance with the RACP's Selection Policy and Standards.

As noted in the College's 2022 monitoring submission to the AMC, the College ceased to offer the Advanced Trainee Selection and Matching program following a review conducted in 2021. The Postgraduate Medical Council of Victoria (PMCV) still administers the Allocation and Placement Service to Victorian Health Services that offer Basic Physician Training (BPT), Advanced Training (AT) and Registrar positions, (as well as other health service positions) and to candidates applying for these posts. The process is conducted at the request of the Victorian Department of Health.

The PMCV coordinated the 2023 RACP Combined Specialty Match for New Trainees in the following specialty groups:

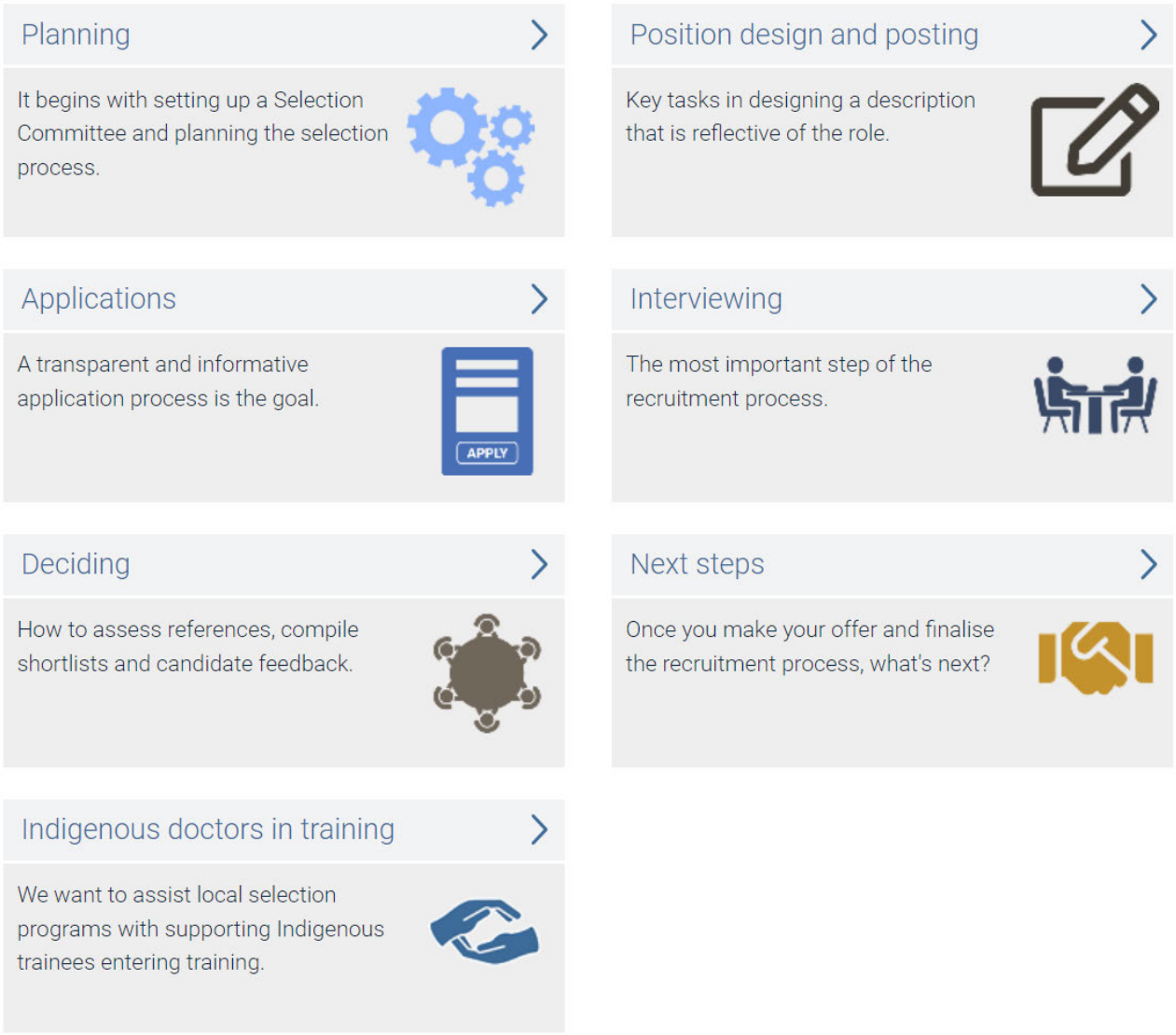
- Cardiology VIC/TAS
- Gastroenterology VIC/TAS
- Geriatric Medicine VIC
- Medical Oncology VIC/TAS
- Nephrology VIC/TAS
- Respiratory and Sleep Medicine VIC/TAS.

Supporting good practice in selection through support and resources

Since the last full accreditation, the College has engaged in a range of activities to support good practice in selection by highlighting College standards and expectations for selection into training and importantly, providing practical guidance.

The RACP provides a comprehensive Trainee Selection and Recruitment Guide (Appendix 7A.1) that supports health services through the following phases of Basic Training selection and recruitment as summarised in Figure 84.

Figure 84. Summary of Trainee Selection and Recruitment Guide



The RACP also provides Guidelines for Training Providers on Local Selection for Training (Appendix 7A.2). This is supplemented by an At a Glance poster (Appendix 7A.3).

The RACP works annually with jurisdictions to provide accurate, centralised information on the RACP website regarding campaigns for selection into Basic Training programs in Australia across

jurisdictions (Appendix 7A.4). This includes information on eligibility, application and selection processes. We are working towards this information as Te Whatu Ora changes evolve. Analysis of website traffic data for each of these pages show peak page view statistics occurring over the annual campaign period window within each jurisdiction, from the time of information sessions before applications open, through to offers of positions.

After a pilot period, in 2023 the RACP launched Capacity to Train Guidance to support settings offering Basic Training to determine their capacity to train (Appendix 7A.5). This assists Directors of Physician/Paediatric Education (DPEs) to plan for recruitment.

Processes for selection (7.1.2)

Published criteria and weightings

The RACP's selection criteria are outlined in the preceding section. The Transparent standard of the Selection Standards requires Training Providers to ensure "eligibility and selection criteria are publicly available". The Planning section of the RACP's Trainee Selection and Recruitment Guide provides guidance to Training Providers on designing position-specific selection criteria and use of weighted criteria in selection processes.

Evaluation of processes

The Evidence-based standard in the Selection Standards requires Training Providers to ensure selection processes are the "subject of regular review and evaluation for continual quality improvement." Guidance is provided to training settings in the Final Evaluation section of the Trainee Selection and Recruitment Guide regarding steps for evaluating and improving recruitment processes.

We provide more detail in Standard 7.1.5 below on how the College evaluates selection programs.

Managing Appeals in Selection

The Procedurally Fair standard of the Selection Standards requires Training Providers ensure "there is a process for formal review of decisions which is outlined to candidates prior to the selection into training process." Guidance is provided to training settings in the Trainee Selection and Recruitment Guide regarding management of appeals in selection. This outlines that settings and networks should have a process to receive, and investigate, if necessary, information that alleges improper behaviour of candidates and/or selection committee members.

Transparent, rigorous and fair processes, capable of standing up to external scrutiny

Our Selection Standards include the standards 'Transparent' and 'Accountable' and 'Rigour and Fairness' is a key principle of the Selection policy. Along with the other Standards, these set the expectation that Training Providers must conduct processes that stand up to external scrutiny. Guidance is provided throughout the Trainee Selection and Recruitment Guide to support Training Providers to comply with these aspects of the policy and standards.

Initiatives to improve the outcomes, processes and experiences of selection into RACP training programs (7.1.1)

The College continues to work with Fellows, trainees and those involved in supporting selection to ensure the standards are met and that trainee recruitment is fair and free of discriminatory practices.

Beyond the implementation resources described above in Standard 7.1.1, there are several initiatives underway to improve the outcomes, processes, and experiences of selection into RACP training programs. These are designed to address the findings of our monitoring and evaluation activities, as described under Standard 7.1.3.

Revision of the Selection into Training Policy

The RACP Selection into Training policy is currently under revision. The aim of the revision is to ensure that the policy supports selection outcomes and experiences that are aligned to the RACP's current strategic objectives. The revision is an opportunity to progress Indigenous equity and entry into training, and gender equity objectives. The review will also address the recommendations emerging from the College's pilot implementation of a situational judgement test, as discussed below. Changes to governance of selection into training decisions and processes are outside the scope of this policy revision.

The methodology for the policy revision follows the RACP's established education policy revision process, as outlined in Standard 1.2. Revision activities follow four phases as shown in Figure 85, with work currently at the Consult phase.

The Consult phase is occurring in multiple rounds. Thus far, consultation has occurred with key RACP committees, with broad support received for the proposed changes along with suggestions for implementation approaches. We paused the policy review until early 2024 to allow key related decisions to occur for other selection initiatives, and therefore enable a more cohesive program of consultation and change. We will next work with Indigenous strategic partners to refine the proposed policy changes. Following that, we will consult with external groups including jurisdictions.

Figure 85. Process for revision of the Selection into Training Policy

Building an expanded roadmap for improving selection

Planning is underway for an expanded roadmap of activities that builds on the work completed focused on entry into Basic Training programs. Work will be expanded to consider selection into Advanced Training programs and include processes of discovery with a current state analysis of selection into training processes across jurisdictions and specialties.

We will work with stakeholders to prototype a "pre application" database for junior doctors interested in applying to Basic Training programs. The database would act as a mailing list and direct communication channel between the College to:

- enable the RACP to engage with prospective applicants before, during and after the selection period and provide targeted information and supporting resources
- gather information on applicants, including demographics, career intentions, application outcomes and experiences and potentially (in the long term) information to support centralised assessment of common criteria
- position the RACP to reduce burden on Training Providers involved in selection
- allow the RACP to monitor application intentions, trends, outcomes and how these vary over time, across applicant groups and across Training Providers/selector groups.

The roadmap will also include planning activities for a potential pilot of a Situational Judgment Test (SJT) for all applicants to Basic Training in 2026 (see below).

Pilot implementation of an SJT for entry into Basic Physician Training

In 2022, the RACP conducted a pilot implementation of an SJT in parallel with the selection processes for entry into first-year basic paediatric training in Australia. The purpose of the project was to understand whether an SJT is feasible and could add value to Basic Paediatric Training selection activities.

The following activities were undertaken as part of the pilot:

1. **Discovery, Mapping and Alignment phase** in collaboration with Acuity Insights. A stakeholder survey (n=169) and several workshops with key stakeholder groups (Entry into Basic Training Working Group Members, Indigenous Strategic Partners and Cultural Advisors, and the Consumer Advisory Group) were used to identify ideal and concerning behaviours in physician training related to the attributes identified in the entry into basic training criteria. This data along with the RACP Professional Practice Framework Standards was used to align SJT material and rating guides to the RACP context and guide the blueprint for the pilot assessments.
2. **Development and piloting an SJT**, called 'Casper', in collaboration with Acuity Insights and five paediatric networks, which was completed by 278 applicants to Basic Training in August 2022.
3. **Evaluation of SJT utility** with respect to the assessment's reliability, validity, feasibility, cost, acceptability and educational impact. A report of the results of the evaluation findings is included as Appendix 7A.6.

   The evaluation found that the SJT could produce reliable performance measures on a construct related to the professional behaviours targeted in the RACP Entry into Basic Training criteria. There was sufficient precision to divide measures into at least three statistically significant bands of performance. Applicants who completed the assessment agreed it was important to include objective measures of such attributes in selection processes but were somewhat divided in their view that the SJT was the most effective assessment of these attributes.

   The evaluation also revealed that most applicants are considered suitable for training, but in some cases, there is not enough capacity to train suitable applicants in accredited training positions, whilst in other contexts, initial screening of applicants is performed by local health departments. The evaluation also found that current selection processes tend to weight assessment of professionalism attributes in the second phase of selection processes, after applicants have been shortlisted to interview, meaning that some participants who had high measures on the SJT but lower measures on other attributes more closely related to medical expertise were screened out early in the selection process. This indicates a need to strengthen the assessment of professional practice criteria in the early stages of the selection process to ensure all applicants have an equitable opportunity to demonstrate their strengths.

   The Entry into Basic Training working group recommended further piloting of the SJT and a pre-application database mechanism across all applicants to Basic Training, additions to the Selection into Training Policy to reflect the conclusions around holistic assessment of selection criteria and a comprehensive analysis of existing selection processes in local contexts.
4. **Determination of next steps** in response to a discussion paper presented to the College Education Committee (CEC), in September 2023. Based on the evaluation findings the CEC concluded:
   - assessment of all selection criteria for training should occur holistically, ie at all stages of the selection process
   - no single instrument can measure all selection criteria, and no single instrument should be used to make high stakes decisions
   - implementing the SJT could provide a robust and feasible way to assess professional attributes, benefiting local selection committees by contributing incremental validity to selection outcomes. It would benefit applicants who possess high levels of professionalism attributes but may currently be being screened out early in the selection process

- however, implementing the SJT would come at a financial cost to applicants and require significant investment from the College. It would also have a moderate-to-high change impact, necessitating careful stakeholder and logistical management to minimise burden, and require the implementation of a pre-application database for doctors wishing to apply to Basic Training and a review of local selection procedures to ensure the integrity of the SJT contribution to individual's selection outcomes.

The CEC determined to wait until late 2025 to pilot a pre application database and quarter two 2026 to pilot a full scale SJT. This is due to other priority initiatives throughout 2024/2025 that have higher change impacts and significant resource requirements. Delaying the SJT pilot until 2026 would allow for better alignment with the ongoing review of the Selection into Training policy and development of an expanded roadmap for improving selection into training.

Data on trainee entry and progression

Table 35 below provides summary data on the number of trainees who commenced an RACP training program in the past three years. Specialty, gender and location specific data for the past five years is provided in Appendix 7D.

Table 35. Number of trainees commencing training

	2021	2022	2023
Commencing	2849	2946	2856

Table 36 below provides summary data on the number of trainees registered in an RACP training programs in the past three years. Specialty, gender and location specific data is provided in Appendix 7D.

Table 36. Trainees registered in training programs

	2021	2022	2023
Registered	9843	10378	10448

Table 37 below provides summary data on the number of trainees who completed an RACP training program in the past three years. Specialty, gender and location specific data for the past five years is provided in Appendix 7D.

Table 37. Training program completions

	2021	2022	2023
Completed	2355	2128	2190

Table 38 below provides summary data on the number of trainees who withdrew from an RACP training programs in the past three years. More detailed data on withdrawals and reasons for this is provided in Appendix 7D.

Table 38. Trainee program withdrawals

	2021	2022	2023
Withdrawn	511	442	500

Growing the Indigenous physician workforce (7.1.3)

The College has a range of multifaceted initiatives to support the increased selection and retention of Aboriginal and/or Torres Strait Islander or Māori trainees in physician training programs. These supports are collectively referred to as our Growing the Indigenous Physician Workforce initiatives, which relate to Priority 2 *Grow and support the Indigenous Physician Workforce* and Priority 4 *Foster a culturally safe and competent College* in our Indigenous Strategic Framework (as outlined in Standard 1.6.4).

In 2019, Associate Professor Wendy Edmondson, in consultation with Indigenous stakeholders, proposed a strategy for increasing the numbers of Indigenous physicians in the 'Report into strategies for increasing Indigenous entry into training'. This report proposed recommendations and options/actions on how to shape a culturally safe and strengths-based attraction and selection experience.

Recommendations reflect the core goals and principles of the RACP Indigenous Strategic Framework and were identified through literature reviews, a review of current college practices, research and consultation with a range of stakeholders. The report identified strong support for a pipeline approach, incorporating multiple strategies on attraction, retention and selection to better support Indigenous trainees throughout their journey, and not just at the point of selection, to become RACP Fellows.

Many of the Growing the Indigenous Physician Workforce initiatives are from recommendations in this report, as outlined below.

The Fee Reimbursement Initiative

The removal of financial barriers via a fee reimbursement was a recommendation from the Strategic Framework for Indigenous Entry into Training Report by Wendy Edmondson in 2019.

Background

In October 2020, the RACP Board resolved to approve the introduction of a fee reimbursement for annual training and examination (first attempt) for Basic and Advanced trainees who identify as an Aboriginal and/ or Torres Strait Islander person, Māori, or Pacific Islander and not directly employed by Te Whatu Ora in Aotearoa New Zealand.

In May 2022, following collaboration between key stakeholders across the College and with the advice and guidance of the Aboriginal and Torres Strait Islander Health Committee, the Fee Reimbursement Initiative was implemented. It aims to support equitable access for Indigenous doctors wishing to specialise as physicians or paediatricians.

Eligibility criteria and assessment

The initiative is for eligible trainees who identify as:

- Aboriginal and/or Torres Strait Islander
- Māori and/or Pacific Peoples and are not directly employed by Te Whatu Ora in Aotearoa New Zealand.

The reimbursement can be used to cover the cost of annual training and/or the first attempt at exams.

To apply for the initiative, trainees need to fulfil all the following criteria:

1. Be registered as a Basic or Advanced Trainee with the College
2. Identify as Aboriginal and/or Torres Strait Islander, Māori, or Pacific Islander and can show proof of their Indigeneity and/or Pacific Islander ethnicity as part of the Fee Reimbursement Application process
3. For College trainees in Aotearoa New Zealand, not be directly employed by a District Health Board
4. Have paid the training and/or exam fee/s being sought for reimbursement. Noting that for exams, a fee reimbursement can only be sought for the first attempt at an exam
5. Seek reimbursement/s of the annual training fee and/or exam fees for exams undertaken and completed from 2022 onwards

6. Complete and submit the Fee Reimbursement Initiative Application Form (Appendix 7A.7).

Applications are accepted on a rolling basis across the year and on receipt, are assessed against the eligibility criteria. Wendy Edmondson, Marnu Wiru (Knowledge Holder) and Lee Bradfield, Manager, Indigenous Strategy, both Indigenous staff, are responsible for confirming that candidates meet the proof of identify requirements for the Initiative in Australia.

Participation rates

In 2022, there were four applicants who applied for and received the Fee Reimbursement Initiative.

In 2023, 12 applications were made to the Fee Reimbursement Initiative. Of those, ten applications were reimbursed, as two applications did not meet the eligibility criteria.

Evaluation

The Fee Reimbursement Initiative will be evaluated from the end of 2023 to assess its impact on the wellbeing and retention of trainees in RACP training programs and to inform continuous improvement.

The growth in Indigenous membership will be reported as part of the five-year evaluation of the Fee Reimbursement Initiative planned for in 2026. Annual reporting against Priority 2 of the Indigenous Strategic Framework includes the overall increase in the number of Indigenous trainees and Fellows and the percentage change as a proportion of overall membership.

Other financial support for Indigenous Members

Financial support is also offered via the RACP Foundation scholarships, prizes, and awards.

The College has a range of scholarships on offer to support medical graduates and current RACP trainees who identify as an Aboriginal and/or Torres Strait Islander person, Māori or Pacific Islander person on their chosen career path to becoming a physician.

The scholarships provide a funded pathway through Basic, Advanced, Faculty or Chapter training in Australia and/or Aotearoa New Zealand.

Coaching programs

Coaching is one of several intended strategies to support the progression and retention of trainees through RACP training pathways. There are two coaching programs in place to support Indigenous trainees as outlined below.

The Indigenous Trainee Wellbeing Program

In June 2023, the RACP introduced an online pilot program to support the wellbeing and resilience of Aboriginal and/or Torres Strait Islander Basic Trainees.

Blak Wattle Coaching and Consulting, an Aboriginal owned organisation, was engaged to deliver the program. While the day-to-day running of the pilot and achievement of outcomes is the responsibility of Blak Wattle, a partnership approach between the RACP and Blak Wattle is in operation for the duration of the project. Blak Wattle is working with relevant College stakeholders including Wendy Edmondson and Alex Kinsey to monitor project progress, ensure the pilot is appropriately tailored to the RACP environment and trainee needs and complements RACP training programs and pathways and prioritises cultural safety.

The program runs over six months and includes a series of online group workshops and resources that utilise Aboriginal knowledge systems to nurture and support the wellbeing and resilience of participants. The program is fully funded for Aboriginal and /or Torres Strait Islander participants and includes for each participant:

- a series of four 60–90-minute group workshops tailored to group priorities; one workshop will be held each four to six weeks
- access to resources, readings, and materials to supplement learning
- the option of one-on-one coaching.

Workshops and resources are designed to utilise Aboriginal and Torres Strait Islander knowledge systems to nurture skills and practices to support the wellbeing and resilience of the participating trainees.

The inaugural Indigenous Trainee Wellbeing Program launched on 24 October 2023 for Basic Trainees only to specifically support wellbeing during the transition to an RACP training pathway and exam preparation and performance. The expansion of the pilot program to other years will be informed through program uptake and a program evaluation.

To ensure sufficient tailoring of the program to trainee needs, ahead of registering in the program, potential participants are asked to nominate their preferences for topic areas for discussion throughout the program, such as burnout, holistic self-care strategies, goal setting and leadership. These topic areas are used to inform the content of the group workshops. The pilot also incorporates feedback received from the College's Coaching Pilot in Aotearoa New Zealand to improve trainee engagement from the outset.

Although jointly promoted by Blak Wattle and the RACP to Aboriginal and/or Torres Strait Islander Basic Trainees, the program is being delivered independently by Blak Wattle. Blak Wattle is handling all registrations and any necessary on-going communications with registrants. RACP is not privy to any personal information about participants. This is to ensure that participants feel safe and secure to participate fully in the program knowing that any information they share during sessions is confidential to Blak Wattle.

In 2023, the program has commenced with four Basic Trainees. The program has been designed with flexibility in mind and group sessions are tailored around participant availability which is crucial for time-poor doctors.

The pilot will be evaluated at the first program's end in March 2024. This will inform the potential to expand the pilot to other years and any necessary program updates.

Coaching program for Māori Basic Trainees

The coaching pilot was offered in 2020 as an additional support for Indigenous trainees whose preparation for their Divisional Clinical Exam in 2020 had been significantly disrupted by the COVID-19 pandemic.

The pilot was first offered in 2021 following the College's engagement of two external professional Māori coaching providers to deliver the program:

- Mr Luke Rowe, Mana Mindset
- Mr Mathew Shepherd, Shepherd Psychology.

Focussed on supporting trainee wellbeing and performance, the program currently includes:

- an initial kōrero with the nominated coach to get a sense of the trainee's goals
- a 90-minute session and up to two additional 60-minute one-on-one sessions which can be virtual or in-person.

Since 2021, there has been limited uptake of the pilot (approximately 3 trainees), though very positive trainee engagement with the pilot. This could be due to the pilot being only targeted at the small cohort of Basic Trainees preparing for the Divisional Clinical Examination.

In 2022, the Māori coaching providers put forward a number of strategies to improve uptake of the program. These suggestions were discussed by the Māori Health Committee, and it was agreed that the pilot be offered to all Māori Basic Trainees to expand the reach of the program. Following promotion of the pilot to all Māori Basic trainees, both coaching providers indicated they had received more interest from trainees in 2023.

Other suggestions from the coaching providers to increase trainee engagement with the program that are currently being considered for implementation by the Māori Health Committee include:

- providing more opportunities for collective learning together with the option for one-on-one coaching
- providing the coaches with an opportunity to introduce themselves to the intended cohort so they can start to build a connection with the trainees. This could be via a zoom

introduction and /or the inclusion of more personal information in the introductory letter about the pilot
- sending a survey to the target trainee audience to give coaches more guidance of topics of interest to trainees
- making the structure of the pilot more prescriptive
- making explicit the link between coaching and improvements to performance and wellbeing.

The contracts for both coaching providers have recently been extended for a further two years to ensure continuation of the pilot to support the wellbeing and performance of Māori trainees on RACP pathways.

Leadership and development support

From 1 January 2021, the Board resolved to approve $100,000 per annum be provided on an on-going basis for Indigenous trainees to access leadership and development support.

In 2023, the Māori Health Committee agreed to an expansion of the Indigenous Leadership Fund so that it can be used to support all Māori members and not just trainees. The scope of the fund was also expanded to clearly articulate support for activities that also supported cultural development and not solely clinical skills.

Work is underway at the College, in collaboration with the Māori Health Committee and the Aboriginal and Torres Strait Islander Health Committee, to establish a more formal structure for the Leadership Fund that makes it clear to members about what the funding can be used for and makes it more accessible for a variety of development and support opportunities across the training pathway, tailored to member needs.

