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Accreditation of anaesthesia departments: Current practice, best practices and future directions

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INTRODUCTION

Five-yearly accreditation of your department can feel like an imposition. The process requires enormous amounts of time and effort from everyone involved. However, training site accreditation is not only required under law in Australia and Aotearoa New Zealand, it also plays a crucial role for the college to support training, maintain professional standards, and advocate for our specialty with governments and health services in both countries.

For the college, the accreditation of a department evaluates whether the anaesthesia curriculum is being implemented as intended in every training location. For departments, it highlights areas where anaesthesia training is going well and areas that need improvement. For trainees, it ensures they are training as intended, in environments that support their learning and professional development. Accreditation supports ANZCA supervisors, giving them time and other resources for their roles. College accreditation supports departments and health services to train specialists who can provide optimal clinical care for the patients they serve. This is a collaborative model, where the college develops the curriculum, assessments and required standards, and training sites subsequently employ trainees and their supervisors while providing the necessary clinical and clinical support experiences.

Currently, accreditation is a “hot topic” for governments, health services and colleges. Governments are driven by various concerns, including workforce shortages in the wake of the COVID-19 pandemic, especially in rural and regional areas.[1] This article provides a brief overview of anaesthesia accreditation for fellows, trainees, and departmental heads, including what it is, how it currently works, ongoing drivers for change,

what the future may hold, and what this means for departments. We outline international best practices and principles in accreditation and the importance of the Clinical Learning Environment (CLE) for anaesthesia training. While the Faculty of Pain Medicine (FPM) accredits pain units for training under the auspices of the college, this article focuses only on anaesthesia accreditation.

WHAT IS ACCREDITATION, AND WHAT DOES IT ACHIEVE?

An internationally accepted definition of accreditation (Table 1) highlights that it is a process of external (usually peer) review, focused on ensuring minimum training standards. In our region, postgraduate (specialist) accreditation works at several levels. Each specialist medical college accredits training sites or posts to ensure they meet discipline-specific training requirements. Additionally, all the medical colleges are accredited by the Australian Medical Council (AMC) and/or the Medical Council of New Zealand (MCNZ), with the two bodies collaborating on the accreditation of binational colleges like ANZCA.

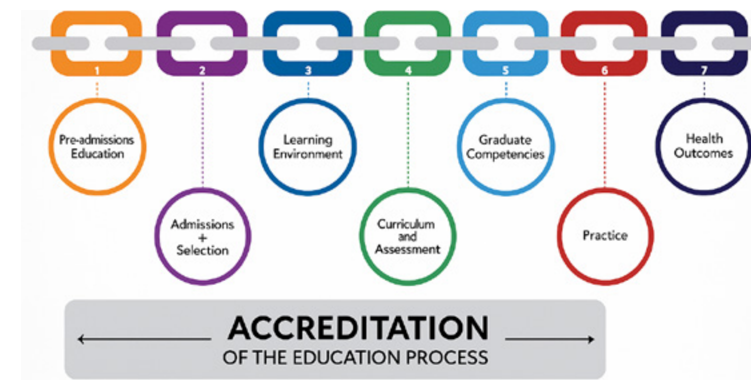
The AMC and MCNZ accredit all aspects of the medical education continuum from medical school through to specialists' continuing professional development. Aspects of college training that the AMC and MZNC accredit include college governance, graduate outcomes (defined in Table 1), the curriculum, teaching and learning methods, the program of assessments (exams, workplace-based assessments and the ANZCA scholar role assessments), monitoring and evaluation processes and outcomes, trainee-related issues (selection, involvement in college governance, college communications, wellbeing and resolution of training problems), and supervision/supervisors.[2,3] The AMC and MCNZ also accredit college accreditation standards and procedures for training sites.

