The Royal Australian & New Zealand College of Psychiatrists

RANZCP Reaccreditation Report to the Australian Medical Council 2022

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College Details

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Training programs offered:

Specialist medical program	Australia	New Zealand
Fellowship of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP)	Yes	Yes

Verify submission reviewed:

The information presented to the AMC is complete, and it represents an accurate response to the relevant requirements.

Verified by: Mr Andrew C Peters

Signature:

Date: 30 June 2022

(Chief Executive Officer/executive officer responsible for the program) Royal Australian and New Zealand College of Psychiatrists

Summary of 2021 Progress Report Findings

Standard	2020 Findings	No. of Conditions remaining
Overall	**Met**	**1**
1. The context of education and training	Met	0
2. The outcomes of specialist training and education	Met	0
3. The specialist medical training and education framework	Met	1
4. Teaching and learning methods	Met	0
5. Assessment of learning	Met	0
6. Monitoring and evaluation	Met	0
7. Issues relating to trainees	Met	New Condition 1
8. Implementing the training program – delivery of educational resources	Met	0
9. Continuing professional development, further training and remediation	Met	0
10. Assessment of specialist international medical graduates	Met	0

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Glossary of Terms

Abbreviation	Term
AAP	Alternative Assessment Pathway
AC	Accreditation Committee
ACEM	Australasian College for Emergency Medicine
ACER	Australian Council for Educational Research
ACDOH	Australian Commonwealth Department of Health
ACRRM	Australian College of Rural and Remote Medicine
ADCET	Australian Disability Clearinghouse on Education and Training
ADHD	Attention Deficit and Hyperactivity Disorder
AGFTPC	Australian Government Funded Training Programs Committee
AGM	Annual General Meeting
AHPRA	Australian Health Practitioner Regulation Agency
AIDA	Australian Indigenous Doctors Association
AMC	Australian Medical Council
AMEE	Association for Medical Education in Europe
AMSA	Australian Medical Students' Association
ANCIPS	Annual National Conference of the Indian Psychiatric Society
ANZCA	Australian and New Zealand College of Anaesthetists
ANZJP	Australian and New Zealand Journal of Psychiatry
AOP	Areas of Practice
AON	Area of Need
AP	Australasian Psychiatry
APT	Associations of Psychiatry Trainees
ATSIMHC	Aboriginal and Torres Strait Islander Mental Health Committee
AV OSCE	Audio Visual OSCE
AVOSCESG	Audio Visual OSCE Steering Group
BAWG	Burden of Assessment Working Group
BCT	Bi-National Committee for Trainees
BIT	Breaks in training

Glossary of Terms

Abbreviation	Term
BPG	Board Priority Group
BPSD	Behavioural and psychological symptoms in dementia
BTC	Branch Training Committee
CAF	Comparability Assessment Framework
CAP	Child and Adolescent psychiatry
COP	Case Based Discussion Oversight Panel
CBME	Competency-based Medical Education
CbD	Case-based Discussion
CCC	Community Collaboration Committee
CCPD	Committee for Continuing Professional Development
CEEMR	Committee for Educational Evaluation Monitoring and Reporting
CEO	Chief Executive Officer
CEQ	Critical Essay Question
CEQR	Committee for Educational Quality and Reporting
CESG	COVID Examination Steering Group
CFE	Committee for Examinations
CFT	Committee for Training
CGRC	Corporate Governance and Risk Committee
C-L	Consultation-Liaison psychiatry
CMC	Council of Medical Colleges
CME	Continuing Medical Education
COI	Conflicts of Interest
CPD	Continuing Professional Development
CPG	Clinical Practice Guideline
CPMC	Committee of Presidents of Medical College
CSIMGE	Committee for Specialist International Medical Graduate Education
DD	Developmental Descriptors
DES	Digital Education Services
DFTP	Dual Fellowship Training Program

Glossary of Terms

Abbreviation	Term
DOAT(s)	Director(s) of Advanced Training
DOH	Department of Health
DOPS	Direct Observation of Procedural Skills
DOT(s)	Director(s) of Training
DOU	Deed of Undertaking
DSM	Diagnostic and Statistical Manual of Mental Disorders
DVA	Department of Veterans' Affairs
EAP	Employee Assistance Program
EAG	Expert Advisory Group
EC	Education Committee
ECT	Electroconvulsive Therapy
EMQs	Extended Matching Questions
EOI	Expression of Interest
EPA(s)	Entrustable Professional Activity/Activities
ERSG	Examinations Review Steering Group
E-LAG	E-Learning Advisory Group
FATES	Flexible Approach to Training in Expanded Settings
FC	Finance Committee
FCAP	Faculty of Child and Adolescent Psychiatry
FEC(s)	Formal Education Course(s)
FECRWG	FEC Review Working Group
FNU	Fiji National University
FRACP	Fellow of the Royal Australasian College of Physicians
FRANZCP	Fellow of the Royal Australian and New Zealand College of Psychiatrists
FTE	Full Time Equivalent
HETI	Health Education and Training Institute
HR	Human Resources
ICD	International Classification of Diseases
ICRE	International Conference on Residency Education

Glossary of Terms

Abbreviation	Term
IMELF	International Medical Education Leaders Forum
IMG(s)	International Medical Graduate(s)
InTrain	Training management system
IPS	Indian Psychiatric Society
IRT	Item Response Theory
IRTP	Integrated Rural Training Pipeline
ITA(s)	In-training Assessment(s)
Learnit	Learning management system
LIME	Leaders in Indigenous Medical Education
LMS	Litmos Learning Management System
LO	Learning Outcomes
MAC	Members Advisory Council
MBA	Medical Board of Australia
MBS	Medicare Benefits Schedule
MCNZ	Medical Council of New Zealand
MCQ	Multiple-Choice Question Examination
MEC	Membership Engagement Committee
MEES	Member E-Learning Education Sessions
MEQ	Modified Essay Question
MSF	Multi-source Feedback
MS OSCE	Multiple -site OSCE
MTRP	Medical Training Review Panel
MTS	Medical Training Survey
MWRAC	Medical Workforce Reform Advisory Committee
MOCI	Modified Observed Clinical Interview
MOU	Memorandum of Understanding
MVPTP	Military and Veteran Psychiatry Training Program
NFPMT	National Framework for Prevocational Medical Training
NMTAN	National Medical Training Advisory Network

Glossary of Terms

Abbreviation	Term
NZMSA	New Zealand Medical Students' Association
NZMSJ	New Zealand Medical Students' Journal
NZTC	New Zealand Training Committee
NZYC	New Zealand Youth Convention
OCA(s)	Observed Clinical Activities
OSCE	Objective Structured Clinical Examination
OPCEO	Office of the President and CEO
OPHELIA	Online Pacific Health Exchange
OTPC	Overseas Trained Psychiatrist Committee
PCARP	Partial Comparability Assessment Review Panel
PDP	Professional Development Plan
PGY	Post-graduate year
PIF	Psychiatry Interest Forum
PMA	Pasifika Medical Association
POST	Postgraduate Overseas Specialist Training
PPC	Policy and Partnerships Committee
PPE	Personal Protective Equipment
PPF	Professional Performance Framework
PPG	Professional Practice Guidelines
PPPC	Practice, Policy and Partnerships Committee
PPR	Practice Peer Review
PROP	Portfolio Review Oversight Panel
PRGs	Peer Review Groups
PS	Positions Statements
PSG	Pacific Steering Group
PTSD	Posttraumatic Stress Disorder
PWC	Psychotherapy Written Case
QA	Quality Assurance
RACP	Royal Australasian College of Physicians

Glossary of Terms

Abbreviation	Term
RACS	Royal Australasian College of Surgeons
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RAP(s)	Reconciliation Action Plan(s)
RCPsych	Royal College of Psychiatry, United Kingdom
RCPSC	Royal College of Physicians and Surgeons of Canada
RCT	Randomized Controlled trials
RPL	Recognition of Prior Learning
rTMS	Repetitive Transcranial Magnetic stimulation
RCPsych	Royal College of Psychiatrists, United Kingdom
SACME	Society for Academic Continuing Medical Education
SAT	Subcommittee of Advanced Training
SCARP	Substantial Comparability Review Panel
SCOT	Site coordinators of training
SEN	Electroconvulsive Therapy and Neurostimulation
SGL	Self-guided learning
SIMG(s)	Specialist International Medical Graduate(s)
SP(s)	Scholarly Project(s)
SPRP	Specialist Performance Remediation Program
SRP	Section of Rural Psychiatry
SRWG	Syllabus Review Working Group
SST	Specialists Specified Training
STP	Specialist Training Program
STSP	Specialist Trainee Support Program
TNA	Tri-Nations Alliance
TOR	Terms of Reference
TRC	Trainee Representative Committee
VEAB	Vocational Education and Advisory Body
VPTPC	Victorian Psychiatry Training Program Committee
WBA(s)	Workplace-based Assessment(s)

Glossary of Terms

Abbreviation	Term
WCAP	World Congress of Asian Psychiatry
WG	Working Group
WPA	World Psychiatric Association
WSC	Writtens Sub Committee

Definition and use of term Indigenous. The term Indigenous is used as a collective term for both Aboriginal and Torres Strait Islander peoples and Māori, e.g. Indigenous psychiatry or Indigenous Entrustable Professional Activity (EPA). Where possible culturally specific terms of Aboriginal and Torres Strait Islander peoples and Māori are applied.

Part A: Executive Summary

Part A: Executive Summary

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand. As a leader in the mental health sector, the College works to prepare medical specialists in the field of psychiatry, support and enhance clinical practice, advocate for people affected by mental illness and advise governments on mental health care.

Initially established as the Australasian Association of Psychiatrists on 9 October 1946, the College was officially incorporated under the Companies Act on 28 October 1963 and the first formal meeting of the new Council was held on 25 October 1964.

This submission has been prepared with input from Fellows and College Staff.

Against each of the ten standards, the Executive Summary provides a summary of:

- significant developments both undertaken and planned
- the strengths and achievements of the College
- current challenges in the delivery of the Fellowship program.

The Executive Summary concludes with a brief comment on the impacts of the restrictions related to the COVID-19 pandemic on the Fellowship program.

Standard 1. The context of training and education

Significant changes to the Constitution and governance of the RANZCP have occurred since the last accreditation by the AMC to enhance engagement with the establishment of:

- a Membership Advisory Council providing advice to the RANZCP Board
- a contemporary Board structure
- six constituent Board committees
- the addition of four Faculties and seven Sections to bring the total to seven Faculties,12 Sections and seven Networks representing areas of practice and special interests in psychiatry.

Developments in governance include the refinement and standardisation of Committee regulations, separating the operational requirements from the specific purposes of the Committee.

Consultation regarding further constitutional reform to provide voting rights in Board elections and the AGM to Associates (trainees) and Affiliates is underway. Associates and Affiliates who participate in College committees have full voting rights.

A review of the Faculties, Sections and Networks is currently being undertaken by the Board, the outcomes of which will impact on the structure and educational activities of the College.

Of critical significance to the educational purpose of the RANZCP is the consultation currently being undertaken to inform the future of assessment for the Fellowship program, with specific consideration of a move to better integration of assessment with training, rationalising the current assessments and the feasibility of a more holistic and longitudinal approach in contrast to the use of high stakes summative assessments. The outcome of this consultation will inform changes to be implemented in coming years.

A strength of the College related to the context of training and education is its ability to reflect on current practices, and to adapt its governance in response to changed circumstances. Key to this has been the engagement of the Fellowship in their College and their support with supervision, examining, governance and the development of guidelines and position statements which set the context for clinical practice and the training environment. Their support has been critical during the last two years in response to the challenges of COVID-19.

Engagement with people with lived experience of mental illness is a strength of the College, with representation of consumers on many College committees, with full voting rights.

Genuine engagement with the community is a cornerstone of the RANZCP. People with experience of mental illness (also referred to as consumers), their carers and families/whānau have unique expertise to help shape mental health policy and practice. Their needs, perspectives, concerns, and values influence RANZCP decisions at all levels. Through participation in committees and other groups, consumers and carers contribute to the training, assessment and accreditation of psychiatrists, mental health policy direction and internal operations of the RANZCP. Position statement 62 has been co-produced by those with a lived experience of a mental health condition and psychiatrists.

This position statement recognises the value of and makes a commitment to partnering with people with a lived experience of a mental health condition (those with a lived experience). Partnering with people with a lived experience involves strong engagement, and valued contributions to clinical governance and quality improvement processes.

Partnering with and engaging with people with a lived experience forms an important part of the history of the RANZCP. The RANZCP affirms the principles of co-design and co-production in mental healthcare and recognises the evidence-base that details its effectiveness in improving health practice and outcomes.

The RANZCP's diversity has increased since the last accreditation, with gender parity amongst trainees and an increasing number of both trainees and Fellows identifying as Aboriginal and Torres Strait Islander or Māori.

The College has made significant progress to address mental health workforce issues through its advocacy, good relationships and engagement with national and jurisdictional governments in Australia and New Zealand. In addition to the significant contribution to training through the Australian Government funded programs such as the STP, IRTP and the MVPTP, the RANZCP has secured support for the enhancement of training opportunities to psychiatry trainees and other medical practitioners through the Rural pathway, Psychiatry Interest Forum and the development of a Diploma of Psychiatry. At a jurisdictional level increased funding has been secured for training in Queensland, New South Wales and Victoria.

Achievements have been made with the digital capacity of the RANZCP and its educational programs. A bespoke trainee management system, InTrain has been introduced which has led to considerable efficiencies in the training experience. The College's Learning Management system, Learnit, has successfully transitioned to a new platform with greater functionality which is now being explored. The RANZCP Fellowship has successfully transitioned to an online CPD portfolio, My CPD which has also been moved to a more contemporary cloud-based technology. The Psych Matters podcast series has been launched and has established a significant audience in a short time.

The RANZCP relies heavily on, and greatly values the voluntary and dedicated contributions of many Fellows, trainees and SIMGs with educational expertise and experience. These members provide valuable contributions to the RANZCP, to its educational activities, projects, and programs. Examples include the PIF volunteers, mentors, Taskforce members and current Expert Advisory Group for the establishment of the Diploma of Psychiatry. The countless hours of pro bono work form the backbone of the RANZCP, despite pressures on members and services due to the pandemic

The increasing burden on Fellows actively engaged in the life of the College is a challenge. Their work is pro bono and service delivery pressures are contributing to an increasing lack of support by employers and health services for education and training as core work for psychiatrists. In Australia, the increasing shift of psychiatry practice to the private sector presents both challenges and opportunities. Private practice psychiatry presents significant opportunity for trainees to gain experience in the management of high prevalence low acuity mental illnesses such as anxiety and depression in contrast to the acute inpatient sector which provides experience in the very acutely unwell psychiatric patient.

Addressing Māori health is an area for growth that is distinct for Aotearoa New Zealand. The RANZCP has developed a position statement as a first, important step in the journey of the RANZCP to ensure that members and staff understand the implications of Te Tiriti in all our mahi/ work. To support this journey the RANZCP will develop a plan outlining the necessary actions required by the RANZCP to enact the principles of Te Tririti. The RANZCP will also move to ensuring communications (oral, written and web-based) reflect Te Tiriti and culturally appropriate wording, imagery and content. This activity includes acknowledging and honouring Te Tiriti in key RANZCP documents.

To achieve these goals, the members and staff must be culturally safe. The RANZCP is committed to developing a plan to implement a Māori cultural safety/ competence program for RANZCP committees, consultants and trainees. The Takarangi Competency Framework is an example of a program that supports a greater understanding of Te Ao Māori, including Whānau Ora. The aim of the program is to encourage ongoing development of culturally safe practice and skills within the mental health and addiction sector.

Standard 2. The outcomes of specialist training and education

There have been no significant changes to the program and graduate outcomes since the last accreditation by the AMC.

The graduate outcomes are clearly articulated as the Fellowship competencies and mapped against the CanMEDS Framework, which forms the basis for the Fellowship program. The current review of RANZCP assessment, with its intention to improve the alignment of training and assessment, offers an opportunity to revisit the Fellowship Program and graduate outcomes. Significant change is unlikely however the work currently being undertaken towards a single framework that illustrates program and graduate outcomes mapped against workplace-based and centrally administered summative assessments will provide greater clarity.

As mentioned under Standard 1, there is gender parity in the trainee cohort, and this is supported by the flexibility of the Fellowship program. It is important that there is not undue focus on the achievement of Fellowship in five or six calendar years, as the flexible nature of the program has contributed to the achievement of gender parity and support of family commitments. At least 50% of trainees achieve Fellowship in less than six calendar years.

The development of a new Reconciliation Action Plan at the Innovate stage of Reconciliation Australia's RAP Framework is a piece of work that is currently underway that will impact positively on the College's progress with cultural safety and engagement with Indigenous people.

Building on prior Aboriginal and Torres Strait Islander initiatives is a complex yet necessary area for the RANZCP to continue to grow. Reconciliation is an approach that can help address the issues that impact on achieving good mental health outcomes for Aboriginal and Torres Strait Islander peoples. The RANZCP, guided by our Aboriginal and Torres Strait Islander Mental Health Committee is developing our first Innovate Reconciliation Action Plan (RAP). The RANZCP will engage with all key stakeholders, Reconciliation Australia and AIDA to continue our journey and furthering the RANZCP's accountability by pushing the boundaries and providing valid indicators that will inform meaningful targets in the next version.

The review of the role and merit of the FECs is a significant undertaking that must be conducted with care to ensure that recommendations are clear and achievable. The scope of the review is being determined prior to the formation of the working group later in 2022.

Standard 3. The specialist medical training and education framework

A number of developments relevant to this standard are currently underway, including the:

- development of an overarching Assessment Framework, integrating assessment and training
- review of the Entrustable Professional Activities (EPAs), with an opportunity to embed cultural safety into the redesign and to rationalise the number of EPAs
- review of the syllabus.

A strength of the RANZCP in relation to this standard is its work on shared decision-making which has progressed significantly over recent years, along with the contribution of people with lived experience to the Fellowship program.

Challenges in this space include embedding cultural safety training and culturally safe practice into all aspects of the specialist medical training and education framework in a way that is meaningful and respectful of the diversity across Australia and New Zealand. There is strong support for trainees to experience Tikanga Māori in an interactive marae setting rather than in a more passive way, and this presents challenges to delivering this experience to the bi-national trainee cohort.

Whilst there is a clear integration for trainees from the PGY medical environment, the integration with the CPD space is less well defined and there is opportunity for the RANZCP to develop a better articulation between the Fellowship program and the CPD program.

Standard 4. Teaching and learning

The great strength of the RANZCP Fellowship program is its workplace-based training, providing authentic and broad-based experiential learning across many settings and with many supervisors.

However, the RANZCP recognises that there are many opportunities for development to improve the program. A review of the EPAs commenced in 2021 and will result in refinement and simplification of the EPA framework more reflective of contemporary educational practice. Critical to the successful utilisation of EPAs are the RANZCP's supervisors, and a supervisor support project has commenced in 2022. Following an initial survey, several recommendations have been made for further exploration, including the development of a role description, supervisor capability framework and further training.

The completion of the syllabus review, anticipated for 2022, will be a key input into the review of the FEC role and purpose, which will commence later in 2022.

The work on supervisor support will contribute to resolution of one of the challenges related to this standard. The Fellowship program relies on its supervisors, Fellows who undertake this role in addition to their clinical duties in health services that are under increasing pressure. The calibration of supervisors, and the support they are provided, are areas for improvement recognised by the RANZCP for the further development of its workplace-based training.

How cultural safety is embedded into the Fellowship program has already been identified as a challenge. An additional challenge is the limited numbers of Child and Adolescent and Consultation- Liaison posts in some jurisdictions. These experiences are mandatory elements for learning, and bottle necks in some programs limit the ability to increase the number of trainees. The College is aware of these challenges and is currently considering an appropriate way forward.

Standard 5. Assessment of learning

A key strength of the assessment of learning in the RANZCP Fellowship Program, that has proven invaluable in the response to the failure of the November 2021 AVOSCE, has been workplace-based assessment and the Fellows who undertake this assessment activity in their pro bono role as supervisors. The quality of the workplace-based assessment provided the basis for the development of the Alternative Assessment Pathway (AAP) as a response that could be quickly deployed.

There are also multiple potential points where trainees who are struggling can be identified and supported to achieve competence, both through the centrally administered summative assessments but also the mid- and end- of-rotation In Training Assessments.

Assessment has been an area of development for the RANZCP over several years prior to the changes precipitated by COVID-19. The MCQ was introduced in 2014, and was rapidly moved to online, rather than paper-based delivery. The introduction of online applications and results letters integrated into InTrain, the strengthening of psychometric analysis of the written examinations, the reduction in the number of items in the Modified Essay Question (MEQ), and the introduction of the Direct observation of Practice as an additional Workplace-Based Assessment (WBA) were all significant improvements.

Recognising that trainees were reporting an increased burden of assessment, and in response to a pass rate in the former written examinations that was consistently low in comparison to the pass rates of other summative assessments, ACER was commissioned to conduct a review of the RANZCP assessment processes. This report was delivered in January 2020, with recommendations that have been accepted by the RANZCP for implementation. These include the key recommendation for the development of an assessment framework that integrates the centrally administered summative assessments, workplace-based assessment, and training into a map against desired Fellowship competencies and graduate outcomes. Development of an assessment blueprint is also planned. This work is currently underway.

Another recommendation that has been implemented is the decoupling of the centrally administered written examination into the MEQ and Critical Essay Question (CEQ) examinations.

The RANZCP has experienced significant challenges in assessment over the last two years, particularly with the centrally administered summative clinical examination, the OSCE. Early attempts at an AVOSCE were successful but not scalable to meet the candidate demand. A multi-site OSCE proved not to be COVID-19 proof and presented significant logistical and resource challenges that also limited its usefulness as an assessment of large numbers of candidates. The AVOSCE in November 2021, using an external provider, had a failure of technology leading to very few candidates progressing through all stations in the morning session, and the subsequent decision to cancel the afternoon session. The RANZCP has acknowledged the significant impact that this has had on trainees.

The delivery of results letters to candidates in a timely manner is identified by the College as an area that requires further work, and it is hoped that some of the work underway will assist in improving efficiencies in this area.

COVID-19 has accelerated change in many areas, including the following developments which are currently underway:

- the introduction of online submission of the SP and PWC assessments
- online applications and payment for the OSCE, SP and PWC
- anti-plagiarism software
- the transition of all written examinations to an online format.

A review of the assessment strategy for the RANZCP Fellowship program is underway. This is a significant recent development, involving consultation with stakeholders and the engagement of external expertise to explore a move away from high stakes summative assessment as hurdles that must be passed for progression to a more holistic approach that is based on assessment **for** learning rather than assessment **of** learning. This approach would be based on:

- programmatic assessment using instructional design focussing on stimulating learning through assessment, sampling in authentic contexts, and combining different methods into programs taking advantage of and building on the significant foundations already in place including WBAs, EPAs and In Training Assessments (ITAs).
- concepts of fairness that are built on a shared objectivity that utilises expert judgement and ensures reliability through increased sampling of candidate performance
- feedback systems that not only provide feedback to individual candidates but develop a feedback culture that informs all aspects of the pathways to Fellowship programs.

Movement towards more fully realising a programmatic assessment approach has the potential to address the burden of assessment. Adopting a recommendation for front loading of some key assessments of knowledge would assist in reducing late-stage bottlenecks and barriers, as well as provide timely feedback to assist trainees in career decisions. These changes would require the development of a stronger culture of feedback, and require investment and effort to engage all stakeholders with the need for increased responsibility, improved quality of feedback, and rigour. This work is also dependent on the work being done to review the EPAs and the syllabus review, and changes would not be expected to be introduced until 2024 at the earliest.

A more immediate challenge is an alternative to the OSCE for the second half of 2022 and potentially for 2023. The College has formed the view that large scale, single site OSCEs, and MSOSCEs are not feasible, and an alternative must be found. Stakeholder consultation indicates that the preferred options for an alternative to the OSCE are a continuation of the current AAP, or an enhanced version of the AAP that includes increased data from the workplace-based assessments for the portfolio review and a mandatory case-based discussion for all candidates.

Standard 6. Monitoring and evaluation

There are many developments that have been completed or are underway in the area of monitoring and evaluation, including for example the:

- ACER review of assessments
- evaluation of the impact of the decoupling of the MEQ and the CEQ
- review of the syllabus
- EPA review
- review of the role of the FEC in the Fellowship program
- review of the Comparability Assessment Framework for SIMGs
- audit of the eLearning catalogue
- evaluation of the AAP, both the Portfolio review and case-based discussion elements.

A strength of the RANZCP is its willingness to embrace review, and the contribution that trainees have made and continue to make to evaluation, an example of which is the Exit Survey with a response rate of over 50%. Paradoxically a challenge is the engagement of trainees in accreditation activities in the online environment and in providing feedback on FEC content and delivery.

An additional challenge is obtaining community and consumer feedback. The consumer representatives on education committees provide valuable input, however obtaining the views of the broader community is very difficult.

Standard 7. Trainees

The failure of the November 2021 AVOSCE has understandably contributed to a climate of general trainee dissatisfaction. The RANZCP acknowledges that engagement with trainees and the provision of certainty in regard to assessments is essential to improve the satisfaction of trainees. An exacerbating factor is the increasing tension between service delivery in strained health services and the requirements of training. The balance between service delivery and training is becoming more difficult to achieve and this is a factor that is not under the complete control of the RANZCP.

The College has recognised the importance of clear, supportive, and contemporary means of communications with its membership. Following the November AV OSCE failure, the RANZCP received significant feedback regarding its communication style and frequency. Following this time, the College has reflected and is committed to communicating to its members in an engaging and supportive manner.

Weekly communications are released from the President, providing the wider membership with updates on College activities and initiatives. Weekly communications are also sent to participants in the AAP to ensure all candidates are aware of progress.

However, the RANZCP acknowledges further work is needed in this area. In recognition of the importance of this, further resources are being recruited to support the development of strategic communications strategies. An external consultancy firm has also been appointed to support the proactive media work undertaken by the College and its members.

Two other significant challenges relevant to this standard are the implications of the revised national Framework for Prevocational Medical Training which proposes a mandatory two year post graduate program. As the RANZCP allows entry to Fellowship programs at the end of PGY1, the introduction of a mandatory PGY2 year, with EPAs and a separate reporting system raises concern about an increased burden of assessment for RANZCP during stage 1 training.

Developments underway include the structural reform of the TRC, agreed in principle by the RANZCP Board which will provide an enhanced structure allowing greater engagement of trainees in the governance of their training program. Constitutional change, aimed at giving Associates and Affiliates voting rights is again being pursued. The appointment of an Appointed Director, Trainee to the RANZCP Board is an important recent development that provides greater engagement of trainees in the governance of the College.

The review of the fee structure, currently underway, should also provide some additional relief to trainees.

The increasing numbers of new applicants for training, that in many jurisdictions now outnumber available Stage 1 places, is both a strength and a challenge. The increasing numbers, necessary to increase the number of psychiatrists in the workforce, are not always matched by an equivalent increase in the DOT and administrative resourcing provided by jurisdictional governments.

The increasing numbers of trainees who identify as Aboriginal and Torres Strait Islander and Māori is pleasing and provides even more reason to address the challenges of embedding culturally safe practice across all aspects of the College, including the Fellowship program.

Standard 8. Implementing the program – delivery of education and accreditation of training sites

A key strength of the Fellowship Program is the engagement of the Fellowship in the supervision of training, with the number of accredited supervisors far more than the number of trainees. The number of supervisors does present some challenges with calibration as workplace-based assessors and with the consistency of assessments and assessment standards in the workplace. This is being addressed through the Supervisor support project which includes the development of a role description and supervisor capability framework along with further training in topics of interest identified by supervisors. Mechanisms to provide structured feedback to supervisors on their performance as assessors, including benchmarking of their performance against their peers and including feedback from trainees, require further development. With the introduction of InTrain there is now more readily available data on the workplace-based assessment and there is opportunity to harness this to provide feedback to supervisors. However, it is also important to note that in the expert judgement of Portfolio Review Oversight Panel (PROP) in the AAP, ITAs appear to capture nuanced and accurate information about trainees, allowing a consistent picture of trainee performance across supervisors and rotations.

Despite the number of supervisors, the pressures of service delivery in an increasingly stressed health system are impacting on their willingness to extend their pro bono work for the College.

The College's accreditation processes, where posts and programs are accredited rather than training sites is a strength, providing a more granular approach to accreditation. If there are issues with one rotation/post at a health service, accreditation is removed from that post rather than from the entire health service.

Developments since the last AMC accreditation include the separation of the Accreditation Subcommittee from the CFT in 2014 and its establishment as a committee of equal standing. The development of policy has codified practice and the introduction of a guideline regarding appropriate workloads in the acute adult inpatient setting has provided valuable guidance to DOTs, and clinical service directors.

The Standards for Programs, Posts, and FECs have all been reviewed and revised.

Standard 9. Continuing professional development, further training and remediation

There have been significant developments in CPD since the last accreditation by the AMC. Completion of CPD became mandatory for the maintenance of Fellowship in 2017 and the first online My CPD portal was launched. The original My CPD was upgraded in 2019 to a more user-friendly web-based platform offering an improved experience for users, and has been further upgraded in 2020 to offer improved performance on mobile devices.

My CPD has permitted the annual audit to move completely away from a paper-based submission to an online process that has provided significant efficiencies. Further efficiency for the management of member's CPD queries had been provided by the extension of the College's Help Desk application for the CPD administrative team.

Further developments include the review of MSF tools, the introduction of the Practice Peer Review program and a dedicated CPD newsletter. The addition of an online PDP function to My CPD will provide an additional option for members to the suite of PDP templates already provided.

Additional governance arrangements have been introduced for the endorsement of rTMS courses at the request of the Australian Department of Health to provide a level of quality assurance to the delivery of rTMS under the Medicare Benefits Schedule.

The use of the full functionality of the LMS through the development of Learning Paths is a development that will provide extended opportunities for CPD for members. Learning paths are curated collections of resources such as eLearning modules, webinars, podcasts, journal articles and College documents on a particular topic, providing an easier way to find content and a greater visibility of key clinical policy and position statements to the Fellowship.

A key change to the CPD program is the redistribution of the allocation of hours in response to the revised registration standard that takes effect in Australia from 1 January 2023. Changes to the program in response to the MCNZ strengthened requirements for recertification have also been introduced.

The introduction of the CPD Homes in Australia, and the need for the RANZCP to not only leverage its significant body of expert content, but to ensure that competitors do not benefit financially or reputationally from the use of that expert content will be a challenge in coming years. The RANZCP is confident that it will meet the criteria for recognition as a CPD Home, and looks forward to the opportunity to expand its CPD offerings and improve the vertical integration with the Fellowship Program.

Standard 10. Assessment of specialist international medical graduates

The review of the Comparability Assessment Framework is underway and is expected to provide recommendations for changes to the framework that will reduce the number of borderline assessments, providing greater certainty to both candidates and assessors.

There are two main challenges relating to this standard. Following a reduction in the number of SIMG candidates due to border closures there is an anticipation that applications will increase significantly in the next couple of years. The other challenge is the increasing number of appeals and requests for reconsideration that are being lodged. Addressing these in a way that ensures procedural fairness is observed is vital despite being resource intensive and takes increasing space on the agendas of the CSIMGE and EC.

The impact of COVID-19

COVID-19 has had a disruptive influence on both the practice of psychiatry and the operations of the RANZCP.

The pivot to the digital environment was not confined to clinical practice, it became the "new normal" for trainees for their FECs, for the Peer Review Groups that are the cornerstone of the CPD program, and as a substitute for face-to-face conferences and workshops. Overall this has worked well and whilst the ability to return to face to face meetings is welcomed, it is clear that elements of the digital way of working have become embedded. Many Peer Review Groups intend to continue with online meetings or a hybrid arrangement of online and in person meetings. The series of online webinars introduced in 2020 as a replacement for the cancelled Congress were very successful, meeting a need for CPD that is accessible.

The operations of the College were moved online from March 2020 when the directive to work from home was implemented. As the College head office is in Melbourne, the majority of central College functions have been conducted remotely since March 2020. This was achieved with minimal disruption to business as usual and staff have continued to meet the operational requirements of the College. Initially telephone communication was limited, however the College's Information Technology team successfully implemented remote technologies enabling the resumption of telephone services. Meetings successfully transitioned to platforms such as Zoom and MS Teams. Committees prefer this technology to the previous teleconference technology and will continue to use it as part of their regular schedule of meetings.