Opportunities through the Leadership Fund

The Leadership Fund has been used to support Indigenous trainees to participate in a number of opportunities. In 2023, opportunities have included:

- Invitation to all Aboriginal and/or Torres Strait Islander trainees to attend the AIDA conference in Tasmania via an Expression of Interest process. Eligible applicants were asked to complete a brief application form which included, as the basis for assessment of the applications, needing to articulate the benefit of the opportunity to the trainee's professional development and/or training pathway. Five applications were received which were assessed by the Marnu Wiru. Five applicants were supported to attend the conference with the College fully funding the costs of registration, travel and accommodation.
- Invitation to all Māori and Aboriginal and/or Torres Strait Islander members to attend the LIME conference in Canberra in October with registration costs covered by the College via an Expression of Interest process. One application was received, but that trainee was unable to attend.
- Invitation to Māori members to attend the RACMA conference in Aotearoa with the registration costs covered via an Expression of Interest process. Unfortunately, a short timeframe may have limited interest in attendance as no applications were received.

In 2022, opportunities on offer through the Leadership Fund included:

- Sponsorship of two Indigenous members to attend the Pacific Region Indigenous Doctors Congress (PRIDoC) in Canada. PRIDoC is being held in December 2024 in South Australia. An EOI will be distributed to Indigenous members to apply for PRIDoC.
- Invitation to Aboriginal and/or Torres Strait Islander trainees to attend the AIDA annual conference in Queensland via an Expressions of Interest process. No trainees took up this fully funded opportunity.
- Invitation to all Aboriginal and/or Torres Strait Islander trainees and members of the Aboriginal and Torres Strait Islander Health Committee to attend the AIDA Gala Dinner in June 2022 to celebrate 25 years of AIDA's amazing work. Ten members attended on RACP's behalf. The Leadership Fund covered the costs of registration, travel and accommodation.

Equipment fund

The Leadership Fund is currently used to cover the costs of purchase and freight for a number of physician briefcases. These are available for Basic Trainees who identify as Aboriginal and/or Torres Strait Islander Peoples and Māori preparing for the Divisional Clinical Examination or other relevant clinical assessments.

This initiative was trialed in 2023. The initiative, essentially an equipment fund, was recommended by AIDA as a retention strategy that removes a financial barrier for Indigenous trainees wishing to specialise as a physician or paediatrician.

Twenty briefcases were initially ordered in 2023 and of these, 11 have been distributed to interested trainees.

AIDA's Specialist Trainee Support Program (STSP)

The RACP is one of 11 non-GP Specialist Medical Colleges that is working with AIDA to support their Specialist Trainee Support Program (STSP). The STSP sees non-GP medical specialists supported through a unique specialist trainee network, as well as a range of other incentives with the aim to provide ongoing, tailored and culturally appropriate support to Aboriginal and/or Torres Strait Islander trainees to support the growth of the Aboriginal and Torres Strait Islander specialist workforce.

Work to progress the STSP will be an opportunity to gain and collate valuable information about Colleges' challenges and good practice regarding growing the Indigenous workforce. This will include best practice regarding culturally appropriate strategies to enable recruitment, selection and retention.

Initiatives on offer through the STSP to provide support to RACP's Aboriginal and/or Torres Strait Islander members in 2023 include:

- one-on-one coaching
- monthly online group yarning sessions
- webinars on interview preparation and CV preparation
- trainee support sessions at the AIDA conference
- Yarn Up sessions to provide Aboriginal and/or Torres Strait Islander doctors with information about the RACP and training pathways.

For supervisors at the RACP, opportunities on offer through the STSP have included:

- a limited number of passes to undertake AIDA's online and face-to-face cultural safety training course
- webinar on addressing racism and providing culturally safe supervision.

Networking and peer support

The Deadly Doctors RACP Online Community (ROC) is a private online community that was set up in 2022 as a place for Aboriginal and/or Torres Strait Islander members to connect, network and have discussions. It is also a mechanism through which limited and relevant staff share the latest updates and resources and can promote events and opportunities directly with this cohort.

The Deadly Doctors network was launched at the AIDA Conference in 2022 and also includes a dedicated email address DeadlyDoctors@racp.edu.au that Aboriginal and/or Torres Strait Islander members are encouraged to use as a central point of contact to Indigenous staff and those working on priorities to grow the Indigenous physician workforce.

The Māori Caucus ROC is similarly set up to support Māori members.

Throughout the year, Indigenous members receive tailored communications from the College promoting relevant events, opportunities and resources. At key points along the training pathway, members also receive communications tailored to their training stage. All communications are developed in collaboration with the Marnu Wiru and/or the Kaitohutuhu Ahurea. For example:

- new members receive a welcome letter that includes a list of useful resources and an orientation to the College

- collaboration with the RACP regional offices to ensure that orientation presentations include information about the support available to Indigenous members
- members preparing for exams receive a letter that includes useful resources for exam preparation and other available initiatives. This is followed up with either a letter of congratulations or a letter of encouragement and support
- members receive information throughout the year about opportunities and support available through other partner organisations including AIDA and LIME.

New webpages for Aboriginal and/or Torres Strait Islander members and Māori members are being developed to improve member access to the range of available resources and initiatives for Indigenous members.

Building the Indigenous workforce and cultural safety

As outlined in Standard 1.6.4, new positions for Māori member leadership have been established, which will aid in reducing the cultural loading on the RACP's Māori leadership and provide 'bridge builder' capacity to assist the RACP achieve its strategic goals.

As outlined in Standards 2 and 3, we continue our work to update the new Basic Training program Curriculum Standards and new Advanced Training program Common Curriculum Standards to align to the RACP's Professional Standard of cultural safety.

Culturally safe collection and management of Indigenous member data

As outlined in Standard 6.2, the RACP has an Indigenous Data Governance Framework, which outlines processes for managing Indigenous member data in a culturally safe manner. The Framework also give members that identify as an Aboriginal and/or Torres Strait Islander person the opportunity to choose to share their information with AIDA.

Data regarding Aboriginal, Torres Strait Islander and Māori trainees

The AMC has asked the RACP to provide selection data for Aboriginal and Torres Strait Islander and Māori applicants including the number of applicants, those interviewed and who entered training. Recruitment and selection into RACP training are linked processes conducted by the employing health service/accredited training provider. The RACP does not collect data from employing health services regarding the number of candidates who applied for accredited training positions and hence is not able to report on the number of unsuccessful applicants for any cohort. As outlined in Standards 7.1.1-7.1.2, in future years, we are looking to implement improved monitoring mechanisms to track variations in selection outcomes for different demographic cohorts.

Appendix 7D provides data on the number of Aboriginal and Torres Strait Islander and Māori trainees who commenced training (ie were successfully selected), along with data on those who registered, completed and/or withdrew from an RACP training program in the past five years.

Informing trainee decision-making at the point of selection (7.1.4)

All program requirements are publicly published on the RACP website in training handbooks, as summarised in Appendix 2D.1, Training Program Details Table, allowing prospective trainees to identify mandatory requirements of the program. Where relevant, the handbooks contain details about exemptions.

Monitoring of selection activities (7.1.5)

We utilise a range of methods to monitor selection activities.

Training Provider Accreditation Program

As described in Standard 8.2, we use Training Provider Standards to underpin our Accreditation Program. Standard 4.5 of these standards is:

4.5 | Trainee recruitment, selection and appointment is fair, rigorous, documented and transparent.

Recruitment satisfies the RACP's Selection into Training Policy and recruitment practices. Where a Training Network exists, recruitment is undertaken by the Training Network. The Settings participating in a Training Network do not recruit trainees separately.

Trainee appointment to employers and rotations is based on a published process that is transparent, rigorous and fair. Trainees receive timely, accurate and comprehensive information about their rotations.

The Training Provider Accreditation Program assesses and monitors compliance with this standard. Where a potential breach of this standard is identified at a setting or network, the RACP has processes in place to manage compliance. Concerns can be raised anonymously with the RACP.

Cross-sectional monitoring

The RACP conducts biennial pulse surveys of trainees to solicit their experiences of selection into training processes. As reported in the update on these provided in Standard 6.1, the surveys identified concerns from Advanced Trainees regarding inconsistencies in application of the RACP's selection standards across locations and specialties. Ensuring consistent compliance with these standards in AT will be a focus area when developing an expanded roadmap for improving selection into training (refer to Standard 7.1.1).

Enhancing our capacity to monitor selection experiences

As outlined in Standard 7.1.1, the College is looking to prototype a pre-selection database that will enable us to collate improved monitoring data on training intentions, applications, outcomes and progression to use in informing our selection initiatives.

7.2 Trainee participation in education provider governance

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

The College has well established structures and processes that facilitate and support the involvement of trainees in governance of the College. Trainees are formally recognised as members of the RACP with voting entitlements and are represented in all levels of College governance, including membership of the Board, trainees' committees in both Australia and Aotearoa New Zealand, and trainee representation on education, assessment and accreditation committees and working groups. Trainees are routinely involved in all educational developments and consulted on changes that may impact them. In addition to this there are well established fora to enable trainees to make recommendations and advocate on behalf of all trainees to the College in relation to any aspect of their education experience.

College Trainees' Committees

The College has several trainees' committees, that provide the voice of trainees.

The College Trainees' Committee (CTC), established by the RACP Board in 2003, is the College's peak representative body of all RACP trainees and their interests. The CTC Terms of Reference (ToR) is at Appendix 7A.8. The ToRs reflect the intended functions of the Committee, with meeting frequency and format mirroring those of other College entities, pursuant to the Governance of College Body By-Laws. The Committee's purpose is to:

- provide a forum for the views of all trainees and dual trainees
- advocate on behalf of trainees in matters relating to their selection, training, assessment, supervision and overall education experience
- make recommendations regarding policy that relates to any training matter
- liaise with all regional trainees' committees
- liaise with trainee representatives across the College and its bodies

- recommend to the appropriate College body any new initiatives to support trainees/dual trainees that can enhance their training experience
- manage the selection, election and nomination of trainee representatives to the various College body councils, committees and groups.

Formed in 2004, the Aotearoa New Zealand Trainees' Committee represents and advocates for Aotearoa NZ trainees in matters affecting selection, training, assessment, supervision, and overall educational experience. The committee also leads the development of the annual Aotearoa New Zealand Trainees' Day. The committee members hold representative positions on RACP Education, Policy & Advocacy, Māori Health, Division, Faculty and Chapter committees of Australasia and New Zealand, as well as the Aotearoa New Zealand Committee.

In addition, state and territory committees in Australia each have a Trainees' Committee reporting to them.

The Aotearoa New Zealand and Australian state and territory Trainees' Committees have representation on the College Trainees' Committee.

Trainee representation on College Committees

In addition to trainee representation via a Trainee Director on the Board, the highest level of College governance, multiple College bodies include trainees in their membership as full members and considered as part of the Committee quorum to ensure the trainee perspective is considered as part of the decision-making process of that committee. Trainees are also involved as representatives of the College at meetings hosted by external bodies that are relevant to trainee matters to ensure their voice in training related matters are considered.

The College Education Committee (CEC) have expanded their membership for trainees by a further two, bring the total trainee membership to four. One Basic and one Advanced Trainee may be invited by the Chair to attend meetings of the CEC as observers however these trainees are not considered as part of the Committee quorum, and only have the right to a proxy vote, should either of the two standing trainee members not be in attendance at a meeting. Details of this is within the CEC ToR in Appendix 1A.17.

Trainees are also included on panels undertaking formal Reconsideration and Reviews of College decisions relating to training matters pursuant to the College Reconsideration, Review and Appeals Process By-law (Appendix 1A.45). Trainees are not included in an Appeals Committee however the Chief Executive Officer may determine to expand the membership of the Appeals Committee to include additional non-Fellow members, as the circumstances of the appeal may warrant.

Standing items for 'The Trainee Voice'

The Trainee Voice has been a standing item on the Board agenda since 2021 and RACP monthly All Teams agenda since 2023. The College invites different trainees to attend and speak to the Board and all RACP teams on broad range of matters or issues that arise from time to time to highlight the trainees' perspective and improve visibility. The Trainees' Voice continues to provide a direct link from the CTC to the College as a mechanism for comprehensive engagement.

The RACP Online Community (ROC)

The College has an online community, the ROC, for our membership, launched in 2021 to help foster communication between members, including trainees. A range of ROC communities have been established for different member profiles. This online community platform for members has enabled us to create targeted communications for member cohorts including our trainee members. The ROC Trainee Community is a secure online forum and a closed group exclusively for Basic and Advanced Trainees. It's a helpful place for trainees to connect with each other, across specialities and levels of training, join in discussions, ask questions, seek advice, grow their network and share their challenges. From the period October 2021 to January 2024, the ROC has been accessed by 3047 trainee users (34% of trainees).

The College also has an RACP Trainees' Facebook group; a space for RACP trainees to meet and share their experiences, tips, events and ideas with each other and also receive relevant trainee material from the RACP. There are over 3700 members in this Facebook group.

7.3 Communication with trainees

AMC accreditation standards	
7.3.1	The education provider has mechanisms to inform trainees in a timely manner about the activities of its decision-making structures, in addition to communication from the trainee organisation or trainee representatives.
7.3.2	The education provider provides clear and easily accessible information about the specialist medical program(s), costs and requirements, and any proposed changes.
7.3.3	The education provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

Keeping trainees informed about decision-making (7.3.1)

Communication mechanisms

The RACP employs a multi-faceted approach to communication, combining online platforms, face-to-face interactions, feedback mechanisms, and support services to create a comprehensive and supportive environment for trainees. The various communication mechanisms used to inform, engage and support trainees of activities, specialist program requirements, decision-making and training status are:

MyRACP Portal: The MyRACP portal serves as a central hub for trainees. It provides access to a range of resources, including educational materials, policies, and progress tracking tools.

Email Communications: Trainees receive important updates and announcements via email. Regular communication through email keeps trainees informed about policy changes, educational opportunities, and other relevant information. In relation to education, the College Education Committee release communiqués thrice a year outlining the decisions made and key issues that were considered. These bulletins are disseminated to all members and education committees for information.

Online Learning Modules: The RACP offers online learning modules to enhance the education and training experience. These modules cover various topics and are easily accessible for trainees through the online platform.

Workshops, webinars and information sessions: Face-to-face workshops, webinars and information sessions provide a valuable opportunity for trainees to engage with experts, share experiences, gain insights into specific topics, Q&A and in-depth discussion/feedback sessions focused on decision and change activities. These events foster networking and professional development and allow trainees to actively participate in change activities.

Supervisor Support: The RACP emphasises the role of supervisors in supporting trainees. Regular meetings and communication between trainees and their supervisors help to address concerns, provide guidance, and ensure a supportive learning environment.

Professional Development: The RACP encourages ongoing professional development. Trainees are informed about relevant conferences, courses, and other opportunities to enhance their skills and knowledge in their respective fields.

Feedback Mechanisms: The RACP values feedback from trainees. Various mechanisms, such as surveys and forums, are in place to gather input on training experiences, educational resources, and overall satisfaction. This feedback helps in continuous improvement. Details are provided in Standard 6.

Direct Liaison with Trainee Representatives: Trainees have representatives who actively participate in decision-making committees. These representatives play a crucial role in conveying committee decisions directly to their fellow trainees and gathering feedback from the trainee community.

Social Media Presence: The RACP uses the RACP Online Community (ROC) and other social media platforms to share updates, educational content, and relevant news with trainees. This provides additional channels for communication and community building.

Regional Committees and Networks: Trainees can connect with regional committees and networks, fostering a sense of community. The RACP often organises events and initiatives to address the specific needs and concerns of trainees in different regions.

Helpline and Support Services: The RACP provides helpline and support services to assist trainees with any challenges they may encounter during their training. This includes guidance on policies, procedural queries, and general support.

Welcome packs: Trainees receive welcome information upon commencement of their first approved Basic or Advanced Training rotation. This includes important administrative and support information that trainees need to be aware of throughout their training journey.

Trainee representative involvement in communication

The CTC are included in the review process of communications relating to training matters prior to release. The CTC has provided feedback and advice to other Board Committees and College teams on a range of topics that affect trainees including:

- Examinations
- Member Journey Mapping
- College Learning Series
- Education Renewal Program
- Training Provider Standards
- Trainee/training fees
- Trainee Wellbeing
- Special Consideration for Assessment Policy
- Governance Review.

We are actively working with the College Trainees' Committee (CTC) to improve the style and tone of voice and the relevance of our communications. The capacity for members of the Trainees' Committees to provide information to trainees in their jurisdiction is facilitated via The ROC (see above), webinars, social media groups, communiques, and access to relevant contact information through our Regional Offices.

Information about training programs (7.3.2)

As outlined in a range of other standards, all training program information is shared with trainees on the RACP website. The College's Marketing and Communications team supports the development of clear and accessible information about our programs, which is further enhanced through review by trainee representatives.

All changes to training programs and policies are consulted on with stakeholders, as outlined in Standard 1.2. Eventuating changes to training programs are communicated following an approved communications plan, which includes mapping of stakeholders, development of key messages, approval of associated collateral and consultation with a range of business units and stakeholders.

We choose communication methods based on the extent of the change, who it impacts and nature of the call to action. We have recently developed a more granular member segmentation framework that will facilitate better targeted communications with trainees.

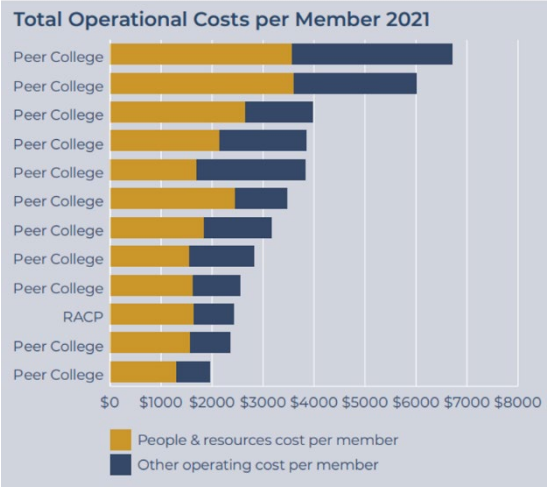
As a large and complex College with numerous training programs, our College website is large and at times can be difficult to navigate. In recognition of this, in 2024, we'll be working to comprehensively improve our website.

Information about the costs of training

The RACP's website provides accurate and up-to-date information on fees related to training, examination, Fellowship and membership (Appendix 7A.9). Terms and conditions are provided for all fees (Appendix 7A.10). Any changes in fees are communicated to affected members via direct email and posted on the ROC.

The College is committed to ensuring that costs associated with training and education align with the principles of the National Registration and Accreditation Scheme (NRAS) and are not prohibitive for potential trainees. Fees and costs associated with training are regularly reviewed to ensure they remain equitable. We benchmark our fees and charges against peer Colleges (Appendix 1A.52) every year and our analysis shows that our annual subscriptions remain lower than most Colleges. Our examination fees are lower than our peers, but our training fees are towards the upper end of the range, reflecting the complexity of our training pathways. Relative to other specialist medical colleges in Australia and Aotearoa New Zealand, the RACP has the third lowest total operating cost per member of any College the RACP was able to obtain data on, as shown in Figure 86.

Figure 86. Total operational costs per Member, 2021



In 2022, when other Colleges increased their fees on average by five percent, the RACP did not increase fees. Over the last decade, we have also consistently held fee increases below Education CPI. In 2023, the RACP announced its decision to increase fees by six percent for both trainees and Fellows for the 2024 year. This change in fees was communicated to trainees via direct email from the RACP President, after consultation with the CTC on how best to approach this. The communication included the rationale for change and for members who may be experiencing financial difficulties, the support options available. In addition, the RACP's website was updated and FAQs provided.

We discuss fee support in Standard 7.3.4.

To improve transparency on how training fees are spent, we have developed an infographic for Basic Trainees (Appendix 7A.11) and are currently developing an infographic for Advanced Trainees, which sets out how their fees are being utilised. These infographics will be updated each year.

Communication with prospective trainees

The RACP has established a strategic communication approach to engage and inform prospective trainees. We maintain a strong online presence through our website and social media platforms to ensure prospective trainees can access comprehensive information about training programs, admission requirements, fees and the benefits of RACP membership. Clear and concise documentation outlining the pathways to becoming a trainee is also available on our website. This includes detailed information about eligibility criteria, application processes, and timelines.

Information Sessions and Webinars to provide prospective trainees with an in-depth understanding of the training programs are also run by our Regional Offices and Aotearoa New Zealand team and cover topics such as curriculum, assessments, and opportunities for specialisation.

In addition to this, prospective trainees have access to the RACP contact centre via email, webchat or phone, where they can seek clarification on queries related to the application process, training pathways, or any other concerns.

By combining these elements, the RACP aims to ensure that prospective trainees receive accurate, accessible, and engaging information about the training programs, ultimately facilitating informed decisions and a positive experience for those considering training with the RACP.

Information about training status and progression (7.3.3)

The RACP aims to provide trainees with a clear understanding of their training status and progression through completion of requirements. The emphasis is on regular communication, feedback mechanisms, and accessible resources to support trainees in successfully navigating their training journey. Trainees have access to the MyRACP portal, an online platform that serves as a hub for information related to their training. The Basic, Advanced and Faculty Portals enable trainees to access information on demand regarding their individual training status and progression through requirements. Each trainee and supervisor has a log in through which they can access records for their current year of training, as well as prior rotations. The College also provides comprehensive training handbooks that outline the requirements for each stage of training on our website. These documents serve as a reference for trainees to understand the expectations, assessment processes, and progression criteria.

Future directions for communication

The College is currently undertaking a technology project to centralise training information in a portal which includes personalised dashboards displaying training progress, completion requirements, and any outstanding tasks.

Our Training Management Platform (as discussed in Standard 1.1) will also provide enhanced technology-solutions to allows trainees and their supervisors to clearly track training progression.

We have also commenced with implementing our Trainee Enquiry Response and Resolution Improvement initiative which will expand the enquiry handling framework used by the RACP's centralised Contact Centre into all areas of the College, starting with our Training Services team. This Business Process Improvement initiative will establish service level agreements that we will be actively monitored and continuously improved in partnership with the RACP Member Services team.

7.4 Trainee wellbeing

AMC accreditation standards	
7.4.1	The education provider promotes strategies to enable a supportive learning environment.
7.4.2	The education provider collaborates with other stakeholders, especially employers, to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training. It publishes information on the services available.

Supportive learning environments (7.4.1-7.4.2)

The College provides a range of complementary initiatives aimed at ensuring learning environments are supportive. We recognise there are cultural issues in medicine and physician training, and that the RACP has a key role to play in effecting positive cultural change and we are also looking to collaborate to achieve systematic change across the sector. We outline these RACP-specific and cross-sector activities below.

Member Health and Wellbeing Strategic Plan

Member Health and Wellbeing remains a key focus for the College, aligning with the College's 2022-2026 Strategic Plan's commitment to 'Lifting member health and wellbeing' under Focus Area 2: Member experience and belonging.

The Member Health and Wellbeing Strategic Plan 2023-2026 (Appendix 7A.12) was developed by the Member Health and Wellbeing Committee (MHWC) with the vision that all RACP members flourish and achieve their full potential in all aspects of life.

The Strategic Plan is founded on four guiding principles:

1. Wellbeing of members is essential in all stages of their careers and lives
2. Individuals, our College, and practice environments have a collective responsibility for member wellbeing
3. Wellbeing must be embedded into all College activities and culture and modelled by leadership
4. Our College will advocate for and enable evidence-based practices to promote wellbeing.

The Plan is organised into four focus areas, each with key priorities to guide the delivery of wellbeing initiatives for RACP members over the next four years. Figure 87 provides a summary of the strategy.

Figure 87. Summary visual of Member Health and Wellbeing Strategic Plan 2023-2026

Focus area 1 | Empower members

We empower and equip members to take control of their health and wellbeing.

Our priorities:

- enable and promote wellbeing and resilience
- normalise self-care and wellbeing
- identify and mitigate barriers that prevent self-care.

Focus area 2 | Educate and Advocate

We educate members on wellbeing and self-care, raise awareness of mental distress and challenge stigma.

Our priorities:

- educate members on wellbeing and self-care as a core competency
- promote help-seeking behaviour
- collaborate with College stakeholders to advocate for and promote safe, equitable, and inclusive working environments.

