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 model standards are easy to read and understand, however are very generic and heavily open to interpretation. Recognising that this may be purposeful to facilitate adoption in so many different contexts, we would be concerned at the ability to robustly implement these standards if the intention is to limit the inclusion of college-specific requirements. The Criteria, as written, are not truly measurable as they do not include specific expectations. Assuming Colleges are able to provide this specificity in the college-specific requirements and evidence requirements, this concern will be addressed.

As an example: Criterion 1.1.6 states *Trainees can access leave arrangements, including leave to fulfil community cultural obligations, in accordance with employment and/or appointment conditions.*

AOA has a Criterion which requires

The department facilitates the completion of training requirements including but not limited to:

- *attendance at Bone Camp,*
- *ensuring trainees can always participate in regional Bone School,*
- *leave for courses or exams.*

We believe it is important to be open and transparent with training sites regarding the training obligations on trainees for activities that are mandatory, but completed outside the training site setting.

Another example would be Criterion 2.2.5: *Supervisors are supported in meeting their education and training responsibilities, including in providing culturally safe supervision and contributing to a culturally safe environment.*

AOA has criteria regarding mandatory training for Directors of Training and Trainee Supervisors which we believe are essential to support them in effectively carrying out their training roles along with protected time. We would want these details clearly laid out in the college-specific requirements section of the Standards to ensure training sites are fully informed regarding the obligations of surgeons involved in delivering training. AOA also has formal position descriptions for these roles which we would seek to reference.

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.

Criterion 1.1.4 requires *Risks to the cultural safety of Aboriginal and/or Torres Strait Islander and Māori trainees are identified, managed and recorded*. The notes for this criterion indicate that *Colleges should have a documented process in place to assess whether training providers identify and manage risks of culturally unsafe, unacceptable, discriminatory or unlawful behaviour at the training setting, relating to Aboriginal and/or Torres Strait Islander and Māori trainees.* AOA does not currently have the expertise to undertake such an assessment and would need expert advice, perhaps from AIDA, on how this should be undertaken. Whilst AOA may assess for some elements of this criterion when considering the culture of a training site and any history of bullying and harassment, the wording of this criterion seems much more targeted towards use of a cultural safety scale such as the one adopted by NSW Health. This may be something better assessed by the Health Service/hospital than by every college.

There are a number of standards that seem to suggest control over training program requirements at the training site level. AOA trainees rotate every 6 months, so while there is an expectation for the Director of Training at a site to ensure continuity of learning and development for their trainee, this is facilitated at a regional level. For example, criterion 2.1.2 *Trainees can provide input and feedback into how their local training is delivered.* Whilst sites may collect targeted feedback internally this is not specific to the training program. AOA collects feedback from trainees on their rotation, however this is a training program activity not a training site activity.

Likewise, criterion 2.2.5 *Supervisors are supported in meeting their education and training responsibilities, including in providing culturally safe supervision and contributing to a culturally safe environment*. The narrative regarding the intent of this criterion discusses monitoring of supervisor performance, this is done at an AOA level rather than a training site level. It is unclear to us how this would be assessed at the site or post level outside of consultants at the training site participating in the AOA monitoring activities.

Criterion 2.3.2 *Trainees are supported in developing specific knowledge and skills to deliver quality patient care, including culturally safe care to Aboriginal and/or Torres Strait Islander and Māori peoples*. Whilst we have requirements for cultural safety learning for trainees, again this is currently delivered at a training program level and not assessed site by site. At a site level, we would probably be assessing whether access to these learning activities is facilitated, unless the expectation is that we assess what educational opportunities the training site provides in this regard?

In some cases, the notes regarding the criterion conflict with AOAs training program requirements – there is a risk that this will cause confusion for training sites depending on how the information is presented. For example, criterion 2.2.2 *Supervisors engage effectively with trainees and provide regular and timely feedback on performance to guide trainee learning*. The notes for this criterion state: *Feedback may be provided through both formal and informal mechanisms and will differ according to the nature of the training setting. Large settings may have more structured opportunities for feedback whereas small settings may depend more on more informal opportunities.* This statement is contradictory to the requirements of the AOA 21 Training Program where a minimum number of workplace-based assessments and formal "feedback entries" are a mandatory requirement of training.

Should there be any additions to, or deletions from, the model standards?

AOA is disappointed to see that there is no longer any requirement in the model standards regarding provision of accommodation or relocation support for trainees rotating away from their primary place of residence.

In an environment where we are working hard to increase the rural workforce, it is counter-productive to remove any support mechanisms for ensuring trainees on regional or rural rotations have a good

experience. Orthopaedic Surgical trainees in Australia rotate every 6 months and will all undertake at least one regional / rural rotation during their training time. In some cases, trainees may complete 3 or more regional / rural rotations.

