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

The Department of Health WA (DoH WA) welcomes the initiatives and principles that underpin transformation of college accreditation practices and processes. It is considered that the standards and procedures developed offer significant benefits and provides structure and supports that are required to address accreditation matters that have been acknowledged as challenging for accredited organisations and will promote clarity and engagement between all parties involved in accreditation of training settings.

Efforts to standardise the approach to accreditation is viewed as a significant step forward. The DoH WA appreciates that reform in this space is subject to a number of complexities. The DoH WA notes that there appears to be a level of insufficient information that is currently available and provided to health jurisdictions regarding the design and planning of the implementation approach. This includes matters such as:

- an outline of timeframes proposed for college adoption of the proposed standards and procedures and if and when there is an implementation deadline required of the Colleges to apply the proposed model standards/procedures in their assessments of training settings. At the last update provided by the Australian Medical Council (AMC) and Health Workforce Taskforce to health jurisdictions on 8 October 2024, it was understood that decisions on transitions were subject to the preferred/determined timeframes of colleges, and particularly for those Colleges who had recently revised the accreditation frameworks that implementation may be on a longer-term basis.
- The oversight and any approval frameworks or mechanisms that may be applied by the AMC to manage the possible extent of “college specific requirements” applied to accreditation assessments. Whilst recognised that there is a need for colleges (and their associated faculties and chapters) to stipulate unique accreditation requirements as relevant to training requirements of their medical specialty, it would appear that there is limited guidance on the scope or guardrails to rationalise individual variances. Divergence from the model standards/procedures via “college specific requirements” without effective governance and monitoring processes may appear to contravene and undermine the significant efforts and intent of the accreditation consistency.
- Transition arrangements for accredited organisations that are subject to previous assessments and ongoing monitoring and any “grandfathering” of accreditation practices/processes do not appear to have been clarified or widely advised. It would be beneficial for advice on transitional arrangements and processes to be incorporated into the proposed model procedures, or developed as a supplement, so that both Colleges and training settings/accredited organisations are aware of transition arrangements prior to full implementation of the proposed model standards/procedures.

- There appears to be limited information on the order of precedence of the proposed model standards/procedures and existing College policies and frameworks. The efforts to update internal policy environments is noted as significant yet it would be beneficial to provide assurance that an order of precedence exists in the event of any required resolution on matters of disagreements between accreditation parties. The DoH WA has assumed that documents are read down from the model standards to the procedures to college policies on topics and items where and as relevant however this does not appear to be specified in communications to date.

The DoH WA would be interested in seeking, or being advised on, additional information on matters relating to the above prior to forming a full view on the proposed model standards and procedures.

Are the model standards easy to read and understand?

The format in which the standards are presented – grouped by Domain, Standard, Criteria – are well structured and provide a level of clarity and ease of interpretation necessary to guide and inform on the applied accreditation scope.

Scalability of the standards as appropriate to the size of the setting is well considered, although some residual concerns are noted in references relating to "informal" or "personalised mechanisms" reserved for assessment of smaller training settings. In some cases, there may be benefit in reconsidering if formal policies and procedures should be extended as an obligatory requirement to small settings; this is considered particularly important for promotion of cultural safety (C1.1.4), management of bullying, harassment, discrimination and racism (C1.1.2) and mechanisms for raising complaints or grievances (C1.1.1).

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.

It is noted that the standards acknowledge that there is a requirement for the standards to be scalable and flexible and reflective of clinical and operational environments. It is also considered that the proposed model standards are somewhat aligned to existing accreditation assessment criteria. Given both factors combined, implementation challenges would be anticipated to be minimal.

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

Some reconsideration may wish to be given to the requirements of Domain 4 "*Educational resources, facilities and equipment*" particularly related to facilities/space noted for trainee learning requirements. Given the increasing use of on-line spaces and environments, and individual trainee preferences for learning/studying activities, it is suggested that the stipulation for "*Trainees have access to an appropriate quiet space with adequate internet access for their learning*" (C4.1.1) may not be fully reflective of modern workplace settings and instead, that "spaces" could be replaced with "adequate opportunities for learning time or periods" either on or near a training setting or at another location of the trainee's choosing.