Table 1. Accreditation glossary

Specialist accreditation	The process by which a credible, independent body assesses the quality of an education program to provide assurance that it produces graduates that are competent to practise safely and effectively as specialist practitioners.[4]
Clinical learning environment (CLE)	How trainees experience the curriculum in their workplaces. It includes interpersonal interactions, culture and resources.[5]
Curriculum	A statement of the intended aims and objectives, content, assessment, experiences, outcomes and processes of a [training] program, including a description of the structure and expected methods of learning, teaching, feedback and supervision. The curriculum should set out the knowledge, skills and professional qualities [each] trainee is to achieve.[2]
Competency-based medical education (CMBE)	Outcomes-based approach to the design, implementation, assessment, and evaluation of a medical education program using an organising framework of competencies.[6]
Cultural safety	The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery; and The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided; and The awareness that cultural safety encompasses a critical consciousness when healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities.[7]
Graduate outcomes	The minimum learning outcomes in terms of discipline-specific knowledge, discipline-specific skills including generic skills as applied in the specialty discipline, and discipline-specific capabilities that [each] graduate or any given specialist medical program must achieve.[2]
Training rotation	A regionally-based group of ANZCA-accredited departments that together are able to provide trainees with a comprehensive and integrated training experience covering all essential requirements of the training program.[8]

Analogous to "closing the loop" in clinical quality improvement processes, accreditation is part of medical education's "quality chain" (Figure 1), ultimately leading to well-trained specialists and better health outcomes. Most elements of this quality chain are developed by ANZCA and accredited by the AMC and MCNZ.

Figure 1. The quality chain in medical education[9]



HOW DOES ANZCA ACCREDIT ANAESTHESIA TRAINING SITES?

ANZCA accredits anaesthesia training sites throughout Australia and New Zealand using the standards and procedures outlined in the ANZCA Handbook for Accreditation.[8] The aim of ANZCA accreditation is to ensure that anaesthesia departments meet training and clinical care standards to ensure high-quality training. Accreditation is overseen by the Training Accreditation Committee (TAC), which implements ANZCA policy on accreditation and reports directly to the ANZCA Council.

ANZCA accreditation standards

The seven ANZCA accreditation standards are:

1. Quality patient care
2. Clinical experience
3. Supervision
4. Supervisory roles and assessment
5. Education and teaching
6. Facilities
7. Clinical governance

These standards align with ANZCA professional documents and the anaesthesia training program curriculum.[10] The *ANZCA Handbook for Accreditation* lists the criteria that underpin each standard, including minimum requirements and how each criterion is assessed. When evaluating a department against the standards, some requirements are quantitative (e.g. the number of specialist-led acute pain rounds), while many are qualitative (e.g. how labour epidurals are assessed for beyond Level 1 Supervision).

ANZCA accreditation procedures

An accreditation team of two to four ANZCA accreditors selected from a pool of volunteer fellows and trainees inspects each training site at least once every five years. There are over 180 ANZCA-accredited training sites across Australia and New Zealand, representing about 50 visits per year, a considerable workload, and one that represents a key "frontline" contact between the college, its fellows and trainees, and health services. Table 2 summarises how accreditors are appointed and trained.

Table 2. ANZCA anaesthesia accreditor management

Selection	Self-nomination. Two referees, both FANZCAs, at least one a current or past ANZCA accreditor. Selection criteria include demonstrated clinical leadership and teaching experience, recent knowledge of the ANZCA training program and associated governance and professional documents.
Orientation and training	Compulsory for all new accreditors. Provided with role description (terms of reference). Videos and guides on Learn@ANZCA. Initial accreditation visit with a more senior visitor (team lead is an experienced accreditor).
Performance appraisal and feedback	Feedback from training site after visit. No individual performance assessment.
Appointment terms and reappointment	Three-year terms to maximum 12 years. Automatic reappointment.
Accreditation team	Led by a senior inspector (a current or former ANZCA councillor or TAC member). Comprises members outside the department and region, and ideally one inspector from the same region (but not the same rotation). Balance of gender and accreditation experience. Trainee included (from 2022). All team members must declare potential conflicts of interest, and these are managed in accordance with ANZCA policy to minimise bias.

Inspection of a training site typically lasts a whole working day. It involves a series of interviews with the head of the anaesthesia department, hospital executives, trainees, supervisors of training and other ANZCA fellows, as well as a physical inspection of all anaesthetising locations to evaluate compliance with ANZCA standards. When a rotation is inspected, a full team of four accreditors visit the larger hospital(s) in that rotation and then splits into pairs to inspect the smaller hospitals. At the end of each hospital visit, the inspection team gives an initial summary of recommendations, which form the basis of their report to TAC. TAC considers the report, determines the accreditation outcome and duration, and any recommendations that must be addressed to achieve unqualified accreditation. A decision to withdraw accreditation can only be made by ANZCA Council. Should TAC consider withdrawal of accreditation, then the hospital, department, and health service will be notified of this outcome and will be allowed to respond before a decision by ANZCA Council. Accreditation decisions can be challenged via the ANZCA reconsideration, review and appeals processes.[11] Table 3 summarises ANZCA accreditation procedures.

