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?
Yes, they are easy to read but several of the standards are open for interpretation. Please see attachment 1 for details on interpretation of the standards conducted by the Evaluation team at the RACP. Feedback from the RACP's Standards review is that explicit direction is required as well as room for flexibility in implementing the standards. Comment from committee member *"My only comment is that the training standards are only looking at trainees, we also provide training to Specialist International Medical Graduates (SIMGs) via our OTP pathway as do all colleges and we will continue to provide to partially comparable SIMGs/OTPs moving into the future. That group needs to be included in the AMC standards if we are truly looking at all training provided by the college/s"*
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.
Should there be any additions to, or deletions from, the model standards?
Yes, there should be additions to the model standards. Please refer to attachment 1 (tab 2) for details on the comparison of AMC Model Standards to RACP Training Provider Standards and the gaps, especially in the AMC model standards. Comments and feedback received from stakeholders referred mainly to what was missing from the AMC model standards rather than a challenge. The RACP wishes to advocate for protected time for supervisors and trainees which has not been included in the AMC model standards. Comment from an accreditor: *"It is important to have a RACP standards 1.1. It provides information about the processes setting have for monitoring and evaluating quality of services. It has longer term impact on training and quality of care. AMC standards 1.1 are close but not enough. AMC 1.1.1 is similar RACP 1.2 and 2.1.2 in many aspects.* *RACP 4.8 would be an issue for all colleges and should be included by AMC, with some caveats.*

Unfortunately, none of the AMC standards focus on the educators (Standard 5 RACP), it has to be included. Educator well being is an essential part for providing successful training.

Criteria 7.7, 8.2 and 8.3 and many requirements under standard 9 if AMC is unwilling, then these can be included against program specific requirements. Suggestion that if the AMC model standards are firm then the details that are lost are included in the Basic Training Program Requirements standards so RACP's integrity is not lost"

Please see the RACP Training Provider Standards linked for your convenience - https://www.racp.edu.au/docs/default-source/about/accreditation/basic-training/bt-training-provider-standards-clinical-training-programs.pdf?sfvrsn=391fc91a_12

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?

RACP does not currently ask this from Training Providers. Is this a Jurisdictional requirement as an existing health setting such an NSHQS? What is a college's role in addressing another accreditation by a health body?

Feedback from an accreditor *"Agree, we would require clarity from our end what this means. Is it just a tick box or the setting has an approval from the College based upon them meeting program criteria in addition."*

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?

Ratios should be included in the specialty program specific criteria. Ratios are different for every specialty. The ratio depends on the complexity of the work and type of role, and as well as the workload of the supervisor. The ratio should be adapted to suit the work context, including the caseloads of the supervisees.

Feedback from an accreditor *"This would be very difficult area as every College is likely to have a a bit different requirement. Maybe we should consider adding specifics into program criteria."*

In regard to criterion 2.2.1, the use of '*effective*' could be risky, open to interpretation and not measurable. A suggestion is updating it to say "The training provider establishes a trainee has accessible, timely and supportive supervision for all aspects of training to support learning and protect patient safety"

