ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Diversity & Inclusion Plan

NOVEMBER 2016

Leading the way towards inclusive participation in the practice of surgery and life of the College.

RACS

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Introduction

CONTEXT AND DEVELOPMENT OF THIS PLAN

This Diversity and Inclusion Plan and policy framework have been developed to build an inclusive culture in the surgical profession. Developing the plan is one of the specific commitments made by the College in the RACS Action Plan: *Building Respect, Improving Patient Safety*. It addresses goal four of the Action Plan - to embrace diversity and foster gender equity. The Diversity and Inclusion Plan applies across all RACS operations.

A significant number of Fellows representing various specialties and areas of interest have contributed to the development of this Plan in addition to the RACS Trainees Association. The consultation process included presenting this plan and seeking feedback from a number of RACS committees.

IMPLEMENTATION AND REVIEW

It is expected that this Diversity and Inclusion Plan will apply across the College, including all Specialty Training Boards. Reports of progress against the adopted targets will be made regularly to the Council. This Plan is expected to be reviewed every two years.

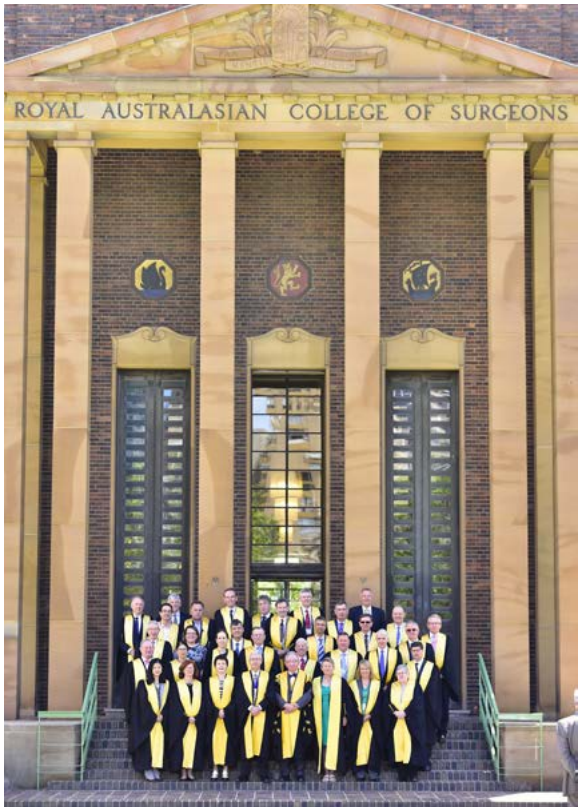
MESSAGE FROM THE PRESIDENT

I have been attending our Convocation ceremony for our new surgeons for many years. It is pleasing to see the rich multicultural diversity and growing number of women amongst our graduates. But this is not enough. There is a considerable advantage to have the Fellowship of our College reflect the diversity of the community that we are privileged to serve. This means that we have to identify and address any impediments in our systems that prevent capable people from being selected and trained to be surgeons. There is undoubted gender inequality that is reflected in almost all specialties, some more than others. There is a significant inequity of Indigenous Australian and Māori surgeons. This document outlines our commitment to assist all interested medical graduates in our communities to choose a surgical career with confidence and equity for all

Mr Phil Truskett, AM, PRACS

Policy

BACKGROUND



RACS recognises that it needs to embrace diversity and develop an inclusive, respectful culture that encourages participation in surgery across all RACS activities. Real leadership in surgical standards, professionalism and surgical education depends on RACS becoming an exemplar in promoting, enabling and supporting diversity within the surgical profession.

Championing the delivery of high quality surgical education and training also demands championing diversity, equity and inclusion for all the groups represented in the wider community. The RACS commitment to diversity and inclusion reflects its stated values of service, integrity, respect, compassion and collaboration.

The RACS capacity to enhance the contribution of surgeons to the broader community is influenced by its own representativeness of the community.

Removal of structural impediments to greater participation of women is inextricably linked to improving flexibility of training models, better reflecting the family and work-life balance needs of all the surgical Trainees, as well as ensuring respectful workplace practices. Achieving this outcome meets a number of the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) standards for Specialist Training Programs, including those relating to Trainee wellbeing, promotion of a supportive learning environment and flexible training. It is linked to one of the Medical Board of Australia's Codes of Conduct, which is 'to ensure doctors' health which includes work-life balance'. It is also consistent with the principles of the MCNZ Good Medical Practice Guide.