AOA currently has a very clear policy on the minimum standard of relocation support and accommodation that must be provided, which is based on the AMA Position Statement. These non-voluntary allocations should not incur costs for the trainee. We strongly recommend this criterion be reinstated.

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?

AOAs current Standards requires the training site to be accredited as meeting the National Safety and Quality Health Service Standards. We also require the site to have an accredited:

• diagnostic laboratory service

• diagnostic and interventional radiology service.

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?

Yes, AOA requires a minimum of 3 consultants in a department to consider accreditation to ensure effective supervision. Due to rostering and on call requirements, any less than 3 consultants would result in a lack of supervision, especially in a situation where a consultant is on leave. A lack of supervision increases the risk of harm to patients. It is important to remember that the purpose of the model standards is to accredit a setting for delivery of training. Trainees are not qualified surgeons and should not be utilized in lieu of consultant services. The priority for accredited trainees should not be service delivery alone.

The AOA 21 training program is a Competency-based Medical Education (CBME) program, designed to provide graduated levels of responsibility to trainees as they demonstrate increasing competence based on a series of entrustment decisions. These decisions are based on observation of the trainee at work – on site supervision is an essential component of this. This approach is consistent with the requirements of the current AMC Standards for Assessment and Accreditation of Specialist Medical Programs.

The assessment strategy of the AOA 21 Training Program utilizes a continuous assessment approach that necessitates regular observation of performance and workplace-based feedback and assessment from a

variety of assessors, in a variety of contexts. Trainees working under the supervision of multiple consultants ensures a broader mix of exposure and a richer training experience.

Due to the nature of surgical practice, onsite supervision is imperative for all but the most senior trainees to ensure patient safety. Even these most senior trainees have a better training experience with onsite supervision as their greater experience allows for direct teaching in more advanced techniques in preparation for consultant practice. More skilled trainees completing the training program are better equipped to provide a broad level of service to the communities they serve. AOA believes that the standards must stipulate a requirement for onsite supervision as a minimum requirement except in exceptional circumstances.

The value of a skilled supervisor cannot be understated. The pro-bono surgical trainer workforce is essential to the effective delivery of training. The contributions of consultant surgeons to delivery of training is extraordinary especially in instances where a trainee may require additional support. AOA recognizes and appreciates the significant amount of time donated to the training program by our Fellows. In particular we acknowledge the burden of assessment in a competency-based program. We also believe it is important that this load be shared to avoid supervisor burnout and attrition.

From time-to-time AOA approves supervision by a consultant who has a FRACS qualification in another surgical specialty (for example, a FRACS-qualified plastic surgeon supervising a hand list).

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?

Yes. To ensure trainees are receiving adequate exposure to effectively develop their skills and knowledge we require a broad caseload and case mix with minimum requirements for: clinical sessions, theatre lists, new patient clinics, on-call participation, and assessment of patients in the emergency department.

We also have varying requirements for posts to be utilized for trainees at the three different stages of training. Whilst all accredited posts can be allocated Core Orthopaedics trainees, there are additional, targeted requirements for Introduction to Orthopaedics (first year) and Transition to Practice (last year).

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?

Yes, a key part of surgical training is the provision of quiet time for study – this includes reading/preparing for a case or reflection following a case. We also require attendance at clinical and multi-disciplinary case meetings, tutorial or education sessions, journal club, M&M meetings and the ability for trainees to teach junior colleges.

As noted under question 1 above, AOA would also need to include provision for the training site to release trainees to attend training obligations or activities that are mandatory but completed outside the training setting. AOA currently has a Criterion which requires:

The department facilitates the completion of training requirements including but not limited to:

- *attendance at Bone Camp,*

• *ensuring trainees can always participate in regional Bone School,*

• *leave for courses or exams.*

These are all learning activities which help trainees develop the skills and knowledge to be effective surgeons across the breadth of the competency domains with well-developed skills in for example, leadership, communication, teamwork, advocacy and critical thinking as well as clinical skills.

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?

Yes, for Orthopaedic Surgery we would need to ensure provision of appropriate imaging and radiation safety equipment. Our current standards include the minimum requirements for these types of equipment.

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

As noted in the first question, given the model standards are very generic, AOA believes that college-specific requirements and examples of required evidence will be needed for most, if not all, of the criteria in order to provide a clear framework of measurable expectations to training sites.

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.)?

A soft introduction/pilot of the model standards alongside the existing process would be readily achievable as AOAs standards map well to the model standards, with the exception of our requirement for provision of relocation support and accommodation which is absent in the model standards.

A more structured implementation, which would require all accreditation standards, policies, processes and templates to be updated and would take more time. Key considerations would be staffing and member resources for undertaking the refresh, and time required for changes to move through approval processes. This would be a major project.