Focus area 3 | Innovate and Develop

We identify, facilitate access, and develop innovative wellbeing programs for our members.

Our priorities:

- promote innovative and successful activities
- develop evidence-based resources based on member needs
- identify and mitigate the adverse impact of College systems on wellbeing
- facilitate access to support services.

Focus area 4 | Evaluate

We evaluate the impact of our health and wellbeing initiatives.

Our priorities:

- commit to continuous improvement of wellbeing initiatives
- encourage ongoing feedback from members.

The MHWC is working on initiatives outlined in the Strategic Plan. These include the following:

- developing a Member Wellbeing Framework that will include a wellbeing navigation tool and assist members in navigating the College's wellbeing resources as well as those of external organisations
- developing an internal member wellbeing campaign
- creating a wellbeing podcast series on the topic of wellbeing as part of Pomegranate Health, the RACP podcast
- improving the communications sent to candidates before and after examination dates, and developing various resources to upskill supervisors in supporting trainee wellbeing. These activities are specifically aimed at supporting trainee wellbeing
- facilitating access to a range of wellbeing services geared to supporting time-poor trainee and consultant physicians
- developing an Evaluation Plan to assess the efficacy of the overall Member Health and Wellbeing Strategic Plan 2023-2026, and to inform the next iteration, from 2027 onwards.

In 2024, the MHWC will advance the development or completion of the above initiatives, and further investigate the progress of a Wellbeing Champions initiative, including the facilitation of a network of established Wellbeing Champions.

It is noted that there is a strong correlation between wellbeing, gender equity, diversity, and inclusion, therefore collaboration across College bodies is essential. This collaborative approach will assist with promoting and advocating for safe, inclusive, and equitable physician working environments.

Gender Equity in Medicine and Membership Diversity and Inclusion Action Plans

In 2024, two multi-year action plans were developed to work towards a more inclusive College. The first, the Gender Equity in Medicine Action Plan 2023-2026 is based on recommendations from the Gender Equity in Medicine Working Group (GEMWG) Report (Appendix 3A.32).

The report sets out six recommendations for implementation to better support gender equity in medicine:

1. Gender equity in medicine is a strategic priority for the College
2. Gender representation and equity on College bodies and College leadership is prioritised.
3. The College is an active advocate for gender equity in medicine
4. College policies reflect the Gender Equity in Medicine Principles
5. The College is an active supporter of gender equity in medicine activity through external partnerships

6. The College establishes a Gender Equity in Medicine College Body to implement the GEM Action Plan and drive member engagement.

The second action plan is the Membership Diversity and Inclusion Action Plan 2023-2026. This body of work marks the beginning of a College-wide journey to advance diversity and inclusion in all College activities. It sets the direction the College will take to recognise the diversity of our membership and work towards a more inclusive physician culture and environment. The high-level actions are outlined below:

1. Diversity, equity and inclusion are strategic priority areas for the College
2. Diverse representation and equity on College bodies and College leadership is prioritised
3. The College is an active advocate for equity, diversity, and inclusion in medicine
4. College policies reflect the Diversity and Inclusion vision and principles
5. The College is an active supporter of diversity and inclusion activity through external partnerships
6. The College establishes a DEI Reference Group to enable member engagement and assist the implementation of the Diversity and Inclusion Roadmap Action Plan.

The Membership Diversity and Inclusion Action Plan was approved by the Board in December 2023. It will be transposed into a published version in Q1, 2024.

Safe Training Environments

Reports from Members, gathered through activities such as the Physician Training Survey and Medical Training Survey (MTS) (refer to Standard 6.2), indicate bullying, harassment, discrimination, and uncivil behaviours are significant issues within medicine. Roughly one in every five RACP trainees who responded to the Medical Training Survey each year since its inception have experienced these behaviours. The data shows that not all events are being reported and, concerningly, those that are reported are not always addressed. A further concern is the data shows that doctors are the main perpetrators of bullying, harassment, and discrimination.

The Safe Training Environments Summit on 5 November 2021 brought together members of the College Education Committee (CEC), College Trainees' Committee (CTC), and invited guests to collaborate and agree a strategic approach to tackling bullying, harassment, and discrimination in training environments.

Summit participants:

- explored bullying, harassment, and discrimination in the training environment, including discussion of root causes and high-level strategies to address these
- heard from Dr Sally Langley, President of the Royal Australasian College of Surgeons (RACS) on RACS' approach to dealing with bullying, harassment, and discrimination in surgical training programs
- developed a leadership statement from the CEC and CTC including next steps and areas for strategic actions
- prioritised key strategic areas for action.

Through the Summit, the CEC and CTC have co-developed a Leadership Statement on Safe Training Environments:

Leadership Statement on Safe Training Environments

The RACP ethos holds that respect and care for our patients and colleagues is our primary goal and thus of the utmost importance.

The RACP has an unambiguous responsibility to lead, promote, and empower Members in delivering safe patient care and facilitating positive learning and work environments.

Reports from our Members indicate that bullying, harassment, discrimination, and uncivil behaviours are significant issues within medicine. Hostile interactions in training and work environments may negatively impact safe patient care, lead to psychological stress and inhibit learning.

Physicians have a critical leadership role in setting the tone and behaviour of healthcare teams to foster respectful behaviour and attitudes. We all need to work together to create safe work and training environments.

A summary report was produced and shared following the Summit and work has been progressing to develop a Strategic Action Plan (Appendix 7A.13).

A comprehensive draft Action Plan was developed over 2022 and 2023, taking into consideration a broad environmental scan undertaken by the College and the different legislative and regulatory frameworks in which specialist medical Colleges operate. The Action Plan was presented to and approved by the Board in December 2023, and an implementation plan is now in development to finalise allocation of work streams across the College, required resourcing and an implementation schedule. An extract of the plan is attached in Appendix 7A.14.

We are working closely with training settings to monitor and act on localised reports of unprofessional behaviours in training environments. We are doing this through two mechanisms:

1. Our follow up process regarding training setting specific results from the Medical Training Survey- refer to Standard 6.3.1 for a full description of this process. The process includes acting on data related to trainee accounts of experiencing or witnessing bullying, harassment, racism and/or discrimination. Educational leaders and training setting executives are asked to respond to concerning data with actions they are taking to address the concerns. This process is integrated with our Monitoring a Training Provider processes, as outlined in Standards 8.2.1-8.2.2.
2. As also outlined in Standard 8.2.1-8.2.2, we have implemented a new process that requires training settings to proactively report to the RACP on any complaints regarding bullying, harassment, racism and/or discrimination. Concerns that arise through this form are managed through the Monitoring a Training Provider processes.

The sections below provide details about other activities that also contribute to the achievement of safe training environments. We are also contributing to the RACMA-led initiative, A Better Culture. In the first instance, this has been through an environmental scan.

Training Provider Accreditation Program

Our training provider accreditation program is outlined in detail in Standard 8.2. This program is based on the College's Training Provider Accreditation Standards (Appendix 7A.15). These standards cover a range of areas that combine to specify expectations for supportive learning environments. Examples include:

- **Standard 1.4-** Trainee and educator work arrangements enables the delivery of high-quality care and optimises learning and wellbeing.
- **Standard 2.2-** The training provider seeks and responds to concerns about training from trainees and educators.
- **Standard 2.3-** The setting has a learning environment and culture which values, supports and delivers equitable physician training.
- **Standard 2.4-** The setting provides a safe, respectful learning environment and addresses any behaviour that undermines self and/or professional confidence as soon as it is evident.

Compliance with these standards is monitored through the Training Provider Accreditation Program, with pathways for raising concerns outlined in Standard 8.2.1.

Supervisor training

Standard 8 describes the roles, responsibilities, criteria and training for those fulfilling educational leadership and supervision functions in College training programs. The SPDP is the key training program offered as part of this and includes a range of content on supportive learning environments.

The topic for the second SPDP module, SPDP2, is *Learning Environment and Culture*. It provides a range of teaching strategies to manage and overcome challenges supervisors face in a complex healthcare setting. These strategies include planning for learning, differentiated instructions for multi-level groups, and using teaching techniques such as questioning. The module explores some cultural aspects that may impact on learning, including the hidden curriculum, tribalism and the need for effective role modelling.

Specifically, the learning objectives are:

- understand how to establish an effective learning environment
- recognise the importance of planning for learning
- define and model professional behaviour
- optimise opportunities for learning.

Respectful behaviour in College training programs

The RACP expects that its Fellows and trainees will observe and maintain the highest possible standards of behaviour and ethics and treat all Fellows and trainees of the RACP community with fairness, dignity, and respect. Bullying and harassment is not acceptable to the RACP. This conduct can be unlawful and also contravenes the standards of conduct required of members of the RACP under the Code of Conduct (Appendix 7A.16).

The College's Statement on Respectful Behaviour in College Training Programs articulates expectations for behaviours and outlines steps members can take if they feel they have been bullied or harassed (Appendix 7A.17).

Pathways for raising concerns and accessing support

We have a range of mechanisms that can be used to raise concerns and seek support, some of which are confidential.

RACP Support Program- a free 24/7, fully confidential and independent help line offering counselling, coaching and support for work and personal issues. RACP partners with Converge International to provide this support to Members.

Potential Breach of Training Provider Standards Process- as outlined in Standard 8.2, this can be used anonymously to raise concerns about a potential breach of the RACP's Training Provider Standards.

Since its introduction in 2022, seven concerns have been raised via this pathway.

Training Support Pathway- as outlined in Standard 5, this pathway provides enhanced support for trainees and/or supervisors experiencing difficulties in training.

Data on use of the Training Support Pathway is provided in Standard 5.

Wellbeing resources- a range of resources and information, including:

Pomegranate Health podcast episodes:

- Setting the standard for workforce wellbeing, newly released September 2023
- Loving Medicine again, 6700 downloads over 1 year 6 months
- Coming back from burnout, 6400 over 1 year 7 months
- Medical Injury, Part 1, 8500 downloads over 2 years 2 months
- Medical Injury, Part 2, 8100 downloads over 2 years 3 months.

The following episodes are older than three years and each have between 10,000 and 12,000 downloads:

- Making a connection
- Being human
- Transitions to Fellowship
- Transitions to retirement
- Physician health thyself.

Self-paced online courses-

- Creating a safe workplace- A self-paced online course designed to improve workplace behaviour by raising awareness and encouraging all physicians to report undesirable behaviour. It helps physicians determine the resources available and appropriate steps for preventing and dealing with bullying and sexual harassment. This course is currently being

reviewed and expanded in collaboration with a reference group of members. To date, 395 users have enrolled in this course (Appendix 7A.18).

- Physician Self-Care and Wellbeing- This resource helps physicians adopt pro-active strategies so they can aim to thrive in their work and help others to do the same. To date, 300 users have enrolled in this course (Appendix 7A.19).
- Physician Wellbeing in Challenging Times- Learn how to better support your own wellbeing, as well as the wellbeing of your staff and colleagues, during times of challenge or crisis. To date, 245 users have enrolled in this course (Appendix 7A.20).

Curated collections- These learning resource guides are based on the contributions and peer review of RACP Fellows and other experts. Each guide presents the most relevant key readings, courses, web resources and tools on a specific topic.

- Creating a safe workplace- 67 users have enrolled to use this collection (Appendix 7A.21).
- Doctors' Health and Wellbeing- 555 users have enrolled to use this collection (Appendix 7A.22).

Trainee perspectives on pathways for raising concerns

Data from the 2023 Medical Training Survey indicates that RACP trainees in Australia are less likely to agree that there are safe mechanisms for raising training/wellbeing concerns with the College, than the national average (RACP 33% versus national average of 52%). While we don't have comparative data for RACP trainees in Aotearoa New Zealand, it is not unreasonable to assume they have similar perceptions.

The RACP acknowledges that there is significant work to be done to improve safe mechanisms to raise concerns and awareness of these. We believe that progressing our work in regard to our Member Health and Wellbeing Strategy, Training Provider Accreditation Program and Safe Training Environments Action Plan will enable the College to see strong improvement in this sentiment.

Fee support

We offer flexible payment plans and other financial hardship assistance, such as exemptions and reduction to fees, to ease the financial burden for trainees. For example, the College offers trainees involved in research a 50% discount on their annual training fees, in recognition of the significant income disparities between trainees in research-based employment and trainees in clinically-based employment.

The Fee Reimbursement Initiative aims to provide equitable access for our Indigenous doctors who wish to specialise as physicians. We also offer scholarships and grants for Indigenous trainees. Refer to 7.1.3 for an update on these.

7.5 Resolution of training problems and disputes

AMC accreditation standards	
7.5.1	The education provider supports trainees in addressing problems with training supervision and requirements, and other professional issues. The education provider's processes are transparent and timely, and safe and confidential for trainees.
7.5.2	The education provider has clear impartial pathways for timely resolution of professional and/or training-related disputes between trainees and supervisors or trainees and the education provider.

Resolving training and supervision issues (7.5.1-7.5.2)

The RACP has implemented a range of support services, professional development initiatives, and training accommodations to facilitate trainee wellbeing, learning needs, and progression through their training pathways. The goal is to be responsive to trainee challenges and foster successful physician training experiences. Within the Education, Learning and Assessment directorate, the Training Support Unit prioritises wellbeing and support for trainees and supervisors in progression

through training. Personalised assistance, through the Training Support Pathway (TSP), provides individually tailored resources, assistance in navigating the process and reporting on progression to training committees.

The TSP has been available to trainees since 2012. It can be used for a range of circumstances, including for issues encountered in the trainee/supervisor relationship. The pathway is comprehensively outlined in Standard 5.

As outlined in Standard 1.3.2, the RACP's Complaint Management Policy and Procedure (Appendix 1A.50) makes provision for the management of anonymous complaints regarding College services and notes the course of action taken is dependent on the information that has been provided by the complainant. An internal review of the Complaints Policy and Procedure is in train and is anticipated to result in identifying a Complaints Officer in the Member Services team to centrally monitor conformance with the policy and timely resolution of complaints across the College's operations.

As outlined in Standard 1.3.1 and Standard 1.3.2, the RACP's Reconsideration, Review and Appeals Process By-law (Appendix 1A.45) provides an internal process for the reassessment of specified decisions made by College Bodies; and a process to Appeal Termination of Membership Decisions.

As outlined in Standard 8.2, the RACP's Potential Breach of Training Provider Standards Process was launched in 2022 and provides a mechanism to raise concerns about a potential breach of the RACP's Training Provider Standards.

Through the Training Services team, trainees are able to directly contact their supervising committee and or the trainee representative on the committee for guidance and support with training issues.

Summary of Standard 7

Strengths and key developments

- selection into Training policy that sets out principles for selection into RACP training, defines the roles and responsibilities in selection of trainees and outlines the eligibility criteria for selection
- comprehensive Trainee Selection and Recruitment Guide that supports good practice in selection by highlighting College standards and expectations for selection into training
- revision of current Selection into Training Policy to ensure that the policy supports selection outcomes and experiences that are aligned to the RACP's current strategic objectives related to progressing Indigenous equity and entry into training and gender equity objectives
- successful pilot implementation of a Situational Judgment Test (SJT) for entry into Basic Physician Training in 2022
- a suite of initiatives to support the increased selection and retention of Aboriginal and Torres Strait Islander and/or Māori trainees in physician training programs
- a network of trainees' committees, that provide the voice of trainees
- established online community for our membership launched in 2021, to help foster communication between members, including trainees
- a multi-faceted approach to communication, combining online platforms, face-to-face interactions, feedback mechanisms and support services to create a comprehensive and supportive environment for trainees
- launch of the Member Health and Wellbeing Strategic Plan 2023-2026
- robust Training Support Pathway that can be used for a range of circumstances, including for issues encountered in the trainee/supervisor relationship.

Current and future focus areas

- completing the revision of the Selection into Training Policy and implementing the changes
- developing an expanded roadmap for improving selection into training, particularly in regards to Advanced Training
- improving the RACP's ability to monitor selection into training through activities such as a prototype of a "pre application" database
- improving communication and support for trainees and their supervisors through expanded use of technology
- finalising and implementing the Strategic Action Plan to support Safe Training Environments.

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

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

8.1 Supervisory and education roles

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

The RACP's system of supervision (8.1.1)

As a vocational training program, supervision is core to implementation of the RACP's training programs. Leadership, guidance, support, assessment and education are all essential for a trainee to be equipped with the tools necessary for successful physician practice. The RACP has two key documents that articulate its overarching system of supervision- the Education Leadership and Supervision Policy (Appendix 1A.23) and the Educational Leadership and Supervision Framework (Appendix 1A.24). Together, these inform our program-specific supervision requirements, eligibility and selection criteria, competencies, roles and responsibilities and appointment processes. They are referred to within our Accreditation Standards and monitored through our Training Provider Accreditation Program (refer to Standard 8.2) and broader evaluation programs (refer to Standard 6.2)

Education Leadership and Supervision Policy

The Education Leadership and Supervision Policy defines educational leadership and supervision in the context of RACP training programs and describes key principles which underpin these activities. It applies to all supervisory and educational leadership roles and responsibilities, carried out under College auspices and with College support. The aim of this policy is to foster excellence in educational leadership and supervision across all RACP training programs and to ensure that learning environments are appropriately resourced to enable delivery of continuous, progressive, dynamic learning.

The policy specifies the four principles of education leadership and supervision, namely:

Quality and safety

Safe and effective patient care is essential during supervision interactions with trainees, ensuring the health, wellbeing and safety of both patients and trainees at all times. Ongoing evaluation and quality improvement activities are important in the delivery of a high-quality training experience.

Learning environment and culture

An effective learning environment is safe, supportive and recognises the importance of culture and equality, ethics and professionalism.

Teaching and facilitating learning

Trainee learning is best facilitated through a wide variety of work-based learning opportunities aligned to identified learning outcomes, educational techniques and tools, research opportunities (where relevant), timely and constructive feedback and self-reflection.

Learning is enhanced through active monitoring of progress towards achievement of identified goals, targeted support, and evidence-based assessment and reporting.

Reflections on teaching and learning approaches are valuable in informing quality improvement activities.

Educational leadership and management

Effective planning and management of the training program and active support for the implementation of College change initiatives is critical to maintaining a high-quality training experience.

Modelling of exemplary professional behaviours by those involved in educational leadership and supervision enables delivery of a high-quality training experience.

Framework for Educational Leadership and Supervision

The purpose of this framework (Appendix 1A.24) is to drive excellence in medical education and optimise physician trainee outcomes. This framework outlines the critical elements to meet best practice standards for educational leadership and supervision while allowing flexibility and refinement for local implementation. The document covers four sections:

1. *The roles and structure of educational leadership and supervision*

   A flexible role structure which outlines core functions, roles and responsibilities of Educational Leaders and Supervisors in the context of the RACP training program. This includes time allocations recommended by the College for educational leaders and a supervisor: trainee ratio for Educational Supervisors in Basic Training. This section is explained in more detail in Standard 8.1.2.

2. *The RACP Standards for Educational Leadership and Supervision.*

   A framework outlining the expected standards, behaviours, skills and knowledge required for excellent educational leadership and supervision. This section is explained in more detail below.

3. *Accreditation, selection and appointment.*

   The selection process and eligibility criteria for newly appointed Educational Leaders and Supervisors. Accreditation upon completion of the Supervisor Professional Development Program. This section is explained in more detail in Standard 8.1.3.

4. *Evaluating the effectiveness of educational leadership and supervision.*

   Tools and guidance to support the monitoring and evaluation of training programs, and supervisor effectiveness. This section is explained in more detail in Standard 8.1.4.

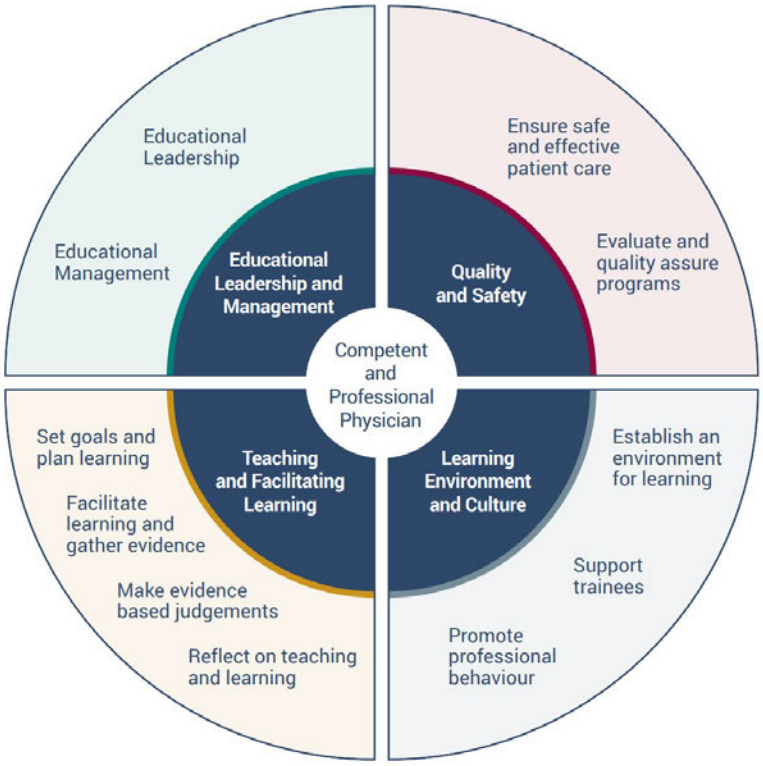
Standards for Educational Leadership and Supervision

The RACP Standards for Educational Leadership and Supervision have been developed to provide clarity about expectations, drive excellence and establish a consistent and transparent approach to providing quality supervision. Four domains have been identified as being key to achieving excellence in the supervision of College trainees with associated foundation, intermediate and advance competencies specified for each of these, as summarised in Figure 88.

The College encourages supervisors and Training Program Directors to use the standards as a self-assessment tool for their own supervisory practice, and to identify areas for targeted learning

and professional development. Many of the skills and competencies outlined in the standards can be developed by completing the Supervisor Professional Development Program. The College also has a variety of related self-paced online courses and e-learning modules. Refer to Standard 8.1.3 for a description of training, development and support for supervisors.

Figure 88. RACP standards for educational leadership and supervision



Mentoring

For trainees that would like a mentor, the College provides a Mentor Match program. This allows mentees and mentors to register their interest in being involved in the program and then being matched into a mentor/mentee relationship. We provide FAQs to members regarding this program (Appendix 8A.1).

Public Health Medicine is the only training program that has mandated and formalised the role of a mentor. This formal mentoring role is to guide the overall professional development of a trainee as they move through training.

Responsibilities of supervisors (8.1.2)

There are two overarching roles in relation to RACP programs, as defined in the RACP Education Leadership and Supervision Policy:

1. **Education leadership**- the provision of oversight for the delivery of RACP training programs, including the planning, implementation, management and advocacy for resources, in accordance with College policies and requirements. Educational leadership aims to ensure delivery of a high-quality training experience and facilitate the achievement of training program objectives. RACP educational leadership roles include but are not limited to Network Directors of Training, Regional Program Directors, Training Program Directors, and Deputy Training Program Directors.
2. **Educational supervision**- the provision of oversight, including guidance, assessment, feedback and support in the context of each trainee's educational experience. Educational supervision aims to enable the trainee to progress towards successful completion of the training program and deliver safe, appropriate and high-quality medical care. RACP

education supervisory roles include but are not limited to Educational Supervisors, Rotational Supervisors, Assistant Supervisors, and Advanced Training Supervisors.

Basic Training

In Basic Training, the required College roles are summarised in Table 43, as outlined in the Framework for Educational Leadership and Supervision. The RACP also acknowledges others may contribute to the teaching and learning of RACP trainees, including clinical line managers, interprofessional disciplines and health care consumers and their families and carers.