A greater focus on developing a culture of inclusion within the surgical profession will lead to better patient outcomes as greater cultural competence is achieved. Health practice with cultural safety and competence are also consistent with the required AMC and MCNZ Standards for Specialist Training Programs.

> *"Diversity is about fairness, inclusiveness, maximising the potential of our organisation and our profession, and about good culture. We need to work tirelessly to ensure that we remove any impediments to the best possible people, irrespective of their background, being given the opportunity to become surgeons.. The challenge is there. Let us ensure we make our profession stronger, more representative and truly reflective of our communities. In the end, it will be our patients who benefit, and it is they who ultimately are our primary responsibility.*
>
> ***Professor Spencer Beasley, RACS Vice President***

STATEMENT OF COMMITMENT

RACS is committed to setting the standards for valuing diversity and inclusion of gender, ethnicity, indigeneity, sexual orientation and identity, age, disability and religion, for participation in surgery and the College's governance and leadership roles. In particular, RACS will actively focus on removing any barriers to the participation of women and increase their representation. RACS recognises that Trainees, International Medical Graduates (IMGs) and Fellows may be under-represented in more than one 'category' of diversity and may have multiple barriers to a successful career in surgery. RACS commits to ensuring a cohesive and comprehensive response that considers the overlap of diversity qualities.

RACS will also continue its current initiatives designed to increase the participation of Aboriginal, Torres Strait Islander and Māori peoples in the practice of surgery.

Diversity & Inclusion Framework

PURPOSE

The purpose of this document is to set out what RACS will do to advance diversity, equity and inclusion and remove barriers that may prevent diverse participation in the practice of surgery or in RACS leadership roles.

RACS' LEADERSHIP ROLE

As a trusted authority on surgical standards and leader in the practice, education and training relating to Surgery, RACS has the capacity to promote diversity and inclusion within the medical profession in the following ways:

a. Using its position as a leader in the health care system, it can convene discussions, disseminate research and communicate around diversity and inclusion.

b. As a surgical training accreditation provider, it can set standards and hold training hospitals accountable to deliver on the expectations relating to employment and funding impacting on training flexibility and workplace practices and thereby gender equity.

c. In collaboration with all RACS Committees, Boards and Specialty Societies, it can set and communicate expectations for, and expressly monitor progress towards, achieving the objectives set out in this Plan.

"Diversity - by reaping the benefit of different perspectives adds depth to decision-making process and improves organiszational outcomes. The value of diversity is cognitive diversity rather than sociological diversity (gender, age, ethnicity etc), however sociological diversity may be a useful proxy for cognitive diversity. By encouraging and including people from different backgrounds and cultures, we will better understand and care for all of our patients.

Dr Ruth Bollard, Chair, Women in Surgery Section

CURRENT CONTEXT

Significant progress has been made towards achieving greater diversity and inclusion within the surgical profession and all RACS activities over the last decade. For example, the representation of women in most of the specialty areas has been increasing and the intake as at June 2015 represented 29% across all specialties. There is also now a greater representation of women in various leadership roles and Committees of the Council than in the past.

The proportion of women obtaining RACS fellowship has increased from 13% to 18% in the last decade and 11% of active RACS Fellows are women. Despite women representing about 55% of all medical school graduates this is not reflected in the proportion of women applying for surgical training. In the period 2012-2016 the proportion of applications received from women was on average 29%. RACS recognises that more needs to be done firstly to identify and then to remove known or perceived impediments to women entering and completing surgical training. The progress towards greater representation of women and various under-represented groups needs to accelerate to achieve community and medical profession expectations of inclusion.

Whilst there is room for further progress, existing policies and initiatives have paved the way for inclusion such as the reasonable accommodation for undertaking examinations on alternative days due to religions reasons or by different means, and the development of Aboriginal and Torres Strait Islander and Māori Health Action Plans.

> *My tribal affiliations are with Ngapuhi and Ngatiwai in Te Taitokerau (Northland). Working in the area that I'm from and in an area of high need is very rewarding and humbling for me. Encouraging more Māori doctors to consider a career in surgery is an important part of addressing health disparities between Māori and Non-Māori. It is vital we mentor medical students and junior doctors to ensure that Māori see surgery as an achievable and fulfilling career option. A more diverse surgical workforce that includes Māori Surgeons in all specialties can make a huge difference to addressing ethnic health disparities in New Zealand.*
>
> ***Dr Maxine Ronald FRACS, Māori General Surgeon; Deputy Chair, Indigenous Health Committee***

STRUCTURE OF THIS DIVERSITY AND INCLUSION PLAN

This Diversity and Inclusion Plan outlines the key priority areas, objectives and initiatives that RACS will undertake to meet its commitment to diversity and inclusion.