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, the specific requirements would sit within the specialty programs requirements. RACP's equivalent is - 7.1 The training program delivers clinical experience, social and formal learning, which provides a trainee with opportunities to increase their professional responsibility and achieve curriculum learning goals. Could perhaps add something about how this is tailored appropriately to their stage or level of learning - drawing on the wording from 7.1 - with opportunities to increase their professional responsibility.
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?
Committee feedback: *"A recurring theme was the necessity for protected teaching time to be explicitly included in training standards. Concerns were raised about teaching being scheduled outside regular hours, leading to trainees working overtime. It was recommended to prescribe protected teaching within rosters, ensure equitable offerings across settings, and provide examples linked to the curriculum. Proposals included removing trainees' pagers to ensure uninterrupted learning and assigning adequate staff to support this structure. Specific examples highlighted how teaching should be embedded in rosters from 8 am to 5 pm, ensuring an outcome-based approach.* *Support for remote and rural trainees was advocated, including access to digital supervision and telehealth. The need for flexible supervision models, such as those championed by Dr. Tony Marin in WA, was highlighted.* *In Victoria, the Enterprise Bargaining Agreement (EBA) mandates five hours of protected teaching time. Successful examples included hospital-wide announcements enforcing protected time, with senior staff collecting trainees' pagers to demonstrate the value placed on training.* *Ensuring that protected teaching time is by the standards needs to be mandatory. Trainees rely on this to ensure that they get their hours for training. Opportunity to attend vs ability to attend due to workload - a Training Provider could very easily produce a list of all available structured and unstructured learning Opp's but attendance at these opportunities is the more meaningful indicator. Risk is an unrealistic portrayal of training Opp's that don't pan out in practice. Could be re-worded to say, "consistent attendance" or "at least half of trainees attend the available structured and unstructured learning activities...."* Please refer to attachment 3 as a letter from the trainees committee on request for protected time for research projects.
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?

This needs more specificity - does it mean physical resources like computers and a library? Or are you referring to medical equipment? Specific medical equipment will sit under the different specialty program requirements.

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

- There are 16 RACPs TPS which are not covered in the AMC model standards and three which are partially covered (please see Attachment 1, (tab 2)).
- There is no specific requirement for trainees protected time for formal learning which has been identified as a major risk. Protected time for formal learning (7.7) in the RACP TPS had the highest number of conditions and recommendations placed against it between 2021 and 2023. In the AMC model accreditation standards, Criterion 3.1.2 provides for trainees to engage in structured and unstructured learning activities to achieve the training program outcomes. This does not stipulate protected time.

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 timelier manner (for example, shared training, shared resources etc.)?

Implementation challenge for Settings – Is there consideration for the settings in ensuring that they are adequately staffed to manage the implementation of the Model Standards and procedures? Has the support staff FTE been organised that will be dedicated to looking after accreditation, where there is none? Are Directors of Physician Educations FTE considered to ensure that they do not have to work out of hours to complete the accreditation Self-Assessment forms?

Timeline:

As this is a major change for our college, we will be expected to give our Settings a minimum of 12 months' notice for a major change. This would also mean that training the staff, accreditors, Settings would need to be considered and time to amend all the paperwork. RACP is currently commencing its next 4-year accreditation schedule from January 2025. To introduce a new set of standards will be challenging. Significant lead time will be needed. A minimum of 1.5 years from the finalising of the standards by the AMC will be needed to implement. The standards impact a lot of other forms and processes we have, so this would require time to update.

Comment from an accreditor: *"We should be able to implement it within a year after final approval. However, it is likely to have major impact on the current model (network + program accreditation) and it would require some changes to be made."*

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

NA

Other feedback

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

Timeline for consultation

Cultural Safety – the short timeline is not culturally safe. The RACP's two Indigenous committees Aboriginal and Torres Strait Islander Health Committee (ATSIHC) and Māori Health Committee (MHC) have informed us that the timeline is insufficient to produce an appropriate response. Feedback received is that this practice is culturally unsafe.

Both Committees have asked for an extension to provide feedback. RACP are currently undertaking its own Training Provider Standards Review. Once feedback has been received from both Indigenous Committees, we can share this with the AMC.

Other accreditation committees that this was presented too also commented on the fact that the 6-week consultation is insufficient time to do a thorough consultation.

Sustainability of the standards

How are the standards going to remain adaptable to future needs? How often would a review occur? If Hospital X was accredited by the RACMA and then RACP were to accredit the same hospital X the following year, what level of passing of the information would occur?

Administrative Burden

Significant frustration was raised about the administrative burden of accreditation forms, particularly for networks, and the time-intensive nature of completing multiple, disjointed forms. The Network Director of Physician/ Paediatric Education (NDPE) emphasized the limited Full-Time Equivalent (FTE) resources and the need to simplify processes, making forms more cohesive. How would this impact the aim of reducing the burden amongst stakeholders?