Table 39. Required College roles in Basic Training programs

Required College roles in Basic Training		
Role	Function	Role summary
Network Director (where a network exists) (also known as a Network Director of Physician / Paediatrics Education)	Educational leadership and oversight of the network training program (where a network exists)	Provides educational leadership across a network of training settings. Responsible for coordinating the delivery of a Basic Training Program (in the first instance, with a view towards all training programs) across all settings within a network to ensure the standards of training are of the highest quality. This includes establishing appropriate systems to support a supportive training culture. As the College moves towards a network training structure, it is anticipated that this role will be a requirement across Australia and New Zealand.
Training Program Director (also known as Director of Physician / Paediatrics Education)	Educational leadership and oversight of training program delivery	Provides educational leadership within a training site. Responsible for planning, implementing, managing and advocating for the RACP Training Program in accordance with College training requirements. May be part of a networked training program.
Educational Supervisor	Oversight of longitudinal progression	Oversees and monitors the longitudinal progress of a trainee. Responsibilities include assisting trainees to plan learning, providing timely feedback on progress and assembling the evidence of progression to make summative progress decisions and mid/end of year progress reports.
Rotation Supervisor (also known as a Ward / Service Consultant)	Oversight of trainee teaching, learning and assessment on a rotation	Provides direct oversight of trainees during a rotation. Responsibilities include assisting trainees to plan teaching opportunities for the rotation, conducting work-based assessments, providing feedback and completing rotation reports.
Recognised, but not required roles		
Deputy Training Program Director (also known as Deputy Director of Physician / Paediatrics Education	Support oversight of training delivery at one setting	Supports the Training Program Director with the planning, implementation and management of the Training Program.
Assistant Supervisor	Support trainee teaching and learning	Supports Rotation Supervisors by providing direct oversight of trainees, additional guidance, assessment and feedback, and facilitating teaching and learning opportunities.

For recognised, but not required, Basic Training roles, there is no position description, formal selection and appointment process required from the College.

The Framework further specifies guidance on the time allocations for these roles, as shown in Figure 89. Our Capacity to Train Guidance, discussed in Standard 8.2 supports training settings to consider the impacts of these time allocations on a setting's capacity to train.

Figure 89. Guidance for time allocations for Basic Training roles

Network Director (also known as Network Director of Physician/Paediatrics Education)	
Trainees per network	FTE
>90	0.7 (may be a shared role)
75-90	0.6 (may be a shared role)
50-74	0.5
30-49	0.4
<30	0.2
Training Program Director (also known as Director of Physician/Paediatrics Education)	
Number of trainees	FTE
• 5-20 trainees OR • Multiple sites in a metro area with less than five trainees	0.1 – 0.2
• 20+ trainees OR • Multiple sites in rural or regional areas	0.2 – 0.3
Educational Supervisor	
• Recommended maximum ratio between Educational Supervisors and trainees	1 supervisor per maximum 10 trainees* **It is recognised that managing a trainee in difficulty can require more time. A supervisor in this instance should be allocated fewer trainees and not the maximum number.*

Advanced Training

Advanced Trainees must have a nominated supervisor who is an experienced physician qualified in their specialty. The primary role of advanced training supervisors is to provide direct oversight and guidance of individual Advanced Trainee teaching, learning, assessment and welfare during a rotation.

The required College roles for Advanced Training are summarised in Table 44, as outlined in the Framework for Educational Leadership and Supervision

Table 40. Required College role in Advanced Training programs

Role	Function	Role summary
Advanced Training Supervisor	Direct observation and oversight of individual trainee teaching, learning and assessment	Provides direct oversight of Advanced Trainees including guidance, assessment, feedback and support in the context of each trainee's experience. Responsible for: 1. Facilitating teaching and learning opportunities, and conducting work-based assessments. 2. Assisting trainees to plan learning for the rotation. 3. Overseeing progression and providing additional support for trainees who are not on track. 4. Transferring information about trainee progress to the next supervisor and evaluating the rotation.

The Framework further specifies requirements that supervisors must adhere to, covering aspects such as maintaining appropriate oversight, being readily available in person or by phone, and escalating concerns. The detailed responsibilities for this role, including RACP reporting lines, eligibility criteria and the selection process is in Table 45.

Table 41. Role overview – Advanced Training Supervisors (Divisions, Faculties and Chapters)

Role purpose	• To provide direct oversight of individual Advanced Trainee teaching, learning, assessment and welfare during a rotation.
Key responsibilities	• Directly observe the trainee and conduct work-based assessments throughout the rotation. • Provide feedback to the trainee about progression. • Complete supervisor reports.
Nominated by	• Training Program Director, Head of Department or Trainee.
Approved by	• Advanced Training Committee via approval of prospective approval application.
College reporting line	• Training Program Director, if applicable. • Relevant Training Committee (Advanced Training Committee or Faculty Training Committee).
Role description	
Manage the learning and development of trainees	• **Plan learning** in collaboration with the trainee, including identifying goals and developing a personal learning plan. • **Facilitate teaching and learning** opportunities, including direct observation of trainees. • **Observe trainee practice** through completing work-based assessments with the trainee where possible. • **Meet regularly with the trainee** (at least twice a year) to review and monitor their progress and professional development. • **Deliver regular feedback** to the trainee on performance and progression. Contact with trainees can take place face-to-face or remotely. • **Review and monitor** trainee performance against the training program curricula and requirements, and the trainee's learning goals and objectives; adjust the learning plan as appropriate. • **Facilitate development** of clinical and non-clinical professional qualities, skills and competencies outlined in the curriculum. • **Draw on evidence of learning** and achievement to assess overall performance against the curricula and training program requirements, and complete assessment reports. • **Motivate trainees** to reflect on non-clinical skills identified in the Professional Qualities Curriculum.
Support trainees and collaborate with other supervisors	• **Identify, support and manage trainees in difficulty** in accordance with the RACP Training Support Policy and Pathway. • **Work closely and communicate regularly** with other supervisors to support trainees to complete the requirements of the Training Program. • **Advocate for College standards** within the training setting and demonstrate a commitment to maintaining professional standards.

Supervisor credentialling, training and support (8.1.3)

The College's Educational Leadership and Supervision Framework (Appendix 1A.24), along with the Supervisor Professional Development Program (SPDP) are the primary methods of ensuring compliance of supervision standards.

Supervisor training, development and support

The RACP has committed to creating a comprehensive training and support system for supervisors that includes workshops, events, easily accessible resources and assistance from College staff experts. Key elements of this integrated supervisor training and support system include:

- professional development workshops to build core supervision competencies
- networking events and discussion forums to share experiences and strategies
- online repositories of tools, templates, and guidance documents
- a dedicated team to answer supervision inquiries and provide advice
- ongoing communications to update on new developments
- opportunities for mentoring and skill refinement.

The SPDP was designed, developed and implemented between 2012-2016 using Curriculum Standards for Supervision as a foundation. SPDP is based on 'Teaching on the Run' and is comprised of three workshops. Prior to each workshop's implementation, pilot workshops were

held across multiple sites where feedback was collected and enhancements to each workshop were made. Implementation of each workshop was staggered to allow for the collection of data and improvements to be made prior to each workshop's complete rollout.

Supervisors that wish to attend an SPDP, register on the RACP Website. The website is kept up to date with available SPDP workshops. A video outlining why SPDP is important is available here.

The three SPDP modules are outlined below. Post workshop reading by SPDP modules are updated our website to ensure the program remains relevant and useful for RACP supervisors.

SPDP 1 Educational Leadership and Management	Educational and leadership management incorporates the overarching themes of developing trainee expertise and using coaching techniques to improve feedback practice. This workshop focuses on delivering feedback using two frameworks, the GROW model and the four areas of feedback. By using these models, supervisors can facilitate change and growth in trainees towards expert performance. As supervision in Occupational and Environmental Medicine and Public Health Medicine is different to other specialties, the AFOEM/AFPHM SPDP 1 module has been tailored. **Objectives** • Demonstrate strong educational leadership. • Plan and manage for effective supervision. • Advocate for enhanced support for trainees. • Self-reflect on supervisory performance.
SPDP 2 Learning Environment and Culture	Learning environment and culture provides a range of teaching strategies to manage and overcome challenges supervisors face in a complex healthcare setting. These strategies include planning for learning, differentiated instructions for multi-level groups, and using teaching techniques such as questioning. This workshop explores some cultural aspects that may impact on learning, including the hidden curriculum, tribalism and the need for effective role modelling. As supervision in Occupational and Environmental Medicine and Public Health Medicine is different to other specialties, the AFOEM/AFPHM SPDP 2 module has been tailored. **Objectives** • Understand how to establish an effective learning environment. • Recognise the importance of planning for learning. • Define and model professional behaviour. • Optimise opportunities for learning.
SPDP 3 Teaching and Facilitating Learning for Safe Practice	Teaching and facilitating learning for safe practice is a complex and necessary part of physician training. The challenges of undertaking work-based learning and assessment along with the complexities of the healthcare environment are many and varied. This workshop offers techniques and solutions to these challenges that will help supervisors in their vital role. As supervision in Public Health Medicine (PHM) is different, the PHM SPDP 3 module has been tailored. **Objectives** • Use safe and effective work-based assessments/activities to guide learning. • Make evidence-based assessment on trainee performance. • Use evidence-based tools to improve supervisory practice.

Each SPDP workshop is delivered by an SPDP Facilitator; usually two. Facilitators attend a three hour face-to-face or virtual training workshop which is run by an experienced facilitator. These workshops encourage new facilitators to interact with their peers, refine their facilitation skills and

dive deeper into SPDP content. To date, there are 354 trained SPDP Facilitators across Australia and Aotearoa New Zealand.

All three SPDP workshops are available in three different formats:

- 3-hour face-to-face workshop
- 3-hour virtual workshop
- 5-week online courses.

Face-to-face and virtual workshops are typically limited to 30 attendees as these workshops are delivered with a single facilitator and RACP staff support with the expectation that the workshop will be interactive with substantial attendee participation.

When SPDP is delivered through the five-week online course, attendee capacity is increased to a maximum of 200 of participants. The increased number of participants is due to the online delivery allowing multiple groups with multiple facilitators at one time. The online SPDP course uses a social learning approach to replicate the high level of participant interaction in the face-to-face/virtual workshops. This includes the use of facilitated interactive discussion boards, trigger videos and other structured activities.

There are no set time slots to login and join the online course. The course has been designed so that typically participants will log into the course area for short periods of time (15-20 mins) a day, to gradually watch the videos and complete the weekly activities. To meet the minimum requirements for the online course, participants must participate in at least 80% of the discussion forums and all practice activities with a colleague and post their reflections. After the course ends, participants have read-only access to the course for 12 months if they wish to revisit and review the content and discussions.

The number of supervisors that the RACP needed to provide training to through SPDP has been a significant challenge. When SPDP was launched, there were over 7,000 supervisors that needed credentialling through the program. In the early stages of the SPDP, recruiting Facilitators was a challenge that continued into 2023. To encourage participation, the RACP implemented several initiatives:

- awarding CPD hours in Category 2 for facilitation to recognise Facilitators' time commitment
- hosting a Recognition and Appreciation lunch in February 2023 to thank engaged Facilitators and celebrate a Fellow who had facilitated 100 SPDP workshops
- launching Facilitator Connected sessions to provide networking, troubleshooting, peer support, and skills development. Three sessions were held in 2023
- continuously recruiting and training new Facilitators to expand and sustain the facilitator pool.

These efforts aim to promote Facilitator engagement and growth, build a supportive community, and ensure the SPDP has sufficient trained Facilitators to meet ongoing program delivery needs.

Prior to 2020/COVID-19 the primary delivery method for SPDP workshops was face-to-face. The requirement of social distancing and the inability for travel required the RACP to transition face-to-face workshops to be delivered virtually. Fortuitously the SPDP transition to digital had already commenced. From February 2020, workbooks were no longer printed and provided online to participants and pre and post workshop evaluation surveys were conducted electronically. Additionally, SPDP via Zoom was trialled with a small pilot group in early March 2020 to gauge whether this would work. Some adjustments were needed to accommodate the group discussions and role plays; however, the workshop progressed well taking the normal three hours to complete.

The RACP Supervisor Handbook (Appendix 8A.2) provides a useful overview of the role of a supervisor, as well as practical tips, tools and strategies for supervisors fulfill their critical role in training the next generation of physicians. The handbook provides a guide on effective supervision noting that it is achieved through a multi-prong approach of planning, engagement and management of the trainee's education, experience and wellbeing. It also includes a section on educator development to support reflection on performance as a supervisor, followed by case studies and a toolbox to support supervisory practice. The RACP's eLearning portal also contains an expanding library of online educational resources for Supervisors including:

- **'Training support: helping trainees get back on track'-** this course supports supervisors and trainees to navigate the Training Support Pathway.
- **'Telesupervision'-** this course explores the process of supervision using technologies such as video conferencing to support trainees and supervisors in rural and remote locations.
- **'Physician self-care and wellbeing'-** this course helps physicians to proactively engage in self-care and wellbeing.
- **'Creating a safe workplace: responding to bullying and harassment'-** this course outlines the resources available, and the appropriate steps, for preventing and dealing with bullying and harassment.

RACP CPD Participants can earn CPD hours in the Other Learning Activities, for the time they spend on these eLearning resources.

Directors of Physician/Paediatric Education (DPEs) are integral to a trainees' success in Basic Training and provide a touchpoint and source of knowledge for many of the stakeholders within the College. Feedback from DPE's highlighted the need for an improved process to support DPEs, especially new DPEs, in their role. Since 2023, we now offer on-demand drop-in sessions for DPEs, designed to provide tailored support for their individual needs. These drop-in sessions are in addition to the welcome pack and DPE Induction Workshops held bi-annually for new DPEs. Key topics covered in the drop-in sessions are:

- Basic Training Requirements
- DPE role and main activities
- online Registration Common Questions
- portal usage.

Additional support for supervisors (Appendix 8A.3) and curated learning (Appendix 8A.4) resources are available on the RACP website.

Culturally safe supervision project

In March 2023, the College received funding from the Department of Health and Aged Care to develop a new suite of resources to support specialist medical college supervisors to provide culturally safe supervision to Aboriginal and/or Torres Strait Islander trainees. The suite of resources includes case-based video scenarios, expert video interviews, webinars and supplementary resources.

Since the funding was received, key project activities have included consulting with relevant internal and external stakeholders, including the RACP's Marnu Wiru (Knowledge Holder), RACP Aboriginal and Torres Strait Islander Health Committee members, Aboriginal and/or Torres Strait Islander members, stakeholders from the Australian Indigenous Doctors' Association (AIDA) and other relevant experts. An Indigenous-led Working Group has been established, to provide expertise from diverse Aboriginal and/or Torres Strait Islander voices, and to guide the development of the suite of resources.

Another key milestone for the project has been delivering the first resource for the suite, which was a live webinar discussion on "Culturally Safe Supervision and the Referendum", held in November 2023. There were over 60 attendees, including supervisors from across specialist medical colleges, staff members from the colleges, and other interested individuals. We received very positive feedback on the insightful and relevant nature of the topic for supervisors. Additional feedback suggestions will also be used to inform the development of future resources.

The current status of the project is that the suite of resources has been built on the RACP Online Learning platform. It is ready to be launched in early 2024, when the recording and supplementary resources for the first webinar are available for dissemination and promotion. Additionally, the Working Group is currently prioritising the next resources for development. Subsequent steps for the project in 2024 include consulting with Aboriginal and/or Torres Strait Islander trainees, to develop authentic case-based video scenarios, as well as releasing expert video interviews and further webinars on various topics relating to culturally safe supervision.

Supervisor credentialling

Since 2012, the College has been phasing in implementation of our supervisor credentialling program, which is based on completion of requisite SPDP modules. This program specifies that only Approved/Provisionally Approved Supervisors are eligible to supervise trainees within RACP physician training programs. Supervisors who haven't met the supervisor training requirements will not be eligible to hold training supervisory roles and formally supervise RACP trainees.
Training requirements are specified in Table 46.

Table 42. Training requirements to be an RACP-approved supervisor

	SPDP1	SPDP2	SPDP3
Directors of Physician/Paediatric Education and Training Program Directors	in line with the setting's accreditation cycle	in line with the setting's accreditation cycle	By 31 July 2023 to be referred to as 'Provisionally Approved'
Advanced Training Supervisors	in line with the setting's accreditation cycle	in line with the setting's accreditation cycle	By 31 July 2023 to be referred to as 'Provisionally Approved'
Education Supervisors	in line with the setting's accreditation cycle	in line with the setting's accreditation cycle	By 31 July 2023 to be referred to as 'Provisionally Approved'
Rotational supervisors and Ward/Service Consultants	encouraged to complete	encouraged to complete	Encouraged to complete. Review of this requirement will be undertaken in 2024.

The first enforcement date for the supervisor credentialling was 1 August 2023, with completion requirements for SPDP3, at a minimum, to be satisfied. Originally, this deadline was scheduled for January 2023, but this was changed to mitigate the risk of not meeting the supervision needs of many training settings.

The completion (or exemption) of SPDP 1 and 2 is aligned with training setting and specialty accreditation cycles. Active Supervisors who have not completed SPDP 1 and 2 by this time will continue to be eligible to supervise, however, recommendations will be made through the accreditation report that those who have not completed are required to do so. This provides an opportunity for settings to manage their supervisors to adhere to the College's accreditation requirements. This also provides assistance in managing the volume of workshops that are required to credential supervisors through SPDP 1 and 2. Completion of SPDP is recognised at CPD Category 2.

Supervisors who are new to supervision have 12 months to complete SPDP requirements. Reminder communications are planned and scheduled monthly to ensure new supervisors are compliant with the requirement.

The RACP recognises that supervisors may have the necessary training or experience for supervision which has been obtained outside of the SPDP program. For these supervisors, an exemption pathway has been established. This SPDP Exemption Pathway is only available for SPDP 1 and 2 and is only possible for supervisors who have both relevant education, skills and experience. All supervisors must complete SPDP 3, including those granted exemption from SPDP 1 and 2. To be eligible for exemption of SPDP 1 and/or 2, a supervisor must have completed both:

- formal medical education studies or equivalent supervisor training with another medical college
- a minimum of three years' experience as a RACP supervisor.

Supervisors who believe they meet the criteria for exemption can apply for an SPDP exemption on the RACP website (Appendix 8A.5). Through this application, supervisors are required to attach evidence that supports their exemption. Once this application for exemption is received, it is

assessed and where all exemption criteria is clearly met an exemption is granted. Where the application is unclear and/or there are further questions relating to the application, the application will be presented to the relevant education committee for consideration.

From 2021, the RACP has been delivering a steady number of workshops and online courses to ensure that we could meet the demand of supervisors needing credentialling. In 2023 as the number of supervisors who had completed the SPDP program reached over 75%, the amount of workshops that were needed slightly reduced (See Table 47).

Table 43. SPDP workshops and online courses overview by year

Year	Number of workshops	Online courses
2021	266	7
2022	263	8
2023	205	7

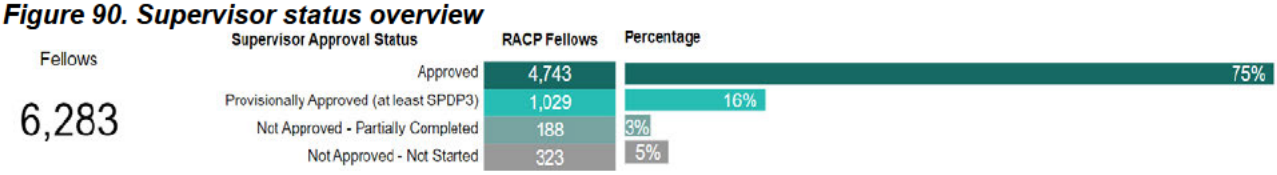
Prior to 2022, SPDP had a relatively slow adoption rate among supervisors. During 2022, the RACP began frequent communication with College Bodies to promote engagement of the SPDP program. By utilising technology, the College was able to provide accurate status reports to training settings to show which supervisors at a setting had not completed/started SPDP (See Table 48).

Table 44. Supervisors Approved/Provisionally Approved by Year

Year End	% Approved/Provisionally Approved
2020	26
2021	40
2022	73
2023	92

As shown in Figure 90, of the current 6,283 supervisors who have actively supervised a trainee in the last 24 months, only 5% of these supervisors are yet to start SPDP. Of this 5%, the vast majority are new supervisors who have 12 months to complete the SPDP credentialling requirements. There are a small number of supervisors have indicated that they do not intend to proceed with credentialling requirements, and we have put in place alternative supervision arrangements of trainees in these settings.

Figure 90. Supervisor status overview



In addition to credentialling the currently active RACP Supervisors, the process has brought forth an additional 1,300 new supervisors.

Figure 91 provides a specialty specific breakdown for completion of each SPDP module.

Figure 91. SPDP Workshop Completion Status by Specialty

SPDP Workshop	SPDP1 Workshop				SPDP2 Workshop				SPDP3 Workshop				Total in Fellow Specialty
Completed Status	Completed		Not		Completed		Not		Completed		Not		
Fellowship Specialty	#	%	#	%	#	%	#	%	#	%	#	%	#
Total	[redacted]	84 %	[redacted]	16 %	[redacted]	81 %	[redacted]	19 %	[redacted]	92 %	[redacted]	8 %	[redacted]
Addiction Medicine	[redacted]	80 %	[redacted]	20 %	[redacted]	77 %	[redacted]	23 %	[redacted]	92 %	[redacted]	8 %	[redacted]
Adolescent and Young Adult Medicine	[redacted]	88 %	[redacted]	12 %	[redacted]	92 %	[redacted]	8 %	[redacted]	88 %	[redacted]	12 %	[redacted]
Cardiology	[redacted]	61 %	[redacted]	39 %	[redacted]	58 %	[redacted]	42 %	[redacted]	79 %	[redacted]	21 %	[redacted]
Child and Adolescent Psychiatry	[redacted]		[redacted]	100 %	[redacted]		[redacted]	100 %	[redacted]	100 %	[redacted]		[redacted]
Clinical Genetics	[redacted]	84 %	[redacted]	16 %	[redacted]	82 %	[redacted]	18 %	[redacted]	94 %	[redacted]	6 %	[redacted]
Clinical Pharmacology	[redacted]	92 %	[redacted]	8 %	[redacted]	81 %	[redacted]	19 %	[redacted]	94 %	[redacted]	6 %	[redacted]
Community Child Health	[redacted]	86 %	[redacted]	14 %	[redacted]	90 %	[redacted]	10 %	[redacted]	95 %	[redacted]	5 %	[redacted]
Dermatology	[redacted]	92 %	[redacted]	8 %	[redacted]	75 %	[redacted]	25 %	[redacted]	92 %	[redacted]	8 %	[redacted]
Endocrinology	[redacted]	85 %	[redacted]	15 %	[redacted]	84 %	[redacted]	16 %	[redacted]	95 %	[redacted]	5 %	[redacted]
Gastroenterology	[redacted]	76 %	[redacted]	24 %	[redacted]	71 %	[redacted]	29 %	[redacted]	90 %	[redacted]	10 %	[redacted]
General & Acute Care Medicine	[redacted]	89 %	[redacted]	11 %	[redacted]	85 %	[redacted]	15 %	[redacted]	96 %	[redacted]	4 %	[redacted]
General Paediatrics	[redacted]	85 %	[redacted]	15 %	[redacted]	85 %	[redacted]	15 %	[redacted]	93 %	[redacted]	7 %	[redacted]
Geriatric Medicine	[redacted]	95 %	[redacted]	5 %	[redacted]	94 %	[redacted]	6 %	[redacted]	97 %	[redacted]	3 %	[redacted]
Haematology	[redacted]	78 %	[redacted]	22 %	[redacted]	74 %	[redacted]	26 %	[redacted]	84 %	[redacted]	16 %	[redacted]
Immunology and Allergy	[redacted]	85 %	[redacted]	15 %	[redacted]	77 %	[redacted]	23 %	[redacted]	92 %	[redacted]	8 %	[redacted]
Infectious Diseases	[redacted]	85 %	[redacted]	15 %	[redacted]	78 %	[redacted]	22 %	[redacted]	92 %	[redacted]	8 %	[redacted]
Intensive care medicine	[redacted]	73 %	[redacted]	27 %	[redacted]	53 %	[redacted]	47 %	[redacted]	73 %	[redacted]	27 %	[redacted]
Medical Oncology	[redacted]	91 %	[redacted]	9 %	[redacted]	88 %	[redacted]	12 %	[redacted]	96 %	[redacted]	4 %	[redacted]
Neonatal/Perinatal Medicine	[redacted]	86 %	[redacted]	14 %	[redacted]	81 %	[redacted]	19 %	[redacted]	91 %	[redacted]	9 %	[redacted]
Nephrology	[redacted]	89 %	[redacted]	11 %	[redacted]	86 %	[redacted]	14 %	[redacted]	95 %	[redacted]	5 %	[redacted]
Neurology	[redacted]	79 %	[redacted]	21 %	[redacted]	75 %	[redacted]	25 %	[redacted]	90 %	[redacted]	10 %	[redacted]
Nuclear Medicine	[redacted]	71 %	[redacted]	29 %	[redacted]	67 %	[redacted]	33 %	[redacted]	90 %	[redacted]	10 %	[redacted]
Occupational & Environmental Medicine	[redacted]	82 %	[redacted]	18 %	[redacted]	73 %	[redacted]	27 %	[redacted]	85 %	[redacted]	15 %	[redacted]
Paediatric Emergency Medicine	[redacted]	79 %	[redacted]	21 %	[redacted]	79 %	[redacted]	21 %	[redacted]	90 %	[redacted]	10 %	[redacted]
Palliative Medicine	[redacted]	94 %	[redacted]	6 %	[redacted]	93 %	[redacted]	7 %	[redacted]	96 %	[redacted]	4 %	[redacted]
Public Health Medicine	[redacted]	74 %	[redacted]	26 %	[redacted]	65 %	[redacted]	35 %	[redacted]	87 %	[redacted]	13 %	[redacted]
Rehabilitation Medicine	[redacted]	91 %	[redacted]	9 %	[redacted]	89 %	[redacted]	11 %	[redacted]	97 %	[redacted]	3 %	[redacted]
Respiratory Sleep Medicine	[redacted]	84 %	[redacted]	16 %	[redacted]	83 %	[redacted]	17 %	[redacted]	93 %	[redacted]	7 %	[redacted]
Rheumatology	[redacted]	83 %	[redacted]	17 %	[redacted]	83 %	[redacted]	17 %	[redacted]	93 %	[redacted]	7 %	[redacted]
Sexual Health Medicine	[redacted]	87 %	[redacted]	13 %	[redacted]	92 %	[redacted]	8 %	[redacted]	97 %	[redacted]	3 %	[redacted]
Unknown	[redacted]	82 %	[redacted]	18 %	[redacted]	79 %	[redacted]	21 %	[redacted]	89 %	[redacted]	11 %	[redacted]

Supervisor selection

Following credentialling as an RACP Approved or Provisionally Approved Supervisor, supervisors can be selected to fulfil a supervision role.