Table 3. Overview of ANZCA accreditation procedures

Procedure	How ANZCA does this
New accreditation application	Initiated by the anaesthesia department which must join a training rotation for accreditation to be considered.
Self-assessment	A department member populates the accreditation datasheet in the ANZCA TSA portal, self-assessing site compliance with criteria under each standard.
Evidence	TPS data: Case numbers per SSU, WBA completion rates, supervision levels, elective versus emergency workload. ANZCA trainee survey results for current and prior HEY. Site rosters (staffing), formal teaching programs, hospital and department metrics (e.g. case load, theatre numbers, trainee numbers, SOT, SSU and other supervisory roles, case details).
Accreditation report	Narrative overview of context and major findings (1-2 pages). Mandatory recommendations (linked to professional documents, training regulations and handbook) and suggestions for improvement (for department consideration). Draft to HOD to correct factual inaccuracies. Final report uploaded to the TSA portal. Letter with recommendations and timeline for compliance sent to hospital administration with copy to head of anaesthesia department.
Potential accreditation outcome	**Unqualified:** all standards and criteria met five years from inspection date. Certificate issued. **Conditional:** subject to corrective actions within a specified timeframe (usually up to one HEY only). Sometimes reinspection. Progress updates to each TAC meeting. Attaining unqualified accreditation depends on achieving full compliance. If struggling to meet standards, TAC may reduce accreditation duration or withdraw accreditation. **Withdrawal:** hospital unable to comply with standards, significant impact on training and professional standards. Requires ANZCA Council decision.
Accreditation duration	26, 52, 104 or 156 weeks of IT, BT and/or AT. Based on clinical and non-clinical educational opportunities, particularly the number of SSUs that can be completed at the site. PFT approval is a separate process.
Other types of ANZCA accreditation	Additional campuses: anaesthesia services provided by the department under the same governance structure (e.g. private hospital theatre with public work), part of same approval. Satellites: partnership arrangement between larger accredited hospital (partner hospital which may provide some accreditation requirements e.g. SOT) and a site with valuable training opportunities (satellite). Trainees allocated to the satellite by blocks of time or on a list-by-list basis. Time spent at the satellite is part of the maximum allowable time at the partner hospital.
Monitoring outside visits	Via the New Zealand national/Australian regional and trainee committees and accreditation officers (one in New Zealand and each Australian region). May result in out-of-cycle review and a visit.
Accreditation system administration	Funded by the college through training fees. Dedicated ANZCA staff members. Annual review of Handbook for Accreditation, including updating criteria underpinning each accreditation standard.

Abbreviations: AT Advanced Training, BT Basic Training, HEY Hospital Employment Year, HOD Head of Department, IT Introductory Training, PFT Provisional Fellowship Training, SOT Supervisor of Training, SSU Specialised Study Unit, TSA Training Site Accreditation, WBA Workplace Based Assessments.

WHAT IS AN INTERNATIONAL LEADING PRACTICE IN ACCREDITATION?

Accreditation decisions are high-stakes for all those involved – for trainees, their supervisors and the patients they will serve; for hospitals, health services and governments; and for accrediting bodies (like ANZCA, the AMC and MCNZ). While accreditation is a powerful mechanism and motivator for change,[12,13] it is also resource-intensive.[14,15] As part of its continuous improvement approach and to ensure an efficient and effective process, from 2019 to 2021, the college convened a project group to define key principles and leading practices in accreditation internationally, identify gaps in existing ANZCA and FPM practices, and make recommendations for future change.[5] The following section summarises the project's main findings.

The ANZCA and FPM Accreditation and Learning Environment Project (ALEP) used mixed methodology, including literature review, environmental scan, and consultation with colleges and regulatory bodies in Australia, Aotearoa New Zealand, the United States, Canada, the United Kingdom, and Ireland. Table 4 shows key aspects of accreditation in these countries.