AOAs Accreditation process is facilitated by an online application and assessment system. Updating technology is a costly and time-consuming process – this will likely be the greatest determinant of our timeline as changes to the system will need to be drawn up, costed, developed, tested etc. once any changes have been approved. This would take a minimum of 12 months.

Prior to implementation, AOAs accreditors would need to be trained in the new standards and processes and a communication strategy with members, sites and jurisdiction would need to be developed and rolled out.

A key consideration is the lead time for the annual accreditation cycle. The deadline for accreditation applications (for review in 2025, outcomes applicable for 2026) has already passed. This deadline falls on 1 November each year, which is 12 months ahead of the final date for extending offers for the following training year.

It is important to note that a full re-structure of AOAs Accreditation Standards and Process would be a major project with significant cost. Currently, the cost of the Accreditation Process is born by trainees as one element of their training fee (which is set via a complex activity-based costing process). The existing cost of training is considerable and any increase to this would not be well received by trainees. Should it be determined that this form of implementation is required, we would advocate that there be some provision of funding so that the cost does not have to be borne by trainees.

Were it determined that mapping to the model standards was sufficient to ensure all colleges were incorporating the same minimum standards – AOA could readily implement this process for 2025. As noted above, AOAs standards map well to the model standards, with the exception of our requirement for provision of relocation support and accommodation which is absent in the model standards.

For health services: What is a reasonable timeframe for your organisation(s) to be ready for assessment against the model standards and why?

Other feedback

Do you have any additional comments regarding the model standards that are not covered above?

AOA recommends a more purposeful integration of the advice presented by Minter Ellison at the joint Health Workforce Taskforce and Australian Medical Council workshop held on 15 August 2024. The shared duty for trainee health & safety should be strengthened in the model standards. The obligation for colleges and health services to

- consult with each other.
- co-operate with one another in the discharge of their duties; and
- co-ordinate activities with each other and any others who have a duty in relation to the same matter

Is fundamental to the effective implementation, especially of Domain 1.

We also believe that provision of relocation support and accommodation for trainees rotating away from their primary place of residence is relevant to meeting these duties.

It is important to remember that no training setting is obliged to apply to be accredited for training. Delivery of training brings with it a considerable number of duties and responsibilities in addition to ordinary care of patients. Only sites that are willing to commit to these extra responsibilities should be encouraged to apply for accreditation to deliver training. Supervision, teaching, mentoring and support of trainees on their learning pathway is a privilege and should be approached with compassion, diligence and a clear understanding of the requirements.

Colleges, health departments, training sites and consultants are all working towards a shared goal and should approach training as a shared responsibility where all parties are committed to excellence through effective partnerships and shared accountability.

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

General feedback

Are the model procedures easy to read and understand?

For the most part, the model procedures are easy to read and understand however there are areas of ambiguity or where the content seems contradictory. These have been outlined below.

Are there any requirements in the model procedures that would raise challenges for your organisation?

With regard to section 4, *Settings applying for accreditation for the first time are recommended to start the application process at least six months before they would like training to begin.* This timeline is too short for the AOA process – we would need to update the procedure with our timelines which require just over a year currently. Accreditation applications are due by 1 November for reviews to be undertaken in the following year (for outcomes to become effective for the following training year). For example, an application for a new post received by 1 November 2024, would be scheduled for a review in the first 6months of 2025. If successful, the additional post will be factored into the number of Selection offers released in July 2025, with the new post activating in the 2026 training year. Shortening this timeline would diminish AOAs ability to undertake a robust assessment process and potentially reduce the current high standards of training and delivery of safe patient care by trainees. Is the goal of introducing standard procedures to shorten timelines for accreditation of new settings?

With regard to section 9, *To ensure procedural fairness, the college will notify the Lead Contact at the training setting/training provider of the proposed decision, providing a copy of the draft report as well as any reasons for its proposed decision*. We note it is proposed that the report is shared with the training site after it has already been to the Accreditation Committee. AOA considers it counterproductive to wait until after the Accreditation Report has been presented to the Accreditation Committee for it to be shared with the site. We recommend that the report should be shared with the site before it is submitted to the Accreditation Committee. If the site corrects factual inaccuracies after a decision has been made, that decision is invalidated. The accreditation team makes its recommendation based on all of the gathered information. If pertinent information is missing, the recommendation is likely to change. It is much more effective use of the Committees time for the draft report to be shared with the site prior to the matter being put before the Committee. This avoids needless delays in decision making and maximises productivity for the committee.

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.

