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**:
General feedback
Are the model standards easy to read and understand?
The Australasian College of Dermatologists (ACD) welcomes the opportunity to provide feedback on the model standards and have consulted with our Fellows and Community Engagement Advisory Committee on the proposals. The model standards are easy to read and understand.
Are there any criteria in the model standards that would raise challenges for your organisation? **For colleges:** this would include any challenges in implementing the model standards. **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.
We do not envisage any challenges in implementing the model standards.
Should there be any additions to, or deletions from, the model standards?
No, the proposed standards are appropriate.
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?

No, we would not support the inclusion in Criterion 2.1.6 of specific requirements such as requiring the training setting/provider to be accredited by an industry body/regulator. Our subject matter expertise is in dermatology, and we consider that this would be an overreach of our accreditation function and expertise.

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?

We would not support the inclusion of specific requirements such as ratios to assess this criterion. Each specialty will have nuanced and individualised supervisory requirements and it is important that this flexibility is retained within the standards, rather than take a uniform approach.

In ACD's accreditation standards, there is a maximum number of trainees per supervisor, with flexibility of minimum number of supervisors per trainee in rural settings. In ensuring effective clinical supervision of trainees, ACD adopts a rigorous and flexible approach that takes into account a broad range of factors when determining supervisory requirements. This includes, for example how busy the clinic is, clinic and case load complexity, staffing volumes and mix. It is critical that this assessment can continue to be made on a case-by-case basis taking into account the unique circumstances in each location, and each specialty.

Being in national undersupply, ACD would have significant concerns that prescribed ratios would have the unintended effect of reducing flexibility, limiting opportunities to adapt and innovate to maximise supervision and training opportunities, and in turn reduce the number of training opportunities available. This would be particularly detrimental in rural settings where we have a very small supervisory pool to draw on.

Similarly, remote supervision models, where implemented, will need to take account of the unique set of resources, skillsets and circumstances both at the trainee end and for the supervisor. As with in-person supervision, this may serve to limit rather than enhance training opportunities.

Criterion 3.1.1 provides for a clinical caseload and casemix to achieve the training program outcomes.

For colleges: Would it be necessary to include specific requirements to assess this criterion, for example, logbook requirements, theatre time?

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

We would not support inclusion of specific requirements to assess criterion 3.1.1 such as logbooks.

While logbooks are used for certain procedural skills, in our experience, the most valuable feedback on the extent to which appropriate caseload/mix is being provided to achieve training program outcomes is through interview with the trainee.

We have deployed logbooks for a small cohort, namely SIMGs doing a 12-month placement in private practice, as a proactive assurance that they gain exposure to a broad range of cases.

Criterion 3.1.2 provides for trainees to engage in structured and unstructured learning activities to achieve the training program outcomes.

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.

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

We strongly support inclusion of a requirement that trainees have protected teaching/study time. ACD's current standards require minimum formal teaching requirements, as well as protected study time. This is critical and making this a standard requirement across all accredited sites will help ensure it becomes embedded and standard practice.

We do *not* support a requirement for trainees to complete a research project in the model standards for site accreditation as it is already part of our overall training program requirements and would be a duplication.

Criterion 4.2.1 provides for clinical or other equipment needed for trainees to achieve the training program outcomes.

For colleges: Would it be necessary to include specific requirements to assess this criterion, such as a list of specialist equipment?

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

No, we do not consider it necessary or appropriate to include specific requirements such as a list of specialist equipment to assess Criterion 4.2.1. Each college should retain the flexibility to adapt the standards to include relevant equipment. ACD standards currently has a minimum equipment checklist for training sites (eg dermatoscope, cryotherapy), while other types of equipment must be available in the training network (state) - e.g. phototherapy, laser, patch testing.

While it is important for us as a College to ensure that across the training network, there is exposure to the full complement of clinical or other equipment available for trainees to achieve the training program outcomes, this is not needed at each individual training site where requirements will differ according to the clinical focus of the service.

Are there any other college-specific requirements that are necessary in relation to other criteria and what should be considered in developing these?

No, with the addition of protected teaching/study time, the requirements are comprehensive and appropriate.

Feedback regarding implementation

For colleges: What is a reasonable timeframe for adoption of the model standards by your college and why? What would assist your college to adopt the model standards in a more timely manner (for example, shared training, shared resources etc.)?
For ACD, a minimum period of 12 months would be required to allow for internal governance processes, update of policies and procedures, training of Fellows and others involved in site accreditation, and other components of the change management process. To assist colleges to adopt the model standards and reduce duplication of effort, shared training and shared resources would be helpful.
For health services: What is a reasonable timeframe for your organisation(s) to be ready for assessment against the model standards and why?
n/a
Other feedback
Do you have any additional comments regarding the model standards that are not covered above?
No.

Consultation questions relating to **draft model procedures**:
General feedback
Are the model procedures easy to read and understand?
Yes, the model procedures are well written and easy to understand.
Are there any requirements in the model procedures that would raise challenges for your organisation?
We have concerns that the Risk matrix could be open to different interpretations by colleges and sites, leading to disagreements over the risk rating and appeals, thus delaying the accreditation process. By determining the risk rating by reviewing the *totality* of the criteria that are substantially met and not met, we have some concerns that in instances where the performance concern is against e.g. one criterion only this may skew the result to a low overall risk rating. While we understand colleges will still have the option of conditional accreditation, this rating may reduce colleges' ability to compel quality improvements. In our view, sites should not be fully accredited if ANY single criterion is 'not met'.
Feedback regarding agreed terminology
For colleges: Are there any obstacles to your college implementing the common terminology for: • assessment against the standards: met; substantially met; not met • accreditation outcomes for new settings: provisionally accredited; not accredited – refused

• accreditation outcomes for existing settings: accredited; conditionally accredited; not accredited – revoked.
We do not envisage any obstacles to implementing the common terminology.
For colleges: In what timeframe could your college implement this terminology? What support may assist quick adoption?
As above, for ACD, a minimum period of 12 months would be required for these updates to be made as part of the broader change management process.
Feedback regarding the risk matrix
Is the risk matrix appropriate for accreditation decision making?
As above, we have concerns that the Risk matrix could be open to different interpretations by colleges and sites, leading to disagreements over the risk rating and appeals, thus delaying the accreditation process.
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. 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.
No, it is our view that there *should* be a requirement for a condition to be imposed for any criterion assessed as 'substantially met' or 'not met'. Being able to address underperformance against individual criterion is critical and the risk matrix as proposed may increase opportunities for challenge, and make it more difficult compel the site to implement the improvements. This would negatively impact trainees and conflict with the priorities of the AMC and incur a response.
The risk matrix indicates that steps to revoke accreditation should be taken when the overall risk assessment is extreme. Is this appropriate?
Yes, we consider this appropriate. The opportunity for remediation should still be retained when the overall risk assessment is high-risk but not for extreme.
Other feedback
Do you have any additional comments regarding the model procedures that are not covered above?
Thank you for the opportunity to provide feedback. We have no further comments.

Organisational details and contact	
Organisation name/details:	The Australasian College of Dermatologists
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.**