Table 4. Specialist accreditation practices in Australia, New Zealand, Canada, the United Kingdom and the United States[5]

	Australia	New Zealand	Canada	United Kingdom	United States
Accreditation of colleges/ universities for specialist training	Australian Medical Council (AMC)	Medical Council of New Zealand (MCNZ)	Royal College of Physicians and Surgeons of Canada (RCPSC)*	General Medical Council (GMC) approves curricula developed by colleges	Accreditation Council for Graduate Medical Education (ACGME)#
Cycle length	10 years	10 years	8 years	Colleges apply for curriculum change approval	10 years
Accreditation of anaesthesia training sites or posts	ANZCA	ANZCA	RCPSC using both cross-specialty generic and specialty-specific standards	Postgraduate deaneries (England, Northern Ireland), Local Education and Training Boards (Scotland, Wales)**	ACGME using common program requirements and specific anesthesiology requirements
Cycle length	5 years	5 years	8 years	Variable	10 years
Anaesthesia examinations	ANZCA	ANZCA	RCPSC	The Royal College of Anaesthetists	The American Board of Anesthesiology

* The Collège des Médecins du Québec (CMQ) and College of Family Physicians of Canada (CFPC) accredit PGME in Quebec and for family medicine, respectively.
# Although this is a voluntary process, ACGME accreditation is required for federal funding and medical licensure in some US states.
** The Royal College of Anaesthetists has a separate accreditation process for anaesthesia clinical services – Anaesthesia clinical services accreditation.[16]

Principles of high-quality accreditation

The project identified five principles of high-quality accreditation: it provides public assurance and accountability, is outcomes-focused, combines quality assurance (QA) and continuous quality improvement (CQI), focuses on the clinical learning environment (CLE), and aligns health service and training priorities.[5]

The ultimate goal of medical accreditation is competent specialists who deliver high-quality and safe care for the patients and communities they serve, resulting in the best possible health outcomes (Figure 1); thus, public assurance and social accountability (to patients and the broader community) underpins specialist accreditation.[17]

Over recent decades, medical education has increasingly focused on outcomes, so-called competency-based medical education (CBME).[18] This is reflected in the ANZCA Training Curriculum through descriptions of outcomes at each stage of training and on graduation, teaching for those outcomes, and assessment of required outcomes to allow progression to the next training stage. Since accreditation is about evaluating how the curriculum is implemented at each training site, accreditation standards should align with the curriculum and focus on educational outcomes.[19,20]

Compliance with minimum standards has long been the main focus of specialist accreditation, including for ANZCA. However, the literature and international authorities increasingly recommend that accreditation evolve beyond this quality assurance (QA) focus to incorporate an ethos of continuous quality improvement (CQI).[21] This involves more regular local self-assessment, measurement, and improvement planning.

Finally, many medical accreditation bodies seek to align the priorities of health services and training organisations (like ANZCA) to achieve a win-win situation where thinking and resourcing achieve desired outcomes for both. This requires greater collaboration and mutual accountability, recognition of common priorities and breaking down of siloed thinking and activity. An example is the meaningful involvement of trainees in systems processes that improve healthcare delivery and in healthcare leadership. While these are priorities for future specialist practice (for both health services and for colleges), current siloed approaches do not necessarily prepare trainees for the responsibilities they will have on graduation.

Leading Australasian and international accreditation practices

While there is no consensus internationally about how accreditation systems should be designed, there is agreement that design must consider local needs and context. Several published frameworks guide accreditation system design decisions.[12,22] Table 5 summarises the findings of the ANZCA and FPM ALE project on leading Australasian and international practices in accreditation.

Table 5. Leading accreditation practices found in the ANZCA and FPM Accreditation and Learning Environment Project[5] *

Accreditation practice	Notes and examples
Explicit philosophy and purpose	Some organisations focus primarily on education and training with clinical care standards only considered where they affect training (e.g. RCPSC).
Aligns with community needs and educational developments	Accreditation standards aligned to curriculum which addresses community care needs (e.g. for culturally safe care). Strategic approaches to accreditation of rural and remote training sites to facilitate access to specialist care.
Proactive monitoring and benchmarking	Annual reporting by accredited sites (e.g. ACEM annual site census, trainee survey, examination report and WBA report). Mid-cycle paper-based monitoring (e.g. RANZCP). Defined quality indicators (e.g. ACGME).
Standards mapped to curriculum and expressed in a standards organisation framework	RCPSC framework includes domains, standards, elements and requirements (all measurable and mapped to the curriculum). CAI produces maps of accredited training sites and the training experiences they provide.
Balances standardisation and flexibility in how standards can be met (to encourage innovation)	RCPSC standards organisation framework includes mandatory indicators (required for compliance) and exemplary indicators (aspirational markers of excellence).