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?

Accreditation by recognised and approved formal bodies at an Australian national level and/or where special circumstances apply, by recognised and approved international bodies is supported as part of the assessment as and where relevant. Consideration of "college specific requirements" in such cases are beneficial to the extent that the accreditation is directly relevant to the medical specialty under assessment. It should be noted that a health service licensing requirement may have been dependent on having priorly achieved/satisfied accreditation for clinical and operational practice; to this end it is not clear what additional benefit would be derived by colleges applying this as an assessment criterion other than for assurance purposes.

Accreditation assessments by Colleges relating to such criteria however would best note that review of the training setting has already been undertaken and sufficient evidence in the form of official advice of approval from the accreditation body to the training setting satisfies assessment. Further substantiating copies of documentation or submissions by a training setting to satisfy any College queries would however be considered to be onerous and potentially impose an additional administrative burden on training settings.

The DoH WA would however be supportive of Colleges making further queries as and when required, and where advised a training setting is advised prior to contact - of direct confirmation by the College with the accrediting body to provide assurance of accreditation.

Further, it is noted that accreditation status may change in the course of the college cycle, therefore it is suggested that consideration is given to rewording the criteria to "Maintains ongoing accreditation and notifies the colleges of any material changes to the accreditation status."

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?

As previously provided, the DoH WA has a level of concern regarding the potential for detracting from the intent of the model standards through the application of "college specific requirements" that allow deviation from uniform criteria. Any specific recommendation proposed by the Colleges should be evidence-based and as far as possible consistent between colleges. The current lack of evidence or rationale for the proposed numbers/ratios etc and significant variability between colleges in terms of requirements makes implementation challenging for health services.

However, it is noted that medical specialties have unique training programs and training supervision models are subject to varying resource investment intensities to ensure outcomes. If College specific requirements are incorporated/supplemented into the standards, the following observations are made:

- Directors of Training (or equivalent) are supported; such roles provide multiple benefits such as a single contact point for trainee support, information on training programs, liaison contact for Colleges and other stakeholders etc. At present, some Colleges stipulate FTE requirements for Directors based on the number of Supervisors (and/or trainees) at a particular site. It is suggested that this is reconsidered by all Colleges with a view to removing the minimum FTE stipulation and instead reserving FTE requirements and ratios as an operational/industrial matter for an employing health service as long as it can be evidenced that training quality outcomes will not be impacted. In

the case of WA given the geographical distance challenges, it is difficult to establish and maintain FTE minimum/ratios at individual sites in regional and rural locations and allowance or exceptions could be considered where Directors and Supervisors/Trainees are not co-located at the same site yet regularly interface on training matters (C2.2.4).

- Aligned to the issue above, it appears that the physical presence of nominated Supervisors are required in some existing College accreditation criteria as opposed to allowing a more flexible rotational approach for supervisory activities and/or leveraging technological innovations such increased use of online channels where a supporting consultant or otherwise appropriately qualified clinical personnel is available to support and assist with on-site training at times where a supervisor is not able to be physically present. Limited guidance appears to be provided on alternate models that may be considered and accepted as meeting the standards' criteria (C.2.2.1). There could be more explicit emphasis on virtual and alternative modalities and models for supervision. This would also assist with addressing workforce maldistribution.
- While noted that a single, dedicated supervisor may enhance and contribute to training outcomes, exposure to rotating or multiple supervisors may also assist in exposing trainees to differing practices, procedures and knowledge sharing/learnings. A level of consideration of how responsive/effective the supervisor model is (possibly based on past trainee outcomes initially and benchmarked going forward) as opposed to applying specific criteria for ratios/on-site physical presence/FTE minimums is seen as more valuable by DoH WA.

It is noted that the proposed model standards attempt to address and overcome FTE/ratio issues and promote that criteria should be flexible, yet there appears to be limited direct guidance that provides information how this would be practicably applied, and a level of concern exists given that there is allowance for college specific requirements an assumption is made that existing protocols may continue to apply in future assessments.