There are identified actions and tasks to help RACS meet the objectives set in this plan, which also includes measures of success, timeline expectations and accountabilities and responsibilities within the College.

This Plan aims to be a living document to be reviewed and revised by the Council every two years. Progress against the set objectives and initiatives and any potential changes to the Plan will be reported to Council by the Governance & Advocacy Committee (GAC). Progress against benchmarks and measurable outcomes will be published annually.

EXPECTED OUTCOMES

Increasing RACS diversity and inclusion as this Plan sets out to do, will have the following benefits:

- Improved experience of Trainees during training, including their work-life balance, leading to better health outcomes.
- Modernisation of surgical training in line with contemporary workplace standards.
- Reduced numbers of surgical Trainees withdrawing from training before completion due to reasons such as discrimination, and lack of flexible and family friendly work practices.
- More effective Council and committees as evidenced through annual Council appraisal.
- Surgeons who are culturally competent will engage better with their patients and their healthcare teams; harmonious clinical work leads to better patient safety and outcomes.
- Improved equity in surgical health outcomes of Aboriginal, Torres Strait Islander and Māori peoples in Australia and New Zealand.
- Enhanced reputation of RACS as a leader in setting standards in line with contemporary community expectations.

"As the Chair of the Trainees' Association of the College of Surgeons, I know that our Trainees come from a diverse background. We need to ensure barriers to participation in surgical careers are actively addressed, and do everything we can to encourage diversity in surgery. We are a long way from gender parity, and we long for greater participation by Aboriginal and Torres Strait Islander and Māori doctors in surgical training. We won't stop working on this until surgeons in New Zealand and Australia are as diverse as the wonderful communities we serve.

Dr Ruth Mitchell, Chair RACS Trainees' Association

OBJECTIVES

The Diversity and Inclusion Plan identifies the following priority areas and objectives:

- **Inclusive culture and leadership excellence:**
  Intentionally create a culture of inclusion amongst the surgical community through advocacy, championing and communicating diversity.
- **Gender equity:**
  Increase the representation of women in the practice of surgery by removing barriers to participation and introducing flexible training models for any Trainee or surgeon, irrespective of gender.
- **Inclusion of all diversity groups:**
  Ensure the profession of surgery is accessible to all people regardless of their minority group status.
- **Diverse representation on Boards and in leadership roles:**
  Increase diversity, and in particular, the representation of women, on training boards and in all leadership roles within the College.
- **Benchmarking and reporting:**
  Be transparent and accountable for increasing diversity and making progress in implementing the Diversity and Inclusion Plan, by gathering data and reporting publicly on progress.

Each of these priority areas is expressed in terms of actions and broken down into tasks outlined in the Plan.
Diversity groups referred to in the Diversity and Inclusion Plan include, but are not limited to, people identified by:

- Gender
- Aboriginal, Torres Strait Islander and Māori peoples
- Ethnicity
- Sexual orientation and identity (LGBTI)
- Disability
- Religion
- Age.

RACS recognises there may be overlap in diversity qualities and Trainees, IMGs and Fellows may be under-represented in more than one category.

RESPONSIBILITIES

All Fellows, Trainees, IMGs and RACS employees play a vital role in helping the College increase diversity and build an inclusive culture. They will influence the success of this Diversity Plan through their clinical activities, decisions or engagement with RACS processes and in their direct interactions with colleagues and other stakeholders.

The following RACS bodies will be responsible for implementing the Plan, monitoring progress and reporting the achievements to Council:

- Executive Committee of Council - oversight of the overall implementation of the RACS Diversity and Inclusion Action Plan; monitoring its progress and reporting it to the Council - Vice President and Governance & Advocacy Committee (GAC).
- Benchmarking and reporting will be the responsibility of the CEO, relevant Committees and all Directors with oversight provided by GAC.
- Diverse representation of Boards and leadership roles - oversight will be provided by GAC and responsibility for implementation will rest with each Divisional Director.
- Gender equity in Surgical Training - oversight will be provided by the Education Board and the Board of Surgical Education & Training (BSET).
- Inclusion of Indigenous diversity group – responsibility will rest with the Indigenous Health Committee and Director of Fellowship and Standards with oversight provided by Professional Development & Standards Board (PDSB).