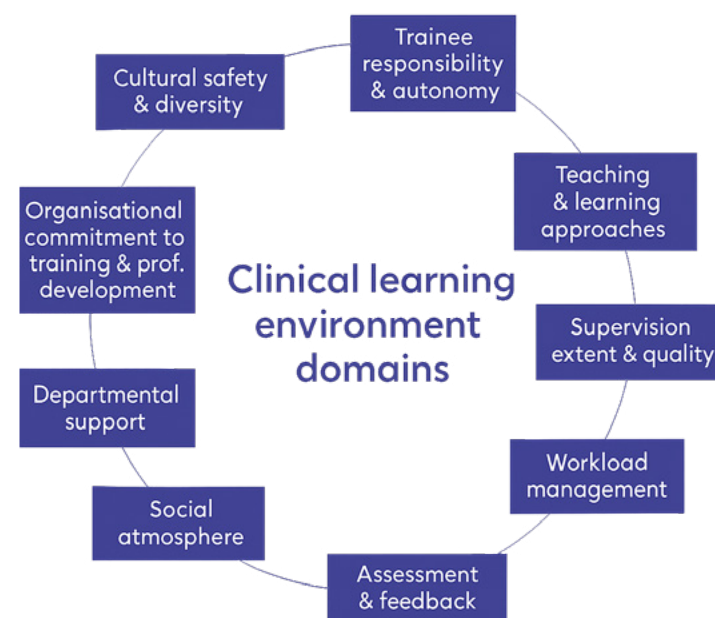
Includes self-assessment and planning for continuous improvement	ACGME Next Accreditation System (NAS) self-study includes local data collection, action plans and remeasurement.
Data driven with outcomes focus	Most accrediting organisations aspire to increase their outcomes focus, although to date this has mostly involved intermediate measures like exam pass rates, graduate satisfaction with training and sense of preparedness for practice, or employer surveys of graduate capabilities.
Promotes trainee voice and safety	Many organisations include trainee representatives on accreditation teams (e.g. AMC, ACEM, CICM, RANZCOG). Many colleges are investigating how to best use existing trainee surveys for site accreditation (while maintaining trainee safety). Some use annual or biennial supervisor surveys (e.g. ACEM, ACGME).
Optimises technological and staff support	Some organisations and colleges include staff members at site visits (e.g. ACEM, RANZCOG). ICT platform should allow easy access for sites and accreditors, allowing updating (rather than re-entry) of data over time, have dashboards displaying trends and a traffic light system for self-assessment and monitoring (e.g. RCPSC). Since the pandemic, the role of videoconferencing has increased, with some organisations using it to sample larger groups of trainees and supervisors (e.g. AMC, RANZCP).
Supports equity, healthcare access and cultural safety	Most Australasian colleges have cultural safety in their curricula and training accreditation standards and require relevant training for both trainees and their supervisors. MCNZ has specific accreditation standards on cultural safety for Māori. Many colleges also have or are working on accreditation standards that support training in rural and remote areas. RACS has a specific accreditation standard on culture of respect, addressing BDSH.
Optimises accreditor training and performance feedback	RCPSC has online training modules for sites, surveyors, and decision-making committees, with short online self-assessment tests.
Standards and procedures are subject to CQI	Regular review of standards (e.g. ACEM every 2 years, ACGME every 10 years).

*All examples from the ALEP Report have been checked for currency using organisational websites. Abbreviations: ACGME Accreditation Council for Graduate Medical Education (US), AMC Australian Medical Council, ACEM Australasian College for Emergency Medicine, BDSH Bullying Discrimination and Sexual Harassment, CAI The College of Anaesthesiologists of Ireland, MCNZ Medical Council of New Zealand, RACP Royal Australasian College of Physicians, RACS Royal Australasian College of Surgeons, RANZCOG The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, RANZCP The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, RCoA Royal College of Anaesthetists (UK), RCPSC Royal College of Physicians and Surgeons of Canada.

WHAT IS THE CLINICAL LEARNING ENVIRONMENT, AND WHY IS IT IMPORTANT FOR TRAINING AND ACCREDITATION?