Consideration may also wish to be given to the future reforms related to expediated pathways for Specialist International Medical Graduate (SIMGs). It is recognised that there would be likely be situations that SIMGs accredited via the alternate AMB pathway would be positioned as a potential supervisor. The proposed standards appear to infer that supervision would be undertaken by a college Fellow; it is not clear how the interface between the college accreditation requirements would accommodate supervision by a specialist consultant who is recognised by the AMB/Australian Health Practitioner Regulation Agency (Ahpra) for practice via the SIMG expedited pathway.

Criterion 3.1.1 provides for a clinical caseload and case mix 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?

Unable to comment.

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?

It is noted that the criteria is flexible and scalable to the training setting size. Large settings may have in place formal learning opportunities, for example tutorials, patient rounds, technology-enhanced/simulation training, quality and safety activities, research, journal club, multidisciplinary meetings, and morbidity and mortality meetings; with small settings offering opportunities through more informal mechanisms, including the diversity of health care provided at the setting, engagement with the

community and other on-the-ground experiences. The DoH WA welcomes the diversity applied for interpretation of structured and unstructured learning activities but notes that this may inadvertently be applied in assessments as a collective suite to be met rather than refined and tailored to the outcome requirements of training programs of the Colleges.

Any specific requirements should also be developed in consultation with all health jurisdictions and an opportunity to contribute also extended to accredited organisations. Presently it is considered that such requirements for most colleges appear based on practices within the jurisdiction that the college is located in and may not take into account other jurisdictional implementation considerations.

As noted above, there are some minor concerns relating to the scope and extent that may be allowable under college specific requirements that continue present practices and promote accreditation approach inconsistency rather than align to the intent of standardisation.

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?

A level of consideration may be given to future procurement or purchases, and/or equipment replacement programs. There may be occasions where a health service intends to commission or upgrade existing clinical infrastructure as part of a funded program however at the time of accreditation this has not been achieved. It is not known if this has previously influenced accreditation decisions, but limited information appears to provide guidance on how, or if, this may be considered as part of an imposed obligation for accreditation (for ongoing monitoring post conditional/provisional accreditation).

Anecdotal observations are also made that this standard has, at times, been applied to influence decisions on investments in equipment and facility upgrades which may have been driven by individual agendas. To mitigate this, it is suggested that the standard could be amended to include clearer guidelines on the minimum required equipment and an independent review process to assess the necessity of upgrades based on objective training needs. Any recommendation should be outcome focused with the training setting supporting the trainee to gain access to the equipment/experience through alternate feasible mechanisms rather than capital investment.

There is also some concern expressed that equipment appears to be required to be located at the physical training setting; it is probable that equipment may be accessible at another site and trainees may have exposure to such infrastructure through access arrangements between facilities. Nevertheless, support is provided that training settings must be fit for purpose and capable of offering appropriate clinical exposure and training for trainees.

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

Refer above.

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?
It is preferred that implementation "go live" is approached consistently by the Colleges and that an agreed date is determined for all Colleges to commence applying the proposed standards. This promotes full standardisation of accreditation assessments at a single point in time, there is a clear and understood approach to accreditation by health services (and mitigates against the present issue of variances that are the source of a level of confusion and frustration), and reform awareness can be approached strategically and messaged appropriately. Given that there is present discrepancy of accreditation practices/reviews/assessments which is currently managed/responded to adequately by health services, it is anticipated that health services would be able to adapt and transition more readily to a single format approach in a short period. It is also noted that some Colleges have pre-emptively revised their accreditation criteria and there appears to be a level of alignment between the proposed standards and existing protocols; as a result it is considered that transition would be able to be accommodated without widespread impact on individual health services. It is suggested that a reasonable timeframe for transition for all parties would be between twelve (12) to eighteen (18) months.
Other feedback
Do you have any additional comments regarding the model standards that are not covered above?

