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 intention for the standards to apply to posts, sites, services and programs (or networks) is acknowledged, however the standards do read as if they are written for sites. This means that the RANZCP will need to contextualise the standards to ensure clarity for its post versus program accreditation. The inclusion of the intent of the standard is helpful as it assists with the consistent interpretation of the standard.
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 RANZCP anticipates there will be some challenges in implementing the model standards. While the standards were written with the intent to cover posts, sites, services and programs (or networks) they would need to be contextualized and socialized to accommodate the current RANZCP process of post and program accreditation. Documentation would need to be updated for both program and post accreditation. Post accreditation is delegated to the RANZCP Branch Training Committees, which are in general supported by administration provided by the jurisdictions. Any changes to procedures will require additional resourcing as the Branch Training Committees are composed of Fellows working pro bono with limited capacity for additional work. There are significant implications for the changes to standards due to the volume of posts. At a program level this would be less of an impost, however the standards are written more for services than networks of posts. The standards have many references to employment legislation or conditions of appointment. This will require additional work to ensure that accreditation panels and secretariat are familiar with legislation and the conditions of appointment. While the intent of the standard states that it "is not intended that colleges regulate whether training providers meet industrial obligations, but to consider outcomes for trainees working at the training setting" the inclusion of a reference to employment and/or appointment conditions

in a standard may be interpreted by some stakeholders as the colleges having an obligation to assess if a training provider is meeting industrial requirements. This may lead to expectations that colleges can influence industrial conditions, which is unrealistic.

As the measurable component of a standard, there are some criteria which will present challenges in measurement. For example, criterion 1.1.3 refers to a "positive learning environment" which may be interpreted in many ways. Does a positive learning environment support trainees to undertake necessary training activities that they may find uncomfortable or confronting, or does it focus on all stakeholders feeling comfortable?

Advice from our Partnership Committees (Aboriginal and Torres Strait Islander Mental Health Committee, Te Kaunihera and Community Collaboration Committee) is that the evidence to support the assessment of criteria related to cultural safety, diversity, inclusivity and equity may be quite specific, including reports on service staffing profiles, lists of experiences/training offered and direct feedback from minority groups.

It may be helpful to provide more specific guidance on the types of evidence expected for these criteria.

The RANZCP anticipates that the implementation of these standards will require further consultation with our stakeholders and key committees to determine what specific evidence would be required to enable an assessment against criteria. This will require some consideration to ensure sufficient evidence is available for panels to make a judgement, balanced against the burden on the training setting.

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

1.1.1 Effective processes are implemented for trainees to raise concerns, grievances and complaints about matters affecting their training. Trainees are informed of these and feel safe to use them.

The intent of this criteria should be expanded to include the presence of a feedback mechanism to ensure that trainees are informed of the outcome of a grievance or complaint. In addition both this criteria and 1.1.2 would benefit from the intent including the requirement that there is an identified person to support the trainee. This may be a Director of Training, or it may be the Branch Training Committee.

1.1.4 Risks to the cultural safety of Aboriginal and/or Torres Strait Islander and Maori trainees are identified, managed and recorded.

Advice on this criterion was sought from the RANZCP Partnership Committees, and there is a strong recommendation that an additional criteria is added to ensure cultural safety for trainees from other cultural and identity-based groups is specifically identified, managed and recorded. It was felt that Criterion 1.1.3 does not place sufficient importance on the steps necessary to ensure the cultural safety of trainees who identify as a member of other cultural and identity-based groups. The RANZCP proposes the following additional criteria:

"Risks to the cultural safety of trainees who identify as members of cultural and identity-based groups are identified, managed and recorded."

The RANZCP suggests that this new criterion become criterion 1.1.5, which retains the important priority of First Nations cultural safety.

1.1.9 Reasonable adjustments for trainees with disabilities are provided, in accordance with legislative requirements and/or employment/appointment conditions

The intent of this criteria should be expanded to make it clear that the definition of disabilities applies to both mental and physical health conditions.

2.1 Clear governance structures support the delivery of effective education and training

This standard also needs to address the relationship with state training bodies, for example in NSW the relationship with HETI. Network governance committees have been established by HETI to oversee psychiatry training, but the conflicts of interest inherent when service directors and managers take key roles are not documented and managed effectively.

There should also be a requirement for processes for regular review of governance effectiveness.