The Clinical Learning Environment (CLE) is the sociocultural environment in which training occurs (see Table 1 for definition). For anaesthesia and other hospital-based specialties this is, primarily, the complex milieu of teaching hospitals. The CLE has multiple dimensions, including organisational and departmental commitment to trainees and their supervisors, quality of supervision, support and social atmosphere, cultural safety, workload management (e.g. rosters, access to required cases) and how teaching and assessment is conducted (Figure 2).

Figure 2. ANZCA and FPM clinical learning environment domains (developed as part of the ALEP)[5]



The CLE in anaesthesia departments can be measured using validated and reliable measures – the Anaesthetic Theatre Educational Environment Measure (ATEEM),[23] the Measure for the Anaesthesia Theatre Educational Environment (MATE) [24] and the Anaesthesia Clinical Learning Environment Instrument (ACLEI).[25,26] The MATE and ACLEI were developed by FANZCAs in New Zealand and Australia, respectively.

Not surprisingly, high-quality CLE motivates trainees and leads to improved learning, greater satisfaction and better examination performance,[27,28] while poor CLE adversely affects trainee wellbeing.[29] While there is limited evidence that directly links accreditation of training sites to patient outcomes, a few studies demonstrate that training location affects specific health outcomes, healthcare spending decisions or intermediary measures like new specialists' views on their "preparedness for specialist practice".[30,31]

There is widespread agreement that accrediting organisations should increase their focus on the CLE, through measurement and monitoring over time. For example, in the United States, the ACGME runs the Clinical Learning Environment Review (CLER) program that focuses on six dimensions of the CLE – including duty hours and fatigue management, supervision, and resident involvement in patient safety and quality systems.[32] CLER is currently optional and not directly linked to accreditation decisions, although findings are used to inform accreditation standards development.

WHAT ARE THE EXTERNAL DRIVERS FOR CHANGES TO COLLEGE ACCREDITATION PROCESSES?

Colleges are under pressure from governments on several fronts regarding accreditation. This has included the implication that training site accreditation may be removed from colleges in Australia. Concerns include that colleges withdraw accreditation with limited notice, impacting service delivery, and that training site accreditation is not sufficiently responsive to community workforce needs, both immediate requirements and longer-term planning.

In late 2023, the Australian National Health Practitioner Ombudsman (NHPO) reported on a major review of specialist training site accreditation.[33] Recommendations were made in five key areas: accountability and transparency of standards, fairness and transparency of procedures, strengthening monitoring of sites, consistency in managing site issues, and management of concerns about accreditation decisions and outcomes. Australian health ministers have directed that the Australian Medical Council work with all medical colleges on 15 NHPO recommendations.[34] The MCNZ is also involved in this work, continuing the close, ongoing collaborative partnership between the MCNZ and the AMC.

In Aotearoa New Zealand, the MCNZ bases its accreditation standards largely on those of the AMC, with country-specific standards, especially around cultural safety for Māori.[3] Standards alignment reflects similarities in healthcare systems and governance structures and streamlines processes for binational colleges. A longstanding and important difference is the requirement for specialist medical colleges to inform the MCNZ with reasonable notice of any intention to limit or withdraw accreditation from any training site. In 2023, ANZCA revised its accreditation processes to include notification to all jurisdictions in Australia and Aotearoa New Zealand of any intention to limit or withdraw the accreditation at a training site.

WHAT ACCREDITATION WORK IS CURRENTLY UNDER WAY?

The college is currently working on its responses to the findings of its internal accreditation project and the recommendations in the NHPO report. Fortunately, these two major work streams are considerably aligned.

The ANZCA and FPM Accreditation and Learning Environment Project

The ALEP final report made 15 recommendations for improvements in ANZCA accreditation standards and procedures.[5] These include:

- Initiating an accreditation renewal project across all college training programs (anaesthesia, pain medicine, diving and hyperbaric medicine, rural generalist anaesthesia).
- Redesigning accreditation standards by mapping them to each training curriculum, ensuring cultural safety at training sites, and supporting community needs, for example, by exploring options to facilitate accreditation of sites in rural and regional areas.
- Strengthening accreditation evidence by developing outcome measures to complement current process measures.
- Formally measuring the clinical learning environment at training sites, with results to be shared with sites for their review and planning for any necessary improvements.
- Introducing proactive monitoring of training sites between five-yearly visits, rather than the current reactive situation, which relies on concerns about sites being raised with the college.
- Strengthening trainee and fellow input to accreditation monitoring while ensuring trainee safety (especially at sites with small numbers of trainees).
- Enhancing support for volunteer accreditors, including through performance feedback for professional development.
- Strengthening accreditation of anaesthesia rotations and evaluating provisional fellowship training at site visits.
- Developing mechanisms to acknowledge and share examples of good practices and solutions to common or challenging problems.