Interviews for SIMG applicants, and CBD assessments for substantially comparable candidates have moved successfully to the online environment and it is likely that this will continue in the future.

Accreditation activities, including accreditation of training programs and FECs, have also moved to the online environment, albeit with some challenges. In comparison to the usual face-to-face accreditation visits it has proven to be more difficult to engage the trainee body in interviews with the panel. This phenomenon has also been observed in committee meetings, where if a doctor is not physically at a meeting away from the ward or health service, they are considered to be available for clinical duties.

Changes were introduced to the Fellowship Program, with flexibility and extensions for trajectories, and "no disadvantage" with respect to expected training progression being applied to several assessments. The most significant impact for trainees was with the centrally administered summative assessments. The change to electronic submission for the Scholarly Project and the Psychotherapy Written Case was successful for both trainees, staff and examiners. For the written examinations such as the MCQ, MEQ and CEQ, reserve papers have been introduced to manage the cancellations associated with COVID-19. These have been implemented for candidates who have been required to miss an examination due to COVID-19 restrictions, and also for candidates who were impacted by the floods in Queensland and NSW in 2022.

The most visible impact of COVID-19 has been on the OSCE, with the cancellation of single site OSCEs in 2020 and the subsequent iterations of the OSCE (AVOSCE and MSOSCE) before the technology failure of the November 2021 AVOSCE for more than 200 candidates. The response to this has required significant reflection by the RANZCP on how trainees and SIMGs are assessed, and the quality of engagement with trainees and SIMGs. It is clear that the OSCE in its traditional format is sensitive to COVID-19 and therefore is not a feasible option for the immediate future. The future assessment strategy is currently being developed and consultation is underway with stakeholders and education specialists.

Standard 1: The context of training and education

Standard 1: The context of training and education

1.1 Governance

1.1.1 The education provider's corporate governance structures are appropriate for the delivery of specialist medical programs, assessment of specialist international medical graduates and continuing professional development programs.

Since the last Australian Medical Council (AMC) accreditation in 2012, a revised Constitution was adopted via Special Resolution on 3 May 2017. Amendments to the Constitution included:

- references in relation to International Corresponding Membership
- rules relating to the suspension of membership
- a reference to Associate Membership and Affiliate Membership only taking effect following payment of the prescribed fee
- differentiating the New Zealand National Committee in recognition of its national status
- clarifying that Exemption from Fees can only be given to Fellows who have reached 65 years of age, and been a Fellow of the RANZCP for at least 30 years
- inclusion of the Australian Charities and Not-for-profits Commission to recognise the RANZCP's charity status
- removal of Article 11.6.9 in relation to Cessation of Office of a Director, as this is inconsistent with Articles pertaining to the election and appointment of Directors.

Since the last AMC accreditation in 2012, corporate governance structure changes include the establishment:

- of the Members' Advisory Council (MAC) in May 2013, which provides information and advice to the Board on a variety of matters, and acts as a forum to raise and discuss issues and provide feedback. MAC represents all Australian Branch and New Zealand National committees, Faculties, Sections, trainees, overseas trained psychiatrists, the RANZCP's Aboriginal and Torres Strait Islander and Māori mental health committees, and community members.
- of six Board constituent committees, including the Audit Committee; Finance Committee; Corporate Governance and Risk Committee (CGRC); Education Committee (EC); Membership Engagement Committee; and Practice, Policy and Partnerships Committee (PPC). Each is Chaired by an Elected Director with an additional Board Member appointed to each. Except for the Audit Committee and Finance Committee, each Board constituent Committee has a Trainee and Overseas Trained Psychiatrist member. The EC also has a Community Member
- of eight Australian Branch Committees, and a Zealand National Committee (Tu Te Akaaka Roa) whose purposes are to promote discussion and cooperation among members of the relevant Branch and the community relevant to the discipline of psychiatry. The Branch/New Zealand Committees report to the Board and a Board Member is Ex-Officio of the Committee should they reside in that jurisdiction. These Committees include Trainee and Overseas Trained Psychiatrist members and where possible, Community Members
- of Faculties. From the conclusion of the RANZCP's Annual General Meeting (AGM) in May 2015, all groups with an associated RANZCP advanced training program became known as Faculties. Faculties represent an internationally recognised body of knowledge in psychiatry in the opinion of the Board. At present there are seven established Faculty Committees under Regulations, including the:

o Faculty of Addiction Psychiatry

o Faculty of Adult Psychiatry

o Faculty of Child and Adolescent Psychiatry

o Faculty of Consultation-Liaison Psychiatry

o Faculty of Forensic Psychiatry

o Faculty of Psychiatry of Old Age

o Faculty of Psychotherapy.

- of Sections. Also from the conclusion of the RANZCP's AGM in May 2015, Special Interest Groups became known as Sections. Sections represent an interest group in psychiatry and satisfy other conditions determined by the Board. Membership of Sections is in accordance with the Section's membership criteria outlined within the Section Membership Regulations and is open to all Members of the College as determined by the Board. At present there are 12 established Section Committees under Regulations, including the:

o Section of Child and Adolescent Forensic Psychiatry

o Section of Early Career Psychiatrists

o Section of Electroconvulsive Therapy and Neurostimulation

o Section of History, Philosophy and Ethics of Psychiatry which has in 2021 become the Section of Philosophy and Humanities

o Section of Leadership and Management

o Section of Neuropsychiatry

o Section of Perinatal and Infant Psychiatry

o Section of Private Practice

o Section of Psychiatry of Intellectual and Developmental Disabilities

o Section of Rural Psychiatry

o Section of Social and Cultural Psychiatry which in February 2020 became the Section of Social, Cultural and Rehabilitation Psychiatry

o Section of Youth Mental Health.

- Networks and Network Committees were re-established by the Board in 2017. Networks represent broad areas within psychiatry, are less formal than Faculties or Sections and membership is not limited to Members of the College. At present there are four Network Committees established under Terms of Reference:

o Family Violence Psychiatry Network

o Asylum Seeker and Refugee Mental Health Network

o Military, Veterans', and Emergency Services Personnel Mental Health Network

o RANZCP Attention Deficit Hyperactivity Disorder (ADHD) Network.

There are also three Networks specifically for Partners, Consumer and Carers, and Nursing related to the Section of Electroconvulsive Therapy and Neurostimulation.

Other than for the RANZCP ADHD Network which reports to the Bi-national Faculty of Adult Psychiatry Committee, all report directly to the Board.

- of other ongoing Committees, Subcommittees, Review Panels, Advisory Groups established for a specific purpose. Almost a third of these relate directly to education and training
- of the RANZCP Foundation Committee, to support the research and educational endeavors of RANZCP members, by promoting research and fostering innovation and partnerships to build knowledge and skills.
- of the Executive Meeting which is Chaired by the President and reports to the Board. It ensures all day-to day RANCZP matters are addressed
- of time limited Steering Groups, Advisory Groups, Working Groups, and Oversight Panels, with Terms of Reference that allow for governance to be established for the Groups in a timely manner
- of a number of groups and committees relating to Government funding, including the Psychiatry Interest Forum Advisory Group (PIF), the Australian Government Funded Training Programs Committee (AGFTPC) (formerly the Specialist Training Program (STP) Committee) and the Tasmanian STP Project Working Group (TAS STP).

In relation to Associate (Trainee) and Affiliate stakeholder voice, a Special Resolution was put to the Fellowship to go to ballot in 2016 to include Affiliates and Associates as voting members under the Constitution. The result of the ballot was that the proposed resolutions were not carried. However, it was acknowledged that Affiliates and Associates will retain voting rights at a committee level.

The Board has remained committed to working with Affiliates and Associates to increase their involvement in College activities and to identify avenues for greater engagement. In relation to Trainees in particular, the Board has co-designed with the Trainee Representative Committee (TRC) a model of representation across the RANZCP committees. This model has evolved over time with consideration being undertaken in 2017/2018, and again in 2020.

In 2018 a Committee Meeting Operations Regulations was approved by the Board. These Regulations (provided as Appendix 1.1.1_1) are generic to all College Committees* (not relevant to Advisory Groups, Oversight Panels or Steering Groups) and are to be read in conjunction with the Committee Regulations/Terms of Reference. A program of work is underway to consider and remove the operational content that appears in Regulations/Terms of Reference.

In September 2020, the Board announced an external review to undertake analysis of the RANZCP's Faculty, Section and Network structures, to determine if these support the College's generalist FRANZCP qualification, how they support the needs of the communities being treated, and how the RANZCP should maintain and enhance its generalist workforce. This follows the strong messaging from governments in Australia and New Zealand of the importance of a generalist workforce. To complement this review, the RANZCP will also consider how best to support, resource and develop its current committees, support the needs of the membership and develop a structure that will sustain growth and development into the future. This review is presently in progress.

A visual representation of the RANZCP governance structure can be found in the RANZCP Website (current-board-and-committee-governance-org-chart-1.aspx (ranzcp.org)), and is provided as Appendix 1.1.1_2.

Categories of fellowship and membership

Members of the RANZCP are part of a collegiate network of psychiatrists across Australia and New Zealand, and have access to resources, programs and events that ensure the highest standard of practice in psychiatry. The College has four membership types:

- **Fellow**: Qualified psychiatrists who have successfully completed the RANZCP training program, or otherwise met the requirements for Fellowship of the RANZCP
- **Associate**: Trainees currently enrolled in the RANZCP training program in psychiatry
- **Affiliate**: Overseas-trained psychiatrists currently working in the field in Australia or New Zealand
- **International Corresponding Member**: Specialist qualified psychiatrists outside of Australia and New Zealand.

* A Committee may be known as a committee, subcommittee, council, network, review panel, or working group.

The College has over 7,400 members, including more than 5400 qualified psychiatrists (consisting of both Fellows and Affiliates of the College) and almost 2000 members who are training to qualify as psychiatrists (referred to as Associate members or trainees).

Table 1.1.1_1. RANZCP membership (Snapshot as 31 December 2021)

Category	Total	Australia	New Zealand	Overseas
Total	**7,413**	**6,308**	**930**	**175**
Fellows	5,172	4,564	454	154
Associate	1,967	1,722	240	5
Affiliate	262	22	236	4
International Corresponding Member	12	-	-	12

1.1.2 The education provider has structures and procedures for oversight of training and education functions, which are understood by those delivering these functions. The governance structures should encompass the provider's relationships with internal units and external training providers where relevant.

Reporting directly to the RANZCP Board, the EC is responsible for formulating and developing strategic education policy advice for the Board on all matters relating to Fellowship and the award of certificates of advanced training. The EC also ensures that the activities and responsibilities of the constituent Committees are directed to ensuring a collaborative approach.

The EC has several constituent committees which are responsible for the educational functions of the College.

Committee for Specialist International Medical Graduate Education (CSIMGE)

The CSIMGE is a bi-national committee that oversees policies and procedures associated with Specialist International Medical Graduates (SIMG) seeking permanent registration as a psychiatrist in Australia or New Zealand and/or seeking to be employed in an Area of Need (AON) position. The CSIMGE has two Review panels reporting to it – the Substantial Comparability Review Panel (SCARP) and the Partial Comparability Review Panel (PCARP).

Committee for Examinations (CFE)

The CFE is a bi-national committee that prepares, administers, and determines the outcomes for centrally administered summative assessments. The CFE regulates the conduct of the summative assessments that lead to the progress of candidates through the training program. The primary responsibilities of the CFE include the development of policies in relation to the examinations, development and oversight of the criteria and standards of performance to satisfy the rules and processes of the College, and the conduct and reporting on College examinations, including the preparation of examination papers.

The CFE has five subcommittees aligned to the summative examinations:

- Case History Subcommittee
- Written Examination Subcommittee
- Objective Structured Clinical Examination Subcommittee
- Scholarly Project Subcommittee
- Multi-site OSCE Steering Group.

Committee for Training (CFT)

The CFT is a bi-national committee that oversees and administers the regulations of the College's Fellowship training program(s) and Certificates of Advanced Training in subspecialty areas. It implements and monitors the operation of the training program, monitors the progress of trainees and oversees all activities of its constituent advanced training subcommittees, other sub-committees and working groups.

The CFT has seven subcommittees aligned to advanced training:

- Subcommittee for Advanced Training Addiction Psychiatry
- Subcommittee for Advanced Training Adult Psychiatry
- Subcommittee for Advanced Training Child & Adolescent Psychiatry
- Subcommittee for Advanced Training Consultation–Liaison Psychiatry
- Subcommittee for Advanced Training Forensic Psychiatry
- Subcommittee for Advanced Training Psychiatry of Old Age
- Subcommittee for Advanced Training Psychotherapies Psychiatry.

CFT also oversees the eight Branch Training Committees (BTCs) and the New Zealand Training Committee (NZTC). Committees are responsible for the local oversight and implementation of the College Fellowship program, including the application and selection process for new trainees. In September 2013, the Board approved a new education governance model to take effect from May 2014. In Australia, there are differences between the multi-training zone states (New South Wales and Victoria), the large single zones states (South Australia, Western Australia and Queensland) and the small single zone territories and state (Northern Territory, Australian Capital Territory and Tasmania).

In New Zealand, the central training committee has five regional training zones and is overseen by subcommittees.

The Directors of Training (DOT) Advisory Group reports to the CFT.

Committee for Educational Evaluation, Monitoring and Reporting (CEEMR)

CEEMR is a bi-national committee of the College, and its role is to facilitate the review of education and training activities through the design, conduct and reporting of evaluations and reviews. The Committee monitors annual reporting requirements across the Education portfolio and broader College, as well as providing assistance and support to other committees undertaking their own evaluation, research or monitoring activities.

Committee for Continuing Professional Development (CCPD)

The CCPD is responsible for setting policy and implementing the Continuing Professional Development (CPD) program for psychiatrists in Australia and New Zealand. It is responsible for the design, promotion, and administration of the CPD program to ensure the continued high standards of psychiatry practice. The CCPD provides advice on the development of CPD policies and programs, including remediation and refresher programs and guidance on the alignment of individual member's CPD activities with the CPD program as required.

The Repetitive Transcranial magnetic simulation (rTMS) subcommittee was established in 2021 to assess and endorse programs of training in the delivery of rTMS in response to a request from the Australian Department of Health.

Accreditation Committee (AC)

The Accreditation Subcommittee was established under the CFT in 2012. In recognition of the conflict of interest inherent in the CFT assessing its own programs, the AC became a constituent committee of the Education Committee in 2014. Accreditation panels report to the AC the findings of their assessments against the standards.

The AC is responsible for the accreditation of training programs in Australia and New Zealand. The AC ensures transparency in the accreditation of rotations/runs and training programs through accreditation standards. The standards apply to the Fellowship program, training rotations/runs, the Formal Education Course (FEC), and the certificates of advanced training. The AC establishes accreditation policy and procedures, reviews accreditation reports and oversees the implementation of recommendations in visit reports.

Australian Government Funded Training Programs Committee (AGFTPC)

Formerly the STP Committee, this committee was renamed in 2021 and its Terms of Reference updated to reflect the expansion of training programs funded by the Australian Government. These now include the Military and Veterans Psychiatry training program. The Tasmania STP project reports to the AGHTPC.

E-Learning Advisory Group (E-LAG)

The E-LAG is responsible for providing advice on e-learning resources.

Time-limited project and working groups are formed for specific purposes, underpinned by clear Terms of Reference (TOR). These are formed for time limited periods to progress educational projects and activities, for example the EPA working group, the Syllabus review working group (SRWG) and the Examinations Review Steering Group (ERSG).

ERSG

In response to consistently low pass rates in the Essay style examinations, the RANZCP Board commissioned the Australian Council for Educational Research (ACER) to conduct a review of the RANZCP examinations. The ERSG was responsible for the oversight and governance of the review of assessments and advising on the implementation of recommendations arising from the review. Following the development of the implementation plan, and the appointment of an external consultant tasked with the delivery of key priorities under the oversight of the EC, the ERSG was disbanded in late 2021. The continued delivery of key priorities is overseen by the EC.

Syllabus Review Working Group (SWRG)

The SRWG was established in 2017 to oversee the review of the syllabus, ensuring that it is reflective of contemporary psychiatry knowledge and practice. The syllabus was last reviewed as part of the introduction of the 2012 regulations.

The TOR for each of these committees are provided as appendices to this submission (Appendices 1.1.2_1 to 1.1.2_10).

1.1.3 The education provider's governance structures set out the composition, terms of reference, delegations and reporting relationships of each entity that contributes to governance, and allow all relevant groups to be represented in decision-making.

The RANZCP is a company limited by guarantee under Australian corporations law, with the head office in Melbourne, Victoria and is a registered charity.

The RANZCP Board

In accordance with the Constitution, the RANZCP Board governs the College and consists of the President, President-Elect and five Elected Directors – all elected from the RANZCP Fellowship; with the possible appointment of up to two Appointed Directors at the discretion of the Board.

The current composition of the Board is as follows:

- President (Position Description)
- President-Elect (Position Description)
- Five Elected Directors (Position Description) one of which must be from Aotearoa New Zealand
- Appointed Director, Trainee (Position Description).

The role of the Board is to oversee the overall governance, management and strategic direction of the RANZCP and to ensure the delivery of its purposes, as defined in Article 2.1 of the RANZCP's Constitution. The Board is responsible for, and has the authority to determine, all matters relating to the strategic direction, policies, practices, goals for management and the operation of the RANZCP.

Without intending to limit this general role of the Board, the specific functions and responsibilities of the Board include:

- oversight of the RANZCP, including its legal, compliance and accountability systems
- ensuring that the RANZCP abides by the objects for which it was established as set out in the Constitution
- determining the RANZCP's vision, values and strategic purpose
- ensuring that the RANZCP complies with its regulatory obligations and ethical standards
- ensuring that policies for governance and risk management are effectively implemented
- approving and monitoring financial statements and performance against the budgets, the financial objectives and performance targets for the RANZCP and other reporting activities
- setting and undertaking Board and Director evaluations
- approving the acquisition and disposal of major assets if not already provided for in the budget approval by the Board
- entering into material financial arrangements, including loans and debt arrangements
- establishing and overseeing the MAC and committees of the Board
- appointing, evaluating and removing the Chief Executive Officer (CEO).

The CEO and executive management oversee the management of the College across both nations.

Members' Advisory Council (MAC)

As a component of the RANZCP's governance model, the MAC provides advice to the Board. A copy of the committee's Regulations is located on the RANZCP website (Members' Advisory Council Regulations /ranzcp.org) and provided as Appendix 1.1.3_1.

Constituent Committees of the Board

The constituent committees of the Board are the:

- Audit Committee

Reporting directly to the RANZCP Board, the Audit Committee oversees and monitors the College's audit processes, including the College's internal control activities.

- Corporate Governance and Risk Committee (CGRC)

Reporting directly to the RANZCP Board, the CGRC role is to advise and recommend to the Board policies, procedures and guidelines which maintain the health and effectiveness of the College, manage risk effectively and ensure governance and compliance in satisfying legal responsibilities as set out in the Corporations Act 2001 and the ACNC Act 2012 (Cth) and the College's Constitution.

- Education Committee (EC)

Reporting directly to the RANZCP Board, the EC is responsible for formulating and developing strategic education policy advice for the Board on all matters relating to Fellowship and the award of certificates of advanced training.

- Finance Committee (FC)

Reporting directly to the RANZCP Board, the FC acts as an advisory body to the Board in relation to statutory and contractual compliance and financial strategy reporting.

- Membership Engagement Committee (MEC)

Reporting directly to the RANZCP Board, the MEC provides a focal point within the RANZCP for considering and recommending policies and systems for effectively engaging with the membership, increasing the value of College membership and ensuring feedback from members is appropriately addressed.

The MEC serves as a conduit between the Board and the wider College membership, providing advice and guidance to the Board that reflects the views of the membership.

- Practice, Policy and Partnerships Committee (PPPC)

Reporting directly to the RANZCP Board, the Practice, Policy and Partnerships Committee (PPPC) is responsible for executing priorities in the College's Strategic Plan as it relates to the practice and profession of psychiatry.

Each constituent Committee is chaired by a Board Director. Board directors have also been allocated ex-officio positions on various committees and are entitled to attend any RANZCP committee meeting.

Company Secretary

The Company Secretary is responsible for administering the reporting and compliance requirements of the RANZCP and for oversight of corporate governance policies and practices within the RANZCP, ensuring compliance with statutory and regulatory requirements. The Company Secretary's responsibilities include ensuring the RANZCP complies with the provisions of the RANZCP's Constitution, monitoring the RANZCP's compliance with any legal obligations.

RANZCP Committees

The College has over 150 committees and the committee structure covers the range of core business and strategic priority areas. Committee Regulations or Terms of reference outline purpose, roles, membership, appointment processes and reporting lines for each committee, sub-committee, steering group and working group.

The Regulations for each constituent committee are located on the RANZCP website (Committees | RANZCP), and outline, among other things, the committee's role(s), responsibilities, composition, and election processes. The Committee Meeting Operations Regulations documents the operations of each of these committees.

Depending on the organisational structures, either the parent Committee or the Board appoints committee chairs, members and other role holders following the AGM. The College staggers the election processes to ensure Committees maintain corporate knowledge. Most committees within the College have a 3-year election cycle. All college committees have members from both Australia and New Zealand, except where their remit is country specific.

Mechanisms have also been developed which allow Trainee and Overseas Trained Psychiatrist representation, via their respective Committees and via specific positions being captured within committee composition across various committees.

The RANZCP partners with people with lived experience of mental illness (also referred to as consumers) and carers, through the Community Collaboration Committee (CCC). The purpose of the CCC is to ensure the College considers the needs, values and views of the community. In relation to the Community Members, following Board approval of Position Statement (PS) 62: Partnering with people with a lived experience and PS 76: Partnering with carers in mental healthcare in 2021, there will be a program of work undertaken to support the recommendation being achieved including to further enhance community engagement across RANZCP committees.

In Australia, the cultural stakeholder voice is captured through the Aboriginal and Torres Strait Islander Mental Health Committee. The Committee is composed of Aboriginal and Torres Strait Islander community members who are involved in mental health service provision and policy development, Aboriginal and Torres Strait Islander psychiatrists, as well as psychiatrists who have direct experience working in Aboriginal and Torres Strait Islander mental health.

In New Zealand, the cultural stakeholder voice is provided through Te Kaunihera. Te Kaunihera is made up of members with direct experience working in Māori mental health, as well as Māori community members who are involved in mental health service provision and policy development.

Te Kaunihera recently oversaw the appointment of Kaumatua (Māori elders). The College is holding a mihi whakatau at the New Zealand office on 28 June 2022 to welcome Mr Ron Baker into his role as kaumatua. He will share this role with kaumātua Ms Moe Milne. A mihi whakatau is a te ao Māori ritual of encounter whereby the host people (tangata whenua) welcome visitors (manuhiri). It removes the tapu (restrictions) of the manuhiri to make them one with the tangata whenua. A pāwhiri and a mihi whakatau are similar. A pāwhiri is usually conducted on a Marae whereas a mihi whakatau can be done in other locations and may not feature a karanga (the call of the woman).

The National Office in New Zealand shares its Māori name with the New Zealand National Committee – Tu Te Akaaka Roa.

As part of appointment considerations, Regulations and Terms of Reference include a provision to endeavour to have gender balance and, where relevant, allow for geographic and other specific representation as required.

The RANZCP is committed to improving inclusion and equity in psychiatry. A consultation with the membership is currently underway to help inform the development of a meaningful RANZCP gender equity statement and action plan. A first step was the publication of a data snapshot and discussion paper, which are provided as appendices 1.1.3_2 and 1.1.3_3.

The following changes are planned for the next three years:

- undertake Constitutional Change to allow for voting rights for trainees and for Affiliates (who are Specialist International Medical Graduates (SIMG))
- pending the outcome of the Faculty, Section and Network review, there may be impact on committees, committee composition and staffing to ensure these are adequately resourced into the future.
- enhancement of the positioning of rural psychiatry within the College.

1.1.4 The education provider's governance structures give appropriate priority to its educational role relative to other activities, and this role is defined in relation to its corporate governance.

The key governance committees and accountabilities for managing training and education activities in the Fellowship program are the committees reporting to the EC and described under standard 1.1.2. These committees operate at the bi-national level, with the CFT additionally having oversight of the BTC/NZTC which are responsible for trainees in the training zones and programs at the operational level.

The CFE is accountable for all activities relating to the centrally administered summative assessments, including the setting of the examinations, marking, reporting and any appeals.

The CFT is accountable for decisions relating to the progression of trainees in the Fellowship program. A CFT operational group meets fortnightly to ensure that decisions relating to training and progression are progressed in a timely manner. This includes applications for breaks in training, learning reviews and appeals.

The AC is accountable for the setting of standards, and oversight of the accreditation processes. The accreditation of FECs and Fellowship programs and zones is the responsibility of the AC; however, the accreditation of training posts has been delegated by the AC to the BTC/NZTC.

The CEEMR is accountable for monitoring and reporting on the educational programs of the RANZCP..

Faculties and Sections are responsible for the provision of subject matter expertise to the Subcommittees of Advanced Training (SATs) that oversee the Certificates of Advanced Training. The outcome of the review of Faculties and Sections currently being undertaken by the RANZCP Board may have an impact on the role of the Faculties and Sections, and the provision of Certificates of Advanced Training particularly if there is an increase in the number of recognised areas of practice.

In collaboration with the Royal Australasian College of Physicians (RACP), the RANZCP offers a dual Fellowship pathway leading to the FRANZCP and FRACP qualification in paediatrics and child and adolescent psychiatry. The Joint Training Committee Dual Fellowship Training Program is responsible for setting policy and implementation of the joint training program. Due to the small number of trainees undertaking a joint Fellowship program, this committee meets on an ad hoc basis.

Governance and accountabilities are flexible and able to respond to changes in circumstances, such as the challenge of COVID-19. Steering groups and taskforces have been implemented as required to address the governance and operational issues – such as the taskforce introduced to manage the AAP, which is discussed in further detail under standard 5. With the current consultation and review of the RANZCP assessment framework, as described in standard 5, it is likely that changes to the governance structure will be required to better integrate assessment and training within the Fellowship program.

As previously stated, the EC is a constituent committee of the RANZCP Board, and education is a primary strategic priority articulated in its strategic plan. The 2022-2025 strategic plan has been agreed in principle by the RANZCP Board, but not yet published. Three priorities, illustrated in Figure 1.1.4_1, have been identified to support the RANZCP purpose, which is:

"To support our members, advance psychiatry, and advocate for the best mental health outcomes for our communities."

Figure 1.1.4_1 RANZCP strategic priorities

In order to achieve the priority of training, education and learning that increases capacity and quality, the strategic plan states:

"We are committed to training, continued learning, education, and research that builds capacity and facilitates the delivery of high-quality psychiatric treatment, care, and support to the community. We will:

- deliver best practice psychiatry training and professional development programs across the career span, from trainee level to advanced specialisation, mid-career, and retirement

- ensure the College remains adaptive and contemporary in its delivery of high standard assessments
- develop, disseminate, and maintain contemporary evidence-informed clinical and practice resources to support the profession to deliver care for those with lived experience and strengthen the provision of culturally safe and inclusive psychiatric car.
- support research, leadership, and policy changes that drives innovation
- adapt our educational processes to meet the needs of all communities."

The RANZCP has a sound governance structure which facilitates the Board being informed of new or significant changes related to educational programs. The EC is Chaired by a Director of the Board, supported by a second Director and more recently, the Appointed Director, Trainee. This structure facilitates swift Board consideration of high-risk issues.

The RANZCP governance structure provides a framework for the RANZCP and its members to interact and engage with the College structures in a supportive and collegiate manner. COVID-19 has strengthened these relationships and like many organisation, the College was able to adapt with the use of technology to engage and strengthen relationships within the membership. Members continued to provide their expertise to local and federal governments and support the wellbeing and mental health response to manage the pandemic.

Management of COVID-19 related impacts has also been challenging but the college has maintained business continuity, good governance and supported staff. Allowances were made to support trainee progression. Many projects have continued, despite additional complexities and constraints caused by COVID-19.

The introduction of offering tailored Governance inductions for new staff to their level of understanding and their roles within the RANZCP, particularly for those who support committees and those with interactions with the CGRC. This induction is on top of the corporate induction undertaken.

The Board has also adapted its practices during the pandemic. Online Board meetings are held on average every three weeks. This model assists business units to inform or raise to the Board pertinent issues, facilitates swift decision making and allows for prompt communication to the wider membership.

The Document Approval Pathway Procedure and Delegation of Authority Guideline (Appendices 1.1.4_1 and 1.1.4_2) provides further information regarding responsibilities. In particular, the Document Approval Pathway Procedure provides a structured approach to managing workflow and the review and approval process for documents by the various internal stakeholders and committees. This structure ensures that key documents within the College are reviewed and submitted to the appropriate approving body within the College. The process adapts according to whether there is a new document created, a major or minor change, resulting in the relevant governing body being informed or accepting responsibility.

The RANZCP Risk Management Framework assists the Board in managing and mitigating risk and provides a mechanism to identify opportunities for improvement. The College's risk management process is underpinned by a framework for the College to articulate activities and expectations in relation to the management of risk across the organisation. It provides direction, guidelines and references for the Board, committees, CEO management group and staff to effectively manage risk.

1.1.5 The education provider collaborates with relevant groups on key issues relating to its purpose, training and education functions, and educational governance.

The representation of key stakeholders on the EC enables collaboration with internal stakeholders and dissemination of policy and strategic developments to relevant constituent committees for consultation and advice. Membership of the committees reporting to the Education Committee includes stakeholders such as representatives of the:

- Trainee Representative Committee (TRC)
- Overseas Trained Psychiatrists Committee (OTPC)
- Community Collaboration Committee (CCC)
- Committee for Specialist International Medical Graduate Education (CSIMGE)

The RANZCP collaborates with State, Territory and Commonwealth governments in Australia to deliver the training program. The STP and the Military and Veteran Psychiatry Training Program (MVPTP) are examples of collaboration to deliver training in specific areas of need. Specific detail on these programs is provided under standard 8 of this submission.

Further detail on how the RANZCP collaborates with external stakeholders including local communities, jurisdictions, and organisations involved with the mental health of the communities of Australia and New Zealand can be found under standard 1.6 of this submission.

Since the failure of the Audio-Visual Objective Structured Clinical Examination (AVOSCE) in November 2021 the RANZCP has broadened its collaboration. External Associations of Psychiatry Trainees (APT) have been included in the Alternative Assessment Taskforce, and wider stakeholder engagement supports the adoption of a co-design model of development in current and future educational structures.

1.1.6 The education provider has developed and follows procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision-making.

The RANZCP requires all Members and external parties appointed to a committee (including Co-opted, Observer and Proxy positions) to sign a Deed of Undertaking in relation to Confidentiality and Conflict of Interest (DOU). Signed Deeds are recorded by the RANZCP Governance Officer, who undertakes regular audits.

The DOU is reinforced by the Declaring and Managing Conflict of Interest Guideline (Appendix 1.1.6_1) which sets out the processes for conflict disclosure and options for management or avoidance of the conflict. Conflicts of Interest (COI) are a standing item on the majority of agendas across the RANZCP and are captured within minutes and, where relevant, on a standing committee COI Register.

The DOU's intention is to:

- keep private and confidential any sensitive information that may be received to in the course of the role of a committee member, examiner or marker, standard setter or question writer
- ensure that information is not used for personal gain or to the detriment of others through unauthorised disclosure
- ensure the disclosure of conflicts (real or perceived) including commercial (where able to disclose) and familial conflicts
- ensure compliance with RANZCP guidelines and codes of conduct and ethics.

Recent improvements to the management of COI within the RANZCP include:

- since February 2020, RANZCP committee election nomination forms ask nominees to declare that they will comply with the RANZCP's DOU. Internal operational processes to capture DOU for those involved in Fellowship Program Accreditation assessments have also been implemented
- a separate Examinations DOU (Appendix 1.1.6_2) was approved by the RANZCP Board in August 2020. This document provides specific guidance for Examination Committee/Subcommittee members, question writers/reviewers, examiners and markers, and standard setters who are engaged in CFE activities.
- a Disclosure Statement has been implemented as part of the Board elections call for nominations processes, and are disclosed to the Membership.

