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?
They are easy to read and understand and have a clear focus on trainee welfare. The only part that appears missing is what evidence should services supply when being accredited, is evidence required for each criteria or standard, or will this be college specific?
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.
N/A
Should there be any additions to, or deletions from, the model standards?
N/A
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?

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?

Current RANZCP regulations allow Supervisors to have a maximum of 2 trainees, this would need to be specified unless the RANZCP regulations were to change or refer back to College regulations. Remote Supervision is currently a pilot however it is hoped this will be approved going forward. RANZCP have developed guidelines and forms to ensure the pilot is meeting requirements, so far feedback has been positive, although the additional hour of supervision requirement at times feels excessive.

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 may be difficult to have overarching specific caseload / case mix for each specialty and may be easier for colleges to specify case load requirements within their own regulations. The AMC standards would then refer training programs back to their College regulations.

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 would be beneficial to include the requirement for protected teaching time. Currently RANZCP trainees are allocated ½ day per week for protected teaching time. If the standard included protected teaching time, the amount of time may be up to interpretation but could refer back to individual College teaching requirements.
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?
Refer back to individual college requirements, clinical or other equipment needed will regularly change and if in a hospital setting would likely be covered by ACHS site accreditation. Colleges may then have specific equipment for each program / site required which could be addressed separately.
Are there any other college-specific requirements that are necessary in relation to other criteria and what should be considered in developing these?
N/A
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.)?
As all training posts across RANZCP are currently on a five year accreditation schedule, a phased approach would be reasonable. With a phased approach, any new or reaccredited posts over the next two years (from implementation date) would be accredited using the new standards, with all posts to be accredited under the new standards with 5 years. This would allow all training programs across the College to adapt to the new standards, however would mean some posts would be accredited by different standards for a period of time.
For health services: What is a reasonable timeframe for your organisation(s) to be ready for assessment against the model standards and why?

As above.

Other feedback

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

Each College will have some mandatory requirements which cannot be standardised with one accreditation process i.e. RANZCP Consultation Liaison and Child and Adolescent mandatory terms and specific EPAs that need completed. The final accreditation standards form may need to refer back to individual College guidelines (or allow Colleges to add in any mandatory requirements in addition to the AMC form).

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

General feedback

Are the model procedures easy to read and understand?

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

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.

This is a similar process followed by RANZCP accreditation currently, however will be more defined for accreditation of training posts across programs.

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

This could happen quite quickly, it is informally occurring across the College already. Clear communication from AMC to all stakeholders (colleges, health services, training programs) across different platforms (info sheets, webinars etc.) would assist with implementing quickly to ensure everyone is aware of new processes.

Feedback regarding the risk matrix

Is the risk matrix appropriate for accreditation decision making?

The risk matrix will enable colleges and training programs to have clearer parameters when accrediting programs, posts and sites and the ability to have clear recommendations and conditions that affect the training which can be addressed and actioned.

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 overall risk assessment is low, the reasoning for the criteria not being met is likely something requiring minimal change or may be timing dependent e.g. trainees commencing. Allowing colleges the flexibility to impose conditions or not is appropriate in these conditions, or there may be a substantial amount of 'very minor' conditions needing imposed due to being substantially met or not met with a low risk. I would expect that most criteria that receive a not met would have conditions imposed naturally. Colleges will then monitor the standard that has been substantially met or not met and any follow up actions to address the accreditation status will be captured, until accreditation is deemed met.

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

Yes, to meet this criterion it would mean the risk would have a severe impact on training and the likelihood of the training setting being unable to implement the required conditions is almost certain so it is unlikely training could proceed there. However, there are currently no indicators on what would determine an extreme risk, although this would change across colleges. The matrix allows for existing settings to have follow up work

Other feedback

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

Organisational details and contact	
Organisation name/details:	Rural Psychiatry Training WA, Training Zone of Royal Australia and New Zealand College of Psychiatrists
Contact name:	Director of Training, Rural Psychiatry Training WA Coordinator Rural Psychiatry Training WA
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.**