Consultation questions relating to **draft model procedures**:
General feedback
Are the model procedures easy to read and understand?
The document offers a basic and high-level overview of accreditation standard operating procedures and practices. Whilst easy to interpret and understand it is considered that the document would need significant refining in future versions to capture nuances and "grey areas" that may arise once operationalised.
Are there any requirements in the model procedures that would raise challenges for your organisation?
Refer to section below "Other feedback".
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.

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

Feedback regarding the risk matrix

Is the risk matrix appropriate for accreditation decision making?

The risk matrix supports a basic methodology for risk identification and classification however as an applied tool in a complex setting the following observations are made:

- It is not clear if the risks are assessed as inherent or residual. This will have a significant impact upon the risk rating. If risks are determined/classified as inherent without consideration of applied controls/mitigations at the training setting, risks may be noted as higher. If an exercise is undertaken to consider the controls/mitigations and then assess the likelihood of improvements being actioned this may impact (lower) the risk rating. It is considered that residual risk application may present a more realistic and feasible assessment of the risk environment. It is acknowledged that the present risk matrix would need to be revised to accommodate this proposal but is viewed as being more appropriate to the professional environment being assessed.
- It is not clear if there are weightings applied to the standards when assessing risk tolerance. For example, while Domain 4 of the Standards (Educational resources, facilities and equipment) is noted as important to supporting training, it may be reasonably viewed that the standards in other Domains have an ability to impact training and learning outcomes, including well-being and support of trainees, at a higher level. If an assessment of not met for Domain 4 is found yet, other Domains are met or substantially met, the lesser rating of Domain 4 may disproportionately influence the overall outcome. There may be a level of benefit in considering development of a risk assessment tool to assist Accreditation Teams that accommodates more complexity and responds adequately to the assessed environment - including applied weightings - as opposed to the simplistic model presented.
- The matrix is exceptionally limiting in providing guidance on the interpretation of risk classification. There appears to be no context or examples provided for determining what would be considered to be a low, medium, high or extreme risk. This presents a high-level concern that there will likely be a level of subjective and inconsistent interpretation in applying a risk category. This section would benefit from significant rework at this point in time to uplift content as opposed to utilising the generic risk model incorporated presently.
- Risk table. It is further considered that the allowance of a “grey” area open to unintended interpretation is promoted via the content and description of “Low risk” in the table in Section 8. It is noted that there are provisions in the “Approach column” for “Low risk” that 1) conditions can be applied and 2) that improvements are still required; ongoing monitoring will occur albeit this will be “light touch”. Given that there is a requirement for a monitoring and reporting regime to assess improvements, it is considered that differentiating “Low risk” from “Medium risk” is somewhat negligible with both requiring largely similar ongoing monitoring and reporting to track improvements. It is suggested to mitigate this that both existing and new settings assessed with a “Low risk” rating are determined as accredited as opposed to the proposed “provisionally” and “conditionally” accredited status as presently captured in the “Outcome” column of the table.

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.

Application of a condition, particularly for those assessed as “substantially met”, would be specific to the individual circumstances to which it applies. Without context it is difficult and problematic to respond to this question.
The risk matrix indicates that steps to revoke accreditation should be taken when the overall risk assessment is extreme. Is this appropriate?
Activities and phasing for revocation of accreditation at training settings is not considered appropriate for inclusion in a risk matrix as a simplistic placement for providing advice/guidance. This matter is considered a complex issue and there is a strong preference that content providing detail on steps for revocation is provided in substantially more depth in a stand-alone section of the model procedures. Additional information required would be to include agreement on consistent timeframes for finalising de-accreditation across all Colleges with definitive periods described, roles and responsibilities of the parties, impact assessments, accountability for transition plans, onus of, and duty of care to, impacted trainees including supports for training at other settings. At present content on this matter is considered insufficient.
Other feedback
Do you have any additional comments regarding the model procedures that are not covered above?
Refer over page for a listing of observations.

