College Submission

November 2024

Consultation on draft model standards and procedures for accreditation of training settings

Thank you for the opportunity to provide feedback to this consultation. ACRRM is dedicated to the education, professional standards and support of our members who work to provide high-quality medical services to people in remote, rural, and First Nations communities. Our feedback reflects the practical issues pertinent to this perspective.

Overarching Comments

Rural general practice and rural generalist training

It is noted that the initial motivation for the series of reforms associated with this framework was to address issues in urban tertiary hospitals and we see risk with that the final framework may be poorly suited to achieving quality-assured training site accreditation in small rural and remote hospitals and general practices.

The economics of assessing and monitoring standards across these training sites in terms of costs and resources is extremely tight and aspects of the draft framework and issues under consideration have the potential to render these systems unviable. For example, procedures which require administratively complex, clinician-led expert committees to review every accreditation site are simply not financially practicable for our sector. Furthermore, the more prescriptive the requirements and the wording of the standards the less likely it is that they will be suitable across the diversity of our training sites, and the less resilient the systems will be to adjust to changes across the sector.

Recommendation 1:

That the Framework overall recognises that small general practices, community health centres and rural hospitals are responsible for a vast proportion of healthcare provision and ensures it enables and does not have unintended costs for quality training in these contexts.

Flexible, outcomes-based approach

The College notes and commends the general approach that has been taken to provide outcomes-based standards and we would recommend the broadest and highest-level approach be taken in all aspects of the framework. In particular, we note that the glossary defines “Model standards” as a “model” for each college’s accreditation standards. We support this approach and would be very

concerned about an approach which demanded verbatim language to be used across all colleges and training sites.

The framework needs to accommodate the considerable diversity in the scale, scope and nature of training sites and this is nowhere more pertinent than in rural generalist training across rural and remote Australia. Our registrars train in primary, secondary and tertiary settings, often concurrently, they work in GP clinics, retrieval services, ACCHs, on islands, on ships, and on military deployments. Flexibility at every level is critical to enabling our training programs and the development of future rural generalist workforce.

Achieving national agreement on these standards is a major undertaking of time and resources. A high-level, outcomes focussed approach is thus important, as we would expect going forward that the standards will be slow to respond and adjust to technological, structural and other system shifts in the healthcare sector.

Recommendation 2:

The Framework and model standards maximise flexibility by adopting a high-level and outcomes-based approach at all levels.

The Framework does not specify the wording used in the standards or elsewhere, only that the college's individualised wording is demonstrably in alignment with the model standards.

Consultation timeframe

At the outset, we would clarify that we do not consider the 6-week timeframe sufficient to enable the college to meaningfully consult with its membership, training sites and representative committees. While the college has reached out to these groups, we do not consider, given the timeframes and the complexity of the standards documentation, that these efforts constitute a thorough consultation process.

Our members and training post staff often work in areas of high workload and staff shortage. They are also working in a consultation and survey heavy space which reduces their capacity for additional consultations. Further, our committee governance structures for review and approvals, involve the participation of many people contributing in a voluntary capacity, and take considerable time to progress. Our colleges have 1,100 training sites, over 2,200 supervisors, and around a hundred senior staff and office bearers on committees with important perspectives on these issues. While we have notified all these people of the consultation, we have not had opportunity to engage them in meaningful consideration regarding its details and implications and received very little feedback.

We would particularly highlight that the ACRRM Aboriginal and Torres Strait Islander Members Group has advised that they would need further opportunity to review across their membership and also to consult with key partner organisations in order to provide meaningful feedback on the standards from their perspective.

Recommendation 3:

That the advice on the Framework to the Health Ministers Taskforce recognises that the consultation advice received from our College does not reflect a comprehensive review of ACRRM governance, members, staff and training sites.

Response to questions on Draft Standards

General Feedback

1. Are the model standards easy to read and understand
The college is comfortable with the general format.
2. Are there any criteria in the model standards that would raise challenges for your organisation?
While the college is comfortable with the current wording which provides some flexibility**,** we note that some criteria at Standards 1 and 2, refer to responding to patterns of behaviours which may be difficult to observe especially for new site accreditations. Even where ongoing monitoring information is available it is noted that patterns of behaviour may reflect issues with individuals in workplaces rather than the workplace itself and where there is high staff turnover this could be problematic.
3. Should there be any additions to, or deletions from the model standards?
Noting the comments above regarding the need for greater time for consultation, we have no specific advice at this stage.