Directors of Physician/Paediatric Education (DPE) and Network DPEs are appointed for each training setting/network. This occurs via a nominations process from the setting's Director of Medical Services, or equivalent. Nominations are confirmed by the relevant Basic Training Committee in Australia and Division Education Committee in Aotearoa New Zealand. A list of appointed Network DPEs and DPEs is provided on the College website (Appendix 8A.6).

Each training setting is required to inform trainees of available supervisors during the onboarding and induction process for the training period. Education Supervisors, Advanced Training Supervisors and Rotation Supervisors are mapped to training settings and available for trainees to select when the trainee submits their Application for Approval of Training via our online registration system. The online registration system has been modified to only show Approved and Provisionally Approved supervisors for a trainee to select. Figure 92 summarises the eligibility and selection criteria for Rotation, Educational and Advanced Training Supervisors.

Figure 92. Supervisor Eligibility and Selection Criteria

	Rotation Supervisor (Basic Training)	Educational Supervisor (Basic Training)	Advanced Training Supervisor
Suggested eligibility criteria	• RACP Fellowship or Fellowship of another college.* • Demonstrated experience educating medical trainees. • Certification of completion of the SPDP Work-based Learning and Assessment workshop.**	• Two years RACP Fellowship or Fellowship of another college.* • Two years' experience as Rotation Supervisor in RACP Basic Training (or equivalent experience). • Certification of completion of all three SPDP workshops.**	• Three years RACP Fellowship or Fellowship of another college.* • Three years' experience supervising medical trainees (or equivalent experience). • Certification of completion of all three SPDP workshops.**
Selection criteria	• Understanding of the RACP Training Program curricula and requirements, best-practice in medical education and principles of adult learning. • Commitment to meeting the principles outlined in the Educational Leadership and Supervision Policy. • Competence at the Intermediate level of the RACP Standards for Educational Leadership and Supervision.	• In-depth understanding of RACP Training Program curricula and requirements, best-practice in medical education and principles of adult learning. • Commitment to meeting the principles outlined in the Educational Leadership and Supervision Policy. • Competence at the Intermediate level of the RACP Standards for Educational Leadership and Supervision.	• In-depth understanding of RACP Training Program curricula and requirements, best-practice in medical education and principles of adult learning. • Commitment to meeting the principles outlined in the Educational Leadership and Supervision Policy. • Competence at the Intermediate level of the RACP Standards for Educational Leadership and Supervision. • Meets requirements set out in the relevant specialty specific Training Program Requirement Handbook.
Desired skills and qualifications		• Qualification in adult education.	• Qualification in adult education.
Confirmed by	• Training Program Director.	• Training Program Director.	• Advanced Training Committee when prospective approval application is submitted and approved.

** For applicants with less post-FRACP year of experience, outline the support for this applicant available at the site.*

***Nominees who have not completed the relevant SPDP workshops should endeavor to complete the workshops within 12 months following appointment to the role. Completion of the SPDP is a requirement for RACP Fellows only.*

For training programs that do not use the College online registration, a manual check by College staff is performed to confirm the nominated supervisor is suitably credentialled. Where their nominated supervisor is not eligible/approved, the College works with the nominated supervisor to ensure that they are registered to complete SPDP or assists the trainee to find an RACP Approved or Provisionally Approved supervisor at the setting.

Assessor credentialling, training and support (8.1.5)

Selection, training and support for assessors involved in RACP examinations are discussed in Standard 5.

SPDP3: Teaching and Facilitating Learning for Safe Practice, is mandatory for a large portion of supervisor roles, who also function as assessors for work-based assessments. SPDP3 has been prioritised for completion as it focusses on equipping participants with an understanding of the challenges of undertaking work-based learning and assessment, safe and effective work-based assessments/activities to guide learning and how to make evidence-based assessments of trainee performance.

Advanced Training Research Project reviewers are appointed by delegation from Training Committees through an expression of interest process. Each reviewer receives a project marking induction pack, support through the relevant Training Committee and the RACP Online Learning Research Curated Collection.

Evaluation of supervisor and assessor effectiveness (8.1.4 and 8.1.6)

Standards 5.4.1 to 5.4.2 provide a discussion of how the College evaluates and improves the quality of assessments, inclusive of aspects related to the role of assessors.

Standard 6.2 provides a description of the following program evaluations that incorporate consideration of supervisor and assessor effectiveness, key findings and associated actions in response:

- program evaluation of the Supervisor Professional Development Program- explores to what extent the program achieves its stated outcomes, and the relevance of the educational theories and tools used in the SPDP to the College's education programs.
- Curriculum Renewal program evaluation. The evaluation on the early adopter experience of the new Basic Training program explored the extent to which assessors and trainees understood the new programmatic assessment program and their perceptions of this and made recommendations for improvement. The evaluation of the full implementation of the renewed programs will further build upon this work.

At a setting level, we encourage training settings to locally review and respond to results of the Medical Training Survey and Physician Training Survey, which each include monitoring data on supervision, work-based assessment and formal and informal feedback used to guide learning. This activity is discussed in Standard 6.

On a personal level, in accordance with the Educational Leadership and Supervision Framework (Appendix 1A.24), supervisors and assessors are encouraged to evaluate their own performance through reflection against the RACP Standards for Educational Leadership and Supervision. Trainee feedback is a vital part of this evaluation and supervisors have indicated that trainees are perhaps the most important source of feedback about their effectiveness in the role. Just as trainees have their performance evaluated, peer review can be a helpful process for supervisors to receive feedback on their teaching.

Data on supervision

Tables 49 and 50 below provide data on supervisor numbers by location and by specialty for the last three years.

Table 45. Supervisors by location, 2020-2022

Location	Number of supervisors		
	2020	2021	2022
ACT	125	127	136
NSW	1,692	1,787	1,863
NT	98	100	106
QLD	1,009	1,043	1,100
SA	409	433	449
TAS	102	113	129
VIC	1,406	1,482	1,588

Location	Number of supervisors		
	2020	2021	2022
WA	541	563	607
Aotearoa New Zealand	849	915	897
Overseas	18	15	14
Grand Total (unique count)	**6,249**	**6,578**	**6,889**

Table 46. Supervisors by specialty, 2020-2022

Fellowship Specialty (Fellows are counted multiple times, ie once for each specialty)	Number of supervisors		
	2020	2021	2022
Basic Training - AMD	251	214	195
Basic Training - PCHD	327	307	276
Addiction Medicine	51	52	59
Adolescent and Young Adult Medicine	17	20	21
Cardiology	387	405	405
Child and Adolescent Psychiatry	1	1	1
Clinical Genetics	62	65	67
Clinical Haematology	7	9	10
Clinical Immunology and Allergy	16	22	29
Clinical Pharmacology	34	35	40
Community Child Health	96	105	126
Dermatology	12	13	12
Endocrinology	306	325	333
Endocrinology and Chemical Pathology	1	1	1
Gastroenterology	301	323	329
General & Acute Care Medicine	703	764	841
General Paediatrics	666	738	817
Geriatric Medicine	553	598	640
Haematology	286	310	327
Immunology and Allergy	72	73	68
Infectious Diseases	242	245	268
Infectious Diseases & Microbiology	55	62	65
Intensive care medicine	17	16	16
Medical Oncology	396	410	442
Neonatal/Perinatal Medicine	179	193	210
Nephrology	323	347	369
Neurology	281	298	304
Nuclear Medicine	49	42	52
Occupational & Environmental Medicine	62	70	72
Paediatric Emergency Medicine	76	81	92
Palliative Medicine	281	304	317
Public Health Medicine	177	196	213
Rehabilitation Medicine	240	244	250
Respiratory Medicine	357	375	400
Rheumatology	140	152	163
Sexual Health Medicine	52	55	54
Sleep Medicine	214	234	260
Grand Total (unique count)	**6,249**	**6,578**	**6,889**

8.2 Training sites and posts

AMC accreditation standards	
8.2.1	The education provider has a clear process and criteria to assess, accredit and monitor facilities and posts as training sites. The education provider: o applies its published accreditation criteria when assessing, accrediting, and monitoring training sites o makes publicly available the accreditation criteria and the accreditation procedures o is transparent and consistent in applying the accreditation process.
8.2.2	The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and: o promote the health, welfare, and interests of trainees o ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner o support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand o ensure trainees have access to educational resources, including the information communication technology applications required to facilitate their learning in the clinical environment.
8.2.3	The education provider works with jurisdictions, as well as the private health system, to effectively use the capacity of the health care system for work-based training, and to give trainees experience of the breadth of the discipline.
8.2.4	The education provider actively engages with other education providers to support common accreditation approaches and sharing of relevant information.

Accreditation Framework (8.2.1-8.2.2)

Accreditation aims and principles

The RACP primarily delivers its training through participation in supervised work-based activities with specialist physicians. The RACP sets the standard of competence for each training program it offers through its curriculum, with RACP accredited programs ensuring the RACP that:

- workplace training is likely to develop competent physicians who deliver safe and effective health care to patients, now and into the future
- trainees and trainee-delivered patient care is safeguarded
- high-quality learning that integrates medical practice, training and research in an optimal environment is promoted
- quality teaching and supervision is supported
- the medical profession is enabled to reflect on training practices and continuously improve
- transparent information is provided to trainees that informs training choices.

The RACP accreditation framework (Appendix 6A.12) operates under the following principles:

- **Focused on training**- the RACP assesses workplace characteristics and training functions which influence the trainee's ability to achieve learning outcomes. Improvement, quality, and best practice training are acknowledged. Less satisfactory practices are identified, and recommendations are made for improvement.
- **Supportive of patient safety and quality care**- patient safety and quality of care are paramount. The RACP will not support training in environments where safety and care are not adequately protected.

- **Flexible**- the RACP takes into consideration training, Training Provider, environment, and service diversity.
- **Proportionate**- when requiring improvements, consideration will be given to the training environment, risk level and cost.
- **Independent and accountable**- accreditation decisions are independent of external and internal influence and consistent with assessment findings. They are based on evidence, clear, predictable, consistent, publicly available, equitable and fairly represented. Real or perceived conflicts of interest on the part of assessors and committee members are recognised and managed appropriately.
- **Transparent**- accreditation information is published. Written and verbal guidance is provided. The accreditation program is guided by principles, a code of conduct and conflict of interest policies.
- **Effective**- the accreditation program has sound governance, sustainable resources, and effective processes.
- **Relevant**- accreditation is responsive to changes in training. The RACP reviews its accreditation program regularly, and participates in accreditation projects, research, and stakeholder consultation.
- **Collaborative**- the RACP undertakes accreditation respectfully and collaboratively. Effective communication occurs between the RACP, Training Providers, jurisdictions and trainees. Trainees are central to the accreditation process, and their opinions are respected.
- **Coordinated**- the accreditation program is streamlined and coordinated to reduce administrative burden.

Accreditation cycle

RACP accreditation programs operate across four- or five-year accreditation cycles (Figure 93) and is articulated in the Accreditation of Training Provider Process (Appendix 8A.7).

Figure 93. Accreditation Cycle

The RACP accreditation cycle consists of five stages:

Self-Assessment

The Training Provider self- rates their compliance with the relevant accreditation standards, requirements, or criteria by completing the RACP self- assessment forms. Scheduled and on-demand training webinars alongside e-modules are available from the Training Accreditation Services team to support stakeholders in the completion of the self-assessment forms. The

completed form and relevant documentation are submitted to the RACP for review. The RACP sends a survey to trainees who have trained with the Training Provider within the last 24 months.

External Assessment

A document review of the completed form and relevant documentation is undertaken by a panel of at least two accreditors. The trainee survey results and relevant information such as reports of potential breaches, change in circumstance, Medical Training Survey results and media clippings relevant to training may also be included in the accreditors pack. Where required, a physical or virtual site visit may be undertaken incorporating interviews with stakeholders such as the Setting Executive, Directors of Physician/Paediatric Education (DPEs), Head of Departments and trainees. The Accreditors complete the Accreditation Findings Form and this is submitted to the Training Provider for factual verification.

External Validation

The Accreditation Findings Form is presented to the relevant RACP accreditation body by the accreditors. The accreditation body discusses the findings and reaches an accreditation decision.

Reporting

The Accreditation decision is communicated to the Training Provider through a notification letter. After the 28-day Reconsideration, Review and Appeal timeframe has lapsed the accreditation status of the Training Provider is published on the RACP website. As of 2024, the RACP will begin to publish an executive summary detailing the accreditation decision and which accreditation standards, requirements and criteria are met, partially met, or not met.

Monitoring

The RACP monitors its Training Providers to ensure that compliance with the standards is maintained across the accreditation cycle. The Monitoring of a Training Provider (Appendix 8A.8) process articulates the mechanisms by which the RACP undertakes mid-cycle monitoring and how potential breaches of the Training Provider Standards are managed. The RACP published its Active Management process in late 2023 (Appendix 8A.9). This process articulates the RACP's response to the very small number of accreditation reviews where serious non-compliance issues are identified. The process also ensures that the RACP communicates any identified issues to the relevant jurisdiction to allow for a collaborative response to resolution.

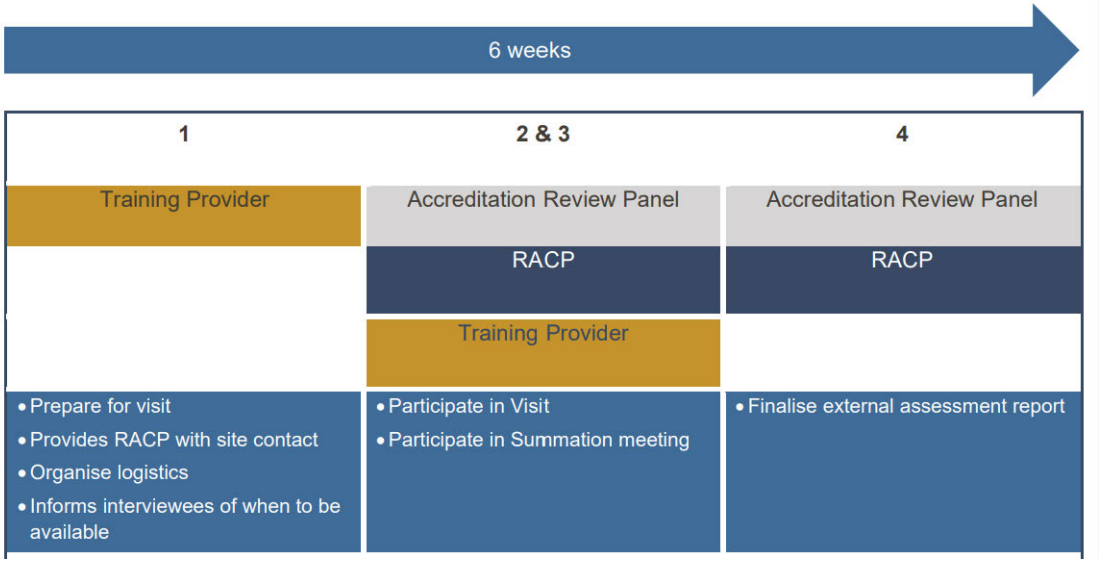
Training Providers are required to document and notify the RACP of any bullying, harassment and/or discrimination complaints in their training program, setting, and training network. If bullying, harassment and/or discrimination complaints are raised, the Training Provider is required to submit the complaints form to the RACP. Concerns that arise from this form are managed through the monitoring process.

Site Visits

The RACP currently undertakes physical site visits for Basic Training program providers that are classified as level two or level three. Physical site visits are also undertaken where serious non-compliance issues are identified within in any accreditation program. The RACP sets its accreditation schedules six months prior to the calendar year and collaborates with Training Providers to allocate dates that cause the least inconvenience (Figure 94).

The physical site visit provides the RACP accreditation panel with the opportunity to tour the training setting and interview key accreditation stakeholders such as DPEs, Setting Executive and trainees. The RACP also undertakes virtual and hybrid accreditation reviews acknowledging the benefits of technology in site visits.

Figure 94. demonstrates roles and responsibilities between accreditation stakeholders across the external assessment stage of the accreditation cycle



Trainee Voice

The RACP will roll out its accreditation Trainee Representative role in 2024. The Trainee Representative will sit on the accreditation panel and participate in the accreditation review with the intent of providing accreditors with the trainee perspective on the findings of the review. The Trainee Representative role has been developed as part of a number of initiatives designed to improve the support and role of trainees in RACP accreditation processes. Other initiatives include increasing the number of College Trainees' Committee-endorsed trainee representative roles on accreditation bodies and the development of tools and resources to support trainees participating in accreditation reviews.

Accreditation decision-making (8.2.1)

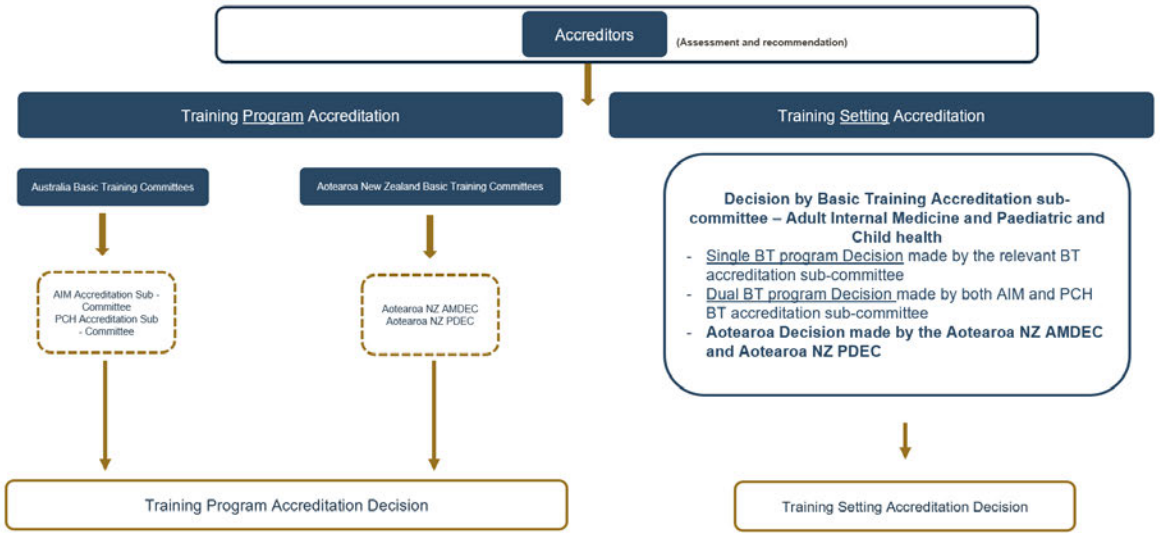
The RACP articulates its approach to decision-making through its Accreditation Decision Guide (Appendix 8A.10).

Training Providers are accredited by the relevant RACP body in Australia and Aotearoa New Zealand. For Basic Training Providers in Australia, these are accredited by the standing Accreditation Subcommittees of the Adult Internal Medicine and Paediatric and Child Health Basic Training Committees. For Basic Training in Aotearoa New Zealand, these are accredited by the Aotearoa New Zealand Adult Medicine Education Committee (AMDEC) and the Aotearoa New Zealand Paediatrics Education Committee (PDEC).

The allocated accreditation panel completes the accreditation findings form and presents their findings to the relevant accreditation body. The accreditation body discusses the findings and where appropriate may alter the decision using their expertise. The decision is issued to the Training Provider via a notification letter from the accreditation body chair (Figure 95).

Examples of the Accreditation Findings Form, inclusive of the self-assessment component, are provided in Appendix 8A.11 - 8A.13.

Figure 95. Governance structure for Basic Training Accreditation decisions



All RACP accreditation decisions are subject to the RACP's Reconsideration, Review and Appeals Process By-law (Appendix 1A.45), as outlined in Standard 1. An accreditation decision is considered final once the 28- day timeframe for submission of an RRA application has lapsed.

Mid-cycle monitoring

The RACP introduced its Monitoring of a Training Provider (Appendix 8A.8) process in 2022. The RACP monitors its Training Providers to ensure that compliance with the standards, requirements and criteria is maintained throughout the accreditation cycle. The RACP monitors through four processes:

1. *Managing Conditions and Recommendations*- where conditions or recommendations are placed on a Training Provider at its comprehensive review, the RACP monitors these through progress reports and site visits to ensure that sufficient progress is made to gain compliance with the standards, requirements, and criteria.
2. *Change of Circumstance*- planned or unplanned changes that affect the delivery of an RACP training program are reported to the RACP by Training Providers through the Managing a Change of Circumstance process.
3. *Managing a Potential Breach of the Training Provider Standards*- where concerns are raised by an accreditation stakeholder or via media reports the RACP may enact the potential breach process and trigger an accreditation review.
4. *Active Management*- where serious issues of non-compliance with the standards, requirements or criteria are identified, the RACP collaborates with Training Providers to establish an action plan to regain compliance. The RACP will closely monitor the Training Provider against this action plan.

Accreditation outcomes

Across its accreditation programs the RACP accredits at four levels:

- training position (Advanced Training only)
- training program
- Training Provider
- training network.

These are further described in Standard 8.2.2 below.

The following accreditation decisions can be made:

- **Accredited**- where full compliance with the relevant standards, requirements and criteria is achieved.

- **Accredited with condition**- where areas of non-compliance with the relevant standards, requirements and criteria are identified.
- **Accredited provisionally**- where a Training Provider is accredited against the relevant standards, requirements, and criteria for the first time.
- **Accredited provisionally with condition**- where a Training Provider is accredited against the relevant standards, requirements, and criteria for the first time and areas of non – compliance are identified.
- **Accreditation not achieved**- where a Training Provider is accredited against the relevant standards, requirements, and criteria for the first time and does not meet the requisite level of compliance.
- **Accreditation withdrawn**- where serious non-compliance issues are identified and the accreditation of a position, training provider, training program or training network is withdrawn.
- **Accreditation lapsed**- where a previously accredited Training Provider does not apply for reaccreditation.

Accreditation criteria (8.2.2)

The RACP accredits against accreditation standards, criteria, and requirements across its accreditation programs.

Training Network Principles

The RACP Training Network Principles (Appendix 8A.14) were published in 2018 as part of the RACP Accreditation Renewal Program. The Training Network Principles aim to support the establishment of training networks to deliver integrated training programs and provide guidance to help training networks:

- access more diverse range of settings
- deliver effective governance
- provide quality training management
- support training
- provide appropriate recruitment and trainee distribution.