AOAs Accreditation assessment language is binary, we currently take a met/not met approach. There is a risk that introduction of "substantially met" will create confusion and potentially minimize the perceived relative value of, and need to work towards meeting, criteria assessed as substantially met. We would argue that met/not met is clearer and should be retained. The risk matrix can then be utilized to provide nuance with regard to severity of the gap between what is in place and the minimum requirement. AOA does not support an approach that allows for anything less than the minimum standard to be considered "good enough".

Proposed terminology for outcomes is consistent with what is currently utilised and we do not foresee any obstacles.

For colleges: In what timeframe could your college implement this terminology? What support may assist quick adoption?

As outlined above, there will be a necessary development and approval period for the updating of documents and processes. Implementing changes on the online platform will be costly and take some time. A minimum of 12 months would be required.

Feedback regarding the risk matrix

Is the risk matrix appropriate for accreditation decision making?

Yes, the risk matrix provides an excellent framework to support decision making

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.

AOA considers that conditions would apply anytime a criterion is assessed as anything other than "Met" (even if the condition is simply meeting the criterion in question within a given timeframe). Accreditation, without conditions, is only granted where every criterion is met, as criteria are minimum requirements.

The risk matrix indicates that steps to revoke accreditation should be taken when the overall risk assessment is extreme. Is this appropriate?

AOA considers this appropriate – however we would recommend more clarity around what is meant by "steps to revoke" and the possible outcomes.

We note the comment that *there may be follow up work undertaken with the setting to help lower the risk rating which in turn moves the setting back to a conditionally accredited pathway.* This seems to contradict the outcome of "accreditation not granted/not accredited (revoked)" listed in the table. Our interpretation is that there are two possible outcomes where the overall risk assessment is extreme, however this is not clear in the documentation which lists "Not accredited (revoked)" as the only possible

outcome. We recommend that including "Conditionally accredited OR Not accredited (revoked)" would be clearer.

In cases where extreme risk has been identified without there being any prior conditions, AOA always attempts to work with the site to rapidly manage the risk. This may include initially deferring decision making on an outcome while liaising with the site on an urgent remediation plan. If the site is willing to commit to working with us, this will usually result in conditional accreditation for a short, defined period. This process seems consistent with what is outlined above and supports our recommendation for including two possible outcomes.

In our experience, there are only a few circumstances where an accreditation review would spontaneously have an extreme risk assessment. More commonly, the initial assessment may be high and progress to an extreme risk due to lack of action on behalf of the training site in response to conditions. There may be value in highlighting the potential for this escalation?

Other feedback

Do you have any additional comments regarding the model procedures that are not covered above?

With regard to section 8, the proposal to provisionally approve a new post in circumstances where the site is not able to meet all criteria, and where the risk assessment is medium or high, is not in the best interests of trainee wellbeing.

Currently, AOA does not accredit a new post without strong evidence that all standards will be met at the time a trainee is allocated. We cannot support a procedure that would see trainees purposefully placed in a sub-optimal training environment. This is especially concerning in situations where the post is in an entirely new training site, which means the consultants may not have any experience in delivering training and the trainee will not have the support of other trainees.

We recommend that a new training setting that does not meet all of the accreditation criteria (which are the minimum standard required to deliver training), and where the risk assessment is medium, high or extreme, should receive and outcome of "Not accredited (refused)".

Under no circumstances should a trainee be placed at a site that has not demonstrated that they are able to safely and effectively support the learning, development and wellbeing of a trainee.

With regard to section 11, *If a setting has a grievance with an administrative aspect of the accreditation process, for example, a conflict of interest,*
lack of procedural fairness, it should follow the college's Complaints policy.

There may be value in:

- Specifying this pathway is for circumstance where the intention isn't to change the accreditation decision. If the intention is to change a decision, this type of concern would presumably be used as grounds for reconsideration.
- Clarifying If an issue of this sort is identified during the accreditation process that is should be flagged with the secretariat, Accreditation Team lead or Accreditation Chair immediately so that it can be addressed / rectified promptly so as not to have a negative impact on the process.

With regard to section 13, there may be value in expanding this to incorporate sites who choose to withdraw from training after being accredited. Periodically training sites will identify for themselves that their circumstances have changed/ they are no longer able to meet the standards, and they withdraw their post(s) from the training program.

With regard to section 16, AOA would not be inclined to direct someone with concerns about a training post to lodge a complaint. We would encourage them to contact a member of staff or a relevant AOA representative (depending on their position). For example, we have a strong track record of affecting change where trainees raise concerns with either their local trainee representative, their Regional

Manager or their Regional Training Committee Chair. Consultants will often contact either the Executive Manager for Education & Training, Accreditation Chair or Federal Chair of Training.

With regard to section 19, it may be clearer to title this section “Training” or “Accreditor Training” rather than *Staff Training* as this could be misunderstood to be referring to college or training site staff.

Organisational details and contact	
Organisation name/details:	Australian Orthopaedic Association
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.**