College Specific Requirements

4. **Criterion 2.1.6 enables recognition of accreditation of training settings/providers by other accreditation bodies e.g. health service quality and safety bodies.** **Would it be necessary to include specific requirements to assess this criterion e.g. requiring the training setting to be accredited by an industry body/regulator?**
The College supports the wording to this criterion as written which recognises the role of other accreditation bodies but leaves flexibility for colleges in the definition and implementation. We would highlight the importance that the college determines which accreditation bodies are appropriate to its training standards and takes responsibility for assessing against these as required and to ensure they remain relevant and applicable to its curriculum and training requirements. The college's general position with respect to college specific requirements associated with training site accreditation standards is as follows: • ACRRM acknowledges the appropriate role of college specific requirements in general and supports the current wording which highlights that these are optional only. • We would stress that these requirements need to reside at the college level. • Colleges need to maintain their role as the source of truth on their respective requirements and we would caution against any nationally-managed facility providing an alternative information point. This would introduce a layer of inflexibility upon the colleges to adjust and refine these to meet their complex and changing circumstances as well as opportunity for misalignment.

- Ideally these requirements should be treated as adjunct rather than part of college training site accreditation standards, detailed in documentation linked to, but not within the standards. This will maximise internal flexibility and responsiveness while keeping the overarching standards consistent. ACRRM's standards are applied equally to a range of different typologies of training sites associated with different training and curriculum components and fields of specialised practice (both mandatory and selective). Thus, while the standards are consistent the associated requirements may differ across different types of training sites. Incorporating requirements into the single set of college standards therefore would not only create inflexibilities, but also complexity and potentially confusion for users.

5. **Criterion 2.2.1 provides for effective clinical supervision of trainees**

   Would it be necessary to include specific requirements to assess this criterion e.g. ratios of supervisors to trainees?

The College notes that there are new Ahpra standards for safe supervisor ratios which ACRRM would incorporate into our training site standards or potentially in associated documentation as required. We would contend however that it remains important that ACRRM and other colleges are able to reserve the right to put in place their own policies to manage these.

ACRRM's position with respect to including specific requirements related to this and any other criteria is detailed at (4) above.

6. **Criterion 3.1.1 provides for a clinical caseload and case mix to achieve the training program outcomes**

   Would it be necessary to include specific requirements to assess this criterion e.g. logbook requirements, theatre time?

ACRRM has a range of requirements regarding caseload and case mix associated with our training site accreditation standards detailed in adjunct documentation. We note that many colleges include additional specific requirements as appropriate to their respective program exigencies.

ACRRM's position with respect to including specific requirements related to this and any other criteria is detailed at (4) above.

7. **Criterion 3.1.2 provides for trainees to engage in structured and unstructured learning activities to achieve the training program outcomes**

   Would it be necessary to include specific requirements to assess this criterion e.g. requirement for trainees to complete a research paper?

We would see potential value for these types of requirements forming part of the adjunct documentation supporting college training site accreditation standards.

ACRRM's position with respect to including requirements related to this and other criteria is detailed at (**4**) above.

8. **Criterion 4.2.1 provides for clinical or other equipment needed for trainees to achieve the training program outcomes.**

   Would it be necessary to include specific requirements to assess this criterion e.g. list of specialist equipment?

We would see potential value for these types of requirements forming part of the adjunct documentation supporting college training site accreditation standards.

ACRRM's position with respect to including specific requirements related to this and any other criteria is detailed at (4) above.

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

We do not have any additional college specific requirements to advise at this stage but note that these are constantly evolving, and we would caution against the national standards documents attempting to anticipate and document every potential requirement.

As per above, we would have concerns with national standards seeking to assume the role of providing an exhaustive list of college-specific requirements. This is beyond the brief and intentions of the NHPO recommendations which were to provide a framework for national consistency. As outlined, above, this would introduce significant potential to create inflexibilities, confusion, and information disparities.

ACRRM and the other individual colleges should document any training requirements if deemed appropriate to their respective contexts and this documentation must reside with the colleges as the source of truth. It is our colleges preference that these would be listed in adjunct documentation to the college training standards to maximise opportunity for flexibility and responsiveness.

Implementation

10. **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 (e.g. shared training, shared resources etc.)?**

Assuming that the final documents align with the recommendations in this submission, the college would expect to have the adjustments in terms of the accreditation terminology, and the associated changes to standards, implemented at earliest, by the end of 2025.

- The College would require approximately six months to review and approve any changes through the various levels of governance.
- Following this, the College would require at least three months to update processes throughout its communications interfaces, then to retrain staff to work with the new frameworks, then to socialise the new arrangements across its registrars and training sites.
- Additionally the College would anticipate requiring some six months to adjust, test and fully implement associated changes to its data interface. This could be undertaken concurrently, following Board approval.