The Legal, Governance and Risk area is reviewing the College's Conflict of Interest Guideline. Particular focus has been placed on scoping the need for enhancement of the declaration of Conflicts of interest in the development of policy, position statements and clinical documentation. The need to enhance the framework to declare relevant conflicts of interest in research outputs, in submissions to ethics committees or when undertaking peer review is a key priority.

The Conflict of Interest Policy (Appendix 1.1.6_3) is scheduled for review in 2022 and will submitted to the Corporate Governance and Risk Committee prior to the end of the year.

Additional information requested by the AMC.

In its response to the 2021 progress report, the AMC requested an update of the co-chair arrangement used by the TRC in 2021.The governance arrangements for the TRC are reviewed and amended to support the needs of the Committee. The Regulations have been amended to allow for flexibility and the implementation of a Chair or Co-Chair arrangement where both positions are Trainees.

This flexibility has not been used by the incoming TRC in 2022 who have elected to have a single Chair and two Deputy Chairs, who will support the operational requirements. At present the RANZCP is working with the TRC to enhance its model to ensure that it is fit for purpose and broadens the stakeholder contributions to the TRC. This is discussed in further detail under standard 7.

1.2 Program management

1.2.1 The education provider has structures with the responsibility, authority and capacity to direct the following key functions:

- planning, implementing and evaluating the specialist medical program(s) and curriculum, and setting relevant policy and procedures
- setting and implementing policy on continuing professional development and evaluating the effectiveness of continuing professional development activities
- setting, implementing and evaluating policy and procedures relating to the assessment of specialist international medical graduates
- certifying successful completion of the training and education programs.

The EC has oversight of the key functions of setting, implementing, and evaluating the Fellowship program, the CPD Program and the SIMG pathways. It has the responsibility for recommending trainees and SIMGs who have completed the requirements of training to the RANZCP Board for admission to the Fellowship. The EC is responsible for overseeing the governance, operational and strategic development and decisions in relation to training programs and education strategy.

The EC, its committees and their subcommittees are illustrated in Figure 1.2.1_1, an extract of the RANZCP governance chart provided under standard 1.1.1.

The Committees reporting to the EC have been discussed in detail under standard 1.1.2.

Fellows with qualifications and experience in medical education and training are represented in the membership of all education committees. Trainees are included in the membership of the following committees:

- EC
- AC
- CEEMR
- CFT
- CFE
- E-LAG.

Members of the community with lived experience are included in the membership of the following committees:

- CCPD
- EC
- CEEMR
- CSIMGE and its SCARP
- CFE.

The secretariat for each of the committees is overseen by the relevant Manager within the Education Department. Working in conjunction with the Chairs of the committees, the managers ensure that bi-national health priorities and bi-national regulatory requirements are addressed by the committee. The federated nature of the RANZCP ensures that local needs and the variations in service delivery are noted, advised to the education committees, and accommodated.

This governance structure for the training program allows for considered and robust decision making. Conflicts of interest are an inherent feature of specialist medical colleges where Fellows bear the responsibility for the training and assessment of trainees and SIMGs. This hierarchical structure allows review of decisions at multiple levels to ensure procedural fairness. There is the risk of this structure prolonging the time required for a decision, however the use of out of session considerations has been used with good effect to minimise this risk.

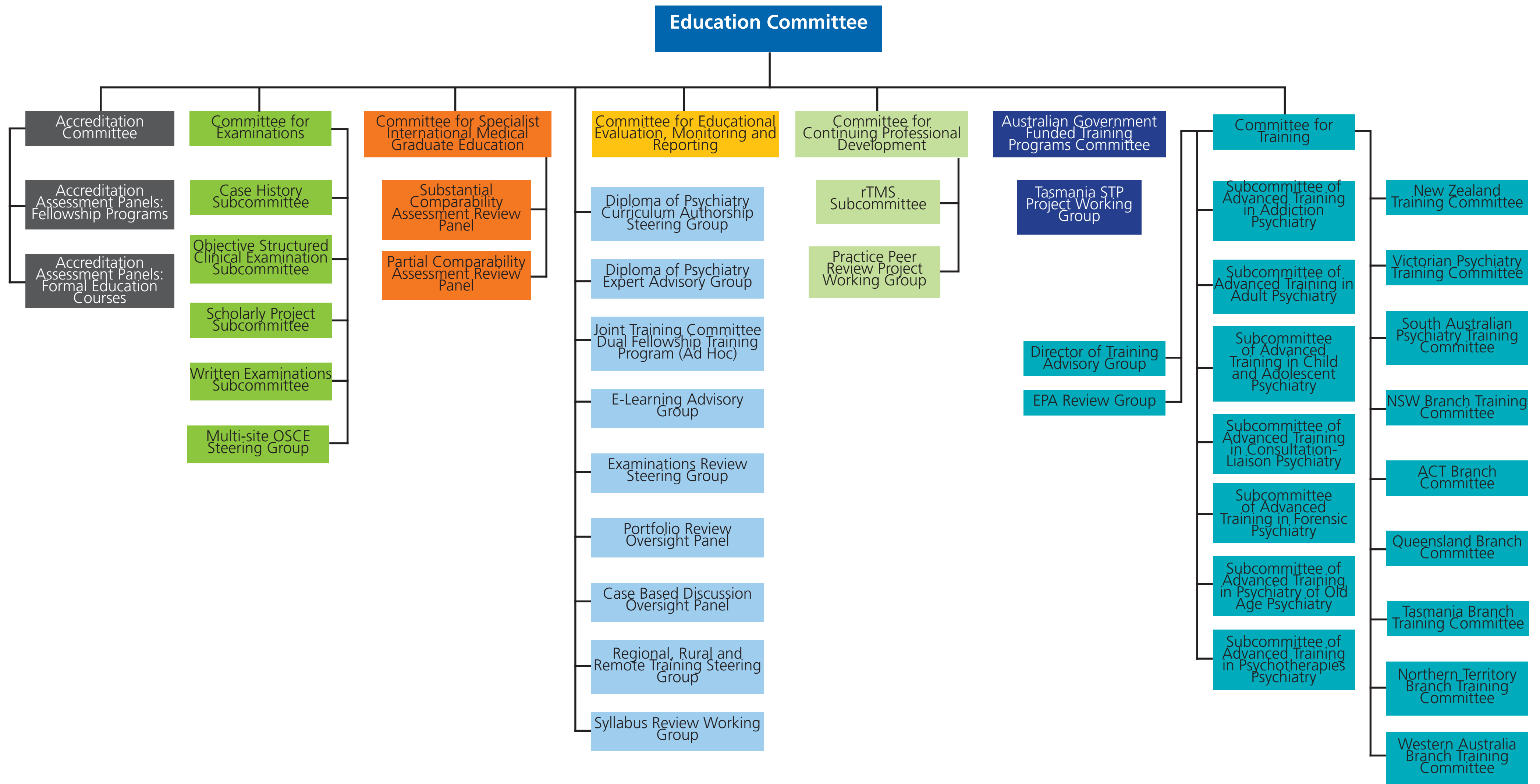
A strength of the RANZCP program management is the flexibility and capacity of its governance structures to gather Fellows to contribute to program development and the addressing of specific gaps or emergency responses. The RANZCP can establish specific working groups with subject matter experts to address and resolve issues and support the educational functions of the College. Examples in the last two years include:

- COVID Examination Steering Group (CESG) established in 2020 under the Board as a crisis management group to oversee operational and strategic responses to COVID-19
- the establishment of the rTMS subcommittee to support the introduction of Medicare items relating to the delivery of rTMS
- Steering groups to oversee the development and delivery of the AVOSCE and the multi-site OSCE (MSOSCE) in response to the restrictions of the pandemic
- Portfolio Review Oversight Panel (PROP) and Case Based Discussion Oversight Panel (COP) for the delivery of the Alternative Assessment Pathway (AAP).

In addition to the expertise within the Fellowship, the RANZCP engages external consultants and external reviews to provide specialist and independent advice. Examples of this from recent years include:

- the review of assessment processes by the Australian Council for Educational Research (ACER)
- the appointment of external consultants in the areas of medical education assessment
- the development of the rural pathway
- the representation of APTs in the development of the AAP.

Figure 1.2.1_1. Education Committee, committees and subcommittees



1.3 Reconsideration, review and appeals processes

1.3.1 The education provider has reconsideration, review and appeals processes that provide for impartial review of decisions related to training and education functions. It makes information about these processes publicly available.

Review process

A review process must be completed prior to the reconsideration and appeal processes being undertaken. To request a review of an education committee recommendation or decision, an individual may write to the committee making the original recommendation or decision, requesting a review and setting out their grounds for review, as well as providing any supporting documentation. The committee which made the original recommendation or decision will then consider the request, along with relevant information. The committee will consider whether RANZCP policies and procedures have been appropriately considered and applied in making the original decision.

The person requesting review will then be advised of the outcome of their request, and their right to lodge an application for reconsideration should they remain dissatisfied.

Reconsideration process

The RANZCP's reconsideration process is set out in the Reconsideration and Appeal Policy ('the Policy') (Appendix 1.3.1_1).

In accordance with the Policy, individuals who are dissatisfied by a RANZCP recommendation or decision may apply for a reconsideration by submitting an Application for Reconsideration Form (Appendix 1.3.1_2), accompanied by any relevant supporting documentation, to the RANZCP (section 3.2 of the Policy). Applicants are required to make this application within three months of notice of the original recommendation or decision (section 2.1 of the Policy) and are also required to pay the prescribed fee (section 3.3 of the Policy). This fee is covering the administrative costs of the reconsideration. As a matter of standard process, an applicant is required to undertake the review process prior to making an application for reconsideration.

In the context of a recommendation made by an education committee, the application for reconsideration will be put before the EC for consideration (section 3.5 of the Policy) in line with the relevant sections of the Policy and procedural fairness (section 3.8 of the Policy). The EC will then make a recommendation to the RANZCP Board in relation to the outcome of the application for reconsideration. The EC's recommendation will then be presented to the Board for final decision. If a final decision is made, the applicant will be advised of the outcome of their application for reconsideration in writing by the Chief Executive Officer, as well as the reasons for that outcome (section 3.14 of the Policy).

Following receipt of the outcome, the applicant may request further clarification of reasons for the outcome (section 2.2 of the Policy), as well as information upon which the outcome was based (section 3.16 of the Policy).

Appeal process

The RANZCP's appeal processes are set out in the Policy. To request an appeal of a recommendation or decision, a person must first have completed the reconsideration process (section 4.1 of the Policy). To commence the appeals process, the person must lodge a Notice of Intention to Appeal (Appendix 1.3.1_3) setting out the grounds of appeal and may provide any relevant supporting documentation (section 7.1.2 of the Policy). The person must also pay the prescribed fee to cover administrative costs.

An appeal hearing will then be scheduled at a time convenient for both the Appeal Committee and the appellant. The appellant will be advised of their rights in relation to the appeal, including that they have an opportunity to provide further submissions for the Appeal Committee's consideration. The Appeal Committee will then conduct a hearing in accordance with section 9 of the Policy, having regard to procedural fairness.

Within two weeks following the appeal hearing, the appellant may lodge further submissions. The Appeal Committee Chair will then write a confidential report setting out their recommendations as to the outcome of the appeal. The RANZCP Board will then consider the Appeal Committee's report and recommendations. Following the Board's decision, the appellant will be advised of the outcome.

The new Review, Reconsideration and Appeal Policy and Procedure (the Policy and Procedure) was approved by the RANZCP Board in February 2022. The following steps were taken during the review:

- consultation with the EC and relevant Education and Training staff, as well as the Board, in relation to the proposed revised review, reconsideration and appeal processes and a revised governance model
- redrafting of the Policy to:
    - o reflect a revised governance model, which will see the establishment of the Education Review Committee and Independent Reconsideration Panel, and the continuation of the Appeals Committee to consider appeals, reconsideration and appeals respectively
    - o incorporate all three steps into a single policy; and
    - o strengthen and lend more clarity to each step of the process and the relevant requirements.
- facilitating a consultation in relation to the draft revised Policy with relevant committees, including the EC, CSIMGE, CFT, CFE, the OTPC, the TRC and the Appeal Committee.

The AMC was advised of this policy in March 2022 via correspondence from the RANZCP. The RANZCP continues to work through the implementation of the Policy, with work underway to establish two new committees relevant to the policy and procedure, the Education Review Committee and the Independent Reconsideration Panel, before declaring the policy and procedure to be in effect.

It is anticipated that the Policy and Procedure will strengthen the processes, their transparency and accessibility to applicants and appellants, the objectivity and independence of decision-making in relation to reviews and reconsiderations, and the general robustness of the procedural fairness afforded to the applicant or appellant.

Reconsideration, review and appeal processes are publicly available for trainees via RAZNCP Website (https://www.ranzcp.org/about-us/governance/governance-documents).

1.3.2 The education provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

The data in Tables 1.3.2_1 to 1.3.2_6 reflect those requests and applications which have been finalised in the period 2019 – 2021. It does not include requests or applications which have been lodged but not finalised by 31 December 2021. Requests and applications are categorized in accordance with the year in which they were finalised.

There has been an increasing number of SIMGs lodging reconsiderations in relation to a withdrawal of their comparability status. This suggests that further efforts could be made to engage with SIMGs lodging these reconsiderations to provide clarification of the process, including its purpose and the possible outcomes of the process. The incoming Policy and Procedure formalizes new steps to assist with this, including clearly setting out application requirements to provide applicants with clarity. In general, the RANZCP is more likely to receive applications requesting a reconsideration of a withdrawal recommendation, given that the implications for SIMGs whose comparability status is withdrawn can flow on to their registration with the Medical Board of Australia (MBA) and visas.

Additionally, increased numbers of trainees applying for reviews of examination results could be a result of several disruptions to the RANZCP examination delivery due to COVID-19. As the AMC is aware, the RANZCP has implemented the AAP to support candidates' progression towards Fellowship.

The RANZCP will continue to enhance its supportive engagement with the trainee and SIMG cohorts during the review, reconsideration and appeal processes, and aim to make these processes as trainee- and SIMG-centric as possible. The RANZCP considers that its new, incoming Policy and Procedure will further strengthen levels of engagement, by increasing the clarity, transparency, and procedural fairness of the appeal mechanisms.

Table 1.3.2_1. Requests for Reconsideration (trainees)

Requests for Reconsideration (trainees)												
	2019			2020			2021			Total		
Subject of Reconsideration	Number	Outcome		Number	Outcome		Number	Outcome		Number	Outcome	
		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed
Examination Marking	-	-	-	-	-	-	1	-	1	1	-	1
Exclusion from the Training Program	-	-	-	-	-	-	1	-	1	1	-	1
Non-acceptance to local training program	2	-	2	-	-	-	-	-	-	2	-	2

Table 1.3.2_2. Requests for Reviews (trainees)

Requests for Reviews (trainees)												
	2019			2020			2021			Total		
Subject of Review	Number	Outcome		Number	Outcome		Number	Outcome		Number	Outcome	
		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed
Review of exam result	-	-	-	5	1	4	16	2	14	16	2	14
Review of exemption application outcome	-	-	-	5	-	5	5	3	2	10	3	7
Rotation fails	-	-	-	-	-	-	2	-	2	2	-	2
Not in training	-	-	-	-	-	-	1	-	1	1	-	1
Rotation accreditation	-	-	-	-	-	-	1	1	-	1	1	-
Exam eligibility	-	-	-	-	-	-	1	-	1	1	-	1
Recognition of Prior Learning	-	-	-	-	-	-	1	-	1	1	-	1
Psychotherapy written case	-	-	-	-	-	-	1	1	-	1	1	0

Table 1.3.2_3. Requests for appeals (trainees)

Requests for Appeals (trainees)												
	2019			2020			2021			Total		
Subject of Review	Number	Outcome		Number	Outcome		Number	Outcome		Number	Outcome	
		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed
Examination marks	-	-	-	-	-	-	1	1	-	1	1	-

Table 1.3.2_4. Requests for Reconsideration (Specialist International Medical Graduates)

Requests for Reconsideration (Specialist International Medical Graduates)												
	2019			2020			2021			Total		
Subject of Reconsideration	Number	Outcome		Number	Outcome		Number	Outcome		Number	Outcome	
		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed
Withdrawal of comparability status and exclusion from RANZCP Specialist Pathway	2	-	2	6	2	4	7	-	7	15	2	13
Comparability assessment	-	-	-	-	-	-	4	-	4	4	-	4
Management of academic misconduct	-	-	-	-	-	-	1	-	1	1	-	1

Table 1.3.2_5. Requests for Reviews (Specialist International Medical Graduates)

Requests for Reviews (Specialist International Medical Graduates)												
	2019			2020			2021			Total		
Subject of Review	Number	Outcome		Number	Outcome		Number	Outcome		Number	Outcome	
		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed
Review of progression on the pathway	-	-	-	4	-	4	3	-	3	7	-	7
Review of comparability assessment outcome	-	-	-	11	1	10	-	-	-	11	1	10
Review of specialist pathway re-instatement decision	-	-	-	1	-	1	-	-	-	1	-	1
Withdrawal of comparability status	3	-	3	-	-	-	-	-	-	3	-	3
Examination results	-	-	-	-	-	-	3	0	3	3	-	3

Table 1.3.2_6. Requests for Appeals (Specialist International Medical Graduates)

Requests for Appeals (Specialist International Medical Graduates)												
	2019			2020			2021			Total		
Subject of Review	Number	Outcome		Number	Outcome		Number	Outcome		Number	Outcome	
		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed		Upheld	Dismissed
Withdrawal of comparability status and exclusion from Specialist Pathway	-	-	-	-	-	-	1	1	-	1	1	-

There are no formal mechanisms for feedback in relation to applicants' experiences of the review, reconsideration, and appeal processes. However, any feedback from applicants received informally throughout the process is monitored by the Legal Services Department, which assists in the administration of the Policy, and has been used to inform the ongoing review of the Policy.

In accordance with the processes described under standard 1.3.1 above, the RANZCP Board is responsible for ratifying the outcomes of reconsiderations and appeals. The Board is therefore able to monitor any issues or patterns arising from reconsiderations or appeals. The Chair of the EC is also a Board member, and therefore any Board-level discussions in relation to these matters can be directly communicated to the EC, which is responsible for considering applications for reconsiderations that relate to recommendations or decisions made by its constituent committees. Through these mechanisms, any recurring issues in decision-making or process can be identified and managed.

The Policy also provides for matters arising out of an appeal which may affect RANZCP policies or procedures being referred to the relevant RANZCP committee for consideration.

1.4 Education expertise and exchange

1.4.1 The education provider uses educational expertise in the development, management and continuous improvement of its training and education functions.

Fellows who are appointed to education Committees have experience and expertise in education, particularly in the workplace. In addition, the staff of the Education Department have experience and expertise in education and training, with skills in:

- assessment
- instructional design
- the management and oversight of educational programs
- program evaluation
- statistical and psychometric analysis.

The staff of the Education Department have a breadth of experience and include members with clinical backgrounds and experience in clinical teaching, and members with experience in the tertiary education sector. Appointments to the Education Department are made with consideration of the specific skillsets necessary to conduct the ongoing educational programs.

Amongst the Fellowship there is a great interest in medical education, and many have pursued further education in clinical/medical education and are engaged with the training program. The governance structures of the RANZCP permit the co-option of Fellows with specific skill sets to committees to address specific issues.

In addition, the RANZCP uses external consultants and fixed term appointments to provide specific skills, advice and management. Most recently the RANZCP has appointed a Medical Education and Assessment specialist to the staff and has engaged external consultants with expertise in the area of medical assessments to assist with the consideration of assessment options for the Fellowship Program and to implement the recommendations of the ACER review.

1.4.2 The education provider collaborates with other educational institutions and compares its curriculum, specialist medical program and assessment with that of other relevant programs.

The RANZCP collaborates with a range of educational institutions and is a member of many specialty societies and organisations contributing to the RANZCP's ability to provide high quality training. Through these collaborations there is opportunity to compare curriculum, program design and assessment with both local and international programs.

Tri Nations Alliance (TNA)

The RANZCP continues to work with the Royal College of Physicians and Surgeons of Canada (RCPSC), the Royal Australasian College of Physicians (RACP), the Royal Australasian College of Surgeons (RACS), and the Australian and New Zealand College of Anaesthetists (ANZCA) to create an effective network through the TNA to promote medical education, research collaboration and development. The RANZCP CEO and the Executive Manager, Education and Training are members of the TNA Management and Executive Committees.

The Memorandum of Understanding (MoU) was renewed in 2022.

The TNA meets regularly subject to COVID-19 capacity to explore and share experiences in medical education and development. Topics have included:

- accreditation in competency-based specialist medical education
- assessment
- research in medical education
- well-being of doctors.

Royal College of Psychiatry, United Kingdom

In July 2019, the RANZCP signed a new 5-year Memorandum of Understanding (MoU) (Appendix 1.4.2) with the Royal College of Psychiatry (RCPsych) which formalized the principles of the valued relationship between the two organisations. The close relationship enabled consultation with the RCPsych on its experience with the introduction of online clinical examinations during 2020 prior to the RANZCP's first "proof of concept" AVOSCE in November 2020.

The RANZCP also has a long-standing agreement with the RCPsych allowing access to the British college's catalogue of e-learning resources, discussed under standard 1.5.

Universities

Many of the FECs that are accredited by the RANZCP are provided by tertiary education providers including:

- University of Melbourne
- Monash University
- Brain Mind Institute, University of Sydney
- Health Education and Training Institute (HETI)
- University of Auckland
- University of Otago.

Representatives of these education providers attend BTCs, where FECs are a standing item on the agenda. This enables collaboration particularly on issues of local content, such as the jurisdictional Mental Health Act. The reaccreditation of FECs, undertaken during 2021, enabled the RANZCP to compare the programs provided by all FEC providers and consider best practices to be recommended to other providers.

Engagement with Medical Education

The RANZCP contributes to consultations on a range of important developments in medical education, and the accreditation reviews of other specialist medical colleges. Most recently these have included the:

- AMC review of the national framework for prevocational medical training
- AMC review of the accreditation standards for primary medical programs
- AMC digital health in medicine strategy
- AMC assessment workshops
- accreditation reviews of the Australasian College for Emergency Medicine, RACS, the Australasian College for Intensive Care Medicine and ANZCA
- Australian Health Practitioner Regulation Agency's (AHPRA) consultation on the revised registration standard: health checks for late career doctors
- AHPRA and National Boards – Preliminary Consultation of revised English Language Standards.

In addition, the RANZCP regularly attends international conferences related to medical education including the Association for Medical Education in Europe (AMEE) conference, the Society for Academic Continuing Medical Education (SACME) annual conference, and the Ottawa conference.

At a more local level, RANZCP staff are active members of the various specialist medical college networks, including the:

- SIMG network
- CPD Managers network
- Education Managers network.

In Australia, the CEO and the President attend the Council of Presidents of Medical Colleges (CPMC) and in New Zealand the Chair of Tu Te Akaaka Roa, relevant Fellows and College staff attend meetings of the Council of Medical Colleges (CMC).

Relevant staff and Fellows also attend any seminar, workshop or meeting conducted by the AMC and the Medical Council of New Zealand (MCNZ).

A major focus of the period since the last AMC accreditation has been the consolidation of the 2012 Fellowship program and its supporting structures. These have included the introduction of a Trainee Management System, InTrain, the external review by ACER of the RANZCP examinations, the review of the syllabus, and the recently commenced review of the EPAs in the Fellowship Program.

1.5 Educational resources

1.5.1 The education provider has the resources and management capacity to sustain and, where appropriate, deliver its training and education functions.

The RANZCP has undertaken significant investment since its last accreditation by the AMC in critical educational infrastructure to support its training and education functions. Including a learning management system (Learnit), a training management system (InTrain), an online CPD portfolio (My CPD), a podcast series (Psych Matters) and the RANZCP website, a detailed description is provided below.

InTrain

In 2018, the College released InTrain, its online training administration system. Initially released in New Zealand it was subsequently released in Australia in early 2019. InTrain allows trainees to access essential training information and training forms. InTrain has been under constant development to introduce new features and improvements in response to change, such as the facilitation of a trajectory pause during COVID-19 and the pivot to the AAP.

Key areas of development since the initial version have included:

- additional certificate forms and functionality
- improved rotation configuration
- SIMG dashboard, term plan and other related functionality
- Site Coordinators of Training (SCOT) and Trainee Groups functionality to improve visibility and access to subsets of trainee training records
- migration of the paper-based application and payment processes to online for the Modified Essay Question (MEQ) examination, the Multiple-Choice Question examination, (MCQ) the Critical Essay Question examination (CEQ), and the AAP
- automated scheduling process for the AAP
- video training resources to assist InTrain users.

The College is committed to delivering further InTrain features to assist trainees, supervisors, DOTs, SIMGs and other users. It is also committed to improving the administration of the training program. To this end, it is constantly evaluating the capability of InTrain by analysing feedback, mostly through email support requests and the direct feedback from DOTs, the CFT and Education and Training administration staff.

Currently, identified future investigations and developments include:

- additional online Advanced Certificate forms and associated workflow
- online tracking of FEC enrolment and attendance
- online Targeted Learning process
- online submission and payment for Scholarly Projects (SP) and Psychotherapy Written Cases (PWC)
- improving the quality of training post data in InTrain
- testing and transitioning SIMG data to InTrain and developing online user resources.

Learnit

The College offers a catalogue of eLearning courses on its learning management system (LMS), known as Learnit. Up until 2019 this was provided and supported by Learning Seat Pty Ltd. Following the acquisition of Learning Seat by SAP Litmos, the College was advised that Learning Seat's LMS product would be retired, and the new entity would offer the SAP Litmos LMS. The College subsequently evaluated the SAP Litmos LMS and decided to move to that platform.

This move was timely as there is interest in enhancing and improving access to the College's eLearning resources.

The College's legacy LMS was replaced with SAP Litmos LMS in 2020 and the process of migrating the eLearning catalogue to the new platform commenced. This included negotiating with the RCPsych for the RANZCP to directly host the RCPsych eLearning content on the new platform. This has improved members' experience by removing the requirement to navigate two LMSs to access the RCPsych eLearning content and improved the flow of eLearning module completion information to members' records in the My CPD system.

With the new LMS implemented, the team has initiated an audit of the eLearning catalogue to identify the status of individual courses, and to establish lifecycle management. This process is expected to take at least 2 years to complete.

At the start of 2021, the Digital Education Services (DES) team was established within the College's education department. This team's responsibilities include managing the Learnit platform, managing the eLearning catalogue, and providing improved capability to produce digital and e-learning resources.

An eLearning Digital Designer has been employed to assist with developing new eLearning courses and to administer Learnit. The DES team is working closely with other teams in the Education department to leverage the functionality of the SAP Litmos platform and the digital assets of the College to deliver greater value to members. One example is a current project to bundle eLearning courses, videos and webinars, policy documents, clinical guidelines, podcasts, journal articles and other content into focussed sub-catalogues known as Learning Paths. Learning Paths will make it easier for members to locate and consume a range of eLearning content on a given topic area.

Psych Matters

In early 2020 the College explored the possibility of producing a podcast to deliver a series of discussions, interviews, lectures, and opinion on topics of interest to mental health professionals. The first episode of the Psych Matters podcast was released in July 2020 and a new episode has been released approximately every two weeks since its launch. At the time of writing, 44 episodes have been released with more in various stages of the production process. Psych Matters has attracted over 40,000 downloads and is proving to be popular with members.

Following the success of Psych Matters, the College employed an Audio-Visual Production Coordinator to assist with podcast production and to allow the podcast to grow. The College intends to establish a multimedia studio in the future, giving more flexibility for podcast recording options.

The College has established two additional podcasts:

- Psych Matters: History of Old Age Mental Health presents a series of interviews by Professor Brian Draper
- The Thought Broadcast, presented by trainees and supported by the College.

RANZCP website

The RANZCP website is a key resource supporting training and CPD. It is the source for trainees and SIMG candidates for all regulations and advice regarding training, as well as specific educational materials. Educational materials available on the RANZCP website currently include:

- clinical guidelines, position statements (PS), professional practice guidelines (PPG) and clinical memoranda
- RANZCP Journals:
    - Australian and New Zealand Journal of Psychiatry
    - Australasian Psychiatry

- Journal Library including:
  - o Medline with Full text
  - o Psychology and Behavioural Sciences collection (Full text)
  - o The British Journal of psychiatry (Full text)
  - o BJPsych Advances
  - o The Australian Journal of Rural Health (Full text)
  - o World Psychiatry
- information regarding educational events, webinars, catchup & on demand video content
- cultural safety resources and information
- curated topics such as rural psychiatry, mental health legislation and Indigenous mental health
- CPD templates, worksheets, program guides and sample activities.

Educational content specific to trainees and SIMGs includes study and assessment supports, including sample papers and exemplars of written assessments. This is discussed further under Standard 5 in this submission.

Recognising the importance of the website to RANZCP members, and the vast amount of content that is developed by the RANZCP, a project to redevelop the website and provide an optimum experience for users commenced in 2021. Following user research, planned work to upgrade the site includes:

- improving user access to key website tasks such as adding CPD activities to My CPD and training forms to InTrain
- restructuring the training, advanced training and SIMG content of the website for greater findability and ease of use
- creating a central learning and catchup library that highlights content that is automatically recorded to My CPD
- developing a College-wide taxonomy of terms so that Members can find related educational content more easily
- reviewing and auditing educational video content.

My CPD

Prior to 2017 completion of the RANZCP's CPD program was voluntary. In 2017 completion of CPD was made a requirement for the maintenance of Fellowship of the RANZCP and the first My CPD online portal was implemented in March 2017. This solution was embedded with the RANZCP's membership database (iMIS) and whilst it was an improvement on the previous paper-based system it was recognised that a second phase was required rapidly to improve the user experience for both members and staff.

In 2018 phase 2 of My CPD was delivered. Moving to a web-based solution provided an improved experience that was greatly appreciated by members. Outcomes included the ability for staff to conduct the annual quality assurance audit online, rather than the previous hard copy method. Also greatly appreciated by the membership, this has improved the efficiency of the audit, and has the added benefit of a reduced environmental footprint through the minimisation of hard copies, printing, and postage.

In 2021 further development of My CPD improved its performance on smaller devices such as smart phones and tablets, providing a more convenient method of recording CPD activity within the workplace.

Current development is focussed on providing functionality for staff to implement pro rata programs. Pro rata programs have been policy for some years for members who have been granted exemptions for family leave or extended absences from practice, however the system to support this policy has not been fully functional. The ability to provide pro rata programs, and for these to be accurately reflected on the individual's My CPD dashboard will be available from mid – 2022 and will be used for the 2022 CPD year.

1.5.2 The education provider's training and education functions are supported by sufficient administrative and technical staff.

Despite global trends and many organisations managing high turnover of staff, the RANZCP has been able to retain and show the value of key staff across the College. The support and acknowledgment of the extra work undertaken by the RANZCP staff throughout the pandemic and following the November AV OSCE failure has meant that the College has been able to maintain operations whilst undertaking key projects.

Recruitment of key roles has focused on employing staff with specific skill sets such as medical education, educational projects, and statistical analysis to enhance the current high-quality skills of staff. Staff continue to partner with Fellows, trainees and SIMGs to progress the growing volume of work committed to by the RANZCP. The College continues to undertake a program of work to understand and support its staff including undertaking an external review of wages and workplace survey.

The RANZP has addressed specific areas of need by recruiting staff to targeted areas in Education. Staff establishment has increased since the last accreditation of the College in response to increased membership needs, enhanced education and training delivery, and to support the strategic directions of the College. Whenever a position becomes vacant, there is a review of the skillsets required and of the position description to meet evolving needs and provide contemporary best practice in education and training. In addition, the engagement of external expertise is considered when necessary.

Additional administrative staff have been employed across all areas of the College. Key strategic areas have increased their technical resourcing to support the education and training of trainees, SIMGs and Fellows across the continuum. This is described below.

Education and Training Department

An Education Projects Advisor, with qualifications and experience in the development and delivery of educational programs in the tertiary and specialist medical college environments, has been appointed to provide high level support to the Education and Training Department management team. There are many important projects of varying scope that are underway or in planning. These include, but are not limited to the:

- development of supervisor supports
- CPD Home development
- development of CPD programs in rehabilitation psychiatry
- development of a Diploma of Psychiatry and
- review of EPAs.

A Medical Education and Assessment specialist, with qualifications and experience in medicine and education, has been appointed to support the RANZCP's work in improving the integration of the centrally administered summative assessments and workplace-based assessments in the Fellowship program.