2.2 Trainees receive appropriate and effective supervision

A criterion should be included to require an independent pathway for trainees to escalate inadequate supervision or problems related to a supervisor.

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 intent of this criterion should be expanded to include an expectation that training providers give appropriate priority and resources to medical education and training, specifically that supervisors have appropriate time to supervise and that this is explicit in their position descriptions and employment conditions.

2.3 Trainees are supported in delivering quality patient care, including culturally safe care.

A critical omission to the criteria for this standard is about trainees and supervisors having the skills to raise concerns regarding the safety of the environment and the care of their patients. This may be implied in criteria 2.3.1 and 2.3.3, however it is clear from the results of the Medical Training Survey that doctors in training do not always feel confident in the processes for raising concerns about the quality of patient care. The focus of criterion 2.3.3 is, to an extent, retrospective with reflection on critical incidents and relies on local clinical governance having adequate and supportive processes for concerns to be raised.

It is important that this criterion is clear that it assesses the support and training for trainees and supervisors to raise the concerns, and the clear articulation of the processes for raising concerns. It is not an assessment of the quality of patient care per se.

The RANZCP suggests the following additional criterion:

Trainees and supervisors are supported to develop the skills to advocate for the safety of the work environment and the quality of patient care.

Domain 3 Educational and clinical training opportunities

Consideration should be given to adjusting standard 3.1.4 to accommodate both learning and working in multi-disciplinary teams. This would encourage interprofessional learning and collaboration.

Domain 4 Educational resources, facilities and equipment

This domain needs to consider other facilities and equipment required for trainees located in rural and remote settings such as safe travel arrangements for outreach work and accommodation. Depending on the nature of the location, these may also be required for posts that are not rural or remote.

In any location there needs to be a standard around trainee safety, and trainee safety does not appear to be adequately addressed in this domain. The nature of psychiatry, where patients with significant behavioural disturbances can become violent, requires that all training settings provide adequate orientation to personal safety arrangements and have appropriate infrastructure including duress alarms, interview rooms with dual egress points and equipped with furniture that cannot be used as a weapon, and adequate staffing to ensure that trainees are not required to interview patients alone if the patient is deemed a risk.

The RANZCP suggests that rather than just “adequate access to the internet” that this standard may need to be expanded to cover the training provider/training setting having sufficient digital maturity to maximise the appropriate use of Artificial Intelligence.

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 RANZCP would not require further accreditation by an industry body or regulator. It would expect that a training setting, such as a hospital, has the usual accreditation to operate.

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?

It is necessary for psychiatry to set trainee to supervisor ratios, and also at the program level a Director of Training to trainee ratio. The practice of psychiatry is different to other more procedural specialties in that it is essential for time to be spent in discussion and reflection on practice – both for the cognitive and emotional growth and support of the trainee, but also to fully consider and explore the patient presentation, progress, and response to therapy. The need for this time means that for appropriate growth and development of the trainee a supervisor cannot support more than a maximum of two trainees at a time. This is an additional college-specific requirement that the RANZCP would need to include.

This parallels with the peer review requirement of the CPD program, where all psychiatrists are required to complete a minimum of 10 hours of formal peer review annually. This is a high-level requirement set by the RANZCP and is a cornerstone of the professional practice of psychiatrists.

The supervision requirement of the training program sets the foundation for the peer review necessary to ensure that psychiatrists are supported to provide safe and effective clinical care and at the same time attend to their wellbeing.

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?

It will be necessary to include specific requirements to assess this criterion. The mandatory rotations in psychiatry – Consultation – Liaison (C-L) and Child and Adolescent (CAP) have specific case mix requirements that must be observed:

- For C-L the inclusion of a Liaison attachment and a maximum 30% of clinical time spent in ED
- For CAP the inclusion of exposure to pre-pubertal children

For programs it will be necessary to demonstrate how trainees will be able to meet the ECT requirement and the requirement for the Psychotherapy Written Case. This long case assessment requires a trainee to

provide a patient with 40 sessions of supervised psychotherapy prior to writing up the case. The completion of the therapy may extend over two or more rotations and may require the trainee to have approved time away from their current rotation to complete the psychotherapy sessions.

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?