Service Delivery vs Training Needs

The balance between service delivery and training was emphasized. Smaller sites face challenges meeting standards, and the current SAF does not account for rotation variations. There were calls to streamline SAF submissions to account for differences between rotations.

Advocate for supervisors

RACP believes it would be valuable to emphasize the need for a criterion to specify that supervisors have protected time for supervision as part of their FTE. The need for protected time was a key theme identified in the Supervisor Voices Survey we conducted back in August and is a consistent theme emerging across many of our recent evaluation activities (i.e curricula renewal). I think this would be a good opportunity to advocate through accreditation standards that supervisors are provided time to carry out supervisory activities, as this is key for trainees to receive high quality supervision.

We're pleased to share that the results of the 2024 Supervisor Voices Survey are now available. The survey ran over a three-week period in August and over 600 supervisors across Australia and Aotearoa New Zealand shared their experiences, insights and challenges. The key findings offer a glimpse into what our supervisors are experiencing:

While most supervisors indicated they get great personal and professional enjoyment and value from supervising, they're struggling:

- Nearly 70% feel their supervisory workload has increased over the past five years.
- More than 80% receive no protected time for supervision, highlighting a critical need for time to carry out supervisory tasks.
- Only a third feel recognised for their contributions to training.
- They want concise, easily accessible supervisory resources and clear role expectations.
- Most were satisfied with their supervisory experiences, although both satisfaction and perceptions of supervision quality have significantly declined since 2022

Explore these findings and more through the 2024 Summary Report published online.

RACP TPS Map to model standards

RACPs preference is to MAP the RACPs TPS to the AMC Model standards rather than to adopt the AMC standards in full. The Training Accreditation Services team conducted a workshop on 24 June 2024 to review the RACP Training Provider Standards. Significant feedback and discussions took place. Key discussion points during the workshop included:

- Identifying current challenges within the standards.
- Assessing the efficacy of existing standards and areas for improvement.
- Identifying instances of duplication within the standards.
- Prioritising standards based on the needs of training programs.

A report has been developed that captured the feedback and proposed amendments to The Training Provider Standards from each of the challenges that were identified within the Training Provider Standards. Issues discussed included supervision adequacy, protected time for trainees, cultural safety, balancing training with service delivery and standardization vs contextualization of the standards for metro/ RRR Settings.

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

No

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.

No this is a doable change. It may take some time to implement but it can be done. A comms plan will need to be drafted to highlight the changes.

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

We would need time to create a comms plan and communicate this change to all of our Committees, Accredited Settings etc. All documents and processes would need to be updated. This could also be completed within 1 year after being finalised by the AMC.

Feedback regarding the risk matrix

Is the risk matrix appropriate for accreditation decision making?

Yes – RACP will be conducting a risk-based framework workshop on 2 December 2024. This workshop will help determine what aspects of the Risk based framework will need amendments to suit an RACP Training Setting.

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.

Yes, we agree that the accreditors should be able to decide whether or not to impose a condition when the overall risk assessment is low. Comment from an accreditor *"I think the y-axis of the proposed matrix should be "Impact on training or trainees" (rather than "Impact on training"). From a governance perspective, this change will align the risk matrix with the first principle of the AMC's proposed decision-making process, "Accreditation is focused on the training settings ability to deliver the training program and to provide a safe learning environment for trainees". From a practical perspective, this change will reflect the reality that the safety of trainees is a pre-requisite to the successful training of trainees."*
The risk matrix indicates that steps to revoke accreditation should be taken when the overall risk assessment is extreme. Is this appropriate?
It is appropriate if the steps to withdraw accreditation are considered. Ensuring that the appropriate steps and opportunity for feedback and change are considered before withdrawal is an option. RACP considers the following active management process (see link - active management process) for its staged withdrawal process. Accreditation needs to be a tool to support change; working with overburdened health care systems to collaborate and make systemic change.
Other feedback
Do you have any additional comments regarding the model procedures that are not covered above?
NA

Organisational details and contact	
Organisation name/details:	RACP
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.**