DES, described under standard 1.5.1, focussed on digital technology in the delivery of education and training, has expanded to 6 FTE with the establishment of positions in digital design, audio visual development and business improvement analysis capabilities.

To ensure that the RANZCP meets the timelines established by the MBA's Standards: Specialist medical college assessment of specialist international medical graduates in 2021, additional staff were appointed to the SIMG team.

The Assessments team has been expanded over the last two years in response to the challenges of developing and delivering assessments during the pandemic, and the increasing numbers of candidates. This response has resulted in changed processes and new assessments, requiring different skillsets to those required for the delivery of traditional face to face clinical examinations. Skills in the delivery of examinations in a virtual environment and online systems have been required and staff have been recruited with this intent.

To meet the increased focus on the use of data to underpin decision making and development, the reporting functions of the Education Department have been strengthened with the appointment of a Data Evaluation Analyst with expertise in social research and data visualisation. In collaboration with the Information Technology Department of the College, the availability of data and information to inform the monitoring and evaluation of the Fellowship Program has been greatly improved. This has enabled improved quality and timeliness of reporting of the educational activity of the College to its members. To support the development, quality improvement and project work across the Education and Training Department there has been an increase in appointments to Coordinator positions in the CPD, Accreditation, Assessment, and Training teams. These positions have a higher skill level than administrative officers and support the managers in higher order functions and quality improvement.

Information Technology

The College's strategy of digital innovation over recent years has been extensive, including:

- the development and introduction of Learnit, the College's trainee management system
- the development and introduction of the My CPD system using cloud-based technology
- the upgrading and deployment of distributed computing and communication systems enabling staff to work remotely and continue business as usual during the pandemic
- review and improvement of the RANZCP website.

To support this strategy, there has been an increase in the resourcing of the Information Technology team, along with the establishment of a key contractual relationship with its technology partner, Evolve IT, the developer of My CPD and InTrain. This relationship covers both development of new functionality in response to evolving requirements and maintenance of the existing product.

Membership and Events

Originally a project supported by STP project funding to promote psychiatry as a career choice, the PIF is now an established program within the Membership and Events department with increased staffing.

Another project originally supported by STP project funding; the Mentoring program has been expanded to include early career psychiatrists as well as STP trainees. It is now an established program within the Membership and Events department with staffing recruited for its support.

To support the increased interest in webinars and online learning opportunities, the Events team has been expanded with a dedicated online events coordinator.

As members of the College increase their engagement through social media channels the Communications team has been augmented by a dedicated social media and communications officer.

Policy

The Policy team has been expanded to include policy officers in each of the RANZCP Branches to address local policy and advocacy issues, including education and training needs. In addition, FTE has been established to address projects in the areas of practice and the development of standards. The policy team collaborate with the Education and Training department to implement strategies to translate policy documents into the practice of psychiatrists.

RANZCP Projects

Under a newly appointed Senior Projects Manager, additional project team members have been appointed within the last year to support the STP, MVPTP, the development of the Rural Psychiatry Training Program (RPTP) and the Diploma of Psychiatry. The emphasis has been on recruitment of skilled project management staff with experience in program development.

Human Resources

The addition of a recruitment coordinator and a people and culture advisor has been made in the last few years.

Office of the President and CEO (OPCEO)

The OPCEO supports governance and legal considerations and has been extended with the addition of a dedicated legal officer.

Challenges for the next five years

Amongst the diverse development work that is currently underway and planned, there are three main challenges:

- delivering fit for purpose assessments and supporting candidates in a time of continued uncertainty
- a move to more workplace-based assessment, requiring investment and effort to engage supervisors with the need for increased responsibility, improved quality, and rigour
- the introduction of the CPD Homes in Australia, and the need for the RANZCP to not only leverage its significant body of expert content, but to ensure that competitors do not benefit financially or reputationally from the use of that expert content.

These challenges also present opportunities to evolve the training program and adopt more contemporary medical education directions.

1.6 Interaction with the health sector

1.6.1 The education provider seeks to maintain effective relationships with health-related sectors of society and government, and relevant organisations and communities to promote the training, education and continuing professional development of medical specialists.

The RANZCP engages with jurisdictions and the national governments through several avenues:

- its Branches, supported by the Policy and Education departments,
- the AGFTPC
- the OPCEO
- Tu Te Akaaka Roa (the New Zealand National Office and the National Committee).

Since the last accreditation by the AMC the RANZCP has worked collaboratively with the Australian Commonwealth Department of Health (ACDOH) to address the issues associated with the Psychiatry workforce, contributing detailed data on progression at the (deidentified) candidate level to support the modelling of the training pipeline. The RANZCP has been an active contributor to this workforce area, consulting with the ACDOH, attending workshops and meetings with the ACDOH over the last four years

To support the inclusion of rTMS in the Medicare Benefits Schedule (MBS) in November 2020, the RANZCP, in particular the Section of Electroconvulsive Therapy and Neurostimulation (SEN) and the Policy department, worked with the ACDOH to implement quality assurance measures such as the endorsement of required training courses for psychiatrists, grandfathering arrangements for psychiatrists who have been using the modality for some time, and recommendations regarding CPD requirements. This saw the establishment of the rTMS subcommittee of the CCPD to oversee the endorsement of training courses and the development of CPD requirements. This work is ongoing.

Major developments in jurisdictional collaboration include:

- an increase in the funding for Queensland training, with the addition of two regional Co-Directors of Training for the Far North and Central regional of the state plus additional administrative support for the increasing number of trainees
- work towards the establishment of a collaborative training consortium in Victoria, with the intent to ensure alignment of training opportunities and increased services arising from the outcomes of the Royal Commission into Victoria's Mental Health system.

The RANZCP is committed to engaging with key stakeholders to position the profession as a leader within mental health. The RANZCP forms strong working relationships with governments and mental health organisations at national, state and territory levels by contributing to consultations to influence the development of policy and practice and advocating for people with mental illness.

Government

The STP is an Australian Government funded initiative which provides funding to health organisations to support specialist medical training experiences in settings beyond traditional public teaching hospitals.

The RANZCP receives funding to administer STP posts, Integrated Rural Training Pipeline (IRTP) posts, Training more specialist doctors in Tasmania (Tasmanian Project) and various support projects. In 2020, the RANZCP was funded to administer:

- STP: 160 FTE
- IRTP: 34 FTE
- Tasmanian project: trainees 3 FTE, supervisors 1.31 FTE.

A new Psychiatry Workforce Program (PWP), introduced by the Australian Government in February 2022, addresses mental health workforce maldistribution and shortages, and aims to improve access to high quality mental health care for all Australians, with a focus on rural and remote areas. Under the PWP, RANZCP has received funding to administer 20 FTE trainee posts and 20 x 0.33 FTE supervisor positions in 2022.

Another initiative, the MVPTP is a Department of Veterans' Affairs (DVA) initiative providing funding to support specialist medical training experiences in facilities that predominantly work with military and veteran person personnel, are based within an area with high defence personnel presence or are DVA service providers. The RANZCP has received funding to administer 10 FTE posts in 2022.

Details of the distribution of these funded training posts is provided under standard 8 of this submission.

Community

In the final quarter of 2021, the RANZCP signed a 3-year MOU with Lived Experience Australia which formalised the principles of a valued and constructive relationship between the two organisations. Lived Experience Australia, formerly Private Mental Health Consumer Carer Network, was founded in 2002 to promote the interests of members of the community requiring private mental health services. While their focus is on private sector mental health services, Lived Experience Australia provides national systemic advocacy for consumers, families, and carers in all mental health settings.

In 2020 and 2021, the RANZCP collaborated with St Vincent's Postgraduate Overseas Specialist Training (POST) program and Fiji National University to run the OPHELIA (Online Pacific Health Exchange) program. OPHELIA provided 10 free, online sessions focused on child and adolescent mental health to health workers delivering child and youth mental health services in Pacific countries. The weekly sessions were held at lunchtime via Zoom and presented by members of the RANZCP Faculty of Child and Adolescent Psychiatry covering topics such as anxiety, PTSD, depression and suicidal behaviour. An advanced program was organised in 2021.

National and international educational institutions

The College President is a member of the CPMC, the unifying organisation of, and support structure for, specialist medical colleges in Australia. The CPMC provides objective advice on health issues to Government and the wider community as the peak specialist medical body in Australia.

The College also has links with specialist medical colleges and associations internationally. It is a member of the World Psychiatric Association (WPA), the global association representing 145 psychiatric societies in 121 counties. The WPA promotes collaborative work in all areas of psychiatry and has developed ethical guidelines and positions statements on topics relevant to psychiatric practice. The WPA and the College have partnered to Support and implement alternatives to coercion in mental healthcare. The project has produced a position statement, discussion paper and is developing a set of case studies that examine how progress has been achieved in different settings in implementing alternatives to coercion.

The College has MOUs with Fiji National University (FNU), the RCPsych, and the TNA. In development is a MOU with the Indian Psychiatric Society. These MOUs formalise the valued relationship between the parties and a common feature is collaboration and exchange of information on matters of training and education.

The College supported a desktop review to determine the mental health workforce training needs in the Pacific to scope the need for a Masters of Medicine (Psychiatry) program at FNU. The desktop review found that there is a need for a Masters (or similar) program in the Pacific region but noted that the 'provision of educational programs alone is not a panacea for the development of a regional mental health workforce'. The FNU Senate endorsed the need for a Masters program in November 2021. Specific support may be requested from the College to implement the program and the College has requested and is waiting for further information.

The College engages with international psychiatry organisations through attendances at conferences. The President is invited to attend a number of events each year (often the American Psychiatric Association, Japanese Society of Psychiatry and Neurology, RCPsych and WPA World Congress) and presents latest updates from Australia, New Zealand or the College. These conferences give the opportunity to strengthen our relationships with these international psychiatry organisations and make new connections. The President is often invited to give keynote addresses to smaller international associations throughout the year which are important opportunities for mutual shared learning.

Policy

Training in psychiatry is primarily based in the workplace. The policy and advocacy work of the RANZCP directly contributes to the practice of psychiatry, and therefore informs the training environment. Changes in policy or developments resulting from government directives may impact significantly on training requirements, and training program and curriculum. Policy documents become key references for trainees and their supervisors.

Examples of the range of policy documents produced by the RANZCP include:

- position statements, such as:
  - o PS 82 Recognising and addressing the harmful mental health impacts of methamphetamine use
  - o PS 74 Electroconvulsive Therapy
  - o Recognising and addressing the mental health needs of the LGBTIQ+ population | RANZCP
  - o PS 46 The provision of mental health services for asylum seekers and refugees
  - o PS 35 addressing the mental health impacts of natural disasters and climate change-related weather events
- clinical practice guidelines, including
  - o Clinical practice guideline for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder (Appendix 1.6.1_1)
  - o Clinical practice guideline for the treatment of deliberate self-harm. (Appendix 1.6.1_2).
- Professional Practice Guidelines, such as:
  - o Professional Practice Guideline for the administration of electroconvulsive therapy (Appendix 1.6.1_3)
  - o PPG 5 Guidance for the use of benzodiazepines in psychiatric practice. (Appendix 1.6.1_4).
- clinical memoranda, including:
  - o Use of ketamine for treatment-resistant depression (Appendix 1.6.1_5)
  - o Therapeutic use of medicinal cannabis products. (Appendix 1.6.1_6).

These documents are all available through the RANZCP website through the Policy and Advocacy Library and the Guidelines and resources for practice pages.

Advocacy

The RANZCP advocates for membership on key external health forums to provide expertise and to influence the development of policy, practice, and standards. Examples of committees and advisory bodies on which the RANZCP was represented include:

- Australian ADHD Professionals Association
- Australian and New Zealand Counter Terrorism Committee's Health Experts Advisory Group
- Department of Health Mental Health Professionals Workforce Online Training in Mental Health of Residents in Aged Care Facilities Expert Reference Group

- Department of Health National Mental Health Policy Renewal Project Steering Group
- Monash University Implementing work related Mental health guidelines in general PRacticE (IMPRovE) trial Steering Group
- National Mental Health Commission National Children's Mental Health and Wellbeing Strategy Aboriginal and Torres Strait Islander Reference Group
- National Disability Insurance Agency National Mental Health Sector Reference Group
- National Rural Health Alliance Council
- Phoenix Digital Disaster Training Platform Consultation Reference Group.
- Australian Commission on Quality and Safety in Health Care
- Australian Hospitals Pricing Authority.

Relative Strengths

A key strength in relation to interactions with the health sector is the strong relationships formed at the jurisdictional level by the RANZCP Branches (New Zealand National Office and Australian Branches). Each Branch completes multiple submissions to inquiries and reviews each year to inform service development and policy relevant to its jurisdiction and advocate for best practice mental healthcare. Branch Chairs meet regularly with jurisdictional Ministers for Health/Mental Health to raise issues of importance at the local level. A recent example includes the announcement of a parliamentary inquiry into mental health services in Queensland following the Queensland Branch's longstanding advocacy for increased funding.

Another strength is increased engagement with the Regional Training Hubs over the past 12–18 months as the RANZCP completed its Supporting Regional, Rural and Remote Training Scoping Project. Engagement with the hubs is likely to continue as the RANZCP works to implement its Rural Psychiatry Roadmap.

1.6.2 The education provider works with training sites to enable clinicians to contribute to high-quality teaching and supervision, and to foster professional development.

The structures that support training vary across jurisdictions. In most jurisdictions there are Site Coordinators of Training (SCOTs) or Hospital Coordinators of Training who oversee training at their health service and undertake activities delegated to them by the DOTs. The accreditation of supervisors and the delivery of local teaching programs including Grand Rounds and Journal Clubs are supported by the SCOTs. Practising clinicians contribute to the formal education of trainees in all jurisdictions.

To maintain their accreditation, supervisors are required to attend at least three peer meetings annually where supervision is the main topic of discussion. These are usually conducted at the local training site level and are designed to meet the need for ongoing professional support in supervision.

1.6.3 The education provider works with training sites and jurisdictions on matters of mutual interest.

It is important to note that the RANZCP does not accredit training sites per se, it accredits training posts. The RANZCP accredits training programs through the AC, but delegates the approval of specific training posts to the local BTC/NZTC. It is possible to have a mix of accredited training posts and services posts at an individual health service or location. This means that engagement with training sites, particularly around the development of new training posts, is usually conducted at the local Branch level.

As a recent example, the DOT in the Victoria North training zone, in collaboration with the Victorian Psychiatry Training Program Committee (VPTPC), has assisted Albury Wodonga Health (a regional health service on the border of Victoria and New South Wales) to establish a training position.

Issues related to trainee welfare are commonly addressed through the accreditation process, either through the training post accreditation process, or through the training program accreditation process. The latter is conducted centrally by the AC of the RANZCP and where trainee welfare issues are identified during the accreditation of a program recommendations are made, with timeframes for implementation, and referred to the CFT for management and monitoring.

Engagement with the jurisdictions regarding training and education is also conducted at the local level through the BTC/NZTC supported by their Branch committees. Policy officers at each branch support advocacy and negotiation around workforce needs, and they are supported by the Education Department at the College with specific advice on training policy and requirements. In recent years this has resulted in an increase in the administrative support for the Queensland Training Program and the establishment of a collaborative training consortium in Victoria. The AGFTPC and its secretariat consults regularly with jurisdictions and training sites regarding applications for, the approval of and contractual arrangements fo funded training positions.

Branch policy officers, with the support of the central Policy Department, make pre-Budget submissions to jurisdictional governments annually making recommendations regarding key issues relating to service delivery, capacity, and quality.

1.6.4 The education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education.

The RANZCP is a proud member of the Australian Indigenous Doctors' Association (AIDA), a member-based professional association supporting Aboriginal and Torres Strait Islander medical students and doctors. The RANZCP has been a sponsor of the annual AIDA Conference since 2014 and participates in Growing our Fellows – a key feature of the conferences (held virtually in 2021).

Growing our Fellows provides an opportunity for AIDA members to have direct engagement with specialist medical colleges to discuss pathways in specialist medical training and their career aspirations. Growing our Fellows also provides a vehicle for AIDA members to provide feedback to colleges on issues of cultural safety, mentoring and supporting Aboriginal and Torres Strait Islander doctors to train in specialty areas.

In collaboration with AIDA, the RANZCP also awards up to four scholarships to AIDA members to support attendance at the annual RANZCP Congress.

In New Zealand, the RANZCP is proud to be a member of Te Ohu Rata O Aotearoa, the Māori Medical Practitioners Association (Te ORA) and provides sponsorship to the annual Te ORA Hui-a-Tau.

The RANZCP also provides sponsorship to the biennial Leaders in Indigenous Medical Education (LIME) Network LIME Connection conference. LIME Connection is a leading international event in Indigenous health and health professional education for academics, students, community members, practitioners and policy makers.

The RANZCP plans to continue its partnership and support of AIDA, Te ORA and the LIME Network into the future.

AIDA FATES consortium

The RANZCP has joined a consortium of specialist medical colleges with AIDA to apply for 3.5 years of funding under the Flexible Approach to Training in Expanded Settings (FATES) 2021–22 Budget measure. The funding is to establish a non-GP Specialist Trainee Support Program (STSP) to augment the recruitment and retention of Aboriginal and/or Torres Strait Islander doctors who wish to commence or are currently undertaking non-GP specialist medical training.

Aboriginal and Torres Strait Islander Trainee Forums

The RANZCP is committed to developing its strategy to better attract and support the Aboriginal and Torres Strait Islander workforce in psychiatry. For the past four years, the RANZCP has delivered Aboriginal and Torres Strait Islander Trainee Forums through the PIF with the goal of ensuring a collaborative process in enhancing the RANZCP's recruitment and retention strategy.

Each year, some of the RANZCP's Aboriginal and Torres Strait Islander Fellows are invited to attend the Trainee Forums. The Trainee Forums provide a valuable opportunity for Aboriginal and Torres Strait Islander trainees to connect, meet role models and find support on their journey towards Fellowship.

AIDA Cultural Safety Training Workshop

AIDA delivers a clinically focused cultural safety training program titled 'Aboriginal and Torres Strait Islander Health in Clinical Practice' that equips Fellows and trainees in any medical specialty with the knowledge, skills and attitudes needed to integrate Aboriginal and Torres Strait Islander holistic health and cultural safety into everyday clinical practice. As part of the RANZCP's commitment to improving the mental health and wellbeing of Aboriginal and Torres Strait Islander peoples and communities, the RANZCP engaged AIDA to facilitate this workshop for RANZCP trainees and Fellows to promote culturally safe mental healthcare delivery.

The workshop is a 1-day, in-person training program, delivered by Aboriginal and Torres Strait Islander doctors, encourages participants to reflect and discuss improvements in clinical practice and cultural safety for Aboriginal and Torres Strait Islander patients. Participants develop knowledge and skills to improve patient engagement and healthcare outcomes for Aboriginal and Torres Strait Islander patients.

The workshop was delivered prior to the RANZCP Congress in Hobart in 2021 with plans to deliver another workshop in 2022.

Transition into Consultancy Workshop

The 2020 Trainee Forum identified the need to provide targeted support, in a culturally safe environment, for Aboriginal and Torres Strait Islander registrars who would soon transition into a consultancy role. In 2022, the RANZCP will host a virtual Transition into Consultancy Workshop to provide trainees with the leadership and management skills needed to more transition into a consultancy role.

RANZCP Aboriginal and Torres Strait Islander Fellows will help to facilitate the workshop.

Western Australia Branch Office

An example of the commitment to working with local Indigenous communities is the new Western Australia Branch office. The local Noongar people participated in all phases of the refurbishment of the building, conducting a smoking ceremony at the commencement of the renovation and advising on the inclusion of Noongar language and art throughout the building.

(171) Incorporating local First Nations knowledge and culture into the RANZCP Western Australia Branch. - YouTube

Te Kaunihera

Reporting to the PPPC, Te Kaunihera executes strategic priorities related to the practice and profession of psychiatry in relation to training, research and relationships with the Māori community. The Te Kaunihera regulation is attached as Appendix 1.6.4_1 .

Significant pieces of work over last five years include:

- the provision of support to the RANZCP Board and the Tu Te Akaaka Roa in the appointment of kaumātua (Māori elders - the kaumātua (male) and kuia (female)) to support and assist the College to uphold the mana of Māori as TeTiriti O Waitangi partner in Aotearoa. The kaumātua guide, mentor and support Te Kaunihera and Tu Te Akaaka Roa, College members and staff, representing or supporting members at hui (meetings) and particularly on areas of cultural importance and significance to Māori. When required the kaumātua provide cultural guidance to the Board, ensuring tikanga Māori principles are followed at official conferences or hui
- the establishment of the RANZCP Aboriginal, Torres Strait Islander and Māori Trainee Financial Support Initiative, a grant for Māori trainees providing up to $6,000 per calendar year to assist with the costs of specialist training (Appendix 1.6.4_2).
- leadership for the development of:
    - o Position statement 104 Whānau Ora
    - o Position statement 105 Cultural safety
    - o Position statement 107 Recognising the significance of the Te Tiriti o Waitangi (Treaty of Waitangi)
- endorsement of the Takarangi Competency Framework to support the development and implementation of a Māori cultural safety training programme for RANZCP trainees and Fellows
- establishing the Aotearoa Cultural Safety Working group together with the NZTC to develop and implement the Takarangi Framework – ToR pending
- leading the delivery of an annual wānanga for Māori trainees, a cultural forum led by the College's kaumātua and/or kuia assisting in the application of knowledge regarding ahuatanga Māori (Māori tradition) according to tikanga Māori (Māori custom)
- leading the delivery of cultural supervision for RANZCP Māori trainees
- in collaboration with Tu Te Akaaka Roa, developing resources to support RANZCP staff in the correct use of Te Reo in college documents (Appendix 1.6.4_3).

Aboriginal and Torres Strait Islander Mental Health Committee

The Aboriginal and Torres Strait Islander Mental Health Committee, also reporting to the PPPC, executes RANZCP strategic in relation to Aboriginal and Torres Strait Islander mental health. The Aboriginal and Torres Strait Islander Mental Health Committee regulation is attached as Appendix 1.6.4_4.

Significant pieces of work over the last five years include:

- Leadership of the development of the College's Aboriginal and Torres Strait Islander mental health e-learning modules
    - o Module 1: Interviewing an Aboriginal or Torres Strait Islander patient (ranzcp.org)
    - o Module 2: Developing a mental health management plan for an Aboriginal or Torres (ranzcp.org)
    - o Module 3: Formulation of a case involving an Aboriginal or Torres Strait Islande (ranzcp.org)
    - o Module 4: Review a model of mental health service delivery in an ATSI community (ranzcp.org)
- establishing the RANZCP Aboriginal, Torres Strait Islander and Māori Trainee Financial Support Initiative a grant for Aboriginal and Torres Strait Islander trainees providing up to $6,000 per calendar year to assist with the costs of specialist training.

- support of the College's development and implementation of a Reconciliation Action Plan (RANZCP Reconciliation Action Plan 2016-18), which is currently being redeveloped at the innovate level
- development of the RANZCP Cultural Protocols – Aboriginal and Torres Strait Islander to follow consistent and appropriate protocols required for regular RANZCP business to demonstrate respect for Aboriginal and Torres Strait Islander peoples
- leadership of the development and/or revision of:
    - o Position statement 42 Acknowledging the Stolen Generations
    - o Position statement 68 Recognition of Aboriginal and Torres Strait Islander peoples in the Australian Constitution
    - o Position statement 100 Trauma informed care
    - o Position statement 105 Cultural safety
- partnership with AIDA in the delivery of forums and grants to support trainee attendance at the RANZCP Congress and the AIDA conference.

Te Kaunihera and the Aboriginal and Torres Strait Islander Mental Health Committee continue their work to support the College in the revision and development of position statements and advocacy relevant to Aboriginal, Torres Strait Islander and Māori mental health. The committees will review the implementation the RANZCP Aboriginal, Torres Strait Islander and Māori Trainee Financial Support Initiative and continue to lead the delivery of trainee forums and cultural supervision. The Aotearoa Cultural Safety Working Group (inclusive of representatives of Te Kaunihera) will work together with the NZYC to develop and implement the Takarangi Framework. The Aboriginal and Torres Strait Islander Mental Health Committee will support the College in its development of a new Reconciliation Action Plan at the innovate level.

1.7 Continuous renewal

1.7.1 The education provider regularly reviews its structures and functions for and resource allocation to training and education functions to meet changing needs and evolving best practice.

Resource allocation is considered annually in conjunction with the development of annual workplans and the process of building the budget. This occurs in the second half of the year and staffing resourcing and operational budget are submitted for consideration and approval of the Finance Committee and the Board.

This process enables a regular review of structures and functions to support training and education with new initiatives, supported by a structured business case template, able to be implemented in response to changing needs and evolving best practice.

The recommendations of reviews such as the ACER review, discussed in detail under Standard 5, are considered as part of the annual workplan development and budget build.

Standard 1: Documents provided check list

	Document
√	College's governance structure with key committees and lead members indicated. Appendix 1.1.1_2 RANZCP Governance Structure Chart
√	Terms of reference and membership of training and education committees. Appendix 1.1.2_1 Committee for Specialist International Medical Graduate Education Regulations Appendix 1.1.2_2 Committee for Examinations Regulations Appendix 1.1.2_3 Committee for Training Regulations Appendix 1.1.2_4 Committee for Educational Evaluation, Monitoring and Reporting Regulations Appendix 1.1.2_5 Committee for Continuing Professional Development Regulations Appendix 1.1.2_6 Accreditation Committee Regulations Appendix 1.1.2_7 Australian Government Funded Training Programs Committee Regulations Appendix 1.1.2_8 Terms of Reference E-Learning Advisory Group Appendix 1.1.2_9 Terms of Reference Syllabus Learning Outcomes and Developmental Descriptor review Appendix 1.1.2_10 Education Committee Regulations
√	Any formal agreements between the education provider and other entities concerning the delivery of training Appendix 1.4.2 5-year RCPsych - RANZCP Memorandum of Understanding (MoU) Appendix 1.10 Specialist Training program (STP) - Executed SGA Appendix 1.11 Psychiatry Workforce Program (PWP) - Executed SGA Appendix 1.12 Flexible Approach to Training in Expanded Settings (FATES) -Executed SGA Appendix 1.13 Military and Veterans' Psychiatry Training Program (MVPTP) - MVPTP - 2021-2025
√	Conflict of interest policy relevant to training and education functions Appendix 1.1.6_1 Declaring and Managing Conflict of Interest Guideline
√	Reconsideration, review and appeals policy Appendix 1.3.1_1 Review, reconsideration and Appeal Policy and Procedure
√	A diagram showing the education provider's staffing structure. Appendix 1.8 RANZCP Organization Chart - Education
√	Most recent Annual Report. Appendix 1.9 RANZCP Annual Report 2021
√	Reports of any relevant reviews. Appendix 5.1.1 ACER RANZCP Examination Review Appendix 5.4.1_1 ACER Review implementation plan

Standard 2: The outcomes of specialist training and education

Standard 2: The outcomes of specialist training and education

2.1 Educational purpose

2.1.1 The education provider has defined its educational purpose which includes setting and promoting high standards of training, education, assessment, professional and medical practice, and continuing professional development, within the context of its community responsibilities.

The RANZCP is the principal organisation providing accreditation and representation for the medical specialty of psychiatry in Australia and New Zealand. The College is responsible for training, examining, and awarding the RANZCP Fellowship qualification to medical practitioners, and for the oversight of continuing professional development to specialist psychiatrists and other doctors working in mental health.

The RANZCP's educational purpose is articulated through its Constitution (provided as Appendix 2.1.1), strategic plan and the multitude of policy documents and position statements that are prepared annually. The specific purposes of the College relevant to this standard include that it should:

- promote and encourage the study, research and advancement of the science and practice of psychiatry
- promote excellence in healthcare services for patients, and their families and carers, and cultivate and encourage high principles of practice, ethics and professional integrity in relation to psychiatric practice, education, assessment, training and research
- determine and maintain professional standards for the practice of psychiatry in Australia and New Zealand
- promote and sustain a bi-national approach to psychiatric affairs in Australia and New Zealand
- advocate on any issue which affects the ability of Members to meet their responsibilities to patients and to the community
- conduct and support programs of training and education leading to the issue of a certificate, diploma, or other certification attesting to the attainment or maintenance of appropriate levels of skills, knowledge, and competencies commensurate with specialist and sub-specialist practice in psychiatry in Australia and New Zealand
- disseminate information and advice on any course of study and training designed to promote and ensure the fitness of persons who wish to qualify for recognition by the College
- conduct and co-ordinate examinations and other assessment processes and to grant registered medical practitioners recognition of special knowledge in psychiatry, either alone or in co-operation with other relevant bodies or institutions
- award certificates, diplomas or other forms of certification evidencing a standard of attainment of specialised knowledge and competencies in the discipline of psychiatry and related subjects
- hold or sponsor meetings, lectures, seminars symposia or conferences, within or outside of Australia and New Zealand, to promote understanding in psychiatry and related subjects and professional relations among Members of the College, members of other health professions and the community in general
- facilitate the advancement of specialist and sub-specialist medical education and training through the conduct of projects and research
- ensure Members undertake continuous professional improvement and participate in effective, ongoing professional development activities
- foster and promote cooperation and association with organizations which have objectives similar to the College in Australia and New Zealand as well as in the wider international arena, including Asia and the Pacific Region

- advance public education and awareness of the science and practice of psychiatry and the health and welfare of patients and their families
- encourage mental health programs concerned with:
    - o the promotion of health and the prevention of disability and disease
    - o the early detection of mental health problems, disabilities, disease and other abnormal states; and
    - o the enhancement of high-quality psychiatric care
- facilitate psychiatric and mental health education to developing nations.

There have been no changes to the role of the RANZCP since the last accreditation.

The RANZCP has commenced the development of a Diploma of Psychiatry, after receiving funding from the Australian Commonwealth Department of Health. The Diploma is targeted at medical practitioners wishing to gain further experience in psychiatry and may offer an exit qualification for trainees who are not able to complete the requirements for Fellowship. When launched, the Diploma will expand the RANZCP's educational purpose and enable other doctors to upskill in the treatment of patients with mental health problems and develop knowledge in psychiatry.

Significant progress has been made with this project being managed by the RANZCP's Senior Project Manager with support from an internal cross-departmental project group and an external consultant. An Expert Advisory Group (EAG) has been established in 2022. Membership, apart from RANZCP Fellows and a career medical officer, includes representatives from the:

- Royal Australian College of General Practitioners (RACGP)
- Australian College of Rural and Remote Medicine (ACCRM)
- Australasian college of Emergency Medicine (ACEM)
- Royal Australasian College of Physicians (RACP)
- Australian Medical Association (AMA)
- Australian Department of Health.

The development of the curriculum for the Diploma, selection and mapping of assessment methods and development of an assessment blueprint, has been delegated to the Diploma Curriculum Authorship Steering Group, to be delivered by the middle of 2023.

2.1.2 The education provider's purpose addresses Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand and their health.

The RANZCP recognises the need for all Australians and New Zealanders to experience good mental health and seeks to redress the inequities in health experienced by Aboriginal and Torres Strait Islander, Māori and Pasifika communities through a variety of initiatives.

Building on previous work in this area, the College is currently developing our first Innovate Reconciliation Action Plan. A working group is being established and the College has engaged with Reconciliation Australia and Indigenous health organisations, prior to the development of the plan.

A key priority of the Colleges Strategic Plan 2018 – 2020 (extended due to COVID-19) is advocacy for improved access to mental health services for Māori, Aboriginal and Torres Strait Islander peoples.

With a commitment to both raise issues with health inequities for first nations people and support the work of the respective national Governments in improving mental health of first nations people, the RANZCP makes submissions to the Aboriginal and Torres Strait Islander Health Plan and has raised issues with the NZ Minister of Health as well taking opportunities to highlight health inequalities within submissions relating to workforce, cultural safety and prevention.

As described in detail under standard 1.6.4, the Aboriginal and Torres Strait Islander Mental Health Committee is composed of psychiatrists who have direct experience working in Aboriginal and Torres Strait Islander mental health and Aboriginal and Torres Strait Islander community members who are involved in mental health service provision and policy development. It is committed to, and passionate about, improving access to effective mental health care for Aboriginal and Torres Strait Islander peoples and their communities.

