# Consultation feedback form

Australian Medical Council Limited

## Draft model standards and procedures for specialist medical college accreditation of training settings

Thank you for providing feedback on the draft model standards and procedures for specialist medical college accreditation of training settings.

In this consultation, the AMC has included particular questions for colleges and health services as the primary users of the standards and procedures. However, the AMC welcomes feedback from all stakeholders, and stakeholders are invited to answer any of the questions as they see relevant.

To return your feedback, please email this form in MS Word format to accreditation@amc.org.au by close of business on 11 November 2024.

| Consultation questions relating to **draft model standards**: |
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| **General feedback** |
| Are the model standards easy to read and understand? |
| Easy to read and mainly easy to understand as well.<br>The College strongly believes the primary consumer of an education program is a trainee/student; and an important byproduct is excellent patient care.<br>• ACEM is pleased that the draft model standards have generally followed the AHMAC framework from 2011-2015 which makes it fairly aligned to our current requirements.<br>• The strong emphasis on cultural safety and diversity (both protecting trainees and giving trainees more skills in these areas), identifying fatigue, return to work after a break, trainees with disabilities, flexible working arrangements are commendable and ACEM strongly supports this.<br>• The emphasis on ensuring processes such as supervision, education, feedback etc are effective rather than just occurring is another positive change. |
| Are there any criteria in the model standards that would raise challenges for your organisation?<br>**For colleges:** this would include any challenges in implementing the model standards.<br>**For health services:** this would include any challenges in being assessed against the model standards, for example, in smaller settings, rural and regional settings, general practice and non-government settings. |
| No major concerns however, clarification may need to be provided particularly with some of the intent and evidence suggested. |
| Should there be any additions to, or deletions from, the model standards? |

- Criterion 1.1.7 – as this is already included in jurisdictions EBAs, is this required?
- A separate domain for research should be included as research is key to evidence-based practice and learning which ultimately leads to better patient safety and care.

**Feedback regarding college-specific requirements**

Criterion 2.1.6 enables recognition of accreditation of training settings/providers by other accreditation bodies e.g. health service quality and safety bodies.

**For colleges:** Would it be necessary to include specific requirements to assess this criterion, for example, requiring the training setting/provider to be accredited by an industry body/regulator such as NATA or a radiation safety authority?

**For health services:** What should be considered in developing college-specific requirements for this criterion?

- Although no site has ever failed this in our current requirement, if this is to be included, suggest amending the wording to include safety aspect intention and provide examples of these bodies eg ACSQH, Ministry of Health New Zealand etc

Criterion 2.2.1 provides for effective clinical supervision of trainees.

**For colleges:** Would it be necessary to include specific requirements to assess this criterion, for example, ratios for supervisors to trainees?

If yes, please explain why ratios are needed, how ratios would be determined and how such ratios align with outcomes based accreditation?

Please explain how would ratios accommodate:

- flexibility for training in regional, rural and remote settings
- situations where training settings have difficulty in recruiting supervisors despite best efforts
- remote supervision?

**For health services**: What should be considered in developing college-specific requirements for this criterion?

- ACEM utilises different tiers of accreditation. Addition of ratios, and/or, allowing College to add their own specific supervision requirements to ensure appropriate safe supervision relevant to the environment will be crucial for ACEM.
- The ratio should be left for the site to determine based on statistics across similar sites, trainees and supervisors' feedback. The draft model should not mandate any specifics as each specialty is different and different models of care can impact on the requirement.
- Our rural and regional sites have expressed using ratios as a much more equitable approach to determine adequate supervision as current metrics are perceived to favour the metro sites. ACEM will be investigating further at the pending College's major review of our requirements.
- ACEM is also piloting Blended Supervision and Accredited Network Training and learnings from these projects are pending hence it is important for flexibility in this criterion.