IMPLEMENTATION AND REVIEW

This Diversity and Inclusion Plan will be implemented over the next two years in accordance with the responsibilities outlined above. It will be then reviewed and revised by the Council in consultation with the key stakeholders responsible for each of the priority areas.

"You try to change things for the better for everyone because we all live together in this beautiful and very diverse multicultural country and we just don't harness enough of the energy that's available. You only have to spend time with the kids in the remote communities, among these linguistically diverse groups, to see the plethora of talent out there.

Associate Professor Kelvin Kong FRACS, Worimi Man

Actions

OBJECTIVE 1. INCLUSIVE CULTURE AND LEADERSHIP EXCELLENCE:

Intentionally create a culture of inclusion amongst the surgical community through advocacy, championing and communicating diversity.

Action	Task	Governance Responsibility	Administrative Responsibility	Timeline	Measurable target
1.1 Implement a consistently inclusive communication strategy.	1.1.1 Add inclusion criteria and review process to all RACS publications	GAC	Communications Manager; Director Relationships & Advocacy; Web Manager	Q1 2017	Our publications, photos, social media and communication approach is inclusive of diversity
	1.1.2 Update RACS website history page with more representation of women surgeon leaders and other diverse groups			Q2 2017	
1.2 Identify and utilise cultural symbols to promote diversity and inclusion	1.2.1 Review prominent displays of photos and other artefacts within RACS premises with a view to be more inclusive	GAC Heritage & Archives	Communications Manager, Curator, Archivist	Q1 2017	Increased number of symbols used to promote diversity and inclusion
	1.2.2.Consider naming rooms or other structures after prominent women surgeons or other diversity champions	GAC Property	Directors & CEO	Q1 2017	
1.3 Promote cultural awareness	1.3.1 Publish articles promoting diversity with real life examples	GAC	Director, R&A; Communications Manager	Qtly	4 articles published
	1.3.2 Create opportunities for discussions and experiences of inclusion for all diversity groups e.g. UN days of celebration		Directors & CEO	ongoing	3 annual events e.g. ASC session, regional events
1.4 Educate in cultural safety and competence	1.4.1. Deliver education programs in cultural competence in line with AMC and MCNZ standards	Education Board/PDSB	Dean of Education Manager, EDR	2017	50% of Fellows, Trainees and IMGS complete the Cultural Competence Program
	1.4.2 Include cultural competence and leading in diversity in the curriculum of relevant RACS courses	Prof Dev Comm	Dean of Education, Director F&S, Manager, PD	2017	25% Fellows complete LDP
	1.4.3. Train surgical educators in identifying and rectifying patterns of unconscious bias.	Prof Dev Comm	Dean of Education, Training Boards	2017	number of courses offered covering this
	1.4.4 Provide cultural competence training to RACS staff as per the RAP.		Directors Director of R&A	2017	75% of staff complete the non-mandatory Cultural Competence Program
1.5. Identify and promote diversity champions	1.5.1 Allocate the roles of diversity champions in various groups (e.g. RACSTA, YF, WISS, Rural SS, IHC, Global Health, Senior Surgeons, Military)	PDSB EB	Directors Director of R&A	Q2 2017	12 diversity champions named and their messages communicated
	1.5.2 Provide communication mechanisms for the messages by diversity champions to reach as wide an audience as possible	GAC	Communications Manager, Director, R&A	ongoing	

Action	Task	Governance Responsibility	Administrative Responsibility	Timeline	Measurable target
1.6 Support research into effects of diversity and inclusion on surgical practice and disseminate findings	1.6.1 Identify research partners with expertise and interest in diversity in surgery	EB RAAS	Dean of Education & CEO with research & evaluation team	Q2 2017	2 research studies completed by end of 2018.
	1.6.2 Develop research proposals and protocols		As above	Q3 2017	
	1.6.3. Collaborate with research partners to complete planned studies			2017-18	
	1.6.4 Publish and communicate the findings internally and externally			2017-18	
1.7 Collaborate with other health care system stakeholders to lead in diversity and inclusion to enhance surgical profession	1.7.1 Identify stakeholders for collaboration and influence – e.g. MoU Partners	GAC	Directors, CE Surgical Directors Group	Q1 2017	Evidence of discussions with stakeholders.
	1.7.2 Engage in discussions and diversity projects		VP, Surgical Directors Group, CEO, Director, R&A	ongoing	Evidence of participation in D&I initiatives

OBJECTIVE 2. GENDER EQUITY:

Increase the representation of women in the practice of surgery by removing barriers to participation and introducing flexible training models for any trainee or surgeon, irrespective of gender.