Also described in detail under standard 1.6.4, Te Kaunihera provides the RANZCP with advice on issues relating to Māori, including clinical practice and psychiatry training, and advocates for the mental health of Māori. It also supports the recruitment of Māori doctors into psychiatry. The committee membership comprises Māori community members who are involved in mental health service provision and policy development, and psychiatrists and trainees with direct experience of working in Māori mental health.

Additionally, projects are underway to:

- develop a proposal for the delivery of training that supports culturally safe practice of psychiatrists and trainees when working with Aboriginal and Torres Strait Islanders. An initial AIDA Cultural Safety Training Workshop was delivered in May 2021. The challenge is for this training to be offered at scale across Australia in a way that maximizes its relevance to the diversity of Aboriginal and Torres Strait communities
- implement cultural safety training, utilising the Takarangi Framework for trainees in New Zealand, with extension to all members over time (Appendix 2.1.2). The Takarangi Framework is specific to the mental health and addictions sector.
- work with the CMC to develop a cultural safety framework for specialist doctors in New Zealand.

As detailed under standard 1.6.4, the RANZCP has several key position statements related to this standard, which are published on the RANZCP website.

These are guiding documents that support the RANZCP's actions in working to promote the highest quality mental health care to the Indigenous peoples of Australia and Aotearoa New Zealand.

2.1.3 In defining its educational purpose, the education provider has consulted internal and external stakeholders.

The constitution of the RANZCP was last amended in 2017. The adoption of changes to the constitution requires consultation with the broader membership and a vote of the membership.

Documents that support the educational purpose of the RANZCP go through an extensive consultation process through the established governance structures. Those structures include the CCC, the Aboriginal and Torres Strait Islander Mental Health Committee and Te Kaunihera. These three committees are key to ensuring that the RANZCP considers the views of people with lived experience, Aboriginal and Torres Strait Islander peoples, and Māori. They actively provide an alternative lens through which the RANZCP must consider its policy development and delivery of training and education.

Consultation for the development of the current RANZCP Strategic plan, not yet published, has included:

- an externally facilitated Board strategic workshop
- consultation with members via an online survey
- consultation forums for the MAC
- consultation with RANZCP staff.

As described under standard 1.6 the College has strong relationships with the respective Departments of Health across Australia and New Zealand, in particular aligning workforce needs with current and ongoing funding such as the PIF, investment and innovation in rural training, and the Diploma of Psychiatry.

2.2 Program outcomes

2.2.1 The education provider develops and maintains a set of program outcomes for each of its specialist medical programs, including any subspecialty programs that take account of community needs, and medical and health practice. The provider relates its training and education functions to the health care needs of the communities it serves.

A psychiatrist is a specialist medical doctor who assesses and treats patients with mental health problems. The RANZCP has one discipline and no changes have been made to the definition.

This definition is consistent with the scope of practice published in the New Zealand Gazette in 2018:

"The assessment, diagnosis and treatment of persons with psychological, emotional, or cognitive problems resulting from psychiatric disorders, physical disorders or any other cause. Treatment interventions provided by psychiatrists will include biological, psychological and existential modalities. Psychiatrists also undertake supervision and consultation with other health professionals working with a broad range of issues" (Scopes of Practice and Prescribed Qualifications for the Practice of Medicine in New Zealand 2018 - 2018-gs2124 - New Zealand Gazette)

and also with the definition of psychiatry published by the World Psychiatric Association in its Madrid Declaration on Ethical Standards for Psychiatric Practice:

"Psychiatry is a medical discipline concerned with the prevention of mental disorders in the population, the provision of the best possible treatment for mental disorders, the rehabilitation of individuals suffering from mental illness and the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources."

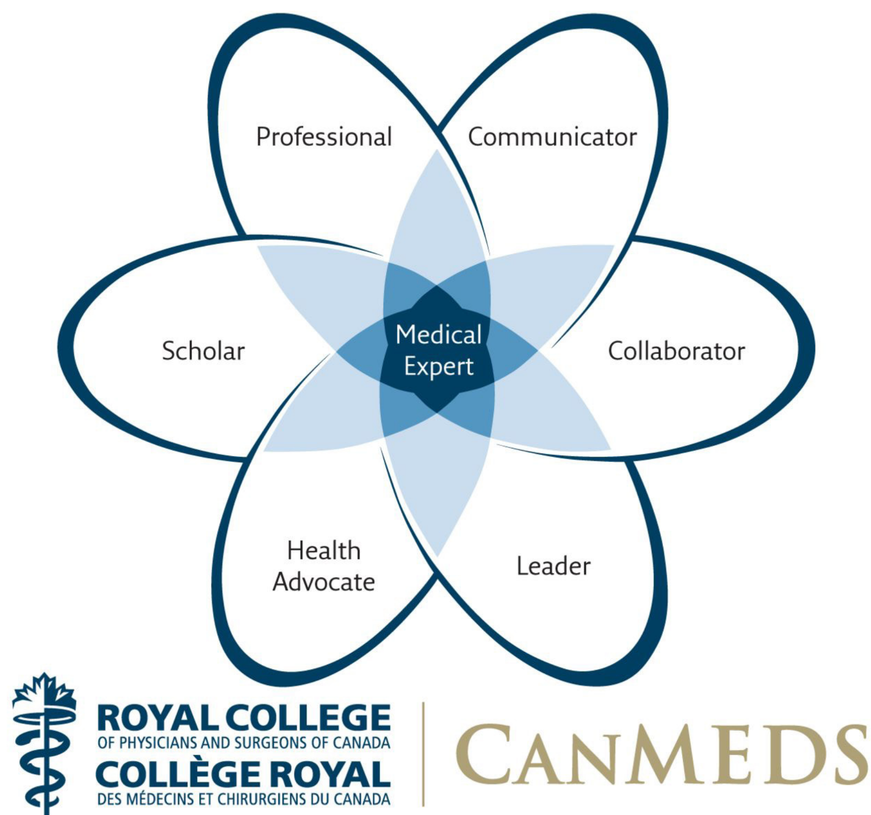
The Madrid Declaration was approved by the General Assembly of the World Psychiatric Association in Madrid, Spain, on August 25, 1996, and enhanced by the WPA General Assemblies in Hamburg, Germany on August 8, 1999, in Yokohama, Japan, on August 26, 2002, in Cairo, Egypt, on September 12, 2005, and in Buenos Aires, Argentina, on September 21, 2011. https://www.wpanet.org/current-madrid-declaration

The role of the psychiatrist in Australia and New Zealand has been articulated in PS 80, which is currently in the consultation phase of review. Initially published in 2013, it has been withdrawn whilst it undergoes revision. The initial consultation phase is expected to conclude in July 2022 and if no further consultation is required following review by the PPPC the draft will proceed to the CGRC and Board later in 2022.

The RANZCP program outcomes are underpinned by its competency- based training program incorporating the development of Fellowship competencies to successfully equip RANZCP graduates with specific knowledge, skills, and attitudes to become specialist psychiatrists. Developed with permission from the RCPSC the graduate outcomes or Fellowship competencies, map to the seven CanMEDS roles illustrated in Figure 2.2.1 below, and described in detail under standard 2.3.

There have been no changes to the program outcomes since the last AMC accreditation in 2012.

Figure 2.2.1. CanMEDS roles*



2.2.2 The program outcomes are based on the role of the specialty and/or field of specialty practice and the role of the specialist in the delivery of health care.

The program outcomes, focused on graduating psychiatrists proficient in all seven of the CanMEDS roles, are designed to meet the increasing expectations of a more informed community for the delivery of health care in a partnership type model, rather than one with a distinct power differential. By ensuring that CanMEDS roles such as Health Advocate and Communicator are given equal weight to the role of Medical Expert, RANZCP trainees are prepared to act as advocates for their patients and the health system and to communicate effectively.

A fundamental program outcome is the graduation of psychiatrists to meet the needs of the communities of Australia and New Zealand in the most efficient way and this was a goal of the 2012 Regulations.

Trainees' progression by Cohort

The RANZCP has been considered by the AMC as a leader in the implementation of competency based medical education (CBME) in Australia and the AMC has requested continued reporting of trainees' progression and the proportion of trainees completing the training program in less than six years. Table 2.2.2_1 illustrates the progression of each cohort since the implementation of the 2012 Fellowship regulations. As of June 2022, at least 50% of each cohort has completed the program within six years. A feature of the Fellowship program is the flexibility for trainees, allowing part time enrolment and breaks in training supportive of family commitments. It is important that a focus on achieving Fellowship in five years does not detract from the flexibility which has contributed to the gender parity in the trainee body.

* "Copyright © 2015 The Royal College of Physicians and Surgeons of Canada. http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e. Reproduced with permission."

Table 2.2.2_1. Progression by cohort (as of 16 June 2022)

Trainees Fellows										
	Cohort 2013	Cohort 2014	Cohort 2015	Cohort 2016	Cohort 2017	Cohort 2018	Cohort 2019	Cohort 2020	Cohort 2021	Cohort 2022 (d)
Intakes	**221**	**236**	**263**	**273**	**246**	**296**	**295**	**360**	**348**	**296**
Inactive										
Deceased	1	-	1	1	-	-	-	-	-	-
Excluded	3	4	5	2	3	-	-	-	-	-
Withdrawn	37	27	30	29	19	22	12	19	5	-
Trainees										
Trainees	43	73	100	146	186	273	281	341	343	296
Fellows (a)										
2014	-	-	-	-	-	-	-	-	-	-
2015	-	-	-	-	-	-	-	-	-	-
2016	1	1	-	-	-	-	-	-	-	-
2017	3	-	-	-	-	-	-	-	-	-
2018	**55**	8	1	-	-	-	-	-	-	-
2019	**37**	**62**	3	1	-	-	-	-	-	-
2020	19	**32**	**68**	2	-	-	-	-	-	-
2021	17	21	**41**	**66**	3	1	1	-	-	-
2022	5	8	14	**26**	**35**	-	1	-	-	-
Fellows	**137**	**132**	**127**	**95**	**38**	**1**	**2**	**0**	**0**	**0**
Attrition rate (b)	**17%**	**11%**	**11%**	**11%**	**8%**	**7%**	**4%**	**5%**	**1%**	**0%**
End (<6 years) (c)	**53%**	**50%**	**50%**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

(a) Those completing the program in five or six calendar years are highlighted in green and blue, respectively.

(b) The RANZCP attrition rates report on the number of trainees who have permanently withdrawn from the Fellowship program but do not include trainees excluded (terminating or dismissing a trainee according to college regulations) or deceased.

(c) The end (>6 years) report on the percentage of intakes (excluding inactive) who have finished the Fellowship program in less than 6 years.

(d) Intakes will conclude in February 2023.

The AMC has requested continued monitoring of inactive trainees by cohort, and these figures are provided in Table 2.2.2_2. After a relatively high number of trainees becoming inactive in the first cohort of the 2012 Regulations the number of inactive trainees by cohort appears to be reducing and stabilising. Details of the reasons for trainee withdrawal and exclusion are provided under standard 5.4.3 and 5.3.3 respectively.

Table 2.2.2_2. 2012 Fellowship Program, Trainees inactive by cohort and year (as of 16 June 2022)

	Trainees inactive									
	Cohort 2013	Cohort 2014	Cohort 2015	Cohort 2016	Cohort 2017	Cohort 2018	Cohort 2019	Cohort 2020	Cohort 2021	Cohort 2022
2013	1									
2014	6	1								
2015	6	7	1							
2016	6	5	5	5						
2017	7	2	9	8	2					
2018	6	4	6	5	7	4				
2019	3	8	6	7	9	7	3			
2020	3	-	4	3	4	7	6	6		
2021	3	4	5	3	-	3	3	10	3	
2022	-	-	-	1	-	1	-	3	2	-
Total	**41**	**31**	**36**	**32**	**22**	**22**	**12**	**19**	**5**	**-**

2.3 Graduate outcomes

2.3.1 The education provider has defined graduate outcomes for each of its specialist medical programs including any subspecialty programs. These outcomes are based on the field of specialty practice and the specialists' role in the delivery of health care and describe the attributes and competencies required by the specialist in this role. The education provider makes information on graduate outcomes publicly available.

The graduate outcomes for the Fellowship program, described in this section, are published on the RANZCP website (Fellowship competencies | RANZCP). The graduate outcomes are modelled on the CanMEDS roles, and except for the Manager role, have not changed since the last accreditation of the RANZCP. The Manager role is currently under review and being updated to Leader, in line with the most current version of the CanMEDS framework.

Medical expert

As medical experts, psychiatrists perform comprehensive, culturally appropriate psychiatric assessments with patients of all ages. Fundamental to the practice of psychiatry is the ability to perform and report thorough mental state exams, integrating all available information to accurately formulate and diagnose patient conditions, subsequently providing an evidence-based bio-psycho-sociocultural management plan, mindful of the impacts of patients' physical health. Demonstrable skills in psychotherapeutic, pharmacological, biological and sociocultural interventions are requisite. Psychiatrists define and review patient outcomes, revising management as appropriate based on this review, and are committed to early intervention and recovery. Medical expertise is supported by the application of contemporary research, psychiatric research and treatment guidelines, as well as the application of mental health and related legislation in patient care.

Fellowship Competencies:

- conduct a comprehensive, culturally appropriate psychiatric assessment with patients of all ages
- demonstrate the ability to perform and report a comprehensive mental state examination, which includes cognitive assessment
- demonstrate the ability to integrate available information in order to formulate the patient's condition and make a diagnosis according to the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM)
- develop, negotiate, implement and evaluate outcomes of a comprehensive evidence-based biopsychosociocultural management plan
- demonstrate skills in psychotherapeutic, pharmacological, biological and sociocultural interventions to treat patients with complex mental health problems
- demonstrate the ability to integrate and appropriately manage the patient's physical health with the assessment and management of their mental health problems
- demonstrate the ability to critically appraise and apply contemporary research, psychiatric knowledge and treatment guidelines to enhance patient outcomes
- demonstrate the ability to appropriately apply mental health and related legislation in patient care.

Communicator

As communicators, psychiatrists communicate effectively with a range of patients, carers, multidisciplinary teams, general practitioners, colleagues and other health professionals, using their interpersonal skills for the improvement of patient outcomes. Communication skills range from the ability to provide clear, accurate, contextually appropriate written communication about patients' conditions, advice, and appropriate reports, as well as conduct a dialogue about psychiatric issues with the wider community.

Fellowship Competencies:

- demonstrate the ability to communicate effectively with a range of patients, carers, multidisciplinary teams, general practitioners, colleagues, and other health professionals
- demonstrate the ability to provide clear, accurate, contextually appropriate written communication about the patient's condition.

Collaborator

Psychiatrists work respectfully with patients, families, carers, carer groups and non-government organisations. As collaborators, psychiatrists are able to work effectively with other psychiatrists, within multidisciplinary teams and with other health professionals, whilst working within relevant health systems and with government agencies.

Fellowship Competencies:

- demonstrate the ability to work respectfully with patients, families, carers, carer groups and non-government organisations
- demonstrate the ability to use interpersonal skills to improve patient outcomes
- demonstrate the ability to work effectively with other psychiatrists, within multidisciplinary teams and with other health professionals
- demonstrate the ability to work within relevant health systems and with government agencies.

Manager

As managers, psychiatrists work within clinical governance structures in health-care settings, providing clinical leadership, work within management structures within the health-care system; require the ability to critically review and appraise different health systems and management structures. Psychiatrists prioritise and allocate resources efficiently and appropriately, with the facility to perform appropriate management and administrative tasks within the healthcare system, applying health and other relevant legislation where appropriate. Psychiatrists also incorporate an awareness and application of information and communication technology into their practice.

Fellowship Competencies:

- demonstrate the ability to work within clinical governance structures in health-care settings
- demonstrate the ability to provide clinical leadership within management structures within the health-care system
- demonstrate awareness of the importance of review of and critical appraisal of different health systems and governance/management structures
- demonstrate the ability to prioritise and allocate resources efficiently and appropriately
- demonstrate the ability to perform appropriate management and administrative tasks within the health-care system.

Health advocate

As health advocates, psychiatrists use their expertise and influence to advocate on behalf of individual patients, their families and carers, as well as more broadly, on an epidemiological level. Psychiatrists lessen the impact of mental illness through their understanding of and application of the principles of prevention, promotion and early intervention.

Fellowship Competencies:

- demonstrate the ability to use expertise and influence to advocate on behalf of patients, their families and carers
- demonstrate the ability to understand and apply the principles of prevention, promotion and early intervention to reduce the impact of mental illness.

Scholar

As scholars, psychiatrists are committed to life-long learning, having the ability to critically appraise and apply psychiatric and other health information for the benefit of patients. Psychiatrists are able to transfer information to patients, families and carers, colleagues, other health professionals, students, and are able to facilitate the learning of colleagues, trainees and other health professionals, contributing to the development of mental health knowledge.

Fellowship Competencies:

- demonstrate commitment to life-long learning
- demonstrate the ability to provide information to patients, families and carers so as to inform healthcare, treatment and lifestyle decisions and choices
- demonstrate the ability to educate and encourage learning in colleagues, other health professionals, students, patients, families and carers
- contribute to the development of knowledge in the area of mental health.

Professional

As professionals, psychiatrists' commitment to their patients, profession and society is demonstrated through their adherence to ethical conduct and practice, complying with all relevant regulatory requirements, at all times comporting themselves with integrity, honesty, compassion and respect for diversity. Psychiatrists actively engage in reflective practice, giving due consideration to feedback received from others. Psychiatrists are expected to contribute to the profession beyond their commitment to patient care, whilst mindful of the necessity of maintaining a responsible equilibrium between personal and professional priorities in the pursuit of sustainable practice and well-being. Psychiatrists have an important role in modelling self-reflection and understanding of how their own assumptions, biases and values may impact the doctor-patient relationship, acknowledging and addressing inherent power imbalances in ways that promotes cultural safety, and to the extent they can addressing health inequities.

Fellowship Competencies:

- demonstrate ethical conduct and practice in relation to patients, the profession and society
- demonstrate integrity, honesty, compassion and respect for diversity
- demonstrate reflective practice and the ability to use and provide feedback constructively.
- demonstrate the ability to balance personal and professional priorities to ensure sustainable practice and well-being
- demonstrate compliance with relevant professional regulatory bodies
- demonstrates understanding of cultural safety through culturally safe behaviours.

Additional information requested by the AMC - FEC review

In its response to the RANZCP's 2021 Progress report, the AMC requested comment on the outcomes of the reaccreditation of the FECs, with particular focus on:

- *How FEC costs are communicated by the College to trainees and prospective trainees?*
- *Have there been any trainees in fee distress because of the FEC arrangements (and how does the College monitor this)?*
- *The details of the considerable fee reduction of two providers - did trainees provide this feedback independently of the College or was it mediated through the TRC? Did the College advocate on behalf of its trainees? Are there plans for future advocacy in this regard? What continuing actions are trainees and the College taking to reduce the inequities evident in the costs to trainees of undertaking the mandatory FECs?*

The reaccreditation of the FECs was originally scheduled for 2020, however the impact of the COVID-19 pandemic caused this activity to be postponed to 2021. All 15 FECs were granted an extension of their accreditation as an interim measure.

The reaccreditation of FECs was undertaken as a project and an external consultant was engaged to provide independent advice and support to the Accreditation Committee during the implementation of the project. The project report is provided as Appendix 2.3.1 to this submission.

The project reviewed the FEC accreditation standards, related policies, and procedures prior to the actual accreditation of assessments which occurred between July and September 2021.

Forty-six Fellows and trainees were appointed to the assessment panels that undertook the assessments. Each panel included a Lead member (a Fellow), a second Fellow and a trainee. College staff provided secretariat support to each panel. Prior to the first meeting of the assessment panels, a one-hour session was conducted to brief panel members on the process.

Assessment panels considered the written submission from the FEC provider, trainee views sourced from surveys conducted by the RANZCP for the purpose of obtaining feedback on the FEC and viewing of the FEC provider's LMS and other course materials. Owing to the restrictions of the pandemic it was difficult to view the FECs in action, and it would be anticipated that for the next scheduled reaccreditation this would be incorporated into the process, along with an interview with the FEC provider.

All 15 FECs were reaccredited, with 13 receiving the maximum period of five years. One FEC initially received six weeks of provisional accreditation followed by three years of accreditation, and one FEC received two years of accreditation. Ten of the 15 FECs received recommendations, ranging from one to eight recommendations.

Each BTC is responsible for communicating the FEC options available to trainees and the costs of any program that it operates. All FEC providers are required to meet the standard that requires costs and payment options to be provided to all participants.

The RANZCP has the capacity to provide payment options for trainees who are experiencing financial difficulties, however this applies only to training and assessment fees, not FEC fees. It is possible that some trainees who have negotiated payment plans for their training fees are experiencing financial stress due to FEC costs, however the RANZCP does not have any quantitative data on this issue. The RANZCP is aware of the dissatisfaction of trainees with the fees charged by the tertiary providers of FECs through surveys conducted for the FEC re-accreditation and through the trainee Exit survey.

During 2021 and 2022, two FEC providers considerably discounted their fees. In 2021, HETI reduced the fee charged for the non-award program for trainees employed by NSW Health. In 2022 a non-award course was offered by the Brain and Mind Centre of the University of Sydney at a significantly lower cost.

FEC providers are almost without exception, members of the RANZCP and have been aware of the dissatisfaction of trainees with the variation in fees. Advocacy has been taking place for many years; it appears that the prospect of a more rigorous accreditation process that considered direct feedback from trainees may have influenced the decision of these FEC providers to reduce fees.

Victoria remains the sole jurisdiction without a locally available low-cost option, however, trainees do have the opportunity to participate in the University of Sydney course online. The RANZCP, through its Victorian Branch, is actively advocating to the Victorian Department of Health to consider the development of a low-cost FEC option as part of the response to the Royal Commission into Victoria's Mental Health System.

In an additional piece of work that will commence in the second half of 2022/early 2023, the purpose and educational merit of the FEC in its current format will be considered by a working group. This work has been delayed due to the postponements of the reaccreditation of the FECs during 2020-2021. The RANZCP acknowledges that any changes arising from the review will need to have staged implementation to ensure minimal disruption to trainees and FEC providers.

Standard 2: Documents provided check list

	Document
√	Program and graduate outcomes for each of the specialist medical training programs. About the training program | RANZCP Learning Outcomes Stages 1, 2 & 3 (ranzcp.org)
√	Statement of purpose About the training program | RANZCP

Standard 3: The specialist medical training and education framework

Standard 3: The specialist medical training and education framework

3.1 Curriculum framework

3.1.1 For each of its specialist medical programs, the education provider has a framework for the curriculum organised according to the defined program and graduate outcomes. The framework is publicly available.

The trajectory to Fellowship of the RANZCP

Figure 3.1.1 illustrates the trajectory to Fellowship of the RANZCP. The program comprises three stages over a period of 60 Full Time Equivalent (FTE) months, with provision for an additional 12 months FTE if needed.

Both Stage 1 and Stage 2 have mandatory rotations. Stage 1 has a duration of 12 months and Acute Adult psychiatry is a mandatory rotation. Stage 2 has a duration of 24 months and includes the two mandatory rotations of Child and Adolescent psychiatry (CAP) and Consultation – Liaison psychiatry (C-L).

Stage 3 has a duration of 24 months and there are no mandatory rotations. Trainees may take the option of undertaking one of the Certificates of Advanced Training in an area of practice, but this is not required.

All rotations have a duration of six months. Trainees must successfully achieve the following workplace-based assessments during each rotation as a minimum:

- two EPAs
- one observed clinical activity (OCA)
- end of rotation In Training Assessment (ITA).

The workplace-based assessments include both mandatory and elective EPAs, and these are discussed in detail under Standard 5. Trainees often do more than the minimum and there is flexibility for them to do some Stage 3 EPAs in Stage 1.

The six summative assessments administered by the RANZCP centrally are the:

- MCQ
- MEQ
- CEQ
- OSCE
- PWC
- SP.

None of the centrally administered summative assessments are barrier examinations that must be met to permit progression through the trajectory, however all must be passed to achieve Fellowship.

Fellowship of the RANZCP is recognised as the qualification for registration as a specialist psychiatrist in Australia, and in the vocational scope of psychiatry in New Zealand. Whilst there are internationally recognised areas of practice, the specialty of psychiatry is a generalist specialty, with no subspecialty areas recognised for registration purposes.

Figure 3.1.1. Fellowship Trajectory

Trainee Progress Trajectory in the Fellowship Program

Supporting document for Policy on Progression through Training and Policy on Failure to Progress (effective 2022)

Intended to provide a trainee (or trainees) with a baseline against which their progress will be monitored to ensure a steady progression → **Expected Fellowship attainment**

	STAGE 1		STAGE 2				STAGE 3					
FTE months*:	**6**	**12**	**18**	**24**	**30**	**36**	**42**	**48**	**54**	**60**	**66**	**72**
Rotation EPAs	ITA with associated OCA + 2 EPAs†	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs	ITA with associated OCA + 2 EPAs
Stage 2 General Psychiatry EPAs x 4		1 of the 4 eg. ECT	1 of the 4 eg. Risk Assessment	1 of the 4 eg. Cultural Awareness		1 of the 4 eg. Mental Health Act						
Stage 2 Psychotherapy EPAs x 3 2 EPAs must be completed by the end of Stage 2				1 of the 3 eg. Therapeutic alliance§		1 of the 3 eg. Supportive Psychotherapy§		1 of the 3 eg. CBT§				
Additional Mandatory Stage 2 EPAs		eg. 1 ADD EPA # (If not elective rotation)	eg. 1 ADD EPA (If not elective rotation)		eg. 2 POA EPAs (If not elective rotation)							
MCQ Exam		Eligible to apply > 6 months				MCQ Paper Pass**	TL = 36	TR = 48				
MEQ and CEQ Examinations				Eligible to apply > 18 months						MEQ & CEQ Pass	TL = 60	TR = 72
OSCE						Eligible to apply > 30 months				OSCE Pass	TL = 60	TR = 72
Scholarly Project					eg. Proposal/ Method outline					Scholarly Pass‡	TL = 60	TR = 72
Psychotherapy Written Case										Written Case Pass‡	TL = 60	TR = 72

Trainee reminders:

After 60 FTE months trainees must ensure their continued placement in an accredited training post with their service/ BTC if Fellowship requirements are still to be completed.

- Summative assessments may be submitted/sat while on a BIT.
- Rotation-based Targeted Learning is not permitted on a BIT. The content and duration of the Targeted Learning depends on each trainee's circumstances.

Case-by-case exceptions can be considered by the Committee for Training.

TL = Targeted Learning (Mandatory)

TR= Training Review Application to the Committee for Training (Mandatory)

BIT = Break in Training

* = Months of accredited training time

§ = Psychotherapy EPAs: Must attain any 2 of the 3 Psychotherapy EPAs by the end of Stage 2. The third one can be attained by the end of Stage 3, still to a proficient standard.

= Must be pre-approved by the Director of Training

** = The MCQ Exam is not a barrier to commence Stage 3 Generalist training. Effective mid-year 2016 intake, it is required for Certificate entry.

† = There is an exception for attaining two EPAs per rotation for the first rotation only

‡ = Allow time for marking.

Dual Fellowship Training Program (DFTP)

In collaboration with the RACP, the RANZCP offers the DFTP. The DFTP is for medical graduates who wish to attain Fellowship in:

- Community Child Health and Child and Adolescent Psychiatry or
- General Paediatrics (Australia and New Zealand) and Child and Adolescent Psychiatry.

Trainees who successfully complete the DFTP gain Fellowship of both Colleges (FRACP and FRANZCP). The minimum overall completion time is 8 years, compared with the 11 years it would take to gain the two Fellowships sequentially.

Trainees must complete:

- all RACP requirements for Advanced Training in Community Child Health or Advanced Training in General Paediatrics
- all RANZCP requirements for the RANZCP 2012 Fellowship Program and Certificate of Advanced Training in Child and Adolescent Psychiatry.

Examples of trajectories to dual Fellowship are shown in the Tables 3.1.1_1 to 3.1.1_2 on the following pages.

Table 3.1.1_1. Example of the Community Child Health and Child and Adolescent Psychiatry reciprocal training arrangement

Year	RACP training - Community Child Health	RANZCP training
1	12 months Basic Physician Training	
2	12 months Basic Physician Training	
3	12 months Basic Physician Training	
	Entry into RACP Advanced Training	
4 and 5	Completion of Core requirements*: • 12 months attendance at an accredited Program of Excellence (This is always completed concurrently with other core requirements) • 6 months Community-based Multidisciplinary Paediatrics • 6 months Developmental-Behavioural Paediatrics • 6 months Core Non-Clinical Activities** • 3 months Child Protection training The balance of 36 months (maximum 15 months) can be completed as non-core training in Child and Adolescent Psychiatry *Some training positions may allow trainees to meet these core requirements concurrently; however, a trainee cannot be certified for more than 1.0 FTE in any given training period (i.e. a trainee cannot complete more than 12 months of training time in a 12-month period). **3 months of Child and Adolescent Psychiatry training can be accepted towards Core Non-Clinical Activities	Not accepted towards RANZCP
		• 6 months consultation–liaison psychiatry o Adult, or o Child and Adolescent
6		• 6 months adult psychiatry
		6 months Adult consultation–liaison psychiatry (if previous 6 months rotation was in CAP)* *If previous rotation was in Adult CL, an elective rotation is permissible
7		24 months Certificate of Child and Adolescent Psychiatry
8		
	Eligible for consideration for FRACP	**Eligible for consideration for FRANZCP**

Summary of assessments and training requirements

- RACP Written and Clinical Examinations
- RACP Research Project
- All RACP formative and summative assessments as outlined in relevant Training Handbook

Supervision:

- RACP supervision required (monthly) during psychiatry rotations

- RANZCP Formative assessments
- Formal Education Course
- EPAs
- Stage 3 Leadership and Management
- Summative assessments: MCQ exam, essay- style exam, psychotherapy written case, OSCE

Table 3.1.1_2. Example of the General Paediatrics (Australia and New Zealand) and Child and Adolescent Psychiatry reciprocal training arrangements

Year	RACP training - Community Child Health	RANZCP training
1	12 months Basic Physician Training	
2	12 months Basic Physician Training	
3	12 months Basic Physician Training	
	Entry into RACP Advanced Training	
4	• 6 months core acute training • 6 months core general paediatrics# # Australian trainees must complete at least 6 months at a site with a perinatal component during this rotation or during their core general paediatrics (rural) rotation.	Not accepted towards RANZCP
5	6 months core general paediatrics (rural*^) *New Zealand trainees must complete rural training in advanced training. ^For Australian trainees rural training can be completed in advanced or basic training. If rural training is completed in Basic Training , this rotation must be core general paediatrics	
6	Interruption of training (Not accepted towards RACP AT)	6 months adult psychiatry 6 months consultation–liaison psychiatry • Adult, or • Child and Adolescent 6 months Adult consultation–liaison psychiatry (if previous 6 months rotation was in CAP)* *if previous rotation was in Adult CL, an elective rotation is permissible
7	• 6 months core community/developmental training • 12 months non-core training This will meet the 6 months developmental and psychosocial requirement	• 24 months Certificate of Child and Adolescent Psychiatry
	Eligible for consideration for FRACP	**Eligible for consideration for FRANZCP**

Summary of assessments and training requirements	
• RACP Written and Clinical Examinations • RACP Research Project • All RACP formative and summative assessments as outlined in relevant Training Handbook Supervision: • RACP supervision required (monthly) during psychiatry rotations	• RANZCP Formative assessments • Formal Education Course • EPAs • Stage 3 Leadership and Management • Summative assessments: MCQ exam, essay- style exam, psychotherapy written case, OSCE

3.2 The content of the curriculum

3.2.1 The curriculum content aligns with all of the specialist medical program and graduate outcomes.

The trajectory to Fellowship, illustrated in Figure 3.1.1 gives a broad alignment of the curriculum with the program and graduate outcomes. The centrally administered summative assessments and the EPAs are mapped to the graduate outcomes, also referred to as the Fellowship competencies. Discussed in further detail under standard 5.2.1 the RANZCP has identified the need for an overarching assessment framework that integrates workplace-based assessment and centrally administered summative assessments and maps these to the curriculum and graduate outcomes.

3.2.2 The curriculum includes the scientific foundations of the specialty to develop skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge.

The scientific foundations and knowledge that underpin the practice of psychiatry are a focus of the FECs that are mandatory for trainees in stages 1 and 2. The syllabus for stages 1 and 2 is available on the RANZCP website and provided as Appendix 3.2.2 to this submission. The RANZCP accreditation standards for FECs require that what is taught is based on evidence-based practice.