These timeframes reflect the expectation that the standards will (as stated in the glossary) provide a 'model' for adoption and will not prescribe the wording or additional specific requirements. If either, of these were not the case we would expect that this would extend the time it would take the college to adjust to changes.

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

Our college has a single set of training post standards encompassing supervisor and training site accreditation that are applied across the colleges' range of different types of training posts. Our preference that additional training requirements are separated from the overarching standards document, stems partly from the need for their continuous refinement and responsiveness. Additionally, the college's range of typologies of training sites relate to different training requirements, and curriculum components, many of which are optional rather than compulsory. Thus, incorporating requirements into the single set of college standards would create unnecessary complexity and potentially confusion for users.

Response to questions on Draft Procedures

General Feedback

1. Are the model procedures easy to read and understand?

The college is comfortable with the general format.

2. Are there any requirements in the model procedures that would raise challenges for you organisation?

The College would need to see some changes made to these procedures in order for them to be practical and affordable for delivery of rural and remote general practice and rural generalist training.

The standards as designed are appropriate for colleges which undertake a relatively small number of major accreditations based in relatively few large facilities most notably in tertiary hospitals. Under these circumstances it is feasible to establish a formal team with diverse representation including expert medical practitioners for every single training site accreditation.

The overarching approach of the proposed procedures does not have sufficient flexibility to incorporate a feasible approach for a general practice college, especially one such as ours which is focused on rural and remote health services. If the procedures are to serve as a nationally consistent framework further amendments will need to be made to the language used. The administrative and financial costs of delivering accreditation as prescribed by these standards to rural and remote primary medical care, whether they be borne by the government, the training practices or the members of our college would be prohibitive.

Our college manages over 1,100 training sites in a 3-year review cycle, most of them small in scale and based in geographically dispersed small and remote communities. Most training posts rely on practice

staff to manage any workload associated with accreditation over and above their clinical responsibilities. They do not have dedicated Directors of Training, or any other such resources to lend to these processes. Similarly, most small rural hospitals do not have dedicated staff resource or budgets for education and training administration matters.

To deliver robust accreditation in these circumstances, requires a different model of allocation of staff and clinician time, administration and resources. Our approach involves each individual accreditation including the site visit being managed by dedicated operational staff. Rather than forming an accreditation team, these officers, follow a structured process of collating feedback from identified key operational and clinical advisors with processes for managing conflicts of interest. A managerial role determines accreditation in the first instance, and, there is a secondary step of reporting pooled clusters of site accreditations through the formal accreditation committee. Accreditation Committee meetings also serve as a forum for review of site monitoring and risk management. The Accreditation Committee composition ensures that the key clinical and stakeholder perspectives are engaged in decision making (including supervisor and registrar representatives), and it provides the more structured governance element to the site accreditation procedures.

The fundamental differences in the rural/general practice accreditation approach, to that described throughout the Model Procedures particularly where they detail and refer to the *Accreditation Team, Accreditation Committee, Accreditation Secretariat* make it problematic to relate or align our processes to those detailed in the document. We note in particular the opportunity to better identify and describe the expertise of technical staff trained in managing site accreditation.

Recommendation 4:

The Model Procedures' terminology and details are revised to enable continuation of the community-based primary care accreditation model as is currently in operation which is necessary for economic and practical feasibility in this sector.

The College also has concerns with references in the procedures to minuting of committee discussions related to training site accreditation. For our college these would include the process of interactions that lead to the accreditation decision that do not take the form of committee meetings as well as the Accreditation Committee meetings.

These complications notwithstanding, there are privacy and confidentiality issues arising from this approach. There is a risk that concerns that these discussions may be shared/publicised beyond the committee membership may inhibit decision makers or training site staff from providing important information to the accreditation process or discourage important discussions about the information that is provided.

Recommendation 5:

The Model Procedures recognise the need for high-level documentation of processes that lead to accreditation outcomes (i.e. dated record of the individuals that have provided input and the ultimate determination) but do not require minuted records of accreditation discussions.

The college has some concerns that the 12-month maximum period on Provisional Accreditation status would see many accredited training sites lapsing their status and having to repeat the entire process regularly without having received a trainee.

Trainees are often in under-supply in many rural and remote areas, and it is common for many of our training sites to attain provisional accreditation for advertising/recruitment purposes. As our placements are often made one year in advance the 12-month maximum period for provisional accreditation may impose significant effort upon rural practices to undergo the accreditation process every year on the off chance of hosting a placement. We would recommend that a little more leeway be given to allow a more simplified renewal or extension process for sites such as these.

Recommendation 6:

The Model Procedures provide some facility for provisional accreditation to be streamlined for training sites repeatedly applying, particularly in areas of workforce shortage.