The RANZCP would need to include specific requirements to assess this criterion. An essential unstructured learning activity in the curriculum is supervision – 4 hours per week, with one hour of this to be one to one supervision and an additional hour of one-to-one supervision for stage 1 trainees in their first year of training. This protected time is essential for the cognitive and emotional growth of the trainee and to develop their diagnostic and formulation skills and the management of patients.

In addition, the Formal Education Course (FEC) is a mandatory component of the training program requiring trainee attendance for three hours per week for 40 weeks of the year across the first three years of training. This protected time is required for trainees to acquire the theoretical knowledge underpinning the specialty of psychiatry.

The ability to participate in research or clinical audit is a requirement of training. This would not be required at the post level of accreditation, but it would be required at the program or network level of accreditation.

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?

Psychiatry does not have specific requirements for clinical equipment; however it is important for trainee (and supervisor) safety that the infrastructure meets some basic requirements:

- Interview rooms with dual egress and doors that open outwards
- Furniture in interview rooms that cannot be used as a weapon
- Line of sight for all rooms used for interviews
- Duress alarms -both personal and fixed.

In the absence of a criterion that addresses trainee safety, a checklist of requirements could be used to assess this criterion. Noting that physical infrastructure alone does not guarantee safety and staffing levels need to be adequate to support safe clinical practice.

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

This has been covered in other sections of this submission, however the RANZCP reiterates that protected supervision time is an important priority as the cornerstone of psychiatry training. Time for the FEC is also an important priority for learning.

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.)?
The RANZCP would expect a minimum of 12 months for implementation of these standards. This is because RANZCP Fellowship training is based on programs or networks of organisations (public, private and not for profit) to provide the training posts required. As the Program structure is fundamental to the Fellowship program, significant work would be needed to adapt the standards to meet the two levels of accreditation to ensure clarity of expectations. As a College with a federated structure, there is already a high workload at the Branch level. The administration of Branch Training Committees is provided almost exclusively through jurisdictional health departments and is already insufficient for current workload. With psychiatry being a specialty of workforce shortage there is significant pressure to increase the numbers of trainees and this impacts on the capacity of the Branch Training Committees and their administration. It is possible that to meet the expectations of the NHPO an additional level of service accreditation would need to be developed. This would increase workload and the increased resourcing necessary may not be provided by jurisdictions. The College would have to fund this, and it also impacts on the support of the Fellows, which is provided pro bono.
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?
Overall, the model standards are reasonable. However, the RANZCP notes that significant adjustments will need to be made to its current procedures, policies and documentation at multiple levels within the organization for implementation and requests that this be considered.

Consultation questions relating to **draft model procedures**:
General feedback
Are the model procedures easy to read and understand?

Yes

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

Yes. The RANZCP accredits at post and program (network) level. The requirement to provide reports to Clinical Directors, CEOs and jurisdictional health departments for all post accreditation activity will result in an overload of reports and is wasteful of resources for all stakeholders. Perhaps for post accreditation this could be restricted to posts at risk rather than all posts.

It is reasonable for us to provide all program/zone reports to the named stakeholders.

The requirement for fact checking of the report to be completed in 10 working days will present challenges given the current workforce pressures on clinical staff, and also given that the administration support of programs/zones is already inadequate in some jurisdictions to meet the pressures of increasing trainee numbers.

To ensure clarity for stakeholders, the RANZCP would need to contextualise sections of the procedures for post versus program accreditation, probably resulting in two versions to avoid confusion.

Implementation of the procedures will present some challenges at the post level as the model procedures introduce additional requirements with documentation and communication.

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.

The RANZCP notes that the terminology for assessment against the standards is consistent with that used in the pre-vocational space and the AMC accreditation for specialist medical colleges and agrees that there are not major obstacles to its introduction However, the RANZCP does note that the use of the adverb substantially may not be the most accurate.

The following are the definitions provided through Oxford Languages (accessed via Google 4/11/24):

- *Substantially* – to a great or significant extent, for the most part/essentially
- *Partially* – only in part, to a limited extent

The use of the adverb substantially, rather than partially, implies that a standard is close to fully met, when in fact it may be far from fully met. The RANZCP suggests that it would be more accurate to use the adverb partially.

The RANZCP has no issues with the introduction of the proposed terminology for the accreditation outcomes for new and existing settings.

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

The RANZCP could introduce this terminology into program accreditation during 2025, as this level of program accreditation is administered centrally.