In addition, all assessments support the development and maintenance of specialist knowledge. The SP, discussed in more detail under Standard 5, particularly focusses on the role of the psychiatrist as a scholar.

3.2.3 The curriculum builds on communication, clinical, diagnostic, management, and procedural skills to enable safe patient care.

The EPAs, discussed in more detail under Standard 5, demonstrate achievement of the graduate competencies in communication, diagnostic, management, and procedural skills. For an EPA to be entrusted, at least three workplace-based assessments (WBA) must be completed, along with information confirming entrustment drawn from other sources such as supervisor observation. This provides a foundation for feedback and progressive development of skills.

3.2.4 The curriculum prepares specialists to protect and advance the health and wellbeing of individuals through patient-centred and goal-orientated care. This practice advances the wellbeing of communities and populations, and demonstrates recognition of the shared role of the patient/carer in clinical decision-making.

The graduate outcomes, based on the CanMEDS framework, include the roles of Health Advocate, Leader and Communicator. EPAs are mapped against the graduate outcomes and their associated CanMEDS roles, ensuring that the curriculum encourages the advancement of the health of individuals and communities.

The RANZCP has published two key documents that inform practice in this area:

- Position statement 62 Partnering with people with a lived experience
- Professional Practice Guideline 20 information sharing with families/whanau/carers (provided as Appendix 3.2.4).

The Takarangi Framework, developed for cultural safety training in the New Zealand mental health and addiction sector is discussed in detail under standard 2.1.2. This framework is planned as the basis for cultural safety training for New Zealand trainees.

3.2.5 The curriculum prepares specialists for their ongoing roles as professionals and leaders.

The curriculum supports the attainment of the graduate outcomes, which are mapped to the CanMEDS framework.

The RANZCP requires all trainees to undertake mandatory Leadership and Management in psychiatry training. Each BTC approves the options for formal leadership and management training in their jurisdiction. It may be satisfied in the following ways, depending on local availability:

- completion of a BTC-approved module or e-module in leadership and management
- achievement of any two Medical administration EPAs under appropriate supervision approved in advance by the BTC
- any Medical administration EPA that fulfils the trainee's Stage 3 leadership and management requirement must be in addition to the trainee's requirement to achieve 2 EPAs in any 6-month FTE rotation
- development, implementation and evaluation of a new policy or procedure in a team or service
- implementation and evaluation of a specific multidisciplinary clinical practice change such as a Clinical Practice Guideline or Clinical Pathway
- facilitation of a specific quality improvement cycle with a peer group, team or service, including elements of assessment, evaluation against external standards, implementing change, reassessment and evaluation
- development of a strategy for how a quality improvement activity might work in a service setting
- development of a program for increasing the engagement of people with mental health problems and mental illness in mental health services.

Information regarding this requirement is provided on the RANZCP website (Leadership and Management Guideline (ranzcp.org).

3.2.6 The curriculum prepares specialists to contribute to the effectiveness and efficiency of the health care system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of health settings within the Australian and/or New Zealand health systems.

Psychiatrists must be able to prioritise and allocate resources efficiently and appropriately, and perform appropriate management and administrative tasks within the healthcare system, applying health and other relevant legislation where appropriate.

To demonstrate the role of Manager and its associated graduate outcomes, trainees must be able to work within clinical governance and management structures in healthcare settings, providing clinical leadership. This is shown through the progressive demonstration of clinical leadership through participation in:

- team and service committees
- service development and planning
- financial and human resource allocation
- service development and planning.

The mid-rotation and end-of-rotation ITAs include the domain of Manager, and this is used to provide feedback to the trainee on the development of these competencies. Many trainees elect to undertake a clinical audit for their SP, thus equipping a growing number of graduates with deeper skills in quality improvement.

3.2.7 The curriculum prepares specialists for the role of teacher and supervisor of students, junior medical staff, trainees, and other health professionals.

The Scholar Fellowship competency recognises the role that trainees have in the teaching and supervision other doctors and health professionals. The following learning outcomes are assessed via the six-monthly end of rotation ITAs.

Table 3.2.7. Learning Outcomes of rotation In Training Assessment

Stage 1	Stage 2	Stage 3
FEEDBACK: Identifies and describes the principles of giving and receiving feedback.	FEEDBACK: Develops the skills to provide effective feedback.	
TEACHING: Describes principles of teaching and learning.	TEACHING: Applies principles of teaching and learning during case presentation, journal club and other professional presentations.	TEACHING AND SUPERVISION: Demonstrates the ability to educate and encourage learning in colleagues, other health professionals, students, patients, families and carers.
PRESENTING: Presents to colleagues, medical students or members of the public, possibly including patients.		

There are also optional EPAs including the teaching of medical students and leading small groups, and the Professional Presentation is one of the WBA tools which can demonstrate teaching competencies.

3.2.8 The curriculum includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, so that all trainees are research literate. The program encourages trainees to participate in research. Appropriate candidates can enter research training during specialist medical training and receive appropriate credit towards completion of specialist training.

The syllabus for the FECs includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice. The accreditation standards for both FECs and Fellowship programs require that these are provided. The SP is specifically designed to support trainees to be research literate.

There are training posts that have a research focus and trainees can elect to include these in their trajectory in stage 2 and stage 3.

3.2.9 The curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia and Māori health, history and cultures in New Zealand as relevant to the specialty(s).

All trainees are required to complete e-learning modules related to Aboriginal and Torres Strait Islander health, history and cultures. These modules provide a practical application of key cultural considerations for the assessment and clinical management of Aboriginal and Torres Strait Islander people presenting with psychiatric problems.

The RANZCP has statements outlining its position on a number of issues related to Aboriginal and Torres Strait Islander peoples that have been referred to under Standard 1 of this submission. These position statements support the practice of psychiatry in the workplace and are important foundational documents for training in the workplace.

The Fellowship program syllabus identifies the knowledge that trainees require in relation to Aboriginal and Torres Strait Islander and Māori health, history and culture. The topics identified within the syllabus are:

- interviewing with cultural sensitivity
- familiarity with the Australian and New Zealand history of colonisation/invasion and the ongoing impact for Indigenous people today
- familiarity with the Indigenous world view, often contrasted as being holistic in comparison with the more categorical 'Western' world view
- specific cultural practices, customs and social structures and their impact on mental illness presentation and intervention.

There are elective EPAs that demonstrate competence in the assessment and clinical management of Aboriginal and Torres Strait Islander and Māori peoples that are underpinned by an understanding of health, history and culture. These EPAs are:

Stage 2

- interviewing an Aboriginal or Torres Strait Islander patient
- develop a mental healthcare management plan for an Aboriginal or Torres Strait Islander patient
- interviewing a Māori patient
- develop a mental healthcare management and recovery plan for a Māori patient.

Stage 3

- formulation of a case involving an Aboriginal or Torres Strait Islander patient
- review a model of mental health service delivery in an Aboriginal or Torres Strait Islander community service
- formulation of a case involving a Māori patient
- review a model of mental health service delivery in a Māori community service (including hospitals and community services attached to hospitals).

In New Zealand, participation in Māori cultural experiences on marae are encouraged, and many trainees have benefitted from the generosity of the local iwi. Work by the Tu Te Akaaka Roa and Te Kaunihera is progressing on the delivery of cultural training specifically relevant to the mental health and addiction sectors for both trainees and Fellows, utilising the Takarangi Framework.

3.2.10 The curriculum develops an understanding of the relationship between culture and health. Specialists are expected to be aware of their own cultural values and beliefs, and to be able to interact with people in a manner appropriate to that person's culture.

The mandatory Stage 2 cultural competency EPA requires the trainee to be able to reflect upon their own cultural and linguistic background and reach an understanding of its contribution to their engagement with, and understanding of, culturally and linguistically diverse patients and their families.

The Fellowship program currently teaches, and requires trainees to demonstrate, cultural competence within training however, it is recognised that current literature and registration bodies require the move to cultural safety concepts.

The RANZCP has published its cultural safety position statement in December 2021 and the concepts are being integrated currently within the Fellowship program. The Stage 1 and Stage 2 syllabus review is being finalised, which will see a shift to cultural safety concepts. In addition, the College has commenced a review of the structure and content of EPAs and part of this work will consider how cultural safety can be incorporated to all assessments and the specific review of the cultural competency EPA.

The Fellowship program syllabus identifies knowledge that trainees are required to acquire in relation to cultural competency. Across the syllabus, trainees are required to incorporate cultural facts into the aetiology and management of specific disorders. Additionally, trainees are required to consider:

- the impact of cultural factors in clinical practice
- psychiatry in a multicultural context
- the impact of migration
- the impact of cultural factors in the general medical setting
- the impact of cultural context within interviewing and assessment.

There is a mandatory Stage 2 Cultural Awareness EPA - Assess and manage adults with cultural and linguistic diversity.

Cultural competence is featured within the learning outcomes and developmental descriptors of the Fellowship program. The developmental descriptors have a specific sociocultural behavioural descriptor which is outlined in Table 3.2.10_1.

Table 3.2.10_1. Socio Behavioural descriptors of the Fellowship program

Aspect of practice	End of Stage 1	End of Stage 2	End of Stage 3
Sociocultural ME1,3	Identifies key sociocultural issues relevant to the psychiatric assessment. Requires supervision to deepen understanding	Integrates sociocultural issues and patient's needs into the psychiatric assessment. Uses supervision to enhance understanding.	Generates a sophisticated sociocultural formulation and applies this formulation to the treatment plan of the patient

Cultural competency is also embeded within the Fellowship program learning outcomes with a specified cultural diversity requirement within the communicator domain in addition to other outcomes where cultural competency feature (e.g., culturally appropriate assessments, cultural contributions to a patient's illness and sociocultural interventions).

Table 3.2.10_2. Cultural competencies of the Fellowship program

End of Stage 1	End of Stage 2	End of Stage 3
CULTURAL DIVERSITY: Recognises and incorporates the needs of culturally and linguistically diverse populations, including the use of interpreters and culturally appropriate health workers.	CULTURAL DIVERSITY: Appropriately adapts assessment and management to the needs of culturally and linguistically diverse populations.	CULTURAL DIVERSITY: Appropriately adapts communication regarding assessment and management to the needs of culturally and linguistically diverse populations, including working with interpreters and cultural advisors.

3.3 Continuum of training, education and practice

3.3.1 There is evidence of purposeful curriculum design, which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice, including continuing professional development.

The curriculum is designed to integrate with the immediate post-graduate (PG) years of training, permitting admission to the training program at the end of PGY1. The RANZCP has contributed to the review of the National Framework for Prevocational (PGY1 and PGY2) Medical Training that the AMC has undertaken over the period 2019 – 2022. The College's EPA working group, as part of its review process, is considering the EPAs that are proposed for introduction as part of the revised National Framework and how they will articulate with the EPAs of the Fellowship Program in the long term.

Certificates of Advanced Training are available to Fellows who wish to gain further training in a recognised area of practice. EPAs that are currently available as electives during stage three of the Fellowship program are used in the Certificate programs, providing vertical integration. Trainees may choose elective EPAs in their Fellowship program, and then supplement these with other EPAs should they go onto a Certificate of Advanced Training.

As the CPD program is self-directed, integration with the Fellowship program is not as well defined. Both are based on the CanMEDS framework, and Fellows are encouraged to reflect on the CanMEDS roles as they choose their CPD activities. An area for future development is the use of certificated short courses, that may use EPAs to demonstrate competence.

3.3.2 The specialist medical program allows for recognition of prior learning and appropriate credit towards completion of the program.

Recognition of prior learning (RPL) is the process by which learning, skills, competence and work experiences acquired outside the RANZCP Fellowship Program are evaluated for the purpose of accrediting them in lieu of elements of training required under the RANZCP Fellowship Regulations 2012. A successful RPL application results in a trainee being granted exemption from training time requirements and/or various assessments. These assessments may include mandatory competency requirements, such as EPAs and formative OCAs, as well as centrally administered summative assessments such as the SP and the PWC.

To be eligible for RPL, training must have been completed in a formal training context with appropriate validation, supervision, feedback, and assessment. Each RPL application is assessed by the CFT on a case-by-case basis. The CFT considers whether the evidence of training, assessment and/or work experience submitted is substantially equivalent to the nominated elements of the RANZCP Fellowship Program (i.e., equivalent in its structure, content, supervision requirements and environment).

The CFT also considers the time passed since any substantially equivalent training was undertaken, and whether the applicant has engaged in relevant practice to maintain their competence since that time.

The policy and procedure document that describes how trainees may apply for and be granted RPL is attached as Appendix 3.3.2. It also describes the process for RPL for trainees planning a period of extended leave overseas.

Table 3.3.2 below provides detail on RPL applications and their outcomes for the period 2017 – 2021. Please note that this Table does not include exemptions for the Scholarly Project based on previous publication of their academic work. This is discussed under standard 5.

Table 3.3.2. Recognition for Prior Learning applications and their outcomes for the period 2017 – 2021

Year	RPL applications	Number granted	% granted	Number rejected	% rejected
2021	19	17	89%	2	11%
2020	22	18	82%	4	18%
2019	19	18	95%	1	5%
2018	25	21	84%	4	16%
2017	21	19	90%	2	10%

3.4 Structure of the curriculum

3.4.1 The curriculum articulates what is expected of trainees at each stage of the specialist medical program.

As illustrated in the Trajectory diagram under standard 3.1, the RANZCP Fellowship program is a five-year FTE program. The last major review of the Fellowship program was completed and resulted in the launch of the 2012 Regulations in December 2012.

The Fellowship program mandates training within specific areas of practice within psychiatry, specifically

- 12 FTE months of Adult psychiatry, including a minimum of six months of Adult Acute psychiatry
- 6 FTE months of Child and Adolescent Psychiatry
- 6 FTE months of Consultation-Liaison Psychiatry.

The remainder of the Fellowship program allows trainees to select rotations in accredited training posts in line with the concept of a generalist Fellowship program. Due to the flexibility within the program, no significant changes have been required to the structure of the program at this stage.

However, the College has recently allowed Faculties and Sections to apply for the recognition of new areas of practice and the introduction of associated certificates of advanced training to be included within the College's education program. It is expected that areas such as Youth Psychiatry will shortly make application for recognition within the program in response to the increase of Youth speciality services within the community.

Specific skill requirements included in the Fellowship program include the delivery of Electro Convulsive Therapy (ECT), and the provision of psychotherapy. These are mandatory EPAs in the program, and can be achieved in a variety of rotations. As outlined in Table 4.1.1 there are also mandatory EPAs in Child and adolescent psychiatry, Addiction psychiatry and Psychiatry of old age and these provide breadth to the experience of trainees.

No other organisations provide similar training within Australia and New Zealand. The RANZCP Fellowship program is highly equivalent to other countries with similar health systems such as the United Kingdom and Canada. This is demonstrated by the fact that the majority of SIMGs originating from these countries are assessed as being substantially comparable to the FRANZCP qualification.

The RANZCP publishes its learning outcomes and developmental descriptors for each stage of training on the College website. These documents are also provided to trainees on acceptance to training with the learning outcomes being discussed and reviewed with trainees at the mid and end point of each six-month rotation with their supervisor.

Supervisors are required to undergo accreditation training every five years where training is provided regarding the Fellowship programs learning outcomes and objectives.

3.4.2 The duration of the specialist medical program relates to the optimal time required to achieve the program and graduate outcomes. The duration is able to be altered in a flexible manner according to the trainee's ability to achieve those outcomes.

The duration of the program is structured in such a way that all the requirements of the Fellowship Program can be met within 60 FTE months of training, and this can be achieved within five years. The period of five years is designed to allow for sufficient dwell time in the program to develop learning and for skill acquisition.

There is significant flexibility allowed for the Fellowship program. If the maximum number of breaks in training (BIT) are taken by a trainee who also takes the option of part time training, the maximum duration is 13 years. This flexibility contributes to the gender parity of the trainee cohort as it allows trainees to continue with their specialist training alongside family commitments.

3.4.3 The specialist medical program allows for part-time, interrupted and other flexible forms of training.

As described under standard 3.4.2, the program allows for part-time training including as little as 0.3 FTE and also for breaks in training. Part time options can be limited by the recruitment and employment practices of health services at the local level. Tables 3.4.3_1 to 3.4.3_4 below detail the requests for part time training and BIT for the period 2019 – 2021. The gender distribution indicates that these options are taken up more frequently by female trainees, which supports the contention that the flexibility of the program is contributing to the achievement of gender parity in the trainee cohort.

Table 3.4.3_1. Part-time and BIT in 2021

Part-time	Number requested	Number granted	% granted	Comments (if required)
Total	-	291	-	Declined part time applications are not visible to the College as this is managed locally. Therefore, the data provided is for approved PT. PT has been considered as any trainee who worked at less than 1.0 FTE for any portion of the training year.
Male	-	68	-	
Female	-	223	-	
ACT	-	7	-	
NSW	-	86	-	
NT	-	2	-	
QLD	-	39	-	
SA	-	19	-	
TAS	-	5	-	
VIC	-	65	-	
WA	-	21	-	
NZ	-	47	-	
BIT (Break in training)	**Number requested**	**Number granted**	**% granted**	**Comments (if required)**
Total	477	476	99%	Breaks in training are counted if commenced in 2020 training year. Any period of break in training time is counted towards this total. Note – rejected breaks in training can only be recorded if break in training application made through InTrain
Male	188	187	99.4%	
Female	289	289	100%	
ACT	9	9	100%	
NSW	106	106	100%	
NT	3	3	100%	
QLD	71	70	98.6%	
SA	25	25	100%	
TAS	8	8	100%	
VIC	92	92	100%	
WA	38	38	100%	
NZ	42	42	100%	
NOZ	25	25	100%	
Withdraw/ Excluded	14	14	100%	
Completed training	44	44	100%	

Table 3.4.3_2. Part-time and BIT in 2020

Part-time	Number requested	Number granted	% granted	Comments (if required)
Total	-	283	-	Declined part time applications are not visible to the College as this is managed locally. Therefore, the data provided is for approved PT. PT has been considered as any trainee who worked at less than 1.0 FTE for any portion of the training year.
Male	-	59	-	
Female	-	224	-	
ACT	-	10	-	
NSW	-	76	-	
NT	-	0	-	
QLD	-	38	-	
SA	-	15	-	
TAS	-	8	-	
VIC	-	67	-	
WA	-	22	-	
NZ	-	47	-	
BIT (Break in training)	**Number requested**	**Number granted**	**% granted**	**Comments (if required)**
Total	374	373	99.7%	Breaks in training are counted if commenced in 2020 training year. Any period of break in training time is counted towards this total. Note – rejected breaks in training can only be recorded if break in training application made through InTrain
Male	160	160	100%	
Female	242	241	99.7%	
ACT	8	8	100%	
NSW	38	38	100%	
NT	3	3	100%	
QLD	62	62	100%	
SA	12	12	100%	
TAS	5	5	100%	
VIC	67	67	100%	
WA	29	29	100%	
NZ	31	30	96.7%	
NOZ	30	30	100%	
Withdrawn/ Excluded	29	29	100%	
Completed training	60	60	100%	

Table 3.4.3_3. Part-time and BIT in 2019

Part-time	Number requested	Number granted	% granted	Comments (if required)
Total	-	242	-	Declined part time applications are not visible to the College as this is managed locally. Therefore, the data provided is for approved PT. PT has been considered as any trainee who worked at less than 1.0 FTE for any portion of the training year.
Male	-	52	-	
Female	-	190	-	
ACT	-	9	-	
NSW	-	60	-	
NT	-	0	-	
QLD	-	39	-	
SA	-	9	-	
TAS	-	5	-	
VIC	-	57	-	
WA	-	23	-	
NZ	-	40	-	
BIT (Break in training)	**Number requested**	**Number granted**	**% granted**	**Comments (if required)**
Total	382	382	100%	Breaks in training are counted if commenced in 2020 training year. Any period of break in training time is counted towards this total. Note – rejected breaks in training can only be recorded if break in training application made through InTrain
Male	167	167	100%	
Female	215	215	100%	
ACT	7	7	100%	
NSW	59	59	100%	
NT	2	2	100%	
QLD	66	66	100%	
SA	14	14	100%	
TAS	6	6	100%	
VIC	55	55	100%	
WA	17	17	100%	
NZ	28	28	100%	
NOZ	30	30	100%	
Withdrawn/ Excluded	33	33	100%	
Completed Training	65	65	100%	

3.4.4 The specialist medical program provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes.

The structure of the Fellowship Program, with its mix of mandatory and elective terms, allows significant flexibility for trainees to pursue study and experience in areas of interest, whilst still demonstrating achievement of graduate outcomes. Trainees have the option of undertaking an approved term overseas in Stage 3 which can have prospective recognition of prior learning.

There is the ability for trainees to undertake specific experience to achieve a certificate of advanced training in an area of practice, however this is not a requirement for Fellowship.

Trainees also have opportunity to pursue areas of interest when undertaking the SP.

Standard 3: Documents provided check list

	Document
√	Curriculum map Stage 1 - Stage 1 Curriculum Map (ranzcp.org) Stage 2 - Stage 2 Curriculum Map (ranzcp.org)
√	Training program handbook(s). If the curriculum documents are available on a members-only section of the website, please provide access. Rather than a lengthy handbook, regulations are broken down by topic with a summary of each document's contents to assist with navigation. Regulations, policies & procedures | RANZCP
√	Policy and procedures for any research project or research requirement. Scholarly Project Policy and Procedure (ranzcp.org) PROC – Scholarly Project (ranzcp.org)
√	Recognition of prior learning policy Policy and Procedure - Recognition of Prior Learning (ranzcp.org)
√	Relevant flexible training policy documents; provide access to application forms Training program forms | RANZCP

Standard 4: Teaching and learning approach and methods

Standard 4: Teaching and learning approach and methods

4.1 Teaching and learning approach

4.1.1 The specialist medical program employs a range of teaching and learning approaches, mapped to the curriculum content to meet the program and graduate outcomes.

The Fellowship program uses a mix of "classroom" type activities and workplace learning within the competency-based medical education program. Training in psychiatry occurs in the workplace as supervised practice. Competencies are based on the CanMEDs framework and articulated as the graduate outcomes, as described under standard 3.

Within the workplace, trainees are assigned a principal supervisor who works with the trainee to achieve the required EPAs through experience and the use of formative WBAs. The supervisor must be present on site with the trainee for a minimum of 0.3 FTE and provide a minimum of four hours of supervision per week. The WBAs, discussed in more detail under standard 5, include opportunities for formative assessment through case-based discussion, observation of clinical interactions, patient formulations, and presentations.

EPAs are used to measure competence in the activities of psychiatric practice. Each EPA corresponds to a particular activity that is undertaken by a psychiatrist. A minimum of three WBAs are required to contribute to the evidence base required for the entrustment of an EPA. In addition, there is a specific requirement that there is at least one OCA conducted and recorded for every 6-month FTE rotation.

A minimum of two EPAs must be attained for every 6-month FTE rotation and there are 17 EPAs that are mandatory for progression through training. Tables of the EPAs for Stages 1, 2 and 3 are provided as Appendix to this submission (Appendix 4.1.1). The EPAs prescribed for the RANZCP training program are reflective of and consistent with the CanMEDs roles underpinning the RANZCP Fellowship Program. Each EPA is set and assessed at the level expected by the end of the stage. For example, Stage 3 EPAs are assessed at the "advanced standard" defined as the standard expected at the end of Stage 3.

In total there are currently 135 EPAs, however, as discussed at the end of this standard there is a review of the EPAs underway. The 17 mandatory EPAs, which must be completed during stages 1 and 2 of training are shown in the Table 4.1.1_1.

Table 4.1.1_1. Mandatory EPAs

Stage 1 mandatory EPAs		
Adult psychiatry 12 months adult psychiatry training, 6 months in an acute setting.	ST1-GEN-EPA5	Use of an antipsychotic medication in a patient with schizophrenia/psychosis.
	ST1-GEN-EPA6	Providing psychoeducation to a patient and their family and/or carers about a major mental illness.
Stage 2 general psychiatry EPAs – may be entrusted during Stage 1, must be entrusted by the end of Stage 2		
General psychiatry Mandatory EPAs to be attained by the end of Stage 2. These general psychiatry EPAs may be attained in any area of practice rotation during Stage 1 or Stage 2 and will be assessed at a proficient (Stage 2) standard.	ST2-EXP-EPA1	Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.
	ST2-EXP-EPA2	The application and use of the Mental Health Act.
	ST2-EXP-EPA3	Assessment and management of risk of harm to self and others.
	ST2-EXP-EPA5	Assess and manage adults with cultural and linguistic diversity.
Psychotherapy EPAs – may be entrusted during Stage 1		
Trainees must attain two (of three) EPAs by the end of Stage 2: The remaining EPA must be attained by the end of Stage 3. These EPAs may be attained in any area of practice rotation and will be assessed at a proficient (Stage 2) standard.	ST2-PSY-EPA2	Psychodynamically informed patient encounters and managing the therapeutic alliance.
	ST2-PSY-EPA3	Supportive psychotherapy.
	ST2-PSY-EPA4	Cognitive–behavioural therapy (CBT) for management of anxiety.
Stage 2 mandatory EPAs		
Child and adolescent psychiatry Mandatory rotation, must complete associated EPAs.	ST2-CAP-EPA1	Develop a management plan for an adolescent where school attendance is at risk.
	ST2-CAP-EPA2	Clinical assessment of a prepubertal child.
Consultation–liaison psychiatry Mandatory rotation, must complete associated EPAs.	ST2-CL-EPA1	Care for a patient with delirium.
	ST2-CL-EPA2	Manage clinically significant psychological distress in the context of the patient's medical illness in the general hospital.
Addiction psychiatry (Elective rotation) Mandatory EPAs, may be attained in any rotation.	ST2-ADD-EPA1	Management of substance intoxication and substance withdrawal.
	ST2-ADD-EPA2	Comorbid mental health and substance use problems.
Psychiatry of old age (Elective rotation) Mandatory EPAs, may be attained in any rotation.	ST2-POA-EPA1	Behavioural and psychological symptoms in dementia (BPSD).
	ST2-POA-EPA2	The appropriate use of antidepressants and antipsychotics in patients aged 75 years and over (or under 75 with excessive frailty).

A summary of the teaching and learning approaches, both formal and informal, utilised in the Fellowship Program is provided in Table 4.1.1_2.

Table 4.1.1_2. Teaching and learning approaches

Learning activity	Overview
Workplace-based learning	Role modelling, workplace experience Mandatory experiences in Child and Adolescent psychiatry (CAP), Consultation -Liaison (C-L) and adult psychiatry Mandatory EPAs which are informed by WBAs, which must include an OCA Formative WBAs • Case-based Discussion (CbD): a discussion based on case notes and other relevant written correspondence to assess a trainee's clinical reasoning and decision making and their ability to document the integration of medical knowledge within case management. • Mini-Clinical Evaluation Exercise: trainees are observed during a clinical encounter with a real patient. The focus is on specific clinical tasks (e.g. talking to a family or conducting a neurological exam) rather than general performance. • Observed Clinical Activity (OCA): supervisors observe trainees during an initial clinical assessment of a real patient then the trainee presents their assessment and corresponding treatment plan to the supervisor. • Professional Presentation: trainees are observed giving a professional presentation to an audience. Examples are case presentations, topic presentations, nursing in-service presentations and community education presentations. • Direct Observation of Procedural Skills (DOPS): supervisors observe trainees conducting a procedural skill and providing feedback to the trainee about their performance. Examples of where the DOPS may be used include psychotherapy, ECT, physical examinations or participating in an interdisciplinary team discussion
Formal Education Course-mandatory	Satisfactory attendance at an accredited FEC is required for all stage 1 and 2 trainees. The FEC provides the theoretical knowledge underpinning the Fellowship program, as described in the syllabus. (Appendix 3.2.2) The syllabus is delivered through a mix of didactic and interactive, online and in person lectures and workshops.
Local health service education programs	Includes Grand rounds, multi-disciplinary meetings, mandatory local training e.g., aggression management or life support training
Self-directed learning	In Stage 3 of training, if an FEC is not available, trainees are provided protected education time to undertake self-directed learning.
SP and PWC	The SP and the PWC are summative assessments, however in the preparation of the work for assessment skills in research, literature review and professional report writing are developed.
Mandatory Leadership experiences	Leadership and management content forms part of the Stage 3 knowledge base. Each BTC approves the options for formal leadership and management training

Table 4.1.1_2. Teaching and learning approaches (Cont.)

Learning activity	Overview
Online modules	The RANZCP has an extensive catalogue of online resources and materials that include specific support for trainees and SIMG candidates. These are available through the RANZCP's LMS (Learnit) and view-on-demand webinars. Learnit modules designed specifically for trainees include: • Aboriginal and Torres Strait Islander mental health - cultural considerations for risk assessment • Aboriginal and Torres Strait Islander mental health - Module 1: Interviewing an Aboriginal or Torres Strait Islander patient • Aboriginal and Torres Strait Islander mental health - Module 2: Developing a mental health management plan for an Aboriginal or Torres Strait Islander patient • Aboriginal and Torres Strait Islander mental health - Module 3: Formulation of a case involving an Aboriginal or Torres Strait Islander patient • Aboriginal and Torres Strait Islander mental health - Module 4: Review a model of mental health service delivery in an Aboriginal or Torres Strait Islander community • Australasian Psychiatry - June 2019 - Trainee Welfare • Borderline Personality Disorder • Building partnerships in Academic Psychiatry: a guide for new Investigators and the Scholarly Project (Part 1) • Building partnerships in Academic Psychiatry: a guide for new Investigators and the Scholarly Project (Part 2) • Child and Adolescent mental health - suicide and self-harm • Communication: External communication - External communication - part 1 • Communication: External communication - External communication - part 2 • Communication: Internal communication - Internal communication • Dementia - the management of confused aggressive older patients • Eating disorders and related exam content • Electroconvulsive Therapy • First Episode Psychosis • Forensic Psychiatry - approaches to violence risk assessment • FEC Accreditation panel briefing webinar module • Guide to the Critical Essay Question • Introduction to InTrain • Mentoring - Module 1: Introduction to mentoring • Mentoring - Module 2: Mentoring for mentees • Mentoring - Module 3: Being an effective mentor • Perinatal psychiatry - psychosis in the perinatal period • Post-Traumatic Stress Disorder and its comorbidities • Side effects of anti-psychotic medications

Table 4.1.1_2. Teaching and learning approaches (Cont.)

Learning activity	Overview
Online modules	• SIMG Centralised Resources – Module 1: Understanding the Australian mental health-care system • SIMG Centralised Resources – Module 2: The work of a psychiatrist in Australia • SIMG Centralised Resources – Module 3: How to become a psychiatrist in Australia • Substance use disorders - depression and alcohol • Trainee support resources: Effective teaching and learning • Trainee support resources: Emerging physical therapies • Trainee support resources: Introduction to Phenomenology • Trainee support resources: Introduction to psychological development • Trainee support resources: Introduction to Psychological Therapies • Trainee support resources: Introduction to Psychopharmacology • Trainee support resources: Introduction to the neuropsychiatric aspects of acquired brain injury (ABI) • Trainee support resources: Introduction to the Theory and Practice of Psychiatric Ethics (PE) • Trainee support resources: Statistics in Critical Appraisal • Trainee Support Webinar series: Making the most of Stage 1 • Trainee Support Webinar series: Making the most of Stage 2 • Trainee Support Webinar series: Managing critical incidents • Trainee Support Webinar series: Navigating the Psychotherapy Written Case • Trainee Support Webinar series: Navigating the Scholarly Project • Trainee Support Webinar series: Rural Training • Trainee Support Webinar series: Self-care: preserving the passion for psychiatry • Trainee Support Webinar series: Staying on track: Making the most of targeted learning • Trainee Support Webinar series: Subspecialties: A day in the life • Trainee Support Webinar series: The worst day at work • Trainee Support Webinar series: Training Program Basics • Trainee Support Webinar series: Transitioning from Stage 3 Trainee to early career psychiatrist • Training Program - In-Training Assessments • Training Program - Observed Clinical Activity • Training Program - Psychotherapy Written Case • Training Program - Scholarly Project

Table 4.1.1_2. Teaching and learning approaches (Cont.)