Organisational details and contact	
Organisation name/details:	Department of Health, Western Australia
Contact name:	Chief Medical Officer
Contact email:	[redacted]

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.**

Observations and commentary are provided on the proposed model procedures. For ease of reference, comments are listed in order of presentation for document sections and are not reflected in order of priority. Please note that the terminology used in the comment/feedback column is aligned to the Definitions/terminology in the procedures document.

Section	Verbatim content (where relevant)	Comment/feedback
1. Accreditation process overview	Figure 1	• A third swim lane is required for Jurisdictional health department as aligned to the requirements and stipulations set out in the Communication Protocol at Sections 4.5 (accreditation decision involvement); 6.6 (notification actions required prior to withdrawal of accreditation); 6.8 (escalation to regarding notice of withdrawal actions); and 5.3(a) (governance responsibilities for health systems/accredited organisations and assistance in resolving disputes). Noted also in this document, refer to Sections 9 and 10. • It may be beneficial to map/identify/reference the flowchart steps to associated sections of the procedures document.
2. Roles and responsibilties	Accreditation Lead Contact (definition for)	• Description of "Accreditation Lead Contact": noting the use of "accreditation" extensively in the naming of roles and responsibilities for the College, it may be potentially and inadvertently confusing to define a training setting role as "Accreditation Lead Contact" – suggest that there may be significant benefits in reconsidering the titling of this role to training setting Lead Contact (or similar). • Accreditation Lead Contact is noted as being responsible for "Implement[ing] actions to meet any conditions on accreditation". Suggest that this is reframed to "Facilitate oversight of implementation actions to meet any conditions on accreditation" noting that the Accreditation Lead Contact may not be responsible for elements of conditions redress.
2. Roles and responsibilities	"Jurisdictional health departments" (not described/included)	• Role of Jurisdictional health departments is not described. • Aligned to concerns noted above in Accreditation process overview; and extended to the general level/intent of collaboration and engagement avenues that are outlined in the Communication Protocol between the Colleges, Jurisdictional health departments and Training (Third swim lane required for Jurisdictional health department as aligned to the requirements and stipulations set out in the Communication Protocol at Sections 4.5 (accreditation decision involvement); 6.6 (notification actions required prior to withdrawal of accreditation); 6.8 (escalation to regarding notice of withdrawal actions); and

Section	Verbatim content (where relevant)	Comment/feedback
		5.3(a) (governance responsibilities for health systems/accredited organisations and assistance in resolving disputes)).
4. Application requirements	The college will contact accredited training settings approximately six months before their existing accreditation expires to remind them to start the reaccreditation process.	• Given the governance role of Jurisdictional health departments, as a courtesy protocol, it may also be beneficial for advice on reaccreditation to also be simultaneously provided to the Jurisdictional health departments.
5. Initial documentation review	The Accreditation Team will review the application form and evidence provided by the training setting, along with any data about the training setting held by the college. This may include trainee and supervisor survey data, prior monitoring submissions, ePortfolio data, complaints received and other relevant correspondence.	• For transparency and procedural fairness and if information is not considered confidential, as a courtesy protocol, it may be beneficial for the Colleges to also provide and disclose "any data about the training setting held by the college" to the Training setting as part of its accreditation renewal notice. This may assist in streamlining and positioning Training settings respond proactively to or being aware of potential queries at the point of application (and as part of procedural fairness) particularly if such information held by the College could be reasonably seen as detrimental to an accreditation outcome but may no longer be relevant or is inaccurate due to circumstances changing, business/operational/clinical systems improvements at a Training setting and may inadvertently led to a perception bias at the outcome of the accreditation process that impacts the accreditation process.
6. Site visit	Interviewees should not be named in reports.	• Provides a specific statement that "Interviewees should not be named in reports". It is suggested to put this beyond dispute that it would be beneficial to reframe this as "Interviewees must not be named in reports" given that there are different obligations imposed by "should" (optional/choice) and must (definitive). • Interviews with the Hospital Executive must include the Director of Medical Services and/or the Principal Medical Administrator within the organisation/health service responsible for medical workforce.
9. Draft and final report	The Accreditation Committee can endorse or modify the report and any proposals.	• It is unclear on what grounds and upon what limitations, extent or scope that an Accreditation Committee may "modify" a report, with concerns raised that direct knowledge and nuances of accreditation recommendations are held principally by an Accreditation Team. • It may be perceived that modifications to a report may be inadvertently viewed as a unilateral executive action should framing around what may be considered