Introduction of this terminology for post accreditation would be anticipated for 2026 in conjunction with the introduction of the new standards. This longer time frame is necessary as the accreditation of posts is delegated to Branch Training Committees, which are supported in the most part by administrators who are employed by the jurisdiction and not the College.

Feedback regarding the risk matrix

Is the risk matrix appropriate for accreditation decision making?

In principle, the risk-based approach is supported – it provides a consistent approach to the decision making between panels. The level of discretion that is permissible needs to be explicitly outlined in the procedures. Without a level of discretion, it is possible that slavish interpretation of the risk matrix and its application to accreditation decisions may have unintended consequences.

The RANZCP questions whether the outcome for New Settings assessed as having a risk rating of High should be provisionally accredited. If there is a high risk that conditions relating to accreditation of a new setting will not be achieved it is not appropriate to place a trainee in that setting. In existing settings, where there is a history of accreditation decisions and of the adequacy and safety of the setting, it is appropriate to place conditions on the setting and place a trainee.

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.

If the term substantially met is to be used, then it is appropriate for Colleges to decide whether a condition should be imposed. If the assessment is that criteria are truly substantially met (ie for the most part) a recommendation may be more appropriate. If the assessment is that criteria are only very partially met then the discretion to impose a condition is necessary to ensure that the setting is aware that action must be taken to ensure that the criteria remains met.

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

Yes.

Other feedback

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

Trainee representatives noted that Section 12 of the procedures, which relates to Trainees impacted by the revocation of accreditation, should explicitly include the supports available for trainees. These may include EAPs, College support services, Director of Training support etc. The current paragraph is too vague and does not recognise the significant stresses placed on trainees in this situation.

Section 10, Communication of the final decision, should include an explicit requirement for communication of the outcomes of accreditation to trainees and supervisors. If the aim of the NHPO recommendations is to increase the transparency of accreditation processes and decisions, these key stakeholders should be included in the communication of the decisions. This section assumes that the final report is the only communication artefact that is developed, and the model procedures should include the production of a summary of the final report for publication and dissemination to stakeholders.

The procedures are not clear on steps to be taken if, after the fact check of the report, there is disagreement between the training setting and the accreditors on the facts of the report. The procedures suggest that the next step would be use of the College's Reconsideration, review and appeals policy or Complaints policy which seems to be a significant escalation that may not be warranted.

Ten days for fact checking may be challenging for some training providers.

The term training provider in the glossary does not fully cover the RANZCP's program level accreditation. This level of accreditation is for the program or zone, which is the network of posts that provide the training experiences. These are governed by a jurisdictional training committee of the RANZCP, which are largely supported by administration from the jurisdictions.

The RANZCP Partnership Committees noted that the input of patients or consumers is minimal in the procedures, and consideration of how their views are incorporated into the accreditation process would be a valuable addition.

Section 2 of the procedures, Roles and Responsibilities, would benefit from the inclusion of Trainees as part of the composition of the Accreditation Committee and the Accreditation Team. The RANZCP has had Trainee representation on both the Accreditation Committee and Accreditation Team for many years and can testify to the value provided by their inclusion in the governance of the accreditation process.

Additionally, the composition of the Accreditation Committee and Accreditation Team in the draft procedures does not adequately cover consumers and Aboriginal and/or Torres Strait Islanders and Māori. For Bi-National Colleges it is worth considering the inclusion of a Māori and an Aboriginal and/or Torres Strait Islander representative and consumer representatives on the Accreditation Committee. The RANZCP Lived Experience strategy proposes that there should be two consumer representatives on committees.

The Accreditation Team composition is more challenging due to the need to balance representation and the size of the team. Stakeholders in interviews with large panels may not feel comfortable.

Section 6 – Site Visit – should include specific advice that separate group interviews for trainees who identify as Aboriginal and /or Torres Strait Islanders or Māori are offered should they not wish to participate in other group interviews. This should also be considered for trainees who identify with other culture or identity-based groups.

Where a site or program has had significant issues with accreditation previously, there may be value in asking a trainee involved in the previous accreditation to be present in interviews with current trainee groups. This may encourage trainees to reflect more openly on whether changes required by previous accreditations have been sustained. However, given that it is likely previous trainees would be Fellows challenges with conflicts of interest would have to be considered.

Organisational details and contact

Organisation name/details:	Royal Australian and New Zealand College of Psychiatrists
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?

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