<table>
<tr><th>Learning activity</th><th>Overview</th></tr>
<tr><td>Podcasts</td><td>Psych Matters, produced by the RANZCP and published fortnightly, includes a range of specific podcasts relevant to trainees and SIMG candidates:
• Training during COVID-19
• Psychotherapy Written Case During COVID-19
• Making the Most of Supervision During COVID-19
• Preparing for the Essay Style Exam - Modified Essay Questions (MEQ)
• How to approach the Critical Essay Question (CEQ)
• A day in the life of Private Practice
• Challenges for Early Career Psychiatrists
• Understanding the process behind the RANZCP Written Exams
• Specialist International Medical Graduates: Transition to Practice
• Why train in psychiatry?
• Leadership and management for psychiatrists during and post COVID-19
• Remote Psychiatry
• Women on the ground: experiences of training and working as a woman in psychiatry
The Thought Broadcast is produced by trainees with the support of the RANZCP Digital Education Services and focuses on issues of interest to trainees and SIMG candidates:
• An Interview with Bryan Bui: “Observation to Publication”
• An Interview with Jeremy Couper: “Start Early”
• An Interview with Jeremy Couper (Part 2): “Granny Flats, Boats and a Block of Flats”
• An Interview with Malcolm Forbes: “Systematic Reviews for Scholarly Success”
• An Interview with Alisha Thomson: “No Substitute for Experience”
• An Interview with Nick O’Connor: “Examining the Examiner”
• An Interview with Skye Kinder: “No Taxation without Representation”
• An Interview with Sonja Cabarkapa: “Think Globally, Act Locally”
• Discussion with The Thought Broadcast Team: “Lessons Learned”</td></tr>
</table>

No significant curriculum changes have been made to the program since the 2012 accreditation.

A strength of the approach taken to teaching and learning is the nature of workplace-based training, with local supervisors. This provides authentic experience with input from multiple psychiatrists, thus exposing the trainee to a great breadth of experiential training and ensuring that teaching is broad-based.

There are, however, some challenges associated with the role of the supervisor. The standardisation of accredited supervisors is perceived as a challenge. While all supervisors are governed by the Supervisor Policy and Procedure, and to some extent by their employing health service, and undergo accreditation training, consistency in assessments across each jurisdiction and supervisor can vary. The supervisor project, developing a central supervisor resource package and additional supports, aims to ensure supervisors are calibrated and provided with sufficient support to conduct their supervisor role confidently. This project is discussed in more detail under standard 8 of this submission.

An intended outcome of the review of EPAs, discussed in detail at the end of this standard, is to streamline and rationalise the EPAs in the program. This is expected to assist supervisors in their role as assessors in the workplace. The aim is to have fewer but more relevant EPAs to foster greater and richer experiential training, confidence, and ability in the assessment of trainee competence in the workplace.

Other challenges have been directly attributed to COVID-19, with several FECs which are usually delivered as face-to-face teaching, having to review their delivery method. Due to COVID-19 restrictions on large gatherings, continuing to deliver face-to-face FEC sessions was not possible in most jurisdictions, resulting in FEC provision via online access, enabling trainees to continue their formal education. While it may not have provided the level of interaction desired by adult learners, it enabled some providers to finesse their content and delivery to accommodate online training and providing greater flexibility to trainees during a COVID-19 environment that was presenting professional and personal challenges. This improvement in the use of technology also benefitted trainees who by circumstance have to attend a FEC remotely. With all trainees having to attend online there was an imperative to improve the online experience.

4.2 Teaching and learning methods

4.2.1 The training is practice-based, involving the trainees' personal participation in the appropriate areas of practice in the aspects of health service, including supervised direct patient care, where relevant.

The Fellowship program ensures that training is practice-based by requiring trainees to work in accredited training positions over the course of the Fellowship program. Accredited against the RANZCP standards, these posts provide sufficient experiential training for the trainee to acquire the required level of competency. These positions require trainees to be attached to hospitals, community mental health services or other services where they undertake supervised clinical practice.

The Fellowship program requires supervision of direct patient care by the utilisation of WBAs. These formative assessments require trainees to be observed and evaluated during clinical interactions. Trainees are provided with feedback regarding their performance to ensure they understand the deficits in their performance, are supported to identify training opportunities to fulfill knowledge gaps, and to encourage reflective practice.

A trainee's principal supervisor must be working in the same clinical setting at the same time as the trainee for at least 0.3 FTE. Trainees are required to undertake three hours of supervision in addition to the one hour of direct one to one supervision of a trainee. A minimum of one hour of the additional three hours must be in clinical setting where the focus is on the clinical supervision of the trainee. Stage 1 trainees must have two hours of face-to-face supervision in acknowledgement of their need for closer support and supervision during their first year of training. Supervisors are also limited to a maximum of two trainees at any one time.

Each trainee is assessed on the Fellowship competency domains within each end of rotation ITA. Some of the domains also require trainees to participate within the health service in non-clinical areas such as governance and may include participating in the organisational structure through activities such as committee representation, rostering, undertaking case presentations and/or teaching.

4.2.2 The specialist medical program includes appropriate adjuncts to learning in a clinical setting.

The approaches to teaching and learning are described in standard 4.1.1 in Table 4.1.1_2, and these include the adjuncts to learning in a clinical setting.

There are three mandatory adjuncts to learning. Leadership and Management in psychiatry training has been described under standard 3.2.5. The FEC and e-learning modules relating to Aboriginal and Torres Strait Islander mental health are described below.

Formal Education Courses (FEC)

Delivering the syllabus for stages 1 and 2, FECs provide the theoretical knowledge that underpins psychiatry practice. A FEC may be provided by an educational institution, organisation, or an approved Training Program. It must be accredited by the RANZCP and must include opportunities for trainees to engage in discussion and critical evaluation of the scientific literature in clinical psychiatry and related fields. They have been a requirement of the RANZCP Fellowship program for many years.

Satisfactory participation in a FEC for stages 1 and 2 of the Fellowship Program is a compulsory requirement of training. FECs provide formal instruction in the syllabus (provided as Appendix 3.2.2), through a mix of didactic and interactive learning and teaching. FECs are conducted throughout the year, and it is a requirement that trainees have protected study time for attendance. Lectures are provided predominantly by psychiatrists to ensure role modelling of the scholar role of the CanMEDS framework and to maximise the clinical applicability of the content.

There is no requirement that a trainee complete an award course at Masters level to achieve Fellowship. In some jurisdictions, universities provide the formal education course and there is an option to complete assessment requirements for the award of a Masters level qualification.

Almost all FECs incur a cost to the participant, including those which receive support from the jurisdiction or health services through direct funding or in-kind support such as the use of video meeting facilities. In smaller jurisdictions and New Zealand, FECs may be provided at no cost to the trainees in that zone. As discussed under standard 2 of this submission, there has been an increase in the number of low-cost FECs available to trainees associated with the introduction of a more rigorous accreditation process.

The details of the FECs available are provided in Table 4.2.2_1, and full details are provided in Appendix 4.2.2.

Table 4.2.2_1. Formal Education Course details

Course	Award	Fee
Health Education and Training Institute (HETI)	Master of Psychiatric Medicine	$27,240
HETI	Postgraduate course in Psychiatry	- NSW Health doctors – total cost $3,000 - Non NSW Health doctors – total cost $17,820
University of Sydney - Brain and Mind Centre (BMC)	Master of Medicine	$27,000
BMC	Continuing Medical Education (non degree)	$5,250 total cost
Hunter New England	None	- No cost to Hunter New England trainees - Non HNE trainees $6,000
ACT FEC	None	- No cost to ACT trainees - Not available to other trainees
South Australia	None	$6,300 Limited availability to other trainees
Tasmania	None	- No cost to Tasmanian trainees - Not available to other trainees
Western Australia	None	$5,400
Queensland	None	$4,500
Monash University	Master of Psychiatry	$23,000, sponsorship for RANZCP trainees reduces cost to $18,080
University of Melbourne	Master of Psychiatry	$30,869
Dunedin FEC	None	No cost to trainee, available only to Dunedin trainees
Christchurch FEC	None	No cost to trainees, available only to Christchurch trainees
Wellington FEC	None	No cost to trainees, available only to Wellington trainees
Auckland	None	No cost to trainees, available only to Auckland trainees
Hamilton	None	No cost to trainees, available only to Hamilton trainees

Aboriginal and Torres Strait Islander mental health modules

All trainees in the Fellowship program are required to complete the series of Aboriginal and Torres Strait Islander mental health modules that are available through Learnit:

- Aboriginal and Torres Strait Islander mental health - cultural considerations for risk assessment
- Aboriginal and Torres Strait Islander mental health - Module 1: Interviewing an Aboriginal or Torres Strait Islander patient
- Aboriginal and Torres Strait Islander mental health - Module 2: Developing a mental health management plan for an Aboriginal or Torres Strait Islander patient
- Aboriginal and Torres Strait Islander mental health - Module 3: Formulation of a case involving an Aboriginal or Torres Strait Islander patient
- Aboriginal and Torres Strait Islander mental health - Module 4: Review a model of mental health service delivery in an Aboriginal or Torres Strait Islander community.

This requirement applies to trainees in both Australia and New Zealand. When developed, the equivalent requirement for Māori mental health will also be mandatory for trainees in both countries. Consideration of how this Māori cultural safety training will be delivered is underway with Te Kaunihera, and this is discussed under standard 2.1.2 in this submission.

4.2.3 The specialist medical program encourages trainee learning through a range of teaching and learning methods including, but not limited to: self-directed learning; peer-to-peer learning; role modelling; and working with interdisciplinary and interprofessional teams.

The Fellowship program is based on adult learning philosophy and trainees are required throughout the program to self-direct their learning and are provided with opportunities for choice throughout their pathway:

- topics of study for the SP
- selection of patient for the PWC
- elective areas of practice
- selection of EPAs during elective rotations
- what WBA tools to utilise
- timing of assessments.

The Fellowship program also has two key learning outcomes in relation to trainee learning. Within the Scholar domain, the following is assessed via the ITAs over each stage of training, demonstrating increasing levels of responsibility and autonomy:

Stage 1 – **Participate in learning**: Actively participates in training program, including supervision, formal education course and academic presentations.

Stage 2 – **Participates in learning**: Develops and presents a professional development plan.

Stage 3 – **Commitment to lifelong learning**: Demonstrates independent, self-directed learning practices through participation in a range of learning activities, including peer review.

Additionally, within the professional domain, the following is assessed via the ITAs over each stage of training:

Stage 1 – **Professional Development**: Identifies learning goals and anticipated milestones in training, in supervision.

Stage 2 – **Professional Development**: Independently self-evaluates strengths and weaknesses and identifies strategies to address areas for development.

Stage 3 – **Reflection and Attitude to feedback**: Demonstrates reflective practice and the ability and willingness to use and provide constructive feedback.

Throughout the Fellowship Program, trainees, whilst encouraged to pursue self-direction in their training, have access to the support of supervisors and DOTs, as well as College resources, to provide assistance, guidance and validation on training, competency achievement and assessment preparation.

Role modelling and multi-disciplinary teamwork

Trainees are assigned a principal supervisor for each training rotation. One function of the supervisor is to provide role modelling for the trainee within the workplace. This is embedded within the program by requiring the supervisor to be co-located with their trainee for at least 0.3 FTE per week. Additionally, the training post accreditation standards enable trainees to achieve the requirement for mutually observed interviews and assessments (trainee observing supervisor and supervisor observing trainee). This is monitored by the end of term ITA where a trainee is asked to report if 'during this rotation I have observed my supervisor(s) during clinical interactions'. Where a trainee advises this has not taken place, the local BTC is requested to review the position to ensure that it continues to meet accreditation requirements and that this opportunity is provided.

The training post accreditation standards require each training post to provide the trainee with the opportunity to work as part of a multi-disciplinary team and that orientation to the multi-disciplinary team is provided.

The Fellowship program also provides trainees with the opportunity to engage in self-directed learning and peer to peer learning through FECs.

4.2.4 The training and education process facilitates trainees' development of an increasing degree of independent responsibility as skills, knowledge and experience grow.

The Fellowship program, via the learning outcomes, developmental descriptors, and syllabus, is designed to progressively build on knowledge and skills acquired through the previous stages of training.

The learning outcomes for Stage 1 (beginner) are focused on the acquisition of knowledge and skills required to practice within the general adult clinical setting, establishing a solid foundation for trainees' later practice.

The learning outcomes for Stage 2 (proficient) enable the trainees to apply their knowledge and skills within a variety of settings and with diverse patient populations.

The learning outcomes for Stage 3 (advanced) reflect the increased level of responsibility expected of trainees at this stage of training, preparing them for the transition to consultant psychiatrists and lifelong learning.

The Developmental Descriptors are behavioural descriptors for the Fellowship Competencies. The developmental descriptors articulate how the overarching Developmental Trajectory applies for each of the Fellowship Competencies at the Basic, Proficient and Advanced level. The descriptors chart the anticipated developmental trajectory of trainees' performance as they progress towards Fellowship.

The Developmental Trajectory illustrated in standard 3 (Figure 3.1.1), illustrates the broad changes expected of trainees' practice as they progress through training. The supporting document, the Progression through Training policy, is provided as Appendix 4.2.4_1. Trainees in Stage 1 are expected to complete straightforward tasks with high levels of supervision compared to Stage 3 trainees who are expected to be capable of completing complex tasks with a high level of independence and a low level of supervision.

Critical to the success of trainee's development of increased responsibility is supervision and workplace-based assessment. As trainees progress, the development descriptors provide guidance to supervisors on the expectations of trainee skill, knowledge, and behaviours.

As the RANZCP is working towards a closer integration of centrally administered summative and workplace-based assessments, the role of the supervisor, and the support program for the supervisors are being reviewed with the aim to enhance the levels of engagement of supervisors in training and assessment. As this work progresses, the inclusion of specific resources to enhance supervisor's skill in the cultural safety area will be considered.

To inform the development of appropriate support and resources for supervisors, a survey was undertaken in January 2022. Supervisors were questioned on:

- demographic data
- satisfaction with the current level of support provided by the College
- perceived needs and preferred method of accessing information
- their interest in a potential Supervisor role description and Supervisor Framework.

Most survey respondents work in the public health system in a capital city, supervise in the Fellowship program and have more than 15 years of supervisory experience. Responses confirm that supervisors are seeking information and direction from the RANZCP on how to handle underperforming trainees and have an interest in skill development to optimise their ability and confidence in providing robust feedback. Seven recommendations arose from the survey, and these are outlined in Table 4.2.4_1 below with proposed actions. A key next action is consultation with the CFT and the DOTs to further explore feasibility.

Table 4.2.4_1. Recommendations and Actions for supervisor's skills development

	RECOMMENDATIONS FOR PROPOSED STRATEGIES	PROPOSED ACTIONS TO ADDRESS RECOMMENDATIONS
1	The College to host a half-day Supervisor workshop the day prior to the Annual Congress in 2023.	Design a half-day Supervisor workshop the day prior to the 2023 Annual Congress.
2	Develop a Supervisor job description	• Consult internal stakeholders • Seek DOTS/CFT and EC input
3	Address the comments regarding InTrain and enhance support services and training	Video training for supervisors is currently being developed internally. Videos are being developed based on the topics that are registered on the help line, for example How to Login Once there are 4-5 videos developed, Supervisors and DOTs will be advised of where they are located on the College website.
4	Develop a Supervisors' handbook	Develop a Supervisors' handbook initially focusing on the top 10 topics identified in the survey. Then continue to build further resources based on other suggestions provided in the survey. As the handbook is developed, seek DOTS/CFT and EC input.
5	Hold a Supervisor workshop	Design a Supervisor workshop to be held at a separate time from Congress.
6	Develop a Supervisor framework using the RACS and RACP frameworks as a guideline	• Consult internal stakeholders • Seek DOTS/CFT and EC input
7	Explore providing online support for Supervisors through an online Supervisor mentor service	• Consult internal stakeholders • Seek DOTS/CFT and EC input

Learning management system SAP Litmos

The AMC has requested that an update on the performance of the new system is included in this submission. Full details of the work related to the change to SAP Litmos is provided under Standard 1.5.1.

EPAs Review

In its response to the RANZCP 2021 Progress report, the AMC noted:

"The College's use of EPAs continues to mature. A review of current EPAs is being undertaken in 2021 to ensure consistency of resources for each, identify any overlaps/duplications, and consider whether retirement, redevelopment or combining any of the EPAs is appropriate. This will be of interest to the team in the 2022 reaccreditation assessment."

As the College EPAs have been in use for around 10 years, it was timely to review them, particularly to identify duplication and repetition, and importantly to address trainees' concerns about the burden of assessments. Considering other review work underway in relation to the review of the syllabus and the development of an Assessment Framework in response to the ACER recommendations, this is a timely and pertinent body of work that is led by a Fellow with clinical education expertise. The project has undertaken a literature review during 2021 (Appendix 4.2.4_2). Two of the Working Group members undertook training with recognised international leaders in the EPA field including Dr Ole ten Cate from the University Medical Center Utrecht. To commence this significant project, a Working Group was established in January 2022, with the Terms of Reference (Appendix 4.2.4_3) outlining the key deliverables as:

- a review of the currency of the existing EPAs undertaken in two phases – Stages 1 and 2 will be undertaken in one phase and Stage 3 will be undertaken in the next phase
- to identify and address any duplication within the catalogue of EPAs by identifying opportunities to streamline or integrate EPAs as required
- to recommend removal or retirement of EPAs if required
- to undertake a gap assessment and identify opportunities for contemporary development in EPAs, and
- to ensure the EPAs are matched to the most appropriate stage of training.

The project plan includes the review of the current EPAs, consistency of resources and addressing any duplication between EPAs. The aim is to identify if any EPAs should be redeveloped, retired, or combined taking into consideration the burden of assessment for trainees, and identify in which stage of training the EPA should be undertaken.

The Working Group comprises Fellows from Australia and New Zealand, a representative of the TRC and Education staff. The Working Group includes members of the Assessment Review Project, with the aim of ensuring alignment of educational outcomes for both projects. The EPA review will engage in targeted consultation with relevant stakeholders and committees throughout the project as required. The Working Group will make recommendations to the CFT and EC to consider any potential impact on training. The project is expected to be completed by the end of 2024.

Standard 4: Documents provided check list

	Document
√	Course outlines for mandated skills courses, or other required courses and awards. Appendix 3.2.2 Syllabus stages 1 and 2

Standard 5: Assessment of learning

Standard 5: Assessment of learning

5.1 Assessment approach

5.1.1 The education provider has a program of assessment aligned to the outcomes and curriculum of the specialist medical program, which enables progressive judgements to be made about trainees' preparedness for specialist practice.

Progression through training is based on WBAs, centrally administered summative assessments, and satisfactory ITAs, and candidates are assessed on their level of competency as measured by these types of assessments.

While the WBAs are formative, they contribute to the evidence base for each of the EPAs and inform evaluation decisions of the EPAs and the end-of-rotation ITA, which is a summative assessment.

Please refer to the details of the WBAs outlined below.

Workplace Based Assessment

The RANZCP has three distinct work-based assessments which trainees are required to complete during each six-month rotation. A summary of the WBAs is provided in Table 5.1.1_1.

Table 5.1.1_1. Workplace based assessments summary

Assessment	Timing	Description
Workplace-based Assessments **(WBAs)**	Throughout training. Trainees must complete one Observed Clinical Activity (OCA), a type of WBA, per 6-month FTE rotation.	Trainees receive structured feedback on their performance in authentic workplace settings (e.g. discussing cases with their supervisors, or being observed during initial patient assessments, during clinical encounters or giving presentations to an audience). A minimum of 3 WBAs are used to inform the assessment of each EPA.
Entrustable Professional Activities **(EPAs)**	Throughout training.	Used to measure competence in the activities of psychiatric practice. Each EPA corresponds to a particular activity. Two EPAs must be attained for each 6-month FTE rotation. Additionally, each stage has particular EPA requirements.
In Training Assessment **(ITAs)**	Throughout training.	Assesses the trainee's performance against each learning outcome for that stage and tracks EPA attainment.

WBAs are a formative tool utilised throughout training to provide trainees with the opportunity to receive feedback on their performance to assist them to improve their knowledge, skill at specific tasks, activities, and clinical management in the workplace setting. Five WBA tools are used:

- Case-based Discussion (CBD)
- Mini-Clinical Evaluation Exercise (Mini C-Ex)
- Observed Clinical Activity (OCA)
- Professional Presentation
- Direct Observation of Procedural Skills (DOPS).

Trainees are also required to complete a minimum of one OCA for each six FTE months of training completed to successfully pass a rotation.

The assessment criteria for each of the WBAs are aligned to the competencies and skills required of a psychiatrist and are outlined in Table 5.1.1_2.

Table 5.1.1_2. WBA – Assessment criteria

Workplace-based Assessments	Assessment criteria includes:
CBD	Clinical record keeping; clinical assessment; risk assessment and management; assessment and treatment of medical comorbidities, treatment planning, referral, follow-up and transfer of care, professionalism, and clinical reasoning
Mini C-Ex	History-taking process; history-taking content; mental state examination skills; physical examination skills; communication skills; data synthesis and organisation/efficiency.
OCA	History-taking process; history-taking content; mental state examination skills; physical examination skills; data synthesis; and management plan development.
Professional Presentation	Introduction to the topic; setting material in context; analysis and critique; presentation and delivery; answering questions and quality of educational content.
DOPS	Communication skills (including therapeutic relationship/approach); demonstrated knowledge of the procedure, procedural or clinical skills, technical or supervision skills (including provision of feedback); organisation, time management and documentation; management of any issues arising (transference, risks, conflicts, adverse reactions etc); boundaries and professionalism.

To pass a rotation, trainees and partial comparability candidates must be successful in their end-of-stage ITAs where they are assessed on all Fellowship competencies and complete the required EPAs and OCAs. Trainees and SIMGs receive feedback about their performance and competency development against the standard required at the end of that stage of training.

EPAs are discussed in more detail under standard 4.1.1 of this submission.

Candidates are also assessed on their progress throughout each rotation by two ITAs:

- the mid-rotation ITA is a formative assessment completed mid-way through each rotation and provides opportunity for feedback and guidance, highlighting any concerns regarding the candidate's performance. It is also used to document supportive plans required to address these concerns
- the end-of-rotation ITA form is a summative assessment completed at the end of each rotation. This provides a record of the supervisor's assessment of the trainee's performance for each Learning Outcome for the respective stage, which closely reflect and map to the developmental descriptors.

Candidates must have completed a successful end-of rotation ITA to be deemed successful in that rotation.

Centrally administered Summative assessments

Assessment and measures of candidates' progression are also made through centrally administered summative assessments. Candidates must be successful in all summative assessments to progress to Fellowship.

Currently the RANZCP conducts six centrally administered summative assessments. In August 2021, the previous Essay style examination was decoupled into two separate components and the exam is now offered as two independent examinations - the MEQ and CEQ. The decoupling of the Essay-style Examination is discussed under Standard 5.4.1 of this submission and is consistent with the recommendations made in the ACER review of RANZCP examinations (Appendix 5.1.1).

All assessments are targeted to a proficiency level expected at the end of stage 3 of the training program. These assessments broadly sample the curriculum and aim to assess the knowledge, skills and attitudes required of a specialist psychiatrist at the end of their training.

A summary of the summative assessments is provided in Table 5.1.1_3.

Table 5.1.1_3. Summative assessments summary

Assessment	Timing	Description	Format
Multiple Choice Question Examination	Available to trainees after 6 FTE months of training.	Covers foundational knowledge in psychiatry sampled from the Stage 1 and Stage 2 syllabuses.	140 Extended Matching Questions (EMQs) worth 1 mark each Two Critical Analysis Problems (CAPs) worth 40 marks in total.
Critical Essay Question Examination	Available to trainees after 18 FTE months of training. Available to SIMG with partial comparability status.	Assesses capacity for critical thinking about clinical practice, the application of clinical knowledge, advocacy and ethical practice	Written response to a quote in an essay format, critically discussing the given statement/proposition from different points of view.
Modified Essay Questions Examination	Available to trainees after 18 FTE months of training. Available to SIMG with partial comparability status.	Assesses capacity for critical thinking about clinical practice and the application of clinical knowledge	Comprises four to six clinical scenarios requiring candidates to provide clinical reasoning and justifications for the questions based on those scenarios; questions may also require consideration of advocacy, ethical practice and cultural safety.
Objective Structured Clinical Examination	Available to trainees after 30 FTE months of training, including 18 FTE months at Stage 2. Available to SIMG with partial comparability status.	Samples clinical assessment and treatment skills across a range of disorder types, contexts and scenarios.	Clinical performance under standardized conditions, using actors rather than patients
Psychotherapy Written Case	No restrictions	Assesses knowledge, skills and attitude developed through the experience of providing psychotherapy	This summative assessment comprises at least 40 supervised sessions of therapy provision; critical thinking about and integration of this experience through a related written case report.
Scholarly Project	No restrictions	Assesses ability to evaluate academic material, demonstrate knowledge of research methods, conduct a clinical audit, produce peer reviewed quality research reports	Written report meeting specified academic criteria, which may or may not be suitable for publication

The assessment formats include multiple choice questions, short answer response, essay style response, clinical performance, written case report and written research report.

The design of the assessments uses the blueprints representing the domains of the CanMEDS Framework, which is the basis of the 2012 Fellowship program.

The standards of performance aligning with trainee progression are available on the College website (Fellowship competencies | RANZCP). The Fellowship competencies, Learning outcomes and Developmental descriptors inform the assessment blueprints and subsequent design of the assessment instrument, as well as define the standard of a successful trainee outcome.

Written examinations

The MCQ tests the understanding and application of medical knowledge. The aim of the MCQ examination, comprising objective type questions (MCQ, EMQ) and Critical Analysis Problems (CAPs), is to assess theoretical, applied, and foundational knowledge in psychiatry. The MCQs and EMQs relate to areas of knowledge such as neuroscience, pharmacotherapy, experimental design and critical analysis, history and philosophy of psychiatry, common psychiatric presentations, phenomenology, and principles of key psychotherapies. The CAP component of the examination assesses basic statistical knowledge and analysis of data and experimental design.

The MEQ comprises scenarios that have a clinical focus and assess capacity for clinical reasoning, critical thinking about clinical practice and the application of clinical knowledge, and demonstration of Fellowship competencies related to medical expert, advocate, collaborator, manager and communicator.

The CEQ comprises one essay question that tests the capacity for real-time written critical analysis and expression regarding issues relevant to the practice of psychiatry including awareness of sociocultural factors, models of illness, ethical and complex service issues.

These written examinations are mandatory, and it is expected that at the end of the training, candidates will have the underlying knowledge, and be able to demonstrate the application of that knowledge appropriately, associated with the Fellowship Competencies assessed through these examinations.

Clinical examinations

Currently the OSCE is the only centrally administered summative clinical exam that candidates need to successfully complete. It is an integrated assessment task that may sample any aspect of primary, secondary or tertiary consultation relevant to the practice of psychiatry. This assessment samples a range of clinical, leadership and allied consultancy skills from the RANZCP Fellowship Program curriculum.

The overarching aim of the OSCE is to assess a candidate's clinical competencies across a range of psychiatric practice areas in a standardised format. The examination requires the integration of general medical skills, knowledge, and attitudes. The AAP is currently replacing the OSCE as an interim measure and is discussed in detail under standard 5.2.1.

Psychotherapy Written Case and Scholarly Project

The PWC requires candidates to prepare a psychiatric report while the SP requires candidates to produce a scholarly work at a substantive academic level represented by potential suitability for publication in a peer-reviewed journal.

The aim of the PWC is for the candidate to:

- demonstrate understanding of psychodynamic principles and the ability to apply these to the psychological treatment of a patient
- demonstrate the ability to communicate their assessment, formulation, and management of a person with psychiatric problems in written professional English
- reflect on their critical involvement with patient care, their interaction with supervision and their role as part of the broader mental health system.

The skills involved in preparing the formal psychiatric report are an integral aspect of a psychiatrist's expertise, necessary in communicating with referring doctors or in constructing medico-legal options. The assessment contributes to the trainee's ability to meet Fellowship competencies, particularly in the CanMEDS role of Medical Expert, Communicator and Professional. The trainee is expected to maturely reflect on all aspects of the therapy (integrating theoretical and clinical knowledge) at the standard expected at the end of stage 3 in the written report, hence also requires the candidate to demonstrate effective self-reflective capacity and ability to utilise feedback.

The SP was designed for trainees to meet CanMEDs Framework roles, especially the Scholar Role. The trainee is expected to critically evaluate academic material, demonstrate knowledge of research methodologies, and generate quality research, clinical audit or other examples of scholarship.

5.1.2 The education provider clearly documents its assessment and completion requirements. All documents explaining these requirements are accessible to all staff, supervisors and trainees.

The RANZCP summative assessments are governed by a set of regulations, policies and procedures that make up the RANZCP Fellowship Regulations 2012.

The regulations define the broad structure of the assessment and are complemented by policies and procedures, which provide the specific rules and detail of the assessment requirements. All documents are published on the RANZCP Website (Regulations, policies & procedures | RANZCP)

Policies and procedures for specific assessments are provided as appendices to this submission:

- Essay Examinations (MEQ and CEQ) (Appendix 5.1.2_1)
- Psychotherapy Written Case (Appendix 5.1.2_2)
- Scholarly Project (Appendix 5.1.2_3)
- Multiple Choice Question Examination (Appendix 5.1.2_4)
- Objective Structured Clinical Examinations (Appendix 5.1.2_5).

The following key policies discuss workplace-based assessments:

- Workplace-Based Assessments Policy and Procedure (Appendix 5.1.2_6)
- Entrustable Professional Activities Policy and Procedure (Appendix 5.1.2_7).

Assessment and completion requirements are documented and accessible to all RANZCP members including trainees, staff, and supervisors. Links to the relevant pages on the RANZCP website are provided in Table 5.1.2_1.

Table 5.1.2_1. Assessments requirements accessible to RANZCP members

Topic	Link	Topic	Link
General	Assessments - College-administered | RANZCP	**OSCE**	OSCE | RANZCP
MCQ	Multiple Choice Question Exam | RANZCP	**PWC**	Psychotherapy Written Case | RANZCP
CEQ	Critical Essay Question Exam | RANZCP	**SP**	Scholarly Project | RANZCP
MEQ	Modified Essay Questions Exam | RANZCP	**Workplace-based**	Assessments - workplace | RANZCP

The published policy and procedures include trainee eligibility requirements to attempt each of the assessments.

The method used to determine the standard being assessed and the process of applying that standard are described in the relevant policy documents and available on the College website. The method for determining the pass mark for the MCQ, MEQ, CEQ and OSCE, that vary in content on each occasion, are described and available to candidates. The methods used include modified Ebel, and Angoff approaches to standard setting. The MCQ, MEQ, and CEQ standard setting procedures use judgments from a core group of committee members as well as multiple smaller 'satellite' groups with a committee member lead. The OSCE employs a Borderline candidate score approach, which effectively uses the combined judgment of all examiners, and uses a compensatory approach to determine overall outcome.

Fellows and Examiners involved with standard setting of the written style examinations are usually actively involved in training and supervision and meet in a group environment with designated experienced leaders providing training and facilitation of calibration. The process used includes the opportunity to discuss, justify, and adjust the level of response expected to demonstrate the required standard.

The marking process and generation of results for the PWC are described on the College website. These include the marking sheets used, the process of aligning examiners to apply a common standard and designs to reduce measurement error due to examiner variability. The marking sheet used for the SP is also available on the website. A recorded webinar is accessible where the type of feedback from the marking process that trainees may receive is discussed and recommendations provided on how to address the feedback.

Examiners in the OSCE participate in a rigorous calibration process over several hours the day before the examination, during which they review their allocated station, watch a video of a simulated candidate and engage in group discussion led by the station writer around the details of what represents a performance at each level of marking, in each domain of marking.

5.1.3 The education provider has policies relating to special consideration in assessment.

Special consideration around assessment conditions is available to all candidates. The process of applying for special consideration is available on the College website (Policy - Special Consideration Policy (ranzcp.org) and is also provided as an Appendix (Appendix 5.1.3).

Candidates may submit a request for special consideration for a particular examination or centrally administered summative assessment, for circumstances that may adversely affect their performance on that examination or assessment.

A request for special consideration must be addressed to the CFE Chair and should accompany the application for the examination or be submitted prior to the relevant submission close date.