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| Criterion 3.1.1 provides for a clinical caseload and casemix to achieve the training program outcomes.<br>**For colleges:** Would it be necessary to include specific requirements to assess this criterion, for example, logbook requirements, theatre time?<br>**For health services:** What should be considered in developing college-specific requirements for this criterion? |
| • Would be critical for ACEM to be able to tailor the intent wording of this criterion particularly as we have different tiers of accreditation. |
| Criterion 3.1.2 provides for trainees to engage in structured and unstructured learning activities to achieve the training program outcomes.<br>**For colleges:** Would it be necessary to include specific requirements to assess this criterion, for example, a requirement for trainees to complete a research project, or a requirement that trainees have protected teaching/study time? Please explain your reasoning.<br>**For health services:** What should be considered in developing college-specific requirements for this criterion? |
| • More clarity on the definitions of “unstructured learning activities”, “informal mechanism” and “small setting” is required. The current wording is open to interpretation and challenge. |
| Criterion 4.2.1 provides for clinical or other equipment needed for trainees to achieve the training program outcomes.<br>**For colleges:** Would it be necessary to include specific requirements to assess this criterion, such as a list of specialist equipment?<br>**For health services:** What should be considered in developing college-specific requirements for this criterion? |
| No further addition is required from ACEM’s perspective |
| Are there any other college-specific requirements that are necessary in relation to other criteria and what should be considered in developing these? |
| • A criterion regarding broader non-clinical educational opportunities would assist in validating ACEM’s many accredited non-ED Special Skills Placements which complement core training. |

| Feedback regarding implementation |
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| **For colleges:** What is a reasonable timeframe for adoption of the model standards by your college and why?<br><br>What would assist your college to adopt the model standards in a more timely manner (for example, shared training, shared resources etc.)? |
| • End of 2026 will be a more workable timeframe especially if IT changes are required.<br>• This will require dedicated resources to undertake as a project as it will be difficult to do as part of BAU for the Committee and staff.<br>• Each College requirements are different and sharing training may provide ideas so may be worthwhile facilitating. |
| **For health services:** What is a reasonable timeframe for your organization(s) to be ready for assessment against the model standards and why? |
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| Other feedback |
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| Do you have any additional comments regarding the model standards that are not covered above? |
| **Comments/Queries:**<br>• Are there limitations on Colleges' ability to enhance/add to the current wording in the "Intent" section of each criterion? Ie can we have College specific intent? Or are these wording to be adopted as is?<br>• Are there limitations on Colleges' ability to utilise College-specific sections to interweave some requirements College considers critical for good training eg 4 hours of structured teaching, good access to teaching, supervisory leadership roles (FTEs and Clinical support time required for these roles) etc.<br>• More clarity is required on definition of "small" settings. And will there be any limitations placed on these small settings? ie only limited training time permitted at these sites.<br>• ACEM accredits both Emergency Departments and Paediatric Emergency Departments and our glossary definition of "Fellow" is perhaps different to other Colleges. Are Colleges able to amend the glossary wording to suit?<br>• Is there ability for College to reference other document(s) in providing clarity/guidance on the criteria?<br>• The list of evidence suggested are mainly data and policies/guidelines based. Including examples of types of evidence that Colleges can gather to ensure effective training is being provided would be valuable.<br>• The College would also like to point out that the consultation timeframe was far from optimal to allow for comprehensive consultations with our relevant committees. |

## Consultation questions relating to **draft model procedures**:

| General feedback |
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| Are the model procedures easy to read and understand? |
| • The model process is aligned to ACEM's current process and is easy to read and understand. |
| Are there any requirements in the model procedures that would raise challenges for your organisation? |
| • The change in the sites' ability to respond to factual errors, conditions, recommendation or comments will significantly increase the workload for both staff and committee. ACEM accredits 160 Emergency Departments (and almost 200 Special Skills Placements which will follow a similar process). This step will generate significant additional work for both accreditation committee and staff.<br>• The immediate removal of trainees when accreditation is withdrawn is another concern as ACEM works on the principle of no disadvantage to trainees. Trainees are generally permitted to complete their term at the site when accreditation is withdrawn unless their safety is at risk. The immediate removal of trainees will have a significant impact on trainees and sites. |
| **Feedback regarding agreed terminology** |
| **For colleges:** Are there any obstacles to your college implementing the common terminology for:<br>• assessment against the standards: met; substantially met; not met<br>• accreditation outcomes for new settings: provisionally accredited; not accredited – refused<br>• accreditation outcomes for existing settings: accredited; conditionally accredited; not accredited – revoked. |
| • This meets ACEM's current terminology. However, ACEM also has the category of "lapsed accreditation" which is used to distinguish accreditation was not withdrawn due to concerns but was due to no trainees at the site or the site has elected to withdraw themselves. |
| **For colleges:** In what timeframe could your college implement this terminology? What support may assist quick adoption? |
| • End of 2026 as implementation of this should be concurrently done with the standards<br>• Providing funding for additional resources for system changes? |
| **Feedback regarding the risk matrix** |