Training Provider Standards

The RACP published its Training Provider Standards (Appendix 8A.15) in 2018 and began accrediting Training Providers of Basic Training programs against the Training Provider Standards in 2021. The Training Provider Standards are an overarching set of standards designed to assess the environment training is delivered within, the oversight and support provided to trainees and the implementation of RACP curricula at the training setting.

The standards articulate the expectations for workplace training and are used to measure the quality of training provided. The RACP has defined nine standards which describe the foundation required to deliver quality physician training. The standards are grouped into four themes:

- environment and culture
- training oversight
- training support
- curriculum implementation.

Under each of the standards there are criteria which need to be met.

Accreditation requirements and criteria

The RACP Basic Training Accreditation requirements for Adult Internal Medicine and Paediatrics and Child Health were published in 2018 and implemented in 2021 (Appendices 8A.16 and 8A.17). Accreditation Criteria for each RACP Advanced Training program is published on the RACP website (Appendix 8A.18).

The requirements and criteria are unique to each training program and articulate actions which need to be addressed for a Training Provider to offer a specific training program.

Alignment of accreditation criteria with outcomes of specialist medical program

The RACP sets the professional standards, curriculum learning outcomes and training program requirements. Training providers are required to:

- implement the curricula and deliver relevant high-quality feedback and assessments
- establish that trainees receive relevant work experiences and learning opportunities
- provide appropriate clinical and educational supervision
- only recommend trainees who have demonstrated the professional standards, curriculum learning outcomes and training program requirements for independent practice.

Standard 7 of the Training Provider Standards outlines expectations regarding implementation of the curriculum and training requirements, ensuring alignment with the program and graduate outcomes.

In accordance with the Training Provider Standards, accreditation requirements are developed for each training program. For example, the Basic Training Adult Medicine requirements for Standard 7 specify:

> 7.5.1- Accredited rotations are to continuously align with the learning goals of the Adult Internal Medicine and/or Paediatrics & Child Health Basic Training Program curriculum, RACP Training Provider Standards and Basic Training accreditation requirements.
>
> 7.8 (Training Network Criteria)- A training network plans, coordinates and implements the delivery of an integrated training program(s). The training network demonstrates:
>
> - how the curriculum and training program requirements are delivered to each trainee
> - how the curriculum is mapped to the rotations and formal learning
> - each setting's role in curriculum delivery
> - how it addresses any training gaps in the integrated training program
> - how it effectively shares and distributes resources across the training network.

In this way, the program allows for flexibility in delivery of the curricula, yet maintains an emphasis on continual alignment with program and graduate outcomes.

Availability of professional experiences to meet curricula outcomes and expanding training settings

As previously referenced, in late 2023 the RACP introduced network accreditation for Basic Training networks. Through the introduction of network accreditation, the RACP hopes to see the continued formalisation of networks for both Basic and Advanced Training, acknowledging the benefits that training networks provide to trainees, supervisors and Training Providers.

The RACP has developed Training Network Principles to support jurisdictions in the formalisation of training networks, acknowledging that a flexible approach to training networks is required across the jurisdictions. The principles support the establishment of training networks to deliver integrated training programs, allowing training networks to:

- access more diverse range of settings
- deliver effective governance
- provide quality training management
- support training
- provide appropriate recruitment and trainee distribution.

The RACP believes that integrated training programs coordinate the delivery of curriculum and training requirements. This facilitates the measurement and synthesis of trainees' skills and professional practice, which informs judgements about their progress and preparation.

Across the above referenced review of the Training Provider Standards in 2024, the RACP will also review its Basic Training classification. The classification of a Training Provider is decided through

their accreditation review and determines the duration of which a Basic Trainee can train at a training setting. The current classification relies on infrastructure requirements, such as the number of specialties available at the training setting, whereas the new classification will move towards an assessment of depth and breadth of experience of training offered by the setting.

By refocusing classification away from infrastructure requirements, the RACP intends to allow training settings that offer the ability to provide a diverse range of training experiences the ability to train trainees for a longer duration. In turn, it is likely that this will expand the range of training settings available.

Through group one of the recommendations in our Regional, Rural and Remote Physician (RRR) Strategy (Appendix 1A.58), as outlined in Standard 1, we will explore ways to build capacity and capability to provide physician training in RRR areas. Subject to implementation planning, this may be achieved through the following proposals:

- move towards a process where each trainee in every specialty and chapter would have adequate opportunity and incentive for RRR immersion during training
- explore options to better support jurisdictions, Fellows currently practicing in RRR settings, RRR health services and RRR training sites to expand the availability of accredited training places
- advocate in support of the establishment of at least one dedicated RRR training network in each jurisdiction
- advocate with RRR health services to fund and support sufficient allocated time for supervisors to ensure adherence with training standards.

Balancing education and service demands

The RACP has observed tension between training and service provision across both Aotearoa New Zealand and Australia. There is an increasing trend for conditions and recommendations being placed on Training Providers in relation to a lack of protected teaching time, workload, rostering, and FTE allowance for DPEs.

The RACP notes that strain often stems from workforce issues, where positions remain vacant, rather than a lack of funding for positions and notes that post COVID-19 there have been significant difficulties in recruiting within a number of specialties and jurisdictions.

The RACP is committed to working with Training Providers to resolve these tensions and to share examples of best practice in relation to these areas that have been observed through accreditation reviews. Through communication with state Health Departments and Te Whatu Ora (Health New Zealand) in Aotearoa New Zealand, the RACP intends to highlight issues identified early and allow for early resolution from the Health Departments, who often have access to the appropriate levers to initiate meaningful change.

Capacity to Train Guidance

The RACP defines ‘capacity to train’ as the number of trainees that can be trained to meet their respective training program requirements and ultimately meet the standard required to comply with the professional and educational requirements of the RACP.

The RACP has developed Capacity to Train Guidance (Appendix 8A.19) and an e-module (Appendix 8A.20) which supports settings offering Basic Training in Adult Internal Medicine or Paediatrics & Child Health to determine their capacity to train. The e-module and guidance are helpful for DPEs to:

- plan for recruitment
- consider when monitoring their training program’s performance
- add or modify rotations
- prepare for accreditation.

The guidance identifies a range of components to consider in determining capacity to train, both with respect to the capacity of a rotation and a training program. These components include the

maximum number of registered trainees, core rotations, breadth of training opportunities, Divisional Clinical Examination capacity and supervisor support.

The RACP uses accreditation as the tool to monitor training settings' capacity to train. The new Training Provider Accreditation Standards and Basic Training Accreditation Requirements require settings to determine the number of trainees they have in relation to their capacity to resource training and ability to deliver training experiences in alignment with the Basic Training curricula (Appendix 8A.21).

To implement the Capacity to Train Guidance, we used a transition phase prior to full implementation. The Guidance was trialled in the self-assessment stage for settings to use to provide their capacity to train for identified training programs. This trial was used to engage stakeholders and to gather feedback about whether the guidance is fit for purpose and supports a setting to determine its capacity to train. The trial aided greater understanding of the steps and information required to calculate capacity to train and identify qualitative factors settings considered when finalising their capacity to train. A survey was conducted about the process used and usefulness of the Guidance. The results of the trial highlighted that the Guidance is overall seen as a necessary and useful document to assist settings in determining their capacity to train.

Assuring the quality of care in training environments

The RACP is assured that trainees are involved in high-quality care by assessing training settings on compliance with specific Standards and Requirements in relation to safety and quality. Specifically, Standard 1 in the Training Provider Standards assesses a training setting's compliance on Safety and Quality. The RACP ensures the environment and culture of training settings encourages the promotion of safe behaviours and supports the delivery of high-quality patient and population-centred care. All training settings have to complete Self-Assessment Forms against these specific standards which accreditors then review as either a document review or site visit. Furthermore, the RACP conducts trainee surveys and reviews Medical Training Survey data which have specific questions on whether trainees are involved in high-quality clinical care.

Assuring trainee access to workplace based educational resources

The RACP's Accreditation program assures that trainees have access to workplace based educational resources. Specifically, we support this through assessment against the following Training Provider Standards:

- **Standard 4.2**- assesses a Training Provider's compliance on offering educational resources to support training. It outlines the educational infrastructure to support work and training including: teaching rooms; clinical skills and wet laboratories; simulation environments; meeting rooms; computers with internet access; technology; visual aids; and specialty specific literature and databases.
- **Standard 7.1**- requires that "The training program delivers clinical experience, social and formal learning, which provides a trainee with opportunities to increase their professional responsibility and achieve curriculum learning goals." This Standard specifies that trainees must have access and protected time to participate in a formal learning program aligned to the curricula. Examples of formal learning opportunities include interprofessional meetings, journal clubs, exam preparation, patient presentations and courses.

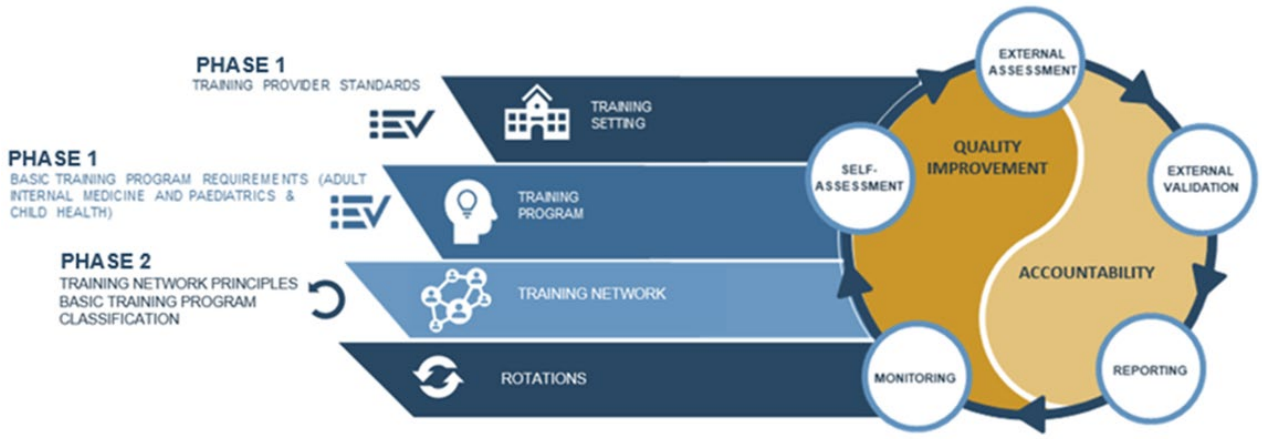
An update on the College's technology to support training, our Training Management Platform, is provided in Standard 1.

The College provides a number of educational resources that are relevant to workplace-based training, as outlined in Standard 4.

Accreditation Renewal (8.2.1)

The RACP commenced implementation of its Accreditation Renewal Program in 2021. Due to the significant scope of the program, it is being implemented in a phased approach, as depicted in Figure 96.

Figure 96. Phases of the Accreditation Renewal Program



Phase 1

Phase 1 was implemented across 2021 and incorporated the introduction of the Training Provider Standards and Basic Training Accreditation Requirements for both Adult Internal Medicine and Paediatrics and Child Health. This means that from 2021 any Training Provider delivering the RACP Basic Training program has been accredited under the new program.

The RACP undertook an evaluation of the implementation of Phase 1 of the new program in 2022. The key focus areas of the evaluation were:

- understanding the perception of the implementation process
- inform improvements to the approach including training and resources
- feedback for future roll outs of the accreditation program.

At a high level, the evaluation found that the program and implementation supports were well regarded, however, stakeholders did not perceive the program documentation (assessment forms) favourably. Full details on the evaluation findings are provided in Standard 6.2. In response to these evaluation findings, we identified possible improvements to the program documentation.

Phase 2

Implementation of the new Accreditation Renewal Program is now in Phase 2. The findings from the Phase 1 implementation have been fed into the development work for Phase 2. Phase 2 incorporates the introduction of network accreditation as well as tools and processes to support both the monitoring and reporting stages of the accreditation cycle.

Following the evaluation of Phase 1, a number of amendments to the forms were made throughout Phase 2, including splitting the forms by roles and responsibilities.

Network Accreditation

The RACP implemented network accreditation through an initial rollout commencing in September 2023 ahead of a full rollout in 2024. Three Adult Internal Medicine Basic Training networks in NSW were selected for the initial rollout; Royal Prince Alfred, Nepean, and Liverpool. Training Providers within the initial rollout networks were provided with additional training and support ahead of the implementation. All stakeholders in the initial rollout are asked to complete an evaluation survey, the findings of which will be used to inform any changes to process ahead of the full rollout in 2024.

Paediatrics and Child Health Basic Training and Aotearoa New Zealand networks will undertake an initial rollout in early 2024 ahead of a full rollout in latter part of 2024.

Networks will undertake accreditation against the Training Provider Standards, Basic Training Adult Internal Medicine Accreditation requirements and Paediatric Requirements and the Training Network principles. The RACP will provide a flexible approach to accrediting networks, acknowledging the differences in governance and approach across the jurisdictions. Through the implementation of network accreditation, the RACP hopes to encourage the continued formalisation of networks and integrated training.

Monitoring

As part of Phase 2, the RACP has introduced the Monitoring of a Training Provider and Active Management processes (Appendices 8A.8 and 8A.9). The RACP monitors its Training Providers to ensure continued compliance with the standards, requirements, and criteria across the accreditation cycle.

The RACP's Active Management process articulates our approach to a very small proportion of Training Providers where serious non-compliance issues are identified. Through this process, Training Providers and the RACP collaborate to create an action plan (Appendix 8A.22) to regain compliance with the relevant standards, requirements, or criteria. Onus is placed on the Training Provider to set the timeframe and deliverables required to implement the action plan and ensure that the approach is appropriate and feasible. The RACP then monitors the Training Provider against the action plan.

Throughout the active management process, the RACP collaborates with accreditation stakeholders such as the trainees, DPEs, supervisors and Setting Executive to triangulate the progress of the action plan. The RACP notifies the relevant health department as a Training Provider is placed under active management and updates them at each milestone. The RACP collaborates with the health department in identifying potential solutions to concerns identified as part of the process. Our communication protocol for this process is discussed in Standard 8.2.3-8.2.4.

Reporting

As part of Phase 2 of the implementation of the Accreditation Renewal Program, the RACP will also introduce the publication of the accreditation executive summary. The executive summary will outline the accreditation programs that a Training Provider is accredited for and whether each standard, requirement or criteria is met, partially met, or not met. The publication of the executive summary will provide further transparency for trainees when selecting their Training Provider.

National Health Practitioner Ombudsman Recommendations (8.2.1)

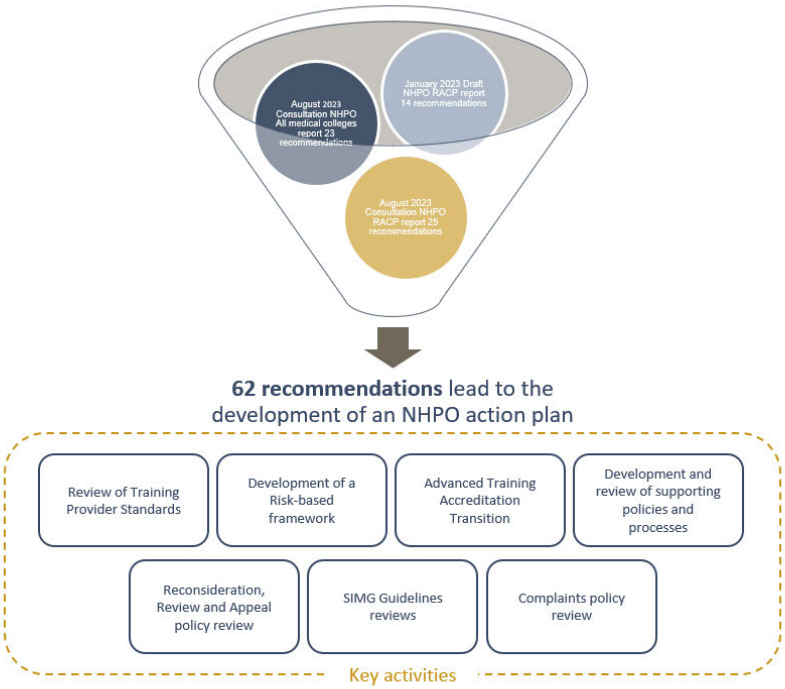
The remit of the National Health Practitioner Ombudsman (NHPO) was extended to cover accreditation bodies in January 2023. As part of its extended remit the NHPO undertook a desktop review of the RACP's and other medical college's accreditation policies and procedures. In total the NHPO has submitted three draft reports to the RACP for its consultation: an entity specific report in January 2023 (Appendix 8A.23), a broad review of accreditation processes across the medical colleges (Appendix 8A.24) with a further entity specific report in August 2023 (Appendix 8A.25). The RACP contributed to the consultation and accepted the recommendations, requesting further discussion on the indicative 12-month timeframe provided.

NHPO Action Plan

Whilst the recommendations from the NHPO are still in draft format, the RACP undertook analysis of the 62 recommendations across the three reports, identifying seven key activities required to implement the recommendations as summarised in Figure 97.

Drawing on this analysis, the RACP has developed an action plan to implement the recommendations across 2023 and 2024, which was endorsed by the College Education Committee in November 2023. The seven key activities in this plan are summarised in Figure 97 and with further detail for the more complex items described in the sections below.

Figure 97. NHPO action plan development and key activities



Review of Training Provider Standards

A review of the Training Provider Standards will be undertaken in 2024, with the aim of removing any duplication across the standards and reducing burden on accreditation stakeholders. Research will be undertaken to identify and map the Training Provider Standards to existing standards and legislative requirements within the health system. Following this, a workshop will be held in early 2024 to refine the existing frameworks, standards, and policies to reduce burden and ensure procedural fairness.

Development of a Risk-Based Framework

A second workshop will be held in 2024 to further develop a risk-based framework, ensuring a fair and proportionate response to non-compliance with the Training Provider Standards. Research into best practice will be undertaken to support the consideration of weighting the standards and the development of a risk-based decision matrix. The decision matrix will be used to inform the review type required (e.g. physical site visit, document review), with more intensive review types being reserved for Training Providers identified as ‘at risk.’

The risk-based framework will consider how data gathered outside of the comprehensive accreditation review (e.g. potential breach, MTS data) can be further utilised to identify ‘at risk’ Training Providers and what comparative data can be made publicly available to provide transparency to trainees.

Advanced Training Accreditation Transition

The RACP’s Training Accreditation Services team was established in 2020 as part of the Accreditation Renewal Program of work. The Training Accreditation Services team currently has operational remit of Basic Training accreditation and nine Advanced Training accreditation programs. Across 2024, the remaining Advanced Training accreditation programs will be transitioned under the operational remit of the Training Accreditation Services team.

As part of the transition, a review of current Advanced Training accreditation programs’ policies and processes will be undertaken to align and streamline these. Consistent policies and procedures will be published for each specialty, including policies for initial application, monitoring, active management of non-compliance with accreditation criteria and a high-level Advanced Training accreditation process.

Governance of accreditation decisions will remain as per existing structures, with the Training Accreditation Services team working closely with existing Advanced Training accreditation bodies.

Consistency in decision-making (8.2.1)

The RACP ensures consistent decision-making across its accreditation programs through a number of mechanisms as outlined below.

Accreditor on-boarding and training

The RACP has undertaken a substantial accreditor recruitment campaign to support the new accreditation program, with the current Basic Training Accreditor pool standing at over 80 accreditors. The RACP has developed an accreditor on-boarding e-module (Appendix 8A.26), which ensures that accreditors are aware of the required behaviours and attributes of an accreditor and that they are trained in relevant RACP accreditation policy such as the Decision-making guide (Appendix 8A.10).

The RACP also runs regular virtual accreditor on-boarding training and training sessions for accreditors on policy and procedure updates.

Accreditor Calibration

The RACP hosted its inaugural accreditors calibration day for its Basic Training accreditors in November 2023. The calibration day provides accreditors with the opportunity to come together to discuss experiences of the new accreditation program, work through case studies to support alignment in decision-making and receive further training on the new accreditation program. It is intended that the event becomes annual, with preparation underway to create formal calibration videos and activities to further support alignment across the accreditor pool.

Accreditor roles and responsibilities

The RACP has two tiers of accreditors; senior accreditors and accreditors. An outline of the accreditors roles and responsibilities is articulated in the accreditor role descriptions (Appendix 8A.27). When assigning accreditors to an accreditation review the RACP allocates based on:

- experience
- skills mix
- diversity of the panel
- rural, regional, or remote experience
- geographic location e.g. accreditors will often be allocated interstate to avoid conflicts of interest.

The use of senior accreditors and accreditor allocation criteria further allows for robust and consistent decision-making.

Conditions and recommendations workbook

The RACP maintains a conditions and recommendations workbook. The workbook serves as a bank of all the recommendations and conditions that have been handed down by the RACP and records against which standard, requirement, or criteria the condition or recommendation was made. The workbook allows the RACP to analyse trends in relation to where non-compliance with the standards is found and allows for consistency in both the approach of giving a condition versus a recommendation, and the wording of recommendations and conditions made.

Accreditation Renewal program evaluation

As outlined in Standard 6.2, the RACP is progressively evaluating the Accreditation Renewal Program. This activity will include an exploration of the extent to which decisions made under the new program align with the objectives of the Accreditation Renewal Program and whether there is consistency in decision-making.

Consistency in policy and procedure

The overarching RACP accreditation framework provides consistency in both policy and procedure and will reduce burden on accreditation stakeholders as policy and procedure are aligned and streamlined. The RACP will review its Advanced Training accreditation programs across 2024 with the intent of reducing burden for stakeholders who deliver a number of RACP training programs.

Communication of accreditation requirements with stakeholders (8.2.1)

The RACP publishes all collateral associated with its accreditation programs on the RACP website. Institutions seeking accreditation with the RACP are able to review all of the associated policies and procedures, alongside the relevant accreditation standards, requirements, and criteria.

The RACP's initial accreditation process (Appendix 8A.7) articulates the process for Training Providers seeking accreditation from the RACP for the first time. Training Providers also have access to an e-module outlining the overarching RACP accreditation program, training sessions hosted by the RACP and one on one support from the Training Accreditation Services team.

For those Training Providers seeking reaccreditation, the RACP schedules accreditation reviews across the calendar year, with schedules being finalised in Q2 of the year prior. The RACP notifies Training Providers of their upcoming review within six months of their review date, the notification correspondence articulates the date of the review, the type of review and links all relevant guidance.

Working with the health system regarding accreditation (8.2.3)

The RACP is committed to working with jurisdictions to share best practices in relation to work-based training, which will assist in providing trainees a breadth of experience in the discipline. The RACP meets with each Health Jurisdiction in Australia and Te Whatu Ora in Aotearoa New Zealand quarterly to provide updates on accreditation, discuss the health care system and notify of any accreditation concerns with Training Providers. A communication protocol has been developed between the AMC, medical colleges and jurisdictions to articulate communication between accreditation stakeholders at the point of which a trainee setting was identified as being at risk. There was agreement to involve the jurisdictions early when serious concerns are identified.

Collaboration with other education providers regarding accreditation (8.2.4)

A communication protocol has been developed between the jurisdictions and medical colleges to articulate communication between accreditation stakeholders at the point of which a training setting was identified as being at risk.

The RACP collaborated with other Colleges and contributed to the development of this communication protocol which seeks to:

- provide clarity on role and responsibilities of colleges, accredited organisations and health departments
- establish effective communication channels between colleges, accredited organisations and health departments
- ensure collaboration between colleges, accredited organisations and health departments to resolve issues arising from accreditation reviews
- ensure that accreditation standards, processes and decisions are clear, informed by evidence and based on the principles of fairness, transparency and accountability
- ensure that all participants have an understanding of the timeframes involved in the accreditation process.

The protocol applies to specialist medical training accreditation in public hospitals and health facilities in Australia and is a good faith agreement between all parties.

The RACP has also collaborated with other Education Providers including the Royal Australasian College of Surgeons (RACS), the Royal Australian and New Zealand College of Ophthalmologists (RANZCO), the Australian and New Zealand College of Anaesthetists (ANZCA), and the Royal Australasian College of Medical Administrators (RACMA), who have partnered to form a consortium for the proposed FATES (Flexible Approach to Training in Expanded Settings) project; 'Rural Training Models'. The Rural Training Models project has been designed to support quality specialist medical training in regional, rural, and remote Australia, reduce barriers to practice rurally, improve maldistribution and provide culturally safe training experiences. FATEs encourage projects that support flexible specialist training, training support and accreditation practices. The RACP is working collaboratively with other Colleges on this project by sharing common approaches and consulting on relevant information with each other.