In 2023, the college formed the Accreditation Renewal Steering Group, tasked with working through the ALEP recommendations. Recommendations such as aligning accreditation terminology and definitions across all ANZCA programs and revising the responsibilities, selection and appointment criteria for accreditation inspectors and leads have been finalised. Improving support for ANZCA's volunteer accreditation inspectors is progressing.

The group also works towards annual, bi-directional reporting between the college and anaesthesia departments. Ideally, these data would allow departments to be tracked and provide benchmarking of their own performance, enabling response, improvement, and creating space for training innovation. TAC could evaluate departmental progression in the preceding five years, rather than relying primarily on the current high-stress, resource-intensive, single-point-in-time assessment. The Training Portfolio System (TPS) dataset currently used by TAC, while valuable, has significant limitations, not least of which is that trainees stop entering cases once volumes of practice are achieved. ANZCA is currently developing the next version of the TPS, which has improved reporting capability and is a highly desirable specification.

However, in the past 12 months, the work of the ANZCA Steering Group has slowed, allowing ANZCA to focus on collaborative work with the AMC and the MZNC.

The NHPO Report recommendations

Individual colleges are working on some of the Australian NHPO recommendations,[33] while the AMC and MCNZ are working with all Australian and binational medical colleges on those recommendations that require harmonisation and streamlining for common approaches. Planned outcomes include:

- model accreditation standards
- best practice policies and procedures
- a common approach to managing complaints and concerns
- a data collection model and reporting process.[35]

Several work streams are now underway to advance progress in these outcomes.

An early result is *The Communication Protocol,* which aims to improve collaboration between colleges, training sites and health departments.[36] The protocol sets out roles, responsibilities and expectations about communication regarding the accreditation of Australian training sites, including the requirement to provide health departments in advance with a timetable of accreditation visits planned for each year. Importantly, if the withdrawal of accreditation is being considered, then colleges must notify both training sites and health departments, giving them reasonable time for a response and resolution of outstanding issues before any action is taken to withdraw accreditation.

In mid-2024, a forum involving more than 150 stakeholders considered recommendation 13 of the NHPO report on managing concerns and complaints about sites, especially regarding bullying, harassment, racism, and discrimination.[33] A significant focus of the forum was who holds what responsibilities when managing these concerns, and the need for all parties to consult, cooperate, and coordinate. This work is ongoing.

Table 6 shows the model accreditation standards to be used by each college, developed by the AMC, released for public consultation, and recently endorsed by the Australian Health Workforce Taskforce (made up of each jurisdictional health department) and the Health Chief Executives Forum. These are expressed in a standards organisation framework, in accordance with best practice. The model standards consultation document also included principles on identifying and using evidence to support accreditation decisions, along with examples of the types of evidence that might be used. Despite their different arrangement, many current ANZCA accreditation standards are reflected in these model standards.

Table 6. Model standards for college accreditation of training sites/posts[37]

Domain	Standard	Criteria
Trainee health and welfare	Training takes place in a learning environment that supports trainee health and welfare	Safe pathways to raise concerns Bullying, harassment, discrimination and racism identified, investigated, managed and recorded Flexible work arrangements Positive learning environment that fosters respect, diversity, inclusion and cultural safety for trainees of diverse backgrounds Risks to cultural safety of Aboriginal and/or Torres Strait Islander and Māori trainees identified, managed and recorded Fatigue risks identified, managed and recorded Access to leave Support for trainees returning to work after a break in training Adjustments for trainees with disabilities Resources to support health and welfare