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| Is the risk matrix appropriate for accreditation decision making? |
| • ACEM supports the use of a risk matrix.<br>• A suggestion to include risk to public/safety into the matrix.<br>• Who defines the risk rating – low, medium, high and extreme?<br>• The wording "*organization being <u>UNABLE</u> to implement required conditions within a reasonable timeframe*" is open to interpretation. How is reasonable timeframe determined?<br>• ACEM has different Tiers of accreditation and the terminology does not cater to a "downgrade".<br>• More clarity on consequences is needed if conditions are not addressed within the timeframes.<br>• How do Colleges ensure a safe training environment if there is a major impact on training but site is still likely not going to address the criterion. As it is not classified as extreme, what avenues do Colleges have to ensure a safe and fit for purpose training environment? Does this mean Colleges must continue to allow trainees to train in these places? What about the Colleges' psychosocial responsibility to the trainees? |
| The risk matrix allows colleges to decide whether or not to impose a condition where the criteria are substantially met or not met but the overall risk assessment is low.<br>Is this appropriate or should there be a requirement for a condition to be imposed for any criterion assessed as 'substantially met' or 'not met'? Please explain your views. |
| • Through our experience criteria that are not fully met without conditions imposed often resulted no action from sites. ACEM currently will impose a condition on any criterion that is not fully met. |
| The risk matrix indicates that steps to revoke accreditation should be taken when the overall risk assessment is extreme. Is this appropriate? |
| • ACEM supports this in general but questions the intent of allowing withdrawal of accreditation in only 3 instances of extreme overall risk. In these circumstances, the situation should be carefully deliberated between the College and Training Site. |
| **Other feedback** |
| Do you have any additional comments regarding the model procedures that are not covered above? |
| • The stipulation to only allow sites to select trainees/consultants for interviews is risky as sites naturally select only trainees/consultants who will provide favourable reviews. There should be a clause for Colleges to request any trainees or consultants they would like to interview.<br>• Accreditation Report:<br>  ○ A comment section should be added for inspectors to provide information to inform the next inspection team. These are comments only with no requirements for the site to action. Inspectors have expressed the comments are often useful and provide good background information on a site. |

- The reports should allow listing the names of the interviewees eg major stakeholders such as department head, hospital executive, director of training etc as it makes the report verifiable.

  This is also useful as majority of our sites have multiple consultants sharing roles and some conditions/comments may only refer to one particular person eg, Dr xxx should complete the assessor course as soon as possible.

- The process appears to be aiming to formalise the monitoring process and expects training sites have ongoing responsibility to inform the Colleges of important changes in governance, resources, training etc, however, how will this be enforced? What are the consequences of non-compliance? Through experience, the College is generally not notified and these changes are only discovered much later through other avenues, normally when a distressed trainee/consultant contacts the College.

| Organisational details and contact | |
|---|---|
| **Organisation name/details:** | ACEM |
| **Contact name:** | [redacted] |
| **Contact email:** | |

The AMC may publish submissions on its website in the interests of transparency and to support informed discussion among the community and stakeholders. Published submissions will include the names of the individuals and/or the organisations that made them, unless confidentiality is expressly requested, or you advise us that you do not want your submission published. We would not include the contact details for individuals.

*We will not place on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation.*

Please advise if you **do not** agree to your feedback being published?

☐ **NO – I do not agree to my feedback being published.**