Summary of Standard 8

Strengths and key developments

- an extensive Education Leadership and Supervision Policy and Framework that defines educational leadership and supervision in the context of RACP training programs while allowing flexibility and refinement for specialty specific and local implementation
- competence-based Standards for Education Leadership and Supervision to provide clarity about expectations, drive excellence and establish a consistent and transparent approach to providing quality supervision
- a well-regarded Supervisor Professional Development Program (SPDP) to support supervisors to grown in their competencies, and use in our supervisor credentialling program
- strong progress with implementation of the supervisor credentialling program
- a continuous improvement approach to supervisor development in the context of our changing education programs, as supported by our program evaluation of the SPDP
- a comprehensive renewed Accreditation Program, incorporating elements of quality assurance and continual quality improvement and support for integrated training pathways
- new RACP Accreditation Standards, Requirements and Training Network Principles which are aligned to support implementation of RACP curricula, policies and frameworks in safe and supportive learning environments
- phase 1 implementation of the new Accreditation Program including communication, change management and training setting and training provider accreditation for Basic Training
- progress with Phase 2 of the new Accreditation Program, including a pilot of network accreditation and new Monitoring Processes
- release of Capacity to Train Guidance and associated e-module
- robust materials to support accreditation activities, including a Potential Breach of Training Provider Standards Process, Active Management Process, Information Sharing Protocols and an Accreditation Decision Guide
- an Action Plan to guide our response to the National Health Practitioner Ombudsman's (NHPO) recommendations regarding accreditation bodies
- a comprehensive plan to conduct program evaluations of the Accreditation Program as it is being implemented, with the first evaluation report delivered and recommendations being addressed.

Current and future focus areas

- implementing the NHPO recommendations and associated seven key activities outlined in the NHPO Action Plan
- implementing all the phases of the Accreditation Renewal Program implementation, including into Advanced Training
- ensuring that accreditation promotes a balance between service provision and training, safe training environments, training in expanded settings including in rural and Indigenous health settings and the development of integrated training pathways.

Standard 9
Assessment of specialist international medical graduates

Explanatory note from RACP on terminology in Standard 9

The term used for Specialist International Medical Graduates (SIMGs) undergoing specialist assessment by the RACP in Australia and Aotearoa New Zealand is Overseas Trained Physicians or Paediatricians (OTPs). Throughout this response the term Overseas Trained Physicians is used to align with our policies and procedures.

Standard 9 Assessment of specialist international medical graduates

9.1 Assessment framework

AMC accreditation standards	
9.1.1	The education provider's process for assessment of specialist international medical graduates is designed to satisfy the guidelines of the Medical Board of Australia and the Medical Council of New Zealand.
9.1.2	The education provider bases its assessment of the comparability of specialist international medical graduates to an Australian- or New Zealand- trained specialist in the same field of practice on the specialist medical program outcomes.
9.1.3	The education provider documents and publishes the requirements and procedures for all phases of the assessment process, such as paper-based assessment, interview, supervision, examination, and appeals.

Background

The RACP assesses approximately 200 applications in Australia via the specialist pathway and 70 in Aotearoa New Zealand each year. Assessment of Overseas Trained Physicians and Paediatricians (OTPs) by the RACP is conducted separately in each country in line with the requirements of the MBA and MCNZ respectively. OTP assessment committees across the Divisions, Faculties and Chapters in Australia and Aotearoa New Zealand oversee the assessments. The process is supported by a team of eight staff across Australia and Aotearoa New Zealand. In Australia, the MBA has assigned the RACP the function of assessing the eligibility of overseas trained specialists for specialist registration in the following specialties:

- Addiction Medicine
- Cardiology
- Clinical Genetics
- Clinical Pharmacology
- Community Child Health
- Endocrinology
- Gastroenterology
- General Medicine
- General Paediatrics
- Geriatric Medicine
- Haematology
- Immunology and Allergy
- Infectious Diseases and Microbiology
- Medical Oncology
- Neonatal and Perinatal Medicine
- Nephrology
- Neurology
- Nuclear Medicine
- Paediatric Emergency Medicine
- Palliative Medicine
- Respiratory Medicine
- Sleep Medicine
- Rheumatology
- Sexual Health Medicine
- Public Health Medicine
- Rehabilitation Medicine
- Occupational and Environmental Medicine

In Australia, the RACP also assesses OTPs who wish to work in Commonwealth designated 'Area of Need' (AoN) positions. An OTP being assessed for an AoN position will be simultaneously assessed for specialist recognition.

The RACP fulfils different roles in Australia and Aotearoa New Zealand in relation to the assessment of OTPs. The RACP determines assessment decisions on the eligibility of OTPs for specialist recognition in Australia. The RACP recommends assessment decisions to the MCNZ on the eligibility of OTPs for vocational registration in Aotearoa New Zealand.

In Aotearoa New Zealand, the assessment of OTPs is managed by the MCNZ and the RACP plays an advisory role as a Vocational and Education Advisory Body to the MCNZ. OTPs in the scopes of Internal Medicine, Paediatrics, Addiction Medicine, Public Health Medicine, Palliative Medicine, Occupational & Environmental Medicine, Sexual Health Medicine, Rehabilitation Medicine, and Dermatology deemed by the MCNZ to be appropriate applicants are referred to the RACP for assessment of eligibility for vocational registration. The RACP works closely and collaboratively

with the MCNZ on OTP assessment processes and meets with Council annually to discuss matters to continually improve assessment processes.

Policies and procedures (9.1.1)

The RACP policies and procedures for assessing OTPs were developed in accordance with the guidelines outlined by the MBA and the MCNZ. Following the release of the MBA Standards for assessment in 2021, our policy and procedures were reviewed and updated.

As a standard, the policy and procedures supporting the OTP assessment processes are reviewed informally on an annual basis to ensure continuous improvement as well as formally every three years. We also respond to regulatory feedback such as the recommendations from the Deloitte review commissioned by the Medical Board of Australia in 2017. The RACP was found to be substantially compliant with the MBA guidelines and has subsequently implemented the recommendations made by Deloitte to strengthen procedures for OTP assessment. The RACP also conducted an internal audit of the OTP Unit in 2021 to assess the effectiveness of controls associated with the assessment of OTPs. A number of recommendations were provided which the college is progressing.

The RACP policy on assessment of Overseas Trained Physicians and Paediatricians (Appendix 9A.1) is the overarching policy which sets out the regulatory framework, RACP role and responsibilities for assessment in Australia and Aotearoa New Zealand as well as OTP responsibilities. Under this policy are three sets of guidelines for each of the pathways assessed by the RACP. There is no divergence from the MBA or MCNZ standards. However, there are two MBA compliance metrics (10 and 11) that the RACP cannot meet due to our processes for procedural fairness. As the RACP assesses more than 30 specialties, assessment decisions are centralised with the sub/committees following paper-based review or interview. This ensures consistency in decision making and effective governance. However, it means that the committee process following interview often means we are unable to release the OTP's assessment decision within the timeframes set under metrics 10 and 11.

Outlined below are the RACP's assessment pathways for both Australia and Aotearoa New Zealand including the associated guidelines for applicants.

Assessment Pathways in Australia

Specialist Assessment

The Overseas Trained Physicians Guidelines (Australia) (Appendix 1A.39) are aligned with the MBA Good Practice Guidelines and more recently Standards for SIMG assessment. They set out all stages of the processes with clear contact points for further information or clarification on the process. We regularly review the specialist assessment procedures and processes for OTPs to:

- maintain alignment with the MBA Standards including working to procedural fairness principles
- meet MCNZ requirements under its Memorandum of Understanding with specialist medical colleges, including timeframes
- ensure continuous improvement and enhancements to the process
- 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 procedures for specialist assessment are set out clearly on the RACP website including instructions for application, a breakdown of fees, eligibility criteria, requirements, and links to guiding documentation. For further information visit Australia | Specialist assessment.

Area of Need Assessment

AoN positions are specialist positions declared by Australian state or territory government authorities in places where there is a shortage of medical specialists. These are often in rural or

remote areas. The RACP does not assess AoN applications alone and OTPs must apply for Specialist Recognition as a part of this process. The OTP Committee determined that it is not possible to assess an OTP's suitability for an AoN position without assessing them for specialist recognition. Therefore, both assessments are conducted simultaneously and the associated timeframes for assessment met.

The process benefits the OTP and the Australian workforce as it provides a pathway for the OTP to achieve specialist registration at the same time as providing an outcome for the area of need position.

The procedures for AoN assessment are set out in the Overseas Trained Physicians Guidelines (Australia) which have a specific section for AoN applicants (see page 18 of the guidelines). The assessment procedures are set out clearly on the RACP website including instructions for application, a breakdown of fees, eligibility criteria and possible outcomes: Area of need positions in Australia for overseas trained physicians (Appendix 9A.2).

Assessment Pathway in Aotearoa New Zealand

Vocational registration

The Aotearoa New Zealand OTP guidelines for applicants (Appendix 9A.3) set out the procedures for applicants seeking vocational registration in Aotearoa New Zealand. These procedures are aligned with the MCNZ Memorandum of Understanding and assist applicants to understand the role of the RACP in conjunction with the policies and procedures set out by MCNZ, who oversee the assessment of OTPs in Aotearoa New Zealand (See Table 51).

The procedures for assessment in Aotearoa New Zealand are set out clearly on the RACP website including links to the MCNZ website for applicants to apply for assessment, information on the RACP interview process, and possible outcomes: Aotearoa NZ | Vocational registration (racp.edu.au) (Appendix 9A.4).

Table 47. Comparison of OTP Assessment Processes in Australia and Aotearoa New Zealand

OTP Assessment	Australia	Aotearoa New Zealand
Role	RACP undertakes the assessment for specialist recognition and AoN in Australia on behalf of MBA. Assessment of OTP eligibility for Fellowship is also undertaken concurrently.	MCNZ manage the assessment process; RACP acts as an advisory body for assessment for registration within a vocational scope of practice. Assessment of OTP eligibility for Fellowship is a separate process
Assessment Methods	**Application** Application documentation plus AoN job description and application (if applicable) is reviewed by Case Officers supported by senior staff and the Chairs of the OTP Assessment Subcommittees to provide preliminary advice to the applicant. This advice may be that: - the applicant does not meet the criteria for the specialist pathway - more information is required or would strengthen the application - the applicant should proceed to interview - the applicant is eligible for paper-based review and an interview is not necessary. **Interview** An interview panel comprised of a member of the OTP assessment subcommittee and a representative from each of the relevant subspecialties	**Application** When preliminary advice is sought by MCNZ, a specialty representative will submit a recommendation on an applicant's suitability for vocational registration based on whether the applicant has qualifications, training, assessment, CPD and experience comparable to that of an Australasian trained Fellow in the specialty concerned. **Interview** When interview advice is sought by MCNZ, two Fellows (one from the appropriate specialty and one from the Aotearoa New Zealand OTP Assessment Committee) conduct an interview to assess whether the OTP's qualifications, training, assessment, CPD and experience are equivalent to that of an Australasian-trained physician. **Committee review**

OTP Assessment	Australia	Aotearoa New Zealand
	collects further information on the applicant's qualifications, training, assessment, CPD and experience. If an AoN application is being considered, the panel considers the specific requirements of the AoN job description. Following the interview there is an opportunity for the applicant to review the interview report and any other documentation collated throughout the assessment process such as referee reports. **Committee review** The relevant OTP Assessment Subcommittee reviews the documented application, interview report, panel recommendation, and any further written material provided by the applicant in response to the interview report to determine the applicant's comparability to an Australasian trained physician.	The Aotearoa NZ OTP Assessment Committee reviews the interview report and recommendations of the interviewers in order to decide a recommendation to the MCNZ. The MCNZ then considers this recommendation to decide a registration outcome.
Outcomes	Possible initial outcomes: 1. Substantially comparable 2. Partially comparable 3. Not comparable. Outcomes are advised to the applicant and to Ahpra through the AMC. For more detail on outcomes, see below.	Possible recommendations: • Option A – Equivalent (supervision pathway) • Option B - Nearly equivalent (assessment pathway) • Option C - Not equivalent • Option D – Interview (preliminary advice only) For more detail on outcomes, see below.
Reconsiderations, reviews and appeals	OTP applicants are entitled to procedural fairness and have access to the same reconsiderations, reviews and appeals process as Fellows and trainees who are affected by decisions of the College. Applicants can seek a reconsideration of the decision by the originating committee (no charge). After reconsideration, they can request a review by a higher committee (cost recovery charges apply). If still dissatisfied, they can appeal and a panel of senior Fellows will be appointed to hear their case (cost recovery charges apply).	Applicants must seek reconsiderations, reviews and appeals from the MCNZ.
Further assessment	Further assessment includes some or all of: an online orientation program, a period of peer review, top up training, work-based assessments, a practice visit and participation in CPD. These are organised and monitored by the College, leading to a final outcome decision by the OTP Assessment Subcommittee.	Further assessment is managed by the MCNZ. In some instances, the College may be asked for advice on the OTP's progress against set assessment criteria.

Alignment of OTP assessment to specialist medical program outcomes (9.1.2)

The RACP OTP assessment standards align to the RACP Advanced Training program and outcomes for the relevant scope of practice. Throughout the assessment process, the RACP takes a holistic approach to assess the OTP's qualifications, training, assessments, experience and CPD. These factors collectively influence the OTP's ability to practice at a level comparable to the standard expected of a specialist trained in Australasia commencing within the same scope of practice.

Our online interviewer training course makes explicit to assessors the level at which they must assess OTPs and the key documents available to them during the process including the Advanced Training Curricula and outcomes, the Professional Practice Framework (Appendix 2A.9) and associated training assessments.

In 2018, the RACP developed decision-making guidelines for OTP Assessment Sub/committees to support interviewers and other Fellows involved in the OTP process. 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 Aotearoa New Zealand physician.

Assessment outcomes Australia - Specialist Pathway

The outcomes of OTP assessment in Australia are either Substantially Comparable, Partially Comparable or Not Comparable in line with the MBA Standards (See Table 52).

Table 48. Outcomes of OTP Assessments

Outcome	Description
Substantially comparable	Requirements: Up to 12 months of satisfactory practice under peer review to ensure the level of practice demonstrated is comparable to that of an Australasian trained specialist. Associated assessments can include a practice visit, multi-source feedback, direct observation of procedural skills, completion of the OTP orientation program and/or completion of CPD requirements.
Partially Comparable	Will be considered comparable to an Australian trained specialist within 24 months of further training, assessment and oversight. Requirements: A combination of the following: • up to 12 months of satisfactory practice under peer review • up to 12 months of top up training (equivalent to Advanced Training) • Associated assessments can include a practice visit, multi-source feedback, direct observation of procedural skills, completion of the OTP orientation program and/or completion of CPD requirements.
Not Comparable	Not eligible to proceed via the specialist pathway — advised to consider alternative pathways to registration and/or enrolment in the College's training program (which includes options for recognition of prior learning).

Assessment outcomes Australia - Area of Need (AoN) Pathway

Table 49. Assessment outcomes – Area of Need Pathway

Outcome	Requirements
Suitable for AoN	12 months of satisfactory AON practice under peer review
Not Suitable for AoN	Not suitable to practise in the position

Due to the demanding nature of AoN positions, the RACP will only support the appointment if there is suitable supervision available and the OTP is found to be substantially comparable to an Australasian-trained specialist. This is because adequate supervision and support is not readily available for partially comparable OTPs in areas of need to ensure a high level of medical service

is maintained. Partially comparable OTPs also require upskilling/training and this is often not available at AoN sites (See Table 53).

Assessment Outcomes Aotearoa New Zealand

As in Australia, the RACP compares OTPs to the level of a first-year consultant in Aotearoa New Zealand and aligns recommendations with the assessment outcomes set by the MCNZ (See Table 54).

Table 50. Assessment Outcomes Aotearoa New Zealand

Outcome	Description
Option A (Supervision Pathway)	The applicant has qualifications, training, assessments, CPD and experience equivalent to a medical practitioner vocationally registered in the same vocational scope. Registration within a vocational scope of practice will be appropriate after 6-12 months of supervised practice and on receipt of satisfactory supervisor's reports, as well as enrolling in MyCPD.
Option B (Assessment Pathway)	The applicant has qualifications, training and experience nearly equivalent to a medical practitioner vocationally registered in the same vocational scope and is expected to reach the standard of competence required for registration within a vocational scope of practice within 12-18 months of supervised clinical experience and assessment (a vocational practice assessment -VPA) as well as enrolment in MyCPD. Council will advise the Vocational Education Advisory Body when the doctor has been granted registration in a vocational scope of practice.
Option C	The applicant's training, qualifications and experience are not equivalent to that of a medical practitioner vocationally registered in the same vocational scope, or the College is unable to provide a recommendation.
Option D (Preliminary advice only)	The College is unable to reach a recommendation, and an interview is required.

Recommending a 'limited scope of practice' outcome

Further to correspondence with and advice from the MBA and MCNZ to clarify options for flexible assessment of OTPs, including registration in a limited scope of practice, the RACP commenced recommending 'limited scope' outcomes for OTPs who are considered to be substantially comparable in a limited scope of a recognised specialty in 2016.

Recognising that medicine is constantly evolving and that often, consultants further specialise once they complete their training, RACP will assess OTPs for a limited scope of practice where they have substantial experience in a particular field of medicine but may not meet the requirements for registration in the full scope of practice. To be considered, applicants should demonstrate a high level of subspecialist skill within their limited scope without being able to demonstrate substantially comparable skill across the full scope of the recognised specialty. The applicant will generally have substantial experience in their country of training as a subspecialist and have well-defined and highly developed subspeciality skills (e.g. in stroke, obesity medicine, or spinal rehabilitation medicine).

Limited scope outcomes are designed to give effect to the MBA's Registration Standard for Specialist Registration and experts within the particular field are recruited to assess the OTPs comparability to an Australian specialist working in a comparable field. Their qualifications, training and assessments are compared with the RACP training program outcomes and assessments and experts provide specific advice on the applicant's experience and CPD.

Publication of requirements and procedures for assessment (9.1.3)

All requirements and procedures for specialist assessment are outlined and published in the Specialist Assessment of Overseas Trained Physicians and Paediatricians Guidelines (Australia).

Requirements and procedures for assessment in a vocational scope are outlined and published in the OTP Guidelines Aotearoa New Zealand.

In addition, the overseas specialists webpage on the RACP website (Appendix 9A.5) outlines the assessment pathways for OTPs, eligibility criteria, resources, application process, assessment outcomes, requirements and fees for Australian and Aotearoa New Zealand OTPs.

The College's Reconsideration, Review and Appeals Process By-Law (Appendix 2A.9) is also available publicly on our website and provides the procedures for applicants to lodge a reconsideration, review or appeal of a College decision. We also have a FAQ section to guide applicants on the timelines, application process and fees.

In response to the National Health Practitioner Ombudsman Review Action Plan in September 2023, we have planned improvement to the published guidelines that will take effect in Q2 2024. These relate to:

- updating the specialist international medical graduate (SIMG) Guidelines and the information available on our website to clearly communicate:
    - the steps involved in assessing an application for re-assessment
    - how to submit an application for re-assessment, with a link to the applicable form
    - possible outcomes from RACP's consideration of a re-assessment application, including whether a re-assessment decision is subject to the Appeals Policy
- updating the SIMG section on our website to:
    - provide further guidance about how the reconsideration, review and appeal processes apply to SIMG assessment decisions
    - include the general FAQ section about reconsideration, review and appeal processes it has developed and expand the FAQs to include more specific information about how these processes apply to SIMG assessment decisions.

Significant changes since previous reaccreditation (2014)

Since the 2014 reaccreditation, there have been significant changes to the governance of OTP assessment as well as process improvements to streamline and increase transparency whilst maintaining robust assessment processes that focus on quality. These changes have been implemented through consultation with the MBA and MCNZ and often as a result of recommendations made by the MBA and the MCNZ. Appendix 9A.6 (RACP OTP Process Improvement Timeline) demonstrates the changes made to the OTP assessment process since 2014.

Improved OTP assessment governance

In 2015, the RACP undertook a review of its governance structures and after wide consultation, introduced an overarching policy-level OTP Committee that was responsible for overseeing the assessment of OTPs. The OTP Committee reports directly to the College Education Committee (CEC), which is the peak body responsible for developing and overseeing College-wide education policy and approving both new and amended training and education programs. The OTP Committee considers policy and procedural matters in line with regulatory requirements and, with approval of the CEC, makes subsequent changes to ensure the RACP remains compliant with regulatory standards as well as contemporary assessment methods aligned with training programs. They are also the review committee for any OTPs that wish to challenge a decision made by the relevant assessment sub/committee. The OTP Committee will provide feedback to the assessment sub/committee following the review outcome.

Reporting to the OTP Committee are two OTP Assessment Subcommittees responsible for assessing OTPs in Australia as well as a dedicated Aotearoa New Zealand OTP Assessment Committee. The members of these Subcommittees are Fellows of the RACP who have particular interest or expertise in OTP assessment. The terms of reference stipulate that at least one previous OTP needs to be represented on the Assessment Subcommittees and Aotearoa NZ OTP Assessment Committee.

The College's OTP assessment sub/committees meet monthly to determine assessment outcomes for OTPs. They also meet jointly to discuss policy and procedure matters and to ensure that practices of each sub/committee remain consistent. The College also participates in the Network of College IMG Managers in Australia to assist in sharing knowledge and standardising processes wherever possible. These activities have led to a range of improvements in the assessment process and to enhanced support for applicants.

Improvements to RACP policy and guidelines

Following the release of the MBA *good practice guidelines for specialist medical college assessment of IMGs*, the RACP undertook a review of all associated policies, procedures, and guidelines to align with the MBA standards. An overarching policy was developed which outlines the RACP's roles and responsibilities in the assessment of OTPs in both Australia and Aotearoa New Zealand. Individual guidelines were then developed for the specialist assessment and short-term training pathways in Australia and the vocational registration assessment pathway in Aotearoa New Zealand.

Introduction of paper-based reviews

In 2016, the RACP implemented the paper-based review process for UK and Irish applicants following research and a subsequent pilot which demonstrated that assessment data supported a streamlined process for applicants being assessed with UK and Irish specialist qualifications. The introduction of paper-based reviews meant that specific cohorts of applicants could receive their interim assessment decision within a three-month timeframe from the date a complete application was received.

Due to the reduction in OTPs being required to be interviewed, this also significantly reduced the interview wait time for other OTP applicants and paved the way for the College to conduct OTP assessments more efficiently, utilising existing assessment data. The introduction of paper-based reviews in 2016 combined with a shift to interview via videoconferencing reduced the wait period for an OTP interview from nine months to eight weeks. We maintained these timeframes to ensure an OTP interview within three months (from date of complete application) as per the MBA benchmarks for specialist assessment.

After successful implementation of the paper-based review process for UK and Irish applicants, the process was introduced for other qualifications in Hong Kong, India and Sri Lanka where data supported a streamlined process with an interview required only where clarifications were sought.

Assessor support and resources

To facilitate consistent decision making, we also introduced country qualification guides for assessors to utilise alongside applicant documentation. These guides were produced using publicly available information on the curricula, training, assessments and experience required for particular international qualifications. The condensed information provides a succinct overview for assessors as well as guidance on the comparability of the qualification based on existing assessment data. This was introduced in recognition that assessor knowledge takes time to build, and many new assessors were spending time reviewing qualifications to compare comparability when assessment data already showed it was either partially, substantially or not comparable.

Use of the country qualification guides provides assessors with reassurance on the comparability of the particular qualification, enabling them to focus their assessment on aspects such as post-qualification experience and Continuing Professional Development (CPD) to determine overall comparability to an Australasian physician. The introduction of these guides has facilitated more consistent decision making as well as efficient processes to upskill new assessors on international qualifications.

In 2017, we introduced interviewer training for all RACP assessors including sub/committee members. The intent of the training is to ensure a robust interview process which is free from an unconscious bias and provides transparency for applicants. It ensures that interviewers obtain the information and clarifications required to build on information provided in the written application, thus strengthening the quality of the assessment documentation provided to the assessment sub/committees for decision making. The programs use a variety of educational approaches to engage participants, including role plays, videos, and group work. In 2020, we developed online

interviewer training programs when face to face workshops were prevented by COVID-19 lockdowns. This has enabled a larger reach to assessors across Australia and Aotearoa New Zealand.