Action	Task	Governance Responsibility	Administrative Responsibility	Timeline	Measurable target
2.1 Set targets and guidelines for increased representation of women in SET across all specialties	2.1.1. Review each specialty's participation rates in surgery for the purpose of monitoring and reporting on the number of women	EB	Director Education & Training;	Q1 2017	As women already represent 29% of trainees RACS target is to reach **40% across all specialties by 2021.**
	2.1.2 Set aspirational and achievable targets for an increased representation of women in SET across all specialties	Council	Director R & A	Q1 2017	
	2.1.3 Issue guidelines and directions to achieve and report on the progress	EB	Directors	Q2 2017	
2.2 Re-design training models and liaise with hospitals to ensure greater flexibility and family-friendly protocols for all with respect to: • opportunities for less than full-time and flexible models • enable easier access to interrupted training e.g. parental and adoption leave • less frequent geographic change of rotation arrangements	2.2.1 BSET and STBs to review/ investigate/create models for flexible training 2.2.2 Review and redevelop if necessary the procedures for Trainees' applications for interrupted training and flexibility, ensuring their availability irrespective of gender 2.2.3 Review educational basis for frequent change of training location.	EB	Director, ETA; Dean of Education	Q1 2017	Reduction in number of Trainees reporting inability to obtain a flexible training position (through RACSTA end of term survey) Reporting through BSET shows progress by each STB in implementing flexible training
2.3 Actively promote the availability of flexible training	2.3.1 Develop communication materials promoting availability of flexible training	EB Training Boards;	Director, ETA; Manager, Surgical Training	2017	Surgical News articles. RACSTA Newsletter, Comms to Specialty Societies
	2.3.2 Communicate new flexible training models available and procedures to access them	EB, Training Boards, GAC	Director, ETA; Manager, Surgical Training		Increased number of trainees applying and utilising flexible training options

OBJECTIVE 2. GENDER EQUITY (CONTINUED):

Increase the representation of women in the practice of surgery by removing barriers to participation and introducing flexible training models for any trainee or surgeon, irrespective of gender.

Action	Task	Governance Responsibility	Administrative Responsibility	Timeline	Measurable target
2.4 Identify the appropriate resources (Fellows, staff) that will support liaison and collaboration between the training boards, hospitals, government and industrial organisations to implement less than full-time training, identify flexible posts and support trainees	2.4.1 Liaise with Training Boards to identify resources required	BSET, EB	Education & Training Administration;	2017	Increased number of flexible posts available and taken up by trainees
	2.4.2 Develop protocols for collaborative use and management of the shared resource				
	2.4.3 Work with employers, government, and industrial organisations to create part-time posts				Improved experience of training for all trainees as evidenced by end of term surveys
	2.4.4 Actively offer support to trainees seeking flexible options				Benefits of flexible posts for employers
2.5 Promote women surgeons as positive role models	2.5.1 Communicate and publicise women's involvement in surgery	GAC	Communications Manager; Director, R&A; Regional Offices, RACSTA	ongoing	
2.6 Promote surgical training to increase the proportion of women applicants	2.6.1 Create opportunities to expose all medical students to positive role models in surgery including women	EB Regional Committees PSEC	Surgical Training Department; Regions Prevocational Learning Dept	ongoing	Regions participate in/host events for medical students
	2.6.2 Publish case studies of women surgeon careers on a ½ yearly basis	GAC	Manager, Communications		Increased number of applicants for surgical training who are women
2.7 Investigate reasons why women are not applying to RACS surgical training programs in proportions representative of graduation from medical schools	2.7.1 Undertake survey of women in the medical workforce and final year medical students to identify real and perceived barriers to applying to surgical training programs	EB	Director, Education and Training Administration	Q2 2017	Survey results to inform a recruitment and promotion strategy.
2.8 Investigate barriers to women's successful participation in and completion of surgical training following selection	2.8.1 Implement responses to findings in Leaving Training Report and SET evaluation	BSET	Education & Training Administration; Training Board Secretariats	Q2 2017	Known improvements to experience of training compared to 2016 benchmark
	2.8.2 Plan a follow up study of experiences of training	EB			
	2.8.3 Explore feasibility with government and other entities to enable parental leave to work across state boundaries		ETA, Regional Offices		

OBJECTIVE 3. PARTICIPATION OF ALL DIVERSITY GROUPS:

Ensure the profession of surgery is accessible to all people regardless of their minority group status.

