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?
A few broad comments around the benefits of accreditation. High quality training enhances the provision of high-quality clinical care, investment in this process will have a positive impact on patient care. Accredited units also benefit from this process as accreditation facilitates access to greater numbers of the junior medical workforce . This makes hospitals safer around the clock with less reliance on the specialist workforce, which can in turn can help with the retention of specialists. These benefits to patients, units, hospitals and the broader system need to be at the centre of decision making. The model standards are easy to read and understand. They are written in plain English and formatted in a logical and methodical manner. It is easy to navigate to sections you may want to find via the dynamic contents page.
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.
The College of Intensive Care Medicine (CICM) training program is very flexible. It allows trainees to move in and out of the training program. This flexibility can make it difficult to identify trainees who have taken a break in the program and understand whether they have been supported to return (Domain 1, criterion 1.1.8). Given the transient nature of the training journey, ICUs may not be necessarily aware that a trainee is on a break in training or that they are considered a trainee, particularly if they are in the early stage of training. The CICM is committed to improving the safety and wellbeing of its trainees and eliminating/reducing incidents of bullying, discrimination, harassment and other unlawful or unacceptable workplace behaviours. This include risks to the cultural safety of Aboriginal and/or Torres Strait Islander and Māori trainees (Domain 1, criteria 1.1.2 and 1.1.4).

However, the current structures and workplace conditions of hospitals mean it is almost impossible to manage negative behaviours, short of those breaching the law. Even when illegal actions/behaviours do occur, it is often difficult to source the required proof for HR and legal processes.

Due to structural power imbalances in the profession, there is a general reluctance to formally complain about negative behaviour when there is little chance of a positive outcome.

The CICM requests guidance and support for how these standards can be achieved when specialist medical colleges have very little influence and control of HR issues in the hospital/workplace setting.

The Colleges has implemented a new Complaints Policy and Process to help address these issues as best we can within these constraints.

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

The Domain *Educational resources, facilities and equipment* could be expanded, articulating that trainees are working in a safe physical environment which adheres to WorkSafe legislation and manages risks around trainee physical and psychological welfare.

While we understand there are some limitations on the role of Colleges in determining whether a unit is suitable from a physical infrastructure perspective (and to hinge accreditation on it is not always reasonable), there should be recognition that College accreditation teams are made up of clinical experts who are often able to identify unsafe or unsuitable practices, infrastructure and environments.

In cases where infrastructure is unsuitable to the running of the unit, there should be the ability to assess this from all colleges and not just to have this as a college-specific requirement. There should be clear guidelines on when a College should contact WorkSafe regarding infrastructure concerns. Additionally, an appropriate regulator should work collaboratively with WorkSafe and colleges to ensure the maintenance of open and transparent communication.

The standards should also acknowledge that specialist medical colleges have significant domains of expertise in their specialty, and as such, their opinions and policies should form part of the evidence base used to make assessments. The standards currently do not reference the wellbeing and training environment of Fellows, this is a serious oversight, given that Consultant teaching conditions are trainee learning conditions. The standards should also assess the training conditions of Fellows.

Often, non-CICM trainees train in ICUs (usually for other training programs). There should be a requirement in the standards for all junior doctors regardless of their speciality or training status to receive appropriate training during their rotations in different specialities. The standards should reflect this.

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?

The CICM is satisfied that training settings that meet the below listed standards and guidelines would be appropriate requirements to assess this criterion in intensive care training settings:

- National Safety and Quality Health Service Standards
- Australasian Health Facility Guidelines – Intensive Care Unit (under review)
- Ngā paerewa Health and Disability Services Standard
- CICM – IC-1 – Minimum Standards for Intensive Care Units (under review)

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?

For the CICM, there are set ratios with which units must comply to ensure adequate supervision not just of CICM trainees but also of other college trainees rotating through the ICU. The ratio is needed to ensure equity of supervision for all trainees across all accredited units. There are no amended ratios for regional, rural or remote as these units tend to have smaller trainee numbers and often don't exceed the ratio.

The College may impose a condition on a unit if the Supervisor of Training (SOT) to Trainee ratio exceeds capacity. This condition would focus on recruiting individuals for the SOT role. The College can support the unit in this effort by sending interested junior Fellows to College SOT training and connecting them with experienced SOTs for mentorship.

Both teaching and training are essential components of accredited units, so without adequate supervision and resources, the environment becomes unsuitable for specialist medical training. To address this, the accreditation team works to resolve such issues during site visits.

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?

Although the CICM has not established it as a formal accreditation requirement, we have been exploring mechanisms such as logbooks to support sub-specialty accreditation. Units receive sub-specialty accreditation if their caseload volume meets our criteria, as evaluated through the Australian and New Zealand Intensive Care Society (ANZICS) core data submissions.