The need for the changes outlined above notwithstanding, the College is generally comfortable with, and in many cases already adheres to the approaches to:

- Assessment against the criteria
- Decision making processes
- Reconsideration, Review and Appeals processes
- Trainees impacted by accreditation being revoked
- Training settings withdrawal from accreditation
- Confidentiality
- Monitoring
- Raising concerns
- Data and Reporting
- Review of accreditation procedures
- Staff Training
- Further information provision

Agreed Terminology

3. 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**

As per above, the detail of the procedures for each of these items is problematic due to the terminology around Accreditation Teams, etc. and the need for some leeway in repeated provisional accreditations.

These issues notwithstanding, we would be comfortable with the transition to using the "*met", "substantially met",* and "*not met"* terminology. We would also be comfortable with adopting the "*provisionally accredited", "not accredited", "accredited conditionally"* and "*not-accredited"* terminology.

We would however not wish to use the terms "refused" and "revoked". These terms are unduly stigmatising to the affected training site and its staff and further, would disproportionately impact their capacity to attract future trainees especially where these outcomes are nationally published.

We see this stigmatisation, as not only unhelpful but also potentially misleading. The outcome of being 'refused' or 'revoked' may reflect a temporary situation (e.g. senior staff who are no longer at the site), a problem beyond the management's control with resourcing or staffing (particularly in remote settings). It may in no way reflect the calibre of the people managing the site, nor necessarily (given some modifications/changes) its future potential as a training facility but may well be publicly perceived in that way.

4. In what timeframe could your college implement this terminology? What support may assist?

Noting as per above, that the college does not consider it practical or feasible to implement the Model Procedures unless greater flexibility is built into these to make them relevant to general practice and rural training site accreditation, the descriptions around the terminology and functions for Accreditation Committees, Accreditation Teams would need to be adjusted in order for this to occur.

Assuming that these adjustments are made, and that the college can continue to deliver it processes within the same resource structures, the college would expect to have the adjustments in terms of the accreditation terminology, and the associated changes to standards, implemented at earliest by the end of 2025.

- The College would require approximately six months to review and approve any changes through the various levels of governance.
- Following this, the College would require at least three months to update processes throughout its communications interfaces, then to retrain staff to work with the new frameworks, then to socialise the new arrangements across its registrars and training sites.
- Additionally the College would anticipate requiring some six months to adjust, test and fully implement associated changes to its data interface. This could be undertaken concurrently, following Board approval.

Risk Matrix

5. **Is the risk matrix appropriate for accreditation decision making?**
The College supports the risk matrix as a tool to strengthen accreditation decision making.
6. **The risk matrix allows colleges to decide whether or not to impose a condition where the criteria are substantially met or not met but the overall risk assessment is low?** **Is this appropriate or should there be a requirement for a condition to be imposed for any criterion assessed as "substantially met" or "not met"? Please explain your views**
The College agrees with this approach and would not support any prescriptive approach being taken whereby risk matrix information forces particular accreditation decisions. ACRRM supports a general framework approach of erring toward allowing as much flexibility as possible, in this case, allowing accreditation decisions to accommodate the diversity and complexity of situations in which they are applied. We consider the risk matrix should appropriately provide a risk lens by which decision-makers can better inform their judgements, and not *of itself* to be the decision-maker. The risk lens approach would enable the most nuanced context-appropriate decisions, it would also avoid a potential adverse consequence whereby, decision makers may see need to skew the risk matrix information to ensure it prescribes, what was considered, the right outcome.
7. **The risk matrix indicates that steps to revoke accreditation should be taken when the overall risk is extreme. Is this appropriate?**
As per 6 above, the College does not see the value of the risk matrix as a decision-making device but rather as a tool to inform the decision-makers. We consider any mandatory rule whereby the risk matrix itself determines the decision invites an unhelpful degree of inflexibility to decision-making. As above we would also be concerned that this inflexibility may perversely lead to risk matrix information being skewed to ensure a preferred outcome.
8. **Do you have any additional comments about the model procedures that are not covered above?**
No further comments.

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***healthy rural, remote and First Nations communities through excellence, social accountability, and innovation***.

The College works to *define, promote and deliver quality standards of medical practice for rural, remote and First Nations communities through a skilled and dedicated Rural Generalist profession*. It provides a

quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM has more than five thousand rural doctor members including over a thousand registrars, living and working in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia and further afield. College members deliver expert front line medical care in a diverse range of settings including general practice, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as the Royal Flying Doctor Service and Australian Antarctic Division.

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ACRRM acknowledges Aboriginal and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and dreamings. We recognise these lands and waters have always been a place of teaching, learning, and healing.