Section	Verbatim content (where relevant)	Comment/feedback
		acceptable and reasonable requests for change not be detailed. For transparency and to understand requested modifications, it may be beneficial to provide guidance on the processes and scope that the Accreditation Committee can request modifications, including any limitations on modifications.
10. Communicating the final decision	To be provided once the training setting and provider have had enough time to prepare advice to the health department if required. Noting for potential decisions to revoke accreditation, the jurisdictions will already have been informed earlier as per process in section 9.	• Concerns are raised about the potential delay of release of the final report to the Jurisdictional health department. It is unclear as to the rationale for withholding release of a report to Jurisdictional health department; whilst acknowledged that a Training setting may require time to consider responses and provide information (as appropriate and relevant), it is noted that this opportunity exists at the time allowed for report finalisation ie while the report is still in draft form, particularly if there are expected adverse findings where there is a reasonable expectation of engagement and communication as per health system governance. • It is requested that this provision is reconsidered, and that the Jurisdictional health department is provided a copy of the final report simultaneously with release to the Training setting.
12. Trainees impacted by accreditation being revoked	The college will work with the relevant training setting/training provider to develop a plan for impacted trainees and any other relevant matters as soon as the setting/provider receives the draft report outlining there is a possibility of accreditation being revoked. The plan will consider how any actions resulting from the accreditation being revoked will impact on the service delivery obligations of the training provider.	• It is not clear where there is reference, guidance on or a description of duty of care (as opposed to an action plan and also a seeming focus on continuance of service delivery obligations), including roles and responsibilities, to trainees who are training at existing Training settings that are recommended for "Not accredited." • Duty of care includes employment contract management, timeframes, relocation assessment impacts, training disruption impacts. • It may be beneficial to consider this aspect of the document in further detail at this time - as opposed to deferring until work on Recommendation 13 progresses - to provide assurance to trainees that their well-being is promoted as priority in such circumstances and forms a consideration of the accreditation process.
14. Confidentiality	The draft and final accreditation decisions will be kept confidential (with the exception of steps identified in sections 8 and 12) until the final	• A minor note that it may be beneficial to note that whilst information is considered confidential, there may be a requirement for legal disclosure (as/if relevant such as subpoenaed information), with a possibility of including that "Information collected through the accreditation process is to be used only for

Section	Verbatim content (where relevant)	Comment/feedback
	decision has been shared with the stakeholders identified in section 10.	the purpose for which it is obtained, unless disclosure to is otherwise required by law."
15. Monitoring	Table reference	• Monitoring activities appear to align to previous accreditation practices although may appear to be an administrative burden on Training settings regarding Additional specific monitoring where items are not scheduled for reporting/monitoring but are noted as "As required".
17. Data and reporting	The college submits collated training setting accreditation data to the Australian Medical Council annually	• As a courtesy protocol, it would be beneficial for Jurisdictional health departments to have access to the consolidated annual list either directly from the Colleges or by hosted information on the AMC website.
18. Review of accreditation procedure	This accreditation procedure will be regularly reviewed and updated based on feedback from participants and assessors, and on benchmarking with other accreditation processes and activities.	• Minor. As a consideration, it would be useful to impose an upper cap on the review timeframe (e.g. 5 years).
19. Staff training	Training setting staff and trainees can access the following resources about the accreditation process:	• It is unclear why the link is noted as being provided specifically to "Training setting staff and trainees" if publicly available.
Additional/Other	N/A	• Some consistency in the forms will be helpful – there are about 50 of these accreditations that health services engage in over the course of 3 or 4 years and the documentation across colleges is very inconsistent and variable contributing to significant administrative burden.