However, the College does not necessarily assess the diversity of caseloads or ensure that each trainee completes the required number of cases with sufficient quality. Consequently, it is possible for a trainee to fulfill their cardiac component without having direct experience with a cardiac case. As such, it may be beneficial to include specific requirements such as logbooks and theatre time, but any new requirement must be flexible to allow for variance between units.

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?

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?

While these key documents are under review, this criterion could be assessed against the below:

- Australasian Health Facility Guidelines – Intensive Care Unit (under review)
- CICM – IC-1 – Minimum Standards for Intensive Care Units (under review)

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

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

The CICM has already undertaken a significant body of work to address the college-specific recommendations as made by the National Health Practitioner Ombudsman.

Specifically, we have been working on:

- developing domains of accreditation which pleasingly align nicely with the domains in the model standards

- developing a hospital accreditation handbook which, when compared to the model procedures document, also aligns nicely.

We would like to seek clarity on whether the model standards are just that – models that can be tweaked and customised to more appropriately fit with respective colleges, or whether the model standard domains and criterion MUST be used as is and then any other College requirements can be assessed through the "college-specific requirements" arm.

Presently, CICM is developing criteria to accompany our domains, and we are slowly starting to embed this in our processes. However, if we will be expected to assess all the listed criteria and pivot to the new AMC drafted domains, we will need sufficient time to:

- change our documentation
- educate our inspectors around the specific criteria and what is being asked of them to assess and how.

As we believe we are already aligning nicely, albeit not exactly, to the draft standards through our development of domains and criteria, we feel an implementation timeframe of around 12 months would be reasonable. Additionally, if expected to pivot to the AMC domains, the AMC should provide specific guidance and maintain a regular and open dialogue with the College to ensure that standards and criteria are appropriately and effectively implemented. There is concern that there may be limited support provided when implementing standards, and that the College will not be fully aware of any significant concerns/ issues until the next accreditation period.

Other feedback

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

For many colleges, moving to the model standards would be a significant change from current processes. One consideration that we would strongly recommend is that a pilot period for the model standards is implemented and that time is given for monitoring and evaluation of this new method to ensure that by the time Colleges are being assessed on them, they have undergone a period of evaluation and feedback.

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

General feedback

Are the model procedures easy to read and understand?

Yes, the model procedures are easy to understand and formatted well for easy navigation.

Are there any requirements in the model procedures that would raise challenges for your organisation?
There are no identified elements within the model procedures which would raise challenges for CICM.
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.
Overalll, the terminology seems acceptable and closely aligns with what we already have in place "full accreditation – no reporting requirement", "full accreditation with reporting requirement", "conditional accreditation", "Removal of accreditation". Reporting requirements are what we have implemented to support units who may not have conditions but who do have elements of their unit which may turn into a condition if they don't address it in a timely manner. In the risk matrix, these units would be considered low risk but still with identified risks that may be flagged as a medium risk if not addressed.
For colleges: In what timeframe could your college implement this terminology? What support may assist quick adoption?
As CICM is already using similar terminology, it would not take us long to pivot to the new terminology. An implementation of 12 months would seem a reasonable time to implement processes and terminology. However, we would like for there to be flexibility to continue using the reporting requirement as we have found success in supporting units through this mechanism.
Feedback regarding the risk matrix
Is the risk matrix appropriate for accreditation decision making?
The risk matrix seems simple to understand and appropriate for accreditation 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.

The College agrees that there should be a requirement for a condition to be imposed if a standard is 'not met'. This approach would reduce the risk of the issue persisting over time and affecting other areas of training.

Just because one standard has been met, doesn't mean that all other areas automatically receive a green card – particularly if it is an area such as culture.

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

Yes, this seems like an appropriate course of action. However, it may be that there are times where it is not, and the situation is more nuanced. In these instances, the rigor of the matrix may be hard to apply and giving the unit a chance to address issues within the scope of conditional accreditation may be the best way forward. This is where the ability for colleges to have discretion is very important.

Other feedback

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

Some training does occur in the private sector (private operator/hospital), this should be highlighted in the glossary.

We would like clarity on whether it is an expectation that Colleges use the procedure verbatim/as it has been designed or whether it is just a guideline for developing a procedural document which Colleges have scope to be able to add to or adjust. We have been told previously that it will be more like a template than a mandated form but there is no clarity in the documentation about expectations to use this.

Overall, the CICM sees this as a valuable piece of work that will make a positive impact on trainees and college accreditation processes. We look forward to contributing to this important work further.

Organisational details and contact

Organisation name/details:	College of Intensive Care Medicine
Contact name:	[redacted]
Contact email:	[redacted]

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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.

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