Action	Task	Governance Responsibility	Administrative Responsibility	Timeline	Measurable target
3.1 Improve and extend our relationships with Aboriginal and Torres Strait Islander peoples and organisations to enable us to better equip the surgical workforce to meet the needs of all Australian Communities	3.1.1 Complete Action Plan Goal 1: *Relationships*, as outlined in the RACS Reconciliation Action Plan 2016-2017	Indigenous Health Committee (IHC)	Fellowship Services Relationships & Advocacy	2016-17	RACS Reconciliation Action Plan actions accomplished as indicated
3.2 Engender respect and enhance cultural competency amongst the surgical workforce	3.2.1 Complete Action Plan Goal 2: *Respect*, as outlined in the RACS Reconciliation Action Plan 2016-2017	IHC	Fellowship Services Professional Standards;	2016-17	RACS Reconciliation Action Plan actions accomplished as indicated
3.3 Promote an increase in the number of Aboriginal and Torres Strait Islander Fellows, Trainees and staff by creating an organisational culture that values and encourages opportunities for Aboriginal and Torres Strait Islander Peoples	3.3.1 Complete Action Plan Goal 3: *Opportunities*, as outlined in the RACS Reconciliation Action Plan 2016-2017	IHC	Human Resources, Fellowship Services Education and Training Administration	2016-17	RACS Reconciliation Action Plan actions accomplished as indicated
3.4 Tracking progress and reporting	3.4.1 Complete Action Plan Goal 4: *Tracking and Progress Reporting* as outlined in the RACS Reconciliation Action Plan	IHC	Fellowship Services	2016-17	RACS Reconciliation Action Plan actions accomplished as indicated
3.5 Provide advocacy for equity of Māori health	3.5.1 Complete Action Plan Goal 1 as outlined in the Māori Health Action Plan	IHC; NZ National Board	Fellowship Services NZ Office	ongoing - 2018	The Māori Health Action Plan Goal 1 achieved
3.6 Implement strategies to increase Māori representation in surgical workforce	3.6.1 Complete Action Plan Goal 2 as outlined in the Māori Health Action Plan	IHC; NZ National Board	Fellowship Services NZ Office	ongoing - 2018	The Māori Health Action Plan Goal 2 achieved
3.7 Promote research and conduct audit in relation to Māori health disparities	3.7.1 Complete Action Plan Goal 3 as outlined in the Māori Health Action Plan	IHC; NZ National Board	Fellowship Services NZ Office	ongoing - 2018	The Māori Health Action Plan Goal 3 achieved
3.8 Increase Māori cultural presence within the College	3.8.1 Complete Action Plan Goal 4 as outlined in the Māori Health Action Plan	IHC; NZ National Board	Fellowship Services NZ Office	ongoing - 2018	The Māori Health Action Plan Goal 4 achieved
3.9 Provide support for people from culturally and linguistically diverse backgrounds (CALD) seeking to apply for IMG assessments and following their acceptance of a pathway to Fellowship	3.9.1 Provide induction or support to assist with understanding AU/NZ culture and working within these health systems.	EB	IMG Assessment Dept; Clinical Director, IMG Assessmenmt & Support	Q2 2017	Number of induction sessions provided, frequency of contact with Clinical Director.
	3.9.2 Create opportunities for active inclusion of IMGs on pathway to fellowship			2017 – 18	
	3.9.3 Develop a responsive support program for those IMGs assessed for Specialist Areas of Need pathways and placed in remote geographical areas		Regions support	Q2 2017	Increased participation of CALD groups within College as reported against the baseline

OBJECTIVE 4. DIVERSE REPRESENTATION ON BOARDS AND IN LEADERSHIP ROLES:

Increase diversity and in particular, representation of women, on training boards and in all College leadership roles.