Wellbeing of OTPs

OTP wellbeing has also been a significant focus for the College, and we have introduced multiple new initiatives to ensure OTPs are supported through their transition to practice in the Australasian healthcare system. This includes the release of a new OTP orientation program in 2018, which aims to educate OTPs on critical aspects of the Australian healthcare system that may differ to overseas systems. Other specialist medical colleges also use our program to orientate their OTPs as it focuses on aspects that are applicable across specialties such as Medicare, MBS, PBS, cultural safety, communication, quality and safety.

In 2018, we expanded access to our RACP support helpline to OTPs which provides fully confidential and independent support through qualified professionals. The introduction of our RACP Online Community in 2022 provided further connections for OTPs undertaking specialist assessment in Australia, with a specific community established for applicants to connect with each other to discuss vital aspects of medical practice in Australia as well as sharing experiences of the assessment process. Some anonymous quotes from applicants engaging on the RACP online community are provided below:

"It is a pleasure to be a part of this group. I hope we can continue to support each other and the next ones to arrive."

"I completed the OTP orientation course last May and found it be very useful. The OTP network may give support and guidance to each other in cultural orientation and healthcare regulations in addition to subject specific advancements."

"I am happy to contribute to the OTP community. I think it is a great initiative to help other OTPs with practical tips as the process can feel a bit of a maze sometimes."

"It is great to hear from and connect with other doctors going through the process. Thank you for sharing your experiences."

Response to the Independent Review of Overseas Health Practitioner Regulatory Settings (the Kruk review), Australia

The College fully supports the overarching objective of the Independent Review of Overseas Health Practitioner Regulatory Settings review (the Kruk review) to recommend reforms to streamline regulatory settings to make it simpler, quicker, and cheaper for OTPs to work in Australia.

There has been, and continues to be, much focus from regulators on streamlining assessment processes to improve timeframes for OTPs with particular focus on College processes. The benchmarks and compliance metrics introduced by Ahpra in recent years have kept Colleges accountable for a fair, transparent, and efficient assessment process that is robust and ensures quality. For public safety, speed and cost of assessment are not the only metrics that the review should be prioritising.

One of the most valuable recommendations from the Kruk report that will improve the experience for OTPs on the specialist pathway, is to remove duplication and align evidentiary requirements between agencies. We hear from our OTPs anecdotally that the same documentation is required for the Ahpra, AMC, College, employers, immigration and Medicare. Applicants become frustrated with the process to have multiple documents formally certified and the lack of cooperation between government agencies to assess the same documentation, which increases costs to the OTP. The linear approach to the assessment of OTPs also means it is a lengthy process to achieve specialist registration.

A centralised portal for all agencies to access OTP documentation such as: identification, medical qualifications, or English language results would significantly streamline processes and timelines

for OTPs. A workflow could also be created so that the OTPs application is seamlessly passed on between agencies once the relevant body has completed its assessment e.g., the applicant completes all required documentation for the AMC, College and Ahpra at the start of the process and the AMC passes documentation to the College upon verification of qualifications and the College to Ahpra upon completion of specialist assessment.

In response to the final report released in December 2023, the College is reviewing the recommendations and collaborating with regulators to progress work required to further streamline processes for OTP assessment.

Response to Deloitte review by the Medical Board of Australia

Following the Deloitte review commissioned by the MBA and the subsequent recommendations, the OTP committee undertook a review of the assessment methods used to determine OTP comparability. Noting the recommendations associated with the use and purpose of examinations in OTP assessment, the RACP examinations were of particular focus due to concerns that they were no longer fit for purpose to assess OTP competence. The MBA guidelines state that partially comparable applicants must be able to reach the level of an Australian trained physician within two years of upskilling and associated assessments. The OTP Committee determined that as the RACP Divisional Examinations are designed to assess readiness for entry into advanced (specialty) training, they were no longer an appropriate assessment tool for OTPs undertaking specialist assessment. Exit exams for Faculties and Chapters are still considered on a case-by-case basis as these exams are designed to assess readiness for specialist practice in Australia and Aotearoa New Zealand.

Service delivery improvements

Finally, recognising the importance of efficient and clear processes that are easy to navigate, we have invested in additional resourcing and staff training to support increased service delivery for OTP assessment. We recognise that the College is only part of the full journey for OTPs to practise in Australia and we are accountable for delivering an efficient and transparent service to enable OTPs to receive an assessment decision and commence practice in Australia as soon as possible. We have digitalised all of our processes and continue to invest in technology to support assessment processes for both applicants, assessors, supervisors and employers.

9.2 Assessment methods

AMC accreditation standards	
9.2.1	The methods of assessment of specialist international medical graduates are fit for purpose.
9.2.2	The education provider has procedures to inform employers, and where appropriate the regulators, where patient safety concerns arise in assessment.

Assessment methods (9.2.1)

Formative assessments focus on assessment for learning through feedback and guidance. They are conducted through structured assessment forms submitted online, which involve the OTP and supervisor/peer reviewer interaction. The College first introduced formative assessment practices into its training programs in 2008 and in the Divisional, Faculty and Chapter Advanced Training programs in 2011. The assessment tools utilised to assess OTP competence align with the tools utilised to assess trainee competence. These tools are designed to facilitate setting learning goals, observation of performance, discussion and written reflection.

A common strength of the College's formative assessments is that they aid the OTP and supervisor through a formal feedback discussion, prompting areas for discussion highlighted by the OTP's performance. The College's formative assessments are based on existing work-based assessment methods and best practice in medical education.

As we move to implement our renewed Advanced Training programs, assessments, and terminology, used in the OTP assessment process will be aligned.

Methods of learning and assessment, Australia

Peer Review (Supervised Practice)

For OTPs with an assessment outcome of substantially comparable, there is a requirement of 12 months of satisfactory practice under peer review to ensure the level of practice demonstrated is comparable to that of an Australasian trained specialist. For those with a partially comparable assessment outcome, the peer review requirement is up to 24 months of satisfactory practice under peer review.

For substantially comparable OTPs, the period of peer review is normally 12 months full time equivalent but this may be extended or reduced at the OTP Assessment Subcommittees discretion. Depending on the OTPs comparability and their exposure to the Australian healthcare system, they may only be required to complete 6 months of practice under peer review.

OTPs are responsible for finding their own peer review positions. The programs for peer review are confirmed between the OTP and the hospital before they submit an application for approval. The OTP's peer reviewers should be on-site and practising (registered as specialists on AHPRA's register of medical practitioners – Appendix 9A.7) in the same subspecialty in which the OTP is applying for peer review. Peer Reviewers should have held Fellowship of the RACP for a minimum of 12 months to be considered suitable for peer review. If an applicant is in a remote area/area of workforce shortage, an alternative proposal of three peer reviewers may be made. These should include two onsite peer reviewers (one in the same subspecialty, and one in a different subspecialty), and the third peer reviewer is to be off-site in the same subspecialty as the OTP, with regular contact with the OTP.

The frequency and type of contact should be documented as part of the Peer review application. All peer review positions must be prospectively approved. The RACP does not retrospectively approve any peer review. Peer review is approved by a Co-opted member of the relevant specialty and a member of the relevant OTP Assessment Subcommittee. Peer review is designed to assess competence at the level of a specialist, entering their first year consultant role and is assessed through peer feedback. The MBA and MCNZ both recognise peer feedback as a valuable professional development tool.

Top up Training (Supervised Practice)

Partially comparable applicants will have to complete a period of Top Up Training (TUT) in order to reach the required standard of a consultant physician or paediatrician in Australia. The period of TUT is normally 12 months, but this may be extended or reduced at the OTP Subcommittee's discretion. During this period, the OTP's supervisors are required to submit supervisor reports on their progress at three, six and twelve month intervals to evaluate progress.

OTPs are responsible for finding their own positions for TUT. All TUT must be undertaken at an RACP accredited site. The programs for TUT are confirmed between the OTP and the hospital before they submit an application for approval. All training positions must be prospectively approved. The RACP does not consider retrospective approval of practice previously undertaken in Australia or Aotearoa New Zealand.

TUT must be satisfactorily completed as well as TUT requirements (Physician Readiness for Expert Practice (PREP) tools, logbooks courses etc) before the OTP can progress to practice under peer review. Note the use of PREP tools will transition to the new Advanced Training Curricula as it is rolled out, the aim of the new curricula is to shift to competency-based assessment for OTPs and Advanced Trainees.

All TUT positions require prospective approval by a Co-opted member of the relevant specialty and a member of the relevant OTP Assessment Subcommittee.

Practice Visits

Practice visits are required for some applicants during peer review (supervised practice). They are one day site visits by two RACP trained assessors and include:

- a review of patient records
- direct observation of the OTPs procedural skills

- observation of the OTPs interactions with patients
- discussion with the OTP and their peer reviewers.

Practice visits are often utilised by the OTP Assessment Subcommittees where there are concerns about the OTPs performance or their supervision arrangements at a particular site.

Multisource feedback

Multisource feedback (MSF) provides specific and actionable feedback and assists the OTP in identifying strengths and areas for practice improvement. OTP's may be required to undertake an MSF if issues are highlighted around professional domains such as communication, personal skills and patient interaction or where there's limited onsite support or remote supervision.

Continuing Professional Development

OTPs assessed as substantially comparable or partially comparable are required to complete the equivalent number of hours of CPD activities in the relevant RACP MyCPD program as an OTP CPD participant. OTPs are required to provide evidence of completion of their CPD to be eligible to apply for Fellowship. Many activities undertaken during the peer review period can be claimed as CPD:

- OTP Orientation Program (see below for details)
- peer review meetings
- teaching
- research
- self-assessment activities.

OTP Orientation Program

The OTP orientation program is a learning tool to prepare OTPs for practice in Australia. OTPs must complete the online OTP orientation program within three months of starting their requirements. The OTP orientation program supports OTPs to:

- understand the Australian healthcare setting, including health services regulation, funding and delivery, as well as emerging models of care
- follow legislative requirements for practice and prescription of pharmaceuticals
- acknowledge the broader context of health, including meeting the needs of diverse patients and delivering culturally safe and person-centred care
- develop professional skills in managing personal health and wellbeing, teaching, communication, working in multidisciplinary teams and administrative skills
- describe the importance of ethical decision making and understand how to deliver safe and high-quality care, which meets quality and safety regulatory requirements
- understand how the RACP can provide support and help to meet their CPD requirements.
- meet the highest standards of professionalism, by following the Professional Practice Framework.

Methods of learning and assessment, Aotearoa New Zealand

In Aotearoa New Zealand the MCNZ determines the type of registration for which an OTP is eligible and makes the final decision on whether registration is granted. The methods of assessment recommended by the Aotearoa NZ OTP Assessment Committee are the same as those utilised to assess OTPs in Australia and link back to our training program assessment requirements as well as medical regulator evidence for activities that increase performance and enhance professional development.

Cultural safety course

Specifically for the Aotearoa New Zealand context, the Aotearoa NZ OTP Assessment Committee usually recommends that the OTP complete a professional development course/training in Māori health and the Aotearoa New Zealand health system. This could either be the RACP's eLearning

course on Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence or the HQSC's learning and education modules on understanding bias in health care.

Informing of patient safety concerns (9.2.2)

Australia

The RACP works closely with employers and regulators to assess OTPs. The RACP balances procedural fairness and confidentiality for the OTP to ensure all OTP applicants have the right to respond and review any information provided to the RACP on their performance.

As a part of the peer review monitoring process for OTPs, the initial three and six month peer review reports are reviewed by the College. If there are any issues outlined in the reports, the relevant Assessment Subcommittee Chair may request additional requirements or support to be put in place to ensure the OTP can upskill appropriately whilst ensuring patient safety.

If an OTP is not performing satisfactorily, the OTP Subcommittee may request completion of an Improving Performance Action Plan (IPAP). An IPAP provides the framework for help OTPs and their supervisors outline:

- learning strategies to be implemented to improve performance in areas identified as below the expected standard
- expected outcomes from these actions and strategies
- agreed dates to meet to review progress.

In some cases, the OTP Subcommittee Chair may request for additional requirements to be completed by the OTP from the Training Support Unit resources. This may involve the completion of a course on the RACP Online Learning portal or the revision of particular webinar or other resources. The Training Support Unit resources may be requested as part of Peer Review as well as TUT.

The College works collaboratively with employers to keep them across the OTP's progress and requirements for assessment to ensure transparent communication and that the appropriate support mechanisms are in place for the OTP. Contact is primarily through the supervisors/peer reviewers who are responsible for overseeing the OTPs performance.

The employers are notified of any decisions related to an OTP's comparability status via the AMC portal primarily. However, if severe concerns are raised or changes to an OTP's comparability which may affect their registration, Ahpra will be contacted directly by the RACP. Employers are notified of the decision relating to the monitoring of supervision and if relevant, Ahpra is also notified if it may affect the applicant's registration and/or patient safety. As an example, if supervision reports identified patient safety concerns and the OTP was relocated to a junior role (meaning they were no longer functioning in the RACP-approved supervised position), Ahpra will be notified that the OTP is no longer practising in an RACP-approved position and that concerns have been raised around performance.

Aotearoa New Zealand

In Aotearoa New Zealand, the MCNZ is responsible for monitoring assessments and supervision during the supervision period for Specialist International Medical Graduates (SIMG).

9.3 Assessment decision

AMC accreditation standards	
9.3.1	The education provider makes an assessment decision in line with the requirements of the assessment pathway.
9.3.2	The education provider grants exemption or credit to specialist international medical graduates towards completion of requirements based on the specialist medical program outcomes.
9.3.3	The education provider clearly documents any additional requirements such as peer review, supervised practice, assessment or formal examination and timelines for completing them.

9.3.4	The education provider communicates the assessment outcomes to the applicant and the registration authority in a timely manner.

Assessment decisions aligned to pathway requirements (9.3.1)

Assessment decisions are made in line with the MBA's Standards for specialist international medical graduates. Assessment decisions are recommended by our OTP interview assessors and are then approved by the relevant OTP Assessment Subcommittee. The requirements for OTPs assessed as Substantially or Partially Comparable are provided in section 9.1.2.

Approach to exemptions or credits (9.3.2)

The RACP does not grant exemptions for OTPs per se but considers all aspects of the OTP's qualification, training, assessment, CPD and experience to compare with a physician trained in Australia or Aotearoa New Zealand. Where an OTP is found to satisfy the criteria of the Advanced Training outcomes, they are not required to repeat any aspects unless there are significant gaps identified in their training that would prevent the doctor from safely practising independently in the Australian or Aotearoa New Zealand healthcare system. For example, if a doctor has satisfied a research requirement during their training that is comparable to that required of RACP trainees, the doctor would not be asked to repeat this requirement during their supervised practice in Australasia unless there was significant cause for concern identified by referee or supervision reports.

Applicants assessed as Substantially Comparable or Partially Comparable and currently working in Australia may be offered a reduced period of supervised practice based on their exposure to the healthcare system.

Clear documentation of additional requirements (9.3.3)

To ensure procedural fairness for the applicant, all aspects of an OTPs assessment are documented and provided to the OTP prior to consideration by the assessment subcommittee. Following a paper-based review or interview, applicants are provided with a summary which details the elements the interviewers documented or the recommendations of the paper-based assessors. This information is reviewed by the OTP and they are provided an opportunity to comment before the subcommittee considers the documentation. Applicants also review their referee reports and have an opportunity to comment before the decision on their comparability is made. The same process is followed for supervision reports during work-based assessment.

The MBA's Report 1 is utilised to clearly outline the OTP's assessment outcome and the requirements they will need to complete to be eligible to apply for specialist recognition. The timeframe to begin and complete assessment are stipulated within this report. Where necessary, an accompanying letter will be provided to explain in further detail the College's assessment decision. This is usually done for applicants that are determined to be not comparable to ensure adequate explanation is provided for the College's assessment decision.

The College's final assessment decision is communicated to the OTP via the MBA's Report 2.

In Aotearoa New Zealand, all assessment decisions are documented within the RGR6 and RGR7 templates and the College has done significant work with Council over the past two years to build a set of templates with the required information that Council needs to make an informed, robust and fair decision on the OTP's equivalency. The development of RGR6 and RGR7 templates in collaboration with MCNZ has reinforced consistent decision making as well as ensuring that MCNZ receive the information they require from the College to determine an OTP's equivalency.

Timely communication of assessment outcomes (9.3.4)

Both the MBA and MCNZ set clear timeframes for colleges to assess OTPs. The College is currently meeting the MCNZ timeframes for preliminary and interview advice for the majority of its applicants. Communication with Council is provided where any delays exist so that applicants can be kept informed.

The RACP meets the majority of the MBA benchmarks for OTP assessment. We do not always meet two timeframes for release of the assessment decision post interview (14 days) due to our committee processes, which reinforce consistency and procedural fairness. As the RACP assesses more than 30 specialties, assessment decisions are centralised with the sub/committees following paper-based review or interview. This ensures consistency in decision making and effective governance. However, it means that the committee process following interview often means we are unable to release the OTP's assessment decision within the timeframes set under metrics 10 and 11.

The RACP has undertaken significant work over the past seven years to streamline service delivery and assessment processes to ensure that applicants and registration authorities receive assessment decisions in a timely manner.

The AMC may wish to refer to the MBA specialist pathway data report which outlines the RACP's performance against the MBA benchmarks and compliance metrics: Medical Board of Australia - Standards, reports and resources (Appendix 9A.8).

Tables 55 and 56 provide a summary of OTP application and assessment outcomes for specialist recognition for the past five years. Appendices 9D.1 and 9D.2 provide a further breakdown of this data by specialty.

Table 51. OTP application and outcomes for specialist recognition, Australia

Year	Specialist registration applications received	Area of Need applications received	Initial assessment outcome: Not comparable	Initial assessment outcome: Partially comparable	Initial assessment outcome: Substantially comparable	Commenced ongoing assessment under top up training or peer review	Completed requirements, eligible for specialist registration and RACP Fellowship
2019	191	[redacted]	13	52	89	104	134
2020	154	[redacted]	18	53	91	87	84
2021	190	6	21	43	106	95	87
2022	200	0	17	42	140	120	99
2023	295	[redacted]	9	71	161	123	120

Table 52. OTP application and outcomes for specialist recognition, Aotearoa New Zealand

Year	Applications received		Preliminary and final preliminary assessment outcomes			Applications received for interview	Interview assessment outcomes		Completed requirements, gained vocational registration and eligible for RACP Fellowship
	For preliminary advice	For final preliminary advice	Equivalent to or as satisfactory as	Not equivalent to or as satisfactory as	Unable to make a recommendation		Equivalent to or as satisfactory as	Not equivalent to or as satisfactory as	
2019	33	39	60	[redacted]	10	36	33	[redacted]	38
2020	35	25	37	[redacted]	20	58	46	12	41
2021	28	28	38	0	18	45	42	[redacted]	41
2022	30	6	23	0	13	48	44	[redacted]	36
2023	35	[redacted]	17	0	17	29	22	[redacted]	44

9.4 Communication with specialist international medical graduate applicants

AMC accreditation standards	
9.4.1	The education provider provides clear and easily accessible information about the assessment requirements and fees, and any proposed changes to them.
9.4.2	The education provider provides timely and correct information to specialist international medical graduates about their progress through the assessment process.

Informing and supporting Overseas Trained Physicians undergoing and seeking assessment (9.4.1 and 9.4.2)

All SIMG (OTP) applicants have access to details of the assessment process on the RACP website- Overseas specialists (Appendix 9A.9).

The website information includes details on the following:

- eligibility
- process
- assessment
- application process and fees
- requirements and timeframe.

For any additional questions and information, the OTP is encouraged to contact the OTP Team via email. Each OTP has a dedicated case officer to manage, monitor and oversee their individual assessment giving them continuity with their college contact.

The RACP OTP Unit use the templates provided by the MBA and MCNZ to communicate critical decisions with SIMGs or Council, including reports 1 and 2, as well as the RGR6 and RGR7.

The RACP OTP Unit utilises standardised and customisable email templates for all communication. The RACP publishes changes to OTP guidelines and policies on the RACP website. Also, OTPs are sent email reminders and communications, and continually kept abreast of any relevant updates.

OTP's have access to the RACP support program, which is a free 24/7, fully confidential and independent help line offering counselling, coaching and support for work and personal issues. RACP partners with Converge International to provide this support to Members, including OTPs. The RACP also provides access to various Health and Wellbeing resources to OTPs. All resources and information are readily available at Resources | RACP Wellbeing (Appendix 9A.10).

OTP's also have access to the resources and support provided by the RACP Training Support Unit. The Training Support Unit prioritises wellbeing and support, and there are various resources and avenues for support as outlined on the RACP website Trainee support.

That vast range of RACP Online Learning resources (outlined in Standard 4) are made available to OTPs, and this resource suite includes access to the College Learning Series. OTPs are also given access to the ROC OTP community, to connect with other OTPs, and learn from one another.

The OTP Unit provides all OTPs with information of the RACP Reconsideration Review and Appeals Process By-law (Appendix 1A.45), and request that they note the timeframes for lodging RRA as set out in the by-law. This is provided to OTPs at every stage of the process and whenever a decision is made about their individual assessment.

The OTP Unit is committed to seeking feedback from OTPs throughout the process, and the RACP has a formal Member Service Satisfaction Survey that is undertaken yearly and sent to current OTPs as well as Fellows and Trainees.

As outlined in Standard 1.3.2, the RACP's Complaint Management Policy and Procedure (Appendix 1A.50) makes provision for the management of complaints from OTPs. Complaints reports are reviewed and used to improve products, services and delivery.

Appeals are managed separately to complaints and fall under the RACP's Reconsideration, Review and Appeal Process By-Law. Refer to Standards 1.3.1 and 1.3.2 for details on this.

Summary of Standard 9

Strengths

- robust and streamlined processes for Overseas Trained Physicians and Paediatricians (OTPs) assessment ensuring quality and efficiency
- use of data to make evidence-based decisions on qualifications, training and assessment which creates efficiencies in the process
- ensures procedural fairness throughout the process for SIMGs resulting in lower numbers of reviews and appeals
- limited scope of practice available in all specialties to ensure there are pathways available for 'super-specialists' to practice in Australia, particularly those that might have trained many years ago and since focused their practice on a specific area of medicine
- collaborative relationships with regulatory bodies and RACP assessors.

Key developments since last AMC accreditation

- Governance: amended the governance of SIMG assessment to increase consistency and introduce a policy level OTP Committee which oversees the performance of the three assessment committees. The OTP Committee also acts formally as the Review committee under the college's RRA By-Law
- Operational efficiency: significantly streamlined processes and timelines to ensure efficient assessment processes which decrease the timeframes for SIMG assessment
- Data-informed decision making: introduced paper-based reviews and country qualification guides to reduce assessment processes for SIMGs where data shows their qualifications, training and assessment are partially or substantially comparable
- Improved assessor training: introduced interviewer training for SIMG assessors which was rolled out across Australia and Aotearoa NZ between 2017 and 2020 via multiple workshops. Pivoted to online delivery during COVID-19 to continue training new assessors.
- Increased use of technology to deliver assessment efficiencies: fully digital application process, use of videoconference for interviewing and use of online courses to deliver assessor training.
- A focus on consistent and robust decisions: introduced guidelines for subcommittee members to ensure consistent and fair decisions across Australia and Aotearoa New Zealand
- Collaboration with regulators to review assessment framework and processes: undertaken a review with Deloitte and worked closely with the MBA to streamline assessment processes whilst ensuring robust and procedurally fair assessments
- Increased support to SIMGs: introduction of the ROC to connect SIMGs throughout the process as well as improvements to ensure SIMGs receive support to upskill whilst in the Australian and Aotearoa New Zealand healthcare systems.

Current and future challenges

- implementing education governance review recommendations is a current and future challenge for the College
- aligning OTP assessment processes with the new Basic and Advanced Training Curricula will present a future challenge once these programs progress for RACP trainees. This will amend the standards in which OTPs are compared against

- the demands of workforce shortages continue to be a challenge for the College as we're seeing a significant increase in application numbers which puts demand on resources to continue assessing to timeframes. Employers want OTPs to commence practice as soon as possible and the College continues to balance efficient but robust assessment processes.