Supervision, management and support structures	Clear governance structures support the delivery of effective education and training	Trainees can provide feedback on local training delivery Rostering, recruitment and other human resources function effectively to support training Effective orientation College engages with training networks (ANZCA rotations) to ensure training outcomes can be achieved
	Trainees receive appropriate and effective supervision	Effective clinical supervision Supervisors provide regular and timely feedback to trainees Support for trainees in difficulty Director of Training given time and resources Supervisors receive support, including for providing culturally safe supervision
	Trainees are supported in delivering quality patient care, including culturally safe care	Trainees supported in developing specific knowledge and skills including for culturally safe care for First Nations Peoples Opportunities to reflect on critical incidents and engage with local clinical governance/QA processes
Educational and clinical training opportunities	Trainees are provided with appropriate depth, volume and variety of clinical and other learning experiences	Clinical caseload and case mix to achieve training program outcomes Opportunities for structured and unstructured learning Clinical handovers Work in multidisciplinary teams
	Learning experiences are transparent, equitable and appropriate for the level of training	Increasing responsibility appropriate to skills and experience Opportunities transparent and equitable for all trainees Support to complete assessments in a timely way
Educational resources, facilities and equipment	Trainees have access to appropriate educational resources and facilities	Appropriate quiet space and internet access Educational resources
	Trainees have access to appropriate clinical equipment	Clinical equipment available, accessible and fit for purpose

The idea of common accreditation standards across colleges is not new. In 2016, Australian-based specialist medical colleges worked with the Federal Department of Health on agreed-upon accreditation standards for college training sites[38]. However, these were only adopted by a few colleges. The 2016 standards had considerable similarity to the 2024 ones (Table 6). However, the latter are expanded to include contemporary expectations, like cultural safety for First Nations trainees and patients, robust approaches to bullying, harassment, discrimination and racism; adjustment for trainees with disabilities; and equitable access to training experiences for all trainees.

WHAT DOES THIS MEAN FOR ANAESTHESIA DEPARTMENTS?

The college must redesign accreditation standards for all its training programs to align with the new harmonised standards (Table 6). After revising accreditation standards, subsequent steps will be to update accreditation processes and systems and explore potential changes to the ANZCA curriculum. Improved reporting from a revised ANZCA TPS will support these changes. Hospital departments will see changes to standards and procedures over the next two years, with full implementation required by 2027.

A known limitation of current ANZCA accreditation standards and procedures is that they only focus on individual training sites rather than on rotations as a whole. The training sites directly influence the quality of the clinical learning environment and ultimately employ a trainee. Yet, the rotations these trainees work through across multiple sites are what provide them with their comprehensive and integrated training experiences, covering all essential requirements of the training program. Current oversight of rotations is the responsibility of the ANZCA national and regional committees, without any central accreditation or formal reporting. Rotational supervisors liaise with the supervisors of training and heads of department within each rotation, as well as the education officer for the region. These interactions allow the rotational supervisors to better monitor the training delivered, the progress of all trainees within the training program, and their access to necessary training requirements. Some training outcome metrics, such as time to complete training and examination success rates, are better matched to rotations than individual sites and may be included in future ANZCA accreditation.

TAC members hold the basic assumption that all staff working in anaesthesia departments want to provide a high-quality clinical learning environment that supports patient care. Despite understandable apprehension about accreditation visits, accreditation inspectors are always warmly welcomed by departments who are keen to demonstrate their commitment to ANZCA training. From time to time, health systems struggle to support the demands of high-quality learning and patient care, and by highlighting the areas that require addressing and advocating on behalf of departments, TAC can work with health services to achieve sustained improvements. In recent years, ANZCA training sites in every region have come under TAC and ANZCA Council watch, which have subsequently achieved accreditation through proactive collaboration and advocacy.

CONCLUSIONS

Accreditation is an important evaluative mechanism for ensuring training quality. It plays a crucial role for the college in maintaining professional standards and advocating for our specialties with governments and health services. Even prior to current governmental demands for college training accreditation reform, the College recognised the need to benchmark ANZCA accreditation against contemporary best practices by initiating the Accreditation and Learning Environment Project. The findings of that project roughly align with the cross-college collaborative work with the AMC and MCNZ. Inevitably, significant change is coming. College fellows, trainees and departments may wish to keep ahead of likely developments by considering how their environments will perform against the model standards developed by the AMC, MCNZ and Australian and binational medical colleges. Critically, representatives of the college are involved closely in this work to advocate for the needs of our specialty. Much of what is proposed already exists within ANZCA standards and procedures, and alignment across specialties increases the likelihood that necessary systematic change will occur to further support high-quality training in the future.

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