Action	Task	Governance Responsibility	Administrative Responsibility	Timeline	Measurable target
4.1 Set targets for women's representation on Training Boards and College Boards including in leadership positions	4.1.1 Develop targets for women's representation on each Training Board	Council	Director, ETA	Q1 2017	20% by 2018 40% by 2020
	4.1.2 Develop targets for women's representation in Committees and other leadership roles	Council	Director, R&A	Q1 2017	20% by 2018 40% by 2020
	4.1.3 Develop targets for women's representation as Examiners	EB	Director, EDA	Q1 2017	
	4.1.4 Publicise the set targets and issue a statement of expectation and intent to fulfil these targets	GAC	Director, R&A	ongoing	
4.2 Achieve greater diversity on Training Boards and within RACS Boards and committees	4.2.1. Create and implement a plan to achieve the desired board composition including adjusting terms of reference	GAC then all RACS committees and Training Boards	all Directors	Q1 2017	More diverse Board membership reported against the baseline benchmark.
	4.2.2 Appoint community, non-surgeons and education professionals	GAC develop process and source; each STB and comm		2017 - ongoing	More effective Council as evidenced by annual appraisal
4.3 Encourage potential candidates to participate in leadership roles (RACS Boards & committees)	4.3.1. Promote opportunities for involvement and encourage diversity in applications (e.g. Council elections and regional committees)	GAC	Director, R&A Manager Communications	ongoing	Increasing participation of women and other diversity groups in leadership roles, as reported annually.
4.4 Provide support for diversity groups to improve their pathways to involvement in leadership roles through mentoring resources and support	4.4.1 Promote the use of current mentoring resources	PDSB	Director, F&S	ongoing	2 x Surgical News annually, monthly Fax Mentis, RACSTA, other newsletters. Feedback via surveys shows usage
4.5 Reduce the barriers to participation in various leadership processes and events	4.5.1 Make greater use of electronic and online technology for meetings e.g. video-conferencing	all committees	all directors	ongoing	Greater participation of women, other diversity groups and greater representation of regional areas in RACS events
	4.5.4 Provide training to chairs of teleconferences to promote participation.	as above	as above		
	4.5.2 Consider selecting venues for professional development activities that provide child minding and/or breast feeding facilities for the parent	PDSB (set standard)	conference & events dept (set standard) for all others		

OBJECTIVE 5. BENCHMARKING AND REPORTING:

Be transparent and accountable for increasing diversity and making progress against the Diversity & Inclusion Plan, by gathering data and reporting publicly on progress.

Action	Task	Governance Responsibility	Administrative Responsibility	Timeline	Measurable target
5.1 Collect data and report on representation of women on Boards and Committees	5.1 Develop data gathering mechanisms	GAC	Directors Director, R&A	Q1 2017	Gender split of Board/Committee memberships regularly reported
	5.2 Collect data on various representation criteria including gender split		Directors EA/PA Manager, Council & Pres	ongoing	
	5.3 Prominently report each Board's composition levels at least annually		Director, R&A	ongoing	
5.2 Collect data and report on offerings and uptake of flexible training options and deferments for each Specialty	5.2.1. Develop data collection protocols and mechanisms for uptake of various aspects of flexible training covering all Boards	Training Boards	Surgical Training Dept	annually	Detailed measures of flexible training uptake regularly reported
	5.2.2 Collect data relating to flexible training offered by each Board				
	5.2.3 Report each Board's flexible training offering				
5.3 Collect robust data on CALD status of RACS membership	5.3.1 Develop and introduce a set of data collection items relating to CALD status	GAC	Director, R&A	Q1 2017	Data of CALD membership status known and reported
	5.3.2 Capture data relating to CALD status of Trainees at SET registration process	EB	Surgical Training/IT Dept	Q2 2017	
	5.3.3 Report the levels of participation of CALD members within surgery and in RACS activities	GAC	all Directors (Activities Report, other)	Q3 2017	
5.4. Creation of sustainable structures to ensure accountability, measurement of results and reporting for all aspects of the Diversity & Inclusion Plan	5.4.1 Allocate clear organisational structure for implementation of the Diversity and Inclusion Plan and reporting of its progress	GAC	all Directors	annual reporting	Clear organisational governance for Diversity and Inclusion established

Related Documentation

Related Documentation

RACS, Annual Activities Report for the period 1 January to 31 December 2015

RACS. Building Respect, Improving Patient Safety. RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery, 2015.

RACS Māori Health Action Plan 2016-18

RACS Reconciliation Action Plan (RAP)

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