The CFE only considers requests that could adversely affect a candidate's ability to complete the examination or assessment within the standard procedures and timing. Each application for special consideration is considered on a case-by-case basis. The CFE may consider other relevant information for example, the granting of special consideration for previous RANZCP examinations or assessments, or special consideration granted by other organisations for the candidate. The RANZCP cannot specify all circumstances that might lead to the granting of special consideration.

There is no distinct special consideration policy for workplace-based assessments. At any time, however, a trainee can request consideration for special consideration from the CFT in relation to any element of the Fellowship program.

The Alternative Assessment Pathway (AAP), introduced initially for candidates from the November 2021 AVOSCE and discussed in detail later in this submission, applied prioritisation to candidates. Candidates closest to achieving Fellowship were given priority for the review of portfolios and for the scheduling of case-based discussions. Candidates with extenuating circumstances, such as the impact of flooding in Queensland and New South Wales, were able to apply for special consideration to have their AAP at a time convenient for them.

The AAP is available to candidates in March 2022 and prioritisation of candidates is again being implemented to support candidates' personal circumstances and needs. The criteria being applied include consideration of circumstances where candidates have been previously delayed in their attempts to be assessed. Candidates who have experienced any extenuating circumstances can apply for special consideration to review their priority level. Candidates have been advised of this option through the College website and communiques during the application period for the AAP.

5.2 Assessment methods

5.2.1 The assessment program contains a range of methods that are fit for purpose and include assessment of trainee performance in the workplace.

Figure 5.2.1_1 provides a schematic of the assessments related to the stage of training. No assessments are barrier or prerequisite assessments that must be passed for progression to the next stage of training, and workplace-based assessment is undertaken throughout the training trajectory.

Figure 5.2.1_1. Psychiatry Training pathway and College administered assessments

Since the last accreditation of the RANZCP, significant changes and quality improvements have been made to assessment methods and standardisation as part of enhancement of delivery, and more recently to accommodate increased demand and backlogs caused by the COVID-19 pandemic. These are discussed in detail later in the response to this standard.

Written examinations including the MCQ, the MEQ and the CEQ

In January 2014, the MCQ Examination was introduced for Trainees in the 2012 Training Program. This ran concurrently alongside the Written Examination (Paper 1 & 2 within the 2003 Training Program).

In January 2015, the Written Exam was divided into two separate exams (MCQ and Essay-style Examinations). The newly divided Written Examination comprised Paper 1 (EMQ and CAP) and Paper 2 (CEQ and MEQ).

In response to the ACER review the Essay-style examination was further decoupled into the MEQ and CEQ examinations in August 2021. Whilst there have only been two rounds of the decoupled examination, results thus far indicate an improvement in pass rates for the CEQ. An evaluation of the two rounds of the examinations is being undertaken. This is discussed in further detail later in this submission under standard 5.4.1.

Table 5.2.1_1 illustrates the changes and overlap of the written examinations during the transition from the 2003 Fellowship program to the 2012 Fellowship program.

Table 5.2.1_1. Changes in the written examinations

	2003 program		2012 program		
2003-2013	Written Examination (Paper 1 & 2)		-		
2014	Written Examination (Paper 1 & 2)		MCQ Examination		
2015	Paper 1 (MCQ)	Paper 2 (Essay)	MCQ	Essay-style Examination	
2016-2021 (March)	-	-	MCQ	Essay-style Examination	
2021 (August) to present	-	-	MCQ	CEQ	MEQ

In November 2014, the cache of Written Exams questions was migrated from an inhouse built Filemaker Pro database to a Pearson Vue web-based exam system called Exam Developer.

In August 2015, the MCQ Exam transitioned from a paper-based exam to a computer-based examination held at testing centres across Australia and New Zealand. Candidates enrol via the Pearson Vue website, select their preferred test centre, and confirm a place in the examination. Once enrolled, candidates receive examination enrolment information (date, time, location) via email from Pearson Vue.

Upon registering at the test centre on exam day, a photo and digital signature are recorded for the verification of identity. Cliftons staff invigilate the exams.

Through a file transfer system setup between RANZCP and Pearson Vue, all exam results are received 24 hours after the exam.

This has significantly streamlined the processes relating to the MCQ, with enhanced experience for trainees, improved security of examination material and a shorter time to the release of examination results.

Data analysis using item response theory (IRT) has been incorporated into the results review process. This analysis method has supported a better understanding of the psychometric properties of the examination and helped identify problematic examination content. The results from the application of IRT via the Rasch model and Masters Partial credit model help identify examination content that is incongruent with the underlying construct being assessed. Examination content that deviates significantly is reviewed for its contribution to construct irrelevant variance. Adjustments to correct answer keys can be made as well as potential exclusion from the final score calculation.

Improvements to the written examinations include the transition to online and typed responses for future assessments with a handwritten response potentially available through special consideration. This work has commenced in 2022 with the recruitment of a Business Improvement Analyst to map out the processes, scope the requirements and potential benefits of integrating the written examinations within an online examination delivery platform. It is expected the outcomes of delivering a platform would include:

- improved flexibility in examination delivery locations
- improved data handling and results processing times
- potential cost savings associated with decentralisation of examination locations and removal of hard copy examination papers
- delivering assessments in a more preferred format.

PWC and SP

Prior to the COVID-19 pandemic, candidates were required to submit hard copies of applications, supporting documentation and a CD to the RANZCP head office in Melbourne. In response to the directions of Governments for working from home, the submission process is now electronic and conducted via email.

Candidates adapted to the transition well and the process is monitored by allocated staff with special folders and electronic management developed in consultation with the Information Technology (IT) Department of the RANZCP.

For trainees seeking an exemption from the SP through the submission of work previously published in a peer reviewed journal there have been some challenges where the word count imposed by the journal is significantly lower than that of the SP. Supplementary material can now be submitted in support of this work.

Moving forward, the College intends to transition the application process for the PWC and the SP to an online system within the College's existing internal system, InTrain. This will be consistent with the process for the OSCE, introduced during 2021/2022.

This process will remove the need for paper applications currently submitted via email and will streamline the application process and allow online payment.

The introduction of software to manage plagiarism is currently under investigation, with several products being evaluated for their suitability and capacity to integrate into the RANZCP systems and workflows.

OSCE

The format of the OSCE has undergone several adjustments in response to increased demand over time for assessment and, more recently, in response to the impacts of COVID-19.

COVID-19 provided an environment that facilitated change and consideration of a different approach to the OSCE, while the College continued consideration of the recommendations of the ACER review.

The station configuration has undergone changes during the period of accreditation. To accommodate increased numbers of candidates, in 2018 additional bye stations were included. For the circuit of short stations, two inactive byes were introduced, and an additional bye station, which could be active or inactive, was introduced to the circuit of long stations. This enabled an increase from 12 to 20 candidates per stream that could be examined without requiring an increase in examiners or additional time.

Since 2020 the delivery format has varied in response to the restrictions of COVID-19 and the College's commitment to expanding assessment opportunities, in particular for candidates closest to Fellowship, with both multi-site and fully online modes used. Several examination delivery formats have been trialled over the period of the pandemic:

- a small scale AVOSCE delivered to a mix of candidates' workplaces and examination centres in November 2020
- an AVOSCE delivered to standardised examination venues in April 2021
- a face-to-face format examination was conducted across multiple sites in Australia and New Zealand concurrently in July 2021 (MSOSCE)
- an AVOSCE to the candidate's home or workplace in November 2021.

This work was overseen by Steering Groups established for the purpose of addressing the challenge of assessing candidates during the COVID-19 pandemic and developing OSCE models that could maximise assessment opportunities in the COVID-19 climate, especially for candidates closest to Fellowship. Reporting to the CFE the AVOSCE Steering Group (AVOSCESG), set up in 2020, developed and ran the November 2020 and April 2021 AVOSCEs. The AVOSCESG included CFE members, Fellows with significant experience in the running of the OSCEs and assessment expertise, trainee and SIMG representatives, College staff and commissioned Project Managers to support the delivery of the AVOSCE.

Following lockdowns that had instrumental impact on examination delivery, the Board determined to return to a face-to-face OSCE across multiple sites for July 2021, the AVOSCE steering group was renamed as the MSOSCE Steering Group.

Candidate eligibility criteria were also developed and implemented for the delivery of the AV OSCEs in November 2020 and April 2021, which controlled candidate numbers and eligibility to sit these examinations due to limited capacity of the AV format and technology. Priority was given to those candidates closest to achieving the requirements of Fellowship.

In 2020, the number of stations changed from three long stations with two examiners per station (five minutes preparation plus 15 minutes assessment) plus eight short stations with one examiner per station (two minutes preparation and eight minutes assessment) to a new format of six long stations with one examiner per station. The domains assessed per station were increased from between three to six, to six. The total number of scored observations per candidate increased as did the reliability of the candidate scores. These changes were implemented in response to the increased number of candidates requiring assessment during the height of COVID-19 restrictions, and to improve the reliability of the measures produced.

Further improvements introduced during 2020/21 included:

- examiner standardised scores were provided to individual examiners as part of monitoring examiner differences. These were also used for examiner selection for future assessments
- station cut-score calculation results are now checked against an alternative method, border-line regression, as part of a more robust verification process
- the scoring rubrics no longer require a ‘Must demonstrate’ requirement to achieve a high score. This change is consistent with maintaining independence between the score criteria used
- online applications, through InTrain, streamlining the process for both staff and candidates.

The AVOSCEs delivered in November 2020 and April 2021 were implemented without any systemic issues affecting multiple candidates. However, the delivery method used for these two examinations could not support the increasing number of potential candidates. The next examination scheduled in July 2021 was changed to a face-to-face format delivered at multiple sites concurrently. It was expected that the maximum number of eligible candidates could be assessed using this format, however, late pandemic related changes and sudden lockdowns in some jurisdictions resulted in cancellations, for example NSW.

As a strategy to avoid a repetition of this situation the College pursued the development and delivery of a large-scale AV OSCE format for November 2021, using a specialist IT solution external vendor. The November 2021 AVOSCE suffered a systemic technology failure resulting in the cancellation of the examination for the candidates enrolled for PM session and in multiple technical errors for the candidates sitting the AM session preventing many of them from completing the examination.

Following the failure of the November 2021 AVOSCE, the RANZCP Board established a Taskforce chaired by the President-Elect to oversee the development and implementation of the AAP. This approach was taken to provide an alternative assessment to candidates in the shortest possible time. The taskforce included Fellows, Board members, trainees, SIMG representatives and College staff, with a focus on a co-design approach in collaboration with trainees. At the conclusion of an intense period of consultation and development, the AMC confirmed that the AAP, as developed by the Taskforce, was consistent with this accreditation standard. During this time Board members also met with Chairs of the APTs to seek their feedback and test the implementation of the AAP. These meetings continue to occur on an ad hoc basis.

The AAP is based on the use of multiple points of assessments over time, demonstrating that graduate psychiatrists are competent generalists, in place of the high stakes OSCE for the cohort of trainees affected by the November 21 AVOSCE. The supporting mapping of Fellowship competencies against assessments is provided as Appendix 5.2.1.

This pathway was made available to those candidates unable to achieve a successful outcome from the November 2021 AV OSCE. Candidates who participated in the morning session were awarded a successful outcome if they were able to achieve a total score based on at least two of the six stations that was higher than the combined cut scores for the scored stations.

The AAP comprises two assessments:

- Portfolio Review, using workplace assessments
- Case based discussion, a 45-minute case discussion with two examiners assessing the performance should the Portfolio Review not demonstrate achievement of the required competencies.

Full details of the AAP are provided on the RANZCP website, accessible to all trainees, SIMG candidates and assessors (March 2022 Alternative Assessment Pathway | RANZCP).

Two panels, the Portfolio Review Oversight Panel (PROP) and the Case based Discussion Oversight Panel (COP) each chaired by a Board Director, were established to oversee the governance and implementation of the two assessments. These panels report to the Taskforce.

A total of 197 trainees had a portfolio review and following the process, 54 candidates progressed to CbD Assessment (42 candidates after Portfolio Review and 12 Candidates progressed directly due to having less than 3 months FTE of Stage 3 training time). The CbD is classified as a no-disadvantage assessment and the result will not count towards the total number of attempts. Candidates can choose to delay the CbD up until November 2022, if that better suits their circumstances. Table 5.2.1_2 details the number and distribution by pathway and training zone of the candidates being assessed via the AAP (AVOSCE 2021).

Table 5.2.1_2. Trainees assessed via AAP (AVOSCE 2021) by pathway and jurisdiction

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUST	NZ	No Zone	Overall
Overall	**4**	**55**	**3**	**35**	**13**	**2**	**58**	**13**	**183**	**13**	**1**	**197**
Trainees	4	50	2	28	13	1	36	13	147	13	1	161
SIMGs	-	5	1	7	-	1	22	-	36	-	-	36

Further information on the AAP, outcomes and evaluation, is provided at the end of this standard.

5.2.2 The education provider has a blueprint to guide assessment through each stage of the specialist medical program.

Blueprinting for the written examinations ensures constructive alignment between the curriculum and the assessment. The MCQ examination is blueprinted at the item level to ensure that a representative sample of topics and related outcomes are covered. Test specific blueprints also exist for the essay examinations, matching the content with the questions. The blueprint for the written examinations is provided as Appendix 5.2.2_1.

The OSCE blueprint is constructed with reference to CanMEDs competencies, and by topic and by station to descriptor categories, areas of practice, and Fellowship Learning outcomes. The OSCE subcommittee selects a range of topics and competencies across the blueprint and refers to previous examinations to limit overlaps when developing stations for OSCEs.

The stations are mapped to the OSCE Blueprint Descriptors, areas of practice, and to the CanMEDS roles and Fellowship Competencies.

The Blueprint descriptors cover eight disorder groups and three skills areas relevant to the practice of psychiatry:

- anxiety disorders
- child and adolescent disorders
- medical disorders in psychiatry
- mood disorders
- personality disorders
- psychotic disorders
- substance use disorders
- other disorders (e.g. neuropsychiatric, sex, sleep, somatoform, eating, etc.)
- clinical assessment skills
- governance skills
- other skills (e.g., ethics, consent, capacity, collaboration, advocacy, indigenous, rural, etc.).

An OSCE will have a mood disorder, psychotic disorder, anxiety disorder, medicine in psychiatry, core skills and other disorder station. The core skills station will focus on testing core clinical assessment skills, including formulation and management planning.

The SP assessment covers nine domains:

- relevance to the theory or practice of psychiatry.
- presentation and content
- objectives and/or hypothesis.
- literature review
- references
- methodology
- results.
- discussion
- conclusions.

The SP mark sheet reflecting the blueprint is provided as Appendix 5.2.2_2.

The PWC assessment covers the following domains:

- assessment (including mental state examination and initial formulation)
- management plan
- clinical progress
- reformulation
- supervision
- communication/liaison
- discussion.

Whilst each domain is required to be covered and the case is marked accordingly, the relative importance of material and hence content will vary according to the case.

The curriculum maps for Stage 1 and Stage 2 are provided as appendices 5.2.2_3 and 5.2.2_4. These document the alignment of competency and learning outcomes with the syllabus, workplace assessments, and the range of learning and teaching options.

The College is also currently working on the development of a broader Assessment Framework that will further strengthen the test-specific blueprinting.

Assessment Framework

The need for an assessment framework, demonstrating the integration between assessments (including workplace-based assessment), outcomes and the curriculum has been identified within the College and included in the ACER review as one of the key recommendations (ACER Report January 2020). This was based on the need for better integration between training and assessment, and hence the development of an Assessment Framework.

A more detailed discussion of the ACER review is included under Standard 5.4.1 of this submission.

The EC and the Board have endorsed the development of an Assessment Framework and the proposed structure to establish an alignment between assessments (both formative and summative), Learning Outcomes and the curriculum. The RANZCP Assessment Framework will articulate to trainees, Fellows, other professional groups, and the public the learning outcomes to be met by RANZCP trainees, and how those outcomes will be measured to ensure that the goals of the RANZCP Program are met.

An Assessment Framework will articulate this integration more comprehensively.

An initial proposal specifying the structure and elements of the Assessment Framework has been approved. Besides the curriculum and assessment map aligning the learning outcomes, curriculum, and assessments, it will be important to include other elements as part of the Assessment Framework, so that a comprehensive document covering all aspects of assessments can be published. These elements include the:

- purpose of the training program
- aim of the RANZCP assessments
- educational and assessment principles followed by RANZCP training
- broad blueprinting indicating how examinations will be blueprinted against the syllabus and learning outcomes
- range of learning and teaching options.

An Assessment Framework Working Group has been established under the remit of the EC to progress the development and make recommendations as needed. The TOR for this group is provided as 5.2.2_5.

The main task of the group is to map the assessments to learning outcomes and recommend an assessment blueprint. Further, any development of the curriculum and assessment map that aligns learning outcomes and assessments will be driven by what outcomes are expected of RANZCP graduates. These broad outcomes will link with the learning outcomes which in turn are aligned to assessments.

The development of an Assessment Framework can also assist in providing an insight into the appropriateness and gaps, if any, of current assessments to achieve and measure the training objectives. While developing the Assessment Framework, changes to assessments may be proposed.

In reviewing the program of assessments, an important focus will be how the outcomes from both the workplace-based assessments and summative assessments can be incorporated into decision-making around trainee progression.

The College has also recently embarked on a review of the overall program of assessments offered at the College, with a view to rationalise the assessment burden and efficiently utilise workplace-based assessments (along with the summative assessments) for making holistic decisions about candidate progress. Three underpinning principles have been considered in this context:

- the aggregation of meaningful data over time, sampled in authentic contexts, and using an approach of assessment for learning rather than assessment of learning
- concepts of fairness as opposed to objectivity that utilises the expert judgement and ensures reliability through increased sampling of candidate performance
- a culture of feedback that informs all aspects of the pathway to Fellowship

The Assessment Framework Working Group is aware that any change to the program of assessments will need to be considered in the context of the Assessment Framework. The Working Group will closely monitor and work with any future emerging decisions about the future RANZCP assessments.

In addition, in 2022 the RANZCP has appointed a Medical Education and Assessment specialist who, in conjunction with external experts in this area, is reviewing the model of assessment. In addition to a need to develop a long-term strategy to address assessments in COVID-19 times and provide RANZCP candidates with access to expanded and flexible assessments, this work is also addressing the recommendations of the ACER review with the aim to improve the alignment between training and assessment. A revision of the workplace-based clinical assessments will be part of this work.

On 17 June 2022 a face-to-face stakeholder forum was held to bring together Fellows, trainees, SIMG representatives and College staff to discuss and reach consensus on assessment options for 2022 and beyond. This forms part of a wider collaborative approach to developing the future of assessments in partnership with candidates and Fellows. This forum was held with the intention to reach consensus on two points:

- the principles that should guide reform of the assessment strategy of the RANZCP Fellowship program over a period of several years
- a preferred option as an alternative to the OSCE for the remainder of 2022 and potentially for 2023.

Ten principles to guide reform were presented to the forum:

- patient safety, which includes workforce distribution
- educational value (assessment and feedback as positive education) rather than "rites of passage" or hurdles
- evidence based rather than opinion based
- feasibility, including consideration of the burden of assessment (which is more complicated than the number of assessments)
- well-being and support for all stakeholders (trainees, SIMGs, supervisors, DOTs, College staff)
- competence as a narrative and a progressive level of trust to act independently
- longitudinal assessment, noting that a single event (i.e., an examination) is not predictive of future performance and that expert judgement is a necessary component
- front loading of the program with any hurdles early in the program
- concepts of fairness
- major change will require surfacing, testing and revising of assumptions and frameworks.

The forum agreed to these principles as presented, and added the following:

- simplicity
- re- imagining of old methods of assessment
- the individualisation of supports to enable individuals to demonstrate their ability and competence

The forum identified the preferred options for an alternative to the OSCE for the remainder of 2022 and potentially 2023 as either the AAP in its present form, or a more robust and standardised AAP that includes additional data for the portfolio review and requires all candidates to undertake CBD.

5.2.3 The education provider uses valid methods of standard setting for determining passing scores.

The centrally administered summative assessments have a high level of standardisation, with a high level of fairness and validity in the assessment outcomes. The standardisation of these assessments contributes to their fitness for purpose as a measure of candidate progression to Fellowship. Their representation of the underlying key constructs for achieving Fellowship remains under continual evaluation.

OSCE

Each domain score has a weighting to determine the relative contribution to the Station score. The Station score is an aggregate of all domain scores for the station. The Pass Mark for each station is determined by the independent process of calculating a ‘cut score’ derived from the Global Proficiency Rating. The average of station scores of all ‘Marginal performance’ candidates on a particular station is used to calculate the cut score for that station. The aggregate of cut scores for all stations becomes the OSCE pass mark. The Standard Error of Measurement (SEM) will not be used to determine the pass mark. A borderline regression method is sometimes used as a validation check on this procedure. Results from both methods are considered when sample sizes are small.

The standard set and subsequent pass mark for an OSCE assessment is based on examiner application of the Global Proficiency Rating. The Marginal performance category represents the borderline for an acceptable standard.

The validity of the procedure used is evidenced from:

- examination construction procedures producing balanced content representation
- station scoring rubrics covering multiple competencies within each station
- examiner training and calibration exercises prior to assessment of candidates
- post examination monitoring and feedback on comparability of examiner standards
- candidate exposure to multiple examiners
- use of multiple calculation methods as a checking procedure and consistency of results.

MCQ

MCQ examination content is presented to the CFE members and other invited Fellows, usually 1 to 3 weeks prior to the examination, for standard setting.

A modified Ebel method is used. Members are divided into groups of four to five and given a section of the content from the examination. They apply an importance and difficulty estimate for each item. A consensus approach is used for each group on each item.

The relative difficulty of the examination items is calculated from the cohort responses and used as a validity check on the estimated difficulties of the items as established in the standard setting procedure. Where large differences exist further evaluation on the item construction/quality, answer key, and standard setting values is undertaken.

PWC and SP

Standard setting is conducted via marker calibration activities held once or twice per year.

Three candidate case submissions are chosen for all markers to assess using the marking sheet. These submissions represent performances at the level of borderline pass, borderline fail and clear fail. Cases are blind marked. Discussion on each case is invited from all markers, with outcomes awarded on each domain reviewed.

During each marking cycle, examiners are paired. If an examiner feels that a case report should fail, or is a borderline fail decision, the case report is passed to the examiner pair for their feedback. Should there not be a consensus; the case report is referred to the Chair, Case History Subcommittee for a final determination.

For the SP, the process is identical, however SP materials are used.

CEQ

The standard is set by experienced members of CFE and Writtens Sub Committee (WSC). The WSC meets bi-yearly to discuss CEQ Standard Setting.

All committee members draft a response and spend time considering the main contention of the author given in the statement; listing a few points which a candidate would be expected to include in an essay at a 'pass' standard. Next, the CEQ marking guide is reviewed and notes the domains (and their weighting) that are to be assessed for the CEQ. Weighting provides an indication of the emphasis given to each domain.

Considering the difficulty of each domain, an estimated score (0, 1, 2 or 3) that would be expected of a minimally competent candidate is made. The group meets to consider the CEQ as a whole and estimate the number of marks (or percentage) that the minimally competent candidate might score. The weighted score for each domain is then calculated to reach the cut score for the CEQ.

There is a group discussion of scores given with justifications and opportunities for members to adjust scores up or down prior to determining the consensus score on each domain used to set the pass mark. Cohort results are used to compare outcomes from previous cohorts as a validity check.

MEQ

The standard setting is conducted for the MCQ and MEQ simultaneously in small groups. Each group is assigned a selection of EMQs, CAPs and MEQs to assess. The pre-determined marking guide for the question is reviewed. Based on the difficulty of the question, the marking guide is reviewed to assess which points a minimally competent candidate would be expected to include in a response. This is the candidate who should be able to pass the paper overall, but may have more accentuated areas of relative strengths and weaknesses than the more competent candidate.

Based on the number of points the panel determines that a minimally competent candidate should demonstrate in their response (as the standard required), a mark out of the maximum mark for that question is estimated. If there is not consensus discussion will be held to reach consensus and the initial mark revised as appropriate.

Finally, the group consider the question as whole, and estimate the number of marks that the minimally competent candidate might score for that question. Marks for each MEQ are aggregated to reach the cut score for the MEQ.

This process is repeated in satellite groups throughout Australia and New Zealand. Standard setting and satellite setting groups are averaged to reach the standard score. Any discrepancies between the two groups are highlighted and discussed at results teleconference along with results data and examiner feedback.

The procedures directly relate to the expected competency levels of the target group. The assessments are based on materials that elicit relevant responses to assess those competencies. The assessments are made by appropriate and experienced College members. Those members are provided all relevant information to make the assessments. There is opportunity to discuss and find a consensus position. The influence of individuals on the outcome is minimised by members working in satellite groups and satellite groups working with a subset of the total exam content only. A core reference group of the most experienced committee members work with all content. The final result is an average between the core reference group and the satellite groups.

Workplace based assessment is conducted by experienced psychiatrists, who make an expert judgement on the performance of the trainee. Standardization is more challenging in the workplace as patients are not standardized, and supervisors may apply the standard variably. However, WBA is a highly authentic assessment in that real clinical situations form the basis of assessment. A trainee will be assessed by many supervisors over the course of their training and the variance of an individual supervisor is minimised due to the number of points of assessment.

5.3 Performance feedback

5.3.1 The education provider facilitates regular and timely feedback to trainees on performance to guide learning.

Both oral and written feedback is provided to trainees throughout work-based assessments.

The WBAs, mid- and end- of- rotation ITAs require supervisors to assess trainees and in the case of the ITA, provide qualitative comments regarding performance and achievement of required standard and competency. Trainees are required to review the feedback provided through InTrain and acknowledge this has been received.

Mid- and end-of-rotation ITAs are generally completed during supervision, providing the opportunity for discussion on the trainee's performance over the course of the rotation, in addition to the completion of written documentation.

The trainee's supervisor/s hold key responsibility for providing feedback regarding their work performance and competency development. Over the course of a training year, there is a minimum of four formal feedback opportunities within the workplace-based assessment for every trainee.

Feedback to trainees regarding their performance on centrally administered summative assessments is provided following the finalisation of the results. Examples of the feedback letters to both successful and unsuccessful candidates are provided as appendices to this submission (Appendices 5.3.1_1 and 5.3.1_2). The aim of the feedback provided is to foster discussions between trainees and supervisors and/or DOTs and identify areas for improvement. Table 5.3.1_1 outlines the mechanism and content of feedback provided by the College for centrally administered summative assessments.

Table 5.3.1_1. Feedback from centrally administered summative assessments

	Mechanism
SP and PWC	Written feedback is provided to trainees who did not demonstrate the required standard. This feedback is generated by the examiners during the marking process. (Appendices 5.3.1_3 and 5.3.1_4)
CEQ and MEQ	A detailed result letter providing feedback and bench marking for each blueprint for MEQ and competencies for CEQ is provided to all candidates. Post examination report based on examiner feedback is published on the RANZCP website (Appendices 5.3.1_5 and 5.3.1_6)
OSCE	A detailed result letter is provided to all candidates including: • total score on each station with the cut score for each station as a reference • total score on Fellowship competencies assessed across stations with a cohort mean and standard deviation as a reference. A post examination report based on examiner feedback, general feedback and station descriptions including some statistics, is published on the RANZCP website (Appendix 5.3.1_7)
MCQ	A detailed result letter is provided to all candidates including: • results broken down by question type and content area • the proportion of marks achieved from each content area as well as the contribution of each content area to the total score, which provides information on candidates relative strengths and weaknesses. A post examination report based on general performance broken down by question type and cohort performance based on question content area, is published on the RANZCP website. (Appendix 5.3.1_1)

It is important for trainees to receive the feedback regarding their performance in summative assessments in a timely way for consideration as they prepare for further assessments. The RANZCP recently reviewed the elapsed time between the assessment and the release of results for each of the summative assessments. The results of this analysis indicate that improvements could be made to the processes for some of the assessments, and that there is room for improvements in the quality and usability of feedback from the written examinations. Table 5.3.1_2 below shows the average number of days elapsing between the assessment and the release of results on the website and through individual candidate letters.

Table 5.3.1_2. Days between assessment and publication of results.

Assessment type	Average days to publication of results on website	Average days to release of individual results letters to candidates
OSCE (2016-2021)	30	31
MCQ (2017-2022)	37	41
SP (2017-2022)	81	82
PWC (2017-2022)	72	72
Essay-style (2017-2021)	85	88
CEQ (2021)	81	113
MEQ (2021)	81	113

The time taken to mark the SP and PWC is reasonable given the lengthy nature of the submissions, as is the time for the release of OSCE results. However, the analysis showed that the time taken for the release of results for the Essay, CEQ and MCQ is longer than ideal.

Multiple factors have led to the increase in the time taken to release detailed result letters. Candidate numbers have increased, resulting in an increased marking load for examiners, who do this work pro bono outside of their work hours. While increasing the number of markers may reduce marking time, it also carries a risk to the quality and consistency of marking.

The increased candidate numbers have increased the administrative requirements and logistics of these paper-based examinations, particularly with the decoupling of the examination into two independent examinations.

Consideration of structural changes to enhance efficiencies in this area is underway. Online options for the written examinations are being explored and it is expected that this will be a mechanism to significantly increase the efficiency of the marking process. In addition, the staffing profile of the Assessments team is undergoing review, with a view to improving efficiencies. The move to online processing of applications and payments will result in additional staff time available to support the processing of results letters.

5.3.2 The education provider informs its supervisors of the assessment performance of the trainees for whom they are responsible.

Usually, the supervisor is providing feedback on work-based assessments to trainees for whom they are responsible. However, a trainee may complete WBAs and EPAs with other RANZCP accredited supervisors.

A principal supervisor will be provided with any WBA and EPAs completed by an alternative supervisor and will be able to access the feedback provided to the trainee via the InTrain system. It is not possible for an alternative supervisor to complete end of rotation ITAs. In most cases where a trainee has an alternative supervisor, the alternative supervisors are colleagues of the principal supervisor. This means that there are also opportunities for discussions on assessment performance of a trainee on an informal level.

Feedback regarding performance on trainee performance in centrally administered assessment is provided to DOTs. Table 5.3.2_1 outlines the mechanism and content of feedback regarding performance in the centrally administered summative assessments.

Table 5.3.2_1. Feedback from centrally administered assessments to DOTs

	Mechanism
SP and PWC	Directors of Training receive an examination result report of the candidates in their zone (Appendix 5.3.2 as example). They also receive a copy of the registrar's feedback letter for each of the unsuccessful candidates.
CEQ and MEQ	Directors of Training receive an examination result report of the candidates in their zone. They also have access via InTrain to receive a copy of the candidates' feedback letters. Post examination report after each exam which is based on examiner feedback survey
OSCE	• Directors of Training receive: • an examination result report of the candidates in their zone. • a copy of the candidate's unsuccessful result feedback letter. • the post examination report after each exam which is based on the examiner post exam meeting and the examiner feedback survey.
MCQ	Directors of Training access a post examination report via InTrain. This report contains the examination status (Successful or Unsuccessful), for each candidate within that DoTs Training zone. The report also includes the number of attempts at the examination as well as a flag indicating if Targeted Learning or Targeted Review is required. A general post examination report is also made available showing cohort characteristics in relation to the content area

5.3.3 The education provider has processes for early identification of trainees who are not meeting the outcomes of the specialist medical program and implements appropriate measures in response.

There are several points where trainees who are possibly not meeting the outcomes of the Fellowship program, can be identified and support measures implemented.

The Mid-rotation ITA and the supportive plan

A mid-rotation ITA is required for every rotation. This ITA is formative, and for trainees identified as struggling, can be completed prior to the mid rotation point and can be completed more than once. Should a supervisor be concerned that the trainee is not meeting the required standards of the rotation, a supportive plan must be documented on the mid-rotation ITA form and commenced immediately.

This documentation includes the competencies requiring attention and the action to be undertaken to support the trainee in achieving the standard required prior to the end of the rotation. As part of a supportive plan, the supervisor must discuss their concerns with the trainee, the DOT or their delegate, try to identify factors affecting the trainee's performance and review progress towards the identified goals with the trainee within 3 months or prior to the end of the rotation, whichever comes first. As part of a supportive plan, the DOT must ensure that timely (for example, within four weeks) and adequate feedback and support is provided to the trainee by the principal supervisor to enable the trainee to identify and correct any perceived difficulties.

Centrally administered assessments

The MCQ is expected to be attempted and passed by the time the trainee has completed 36 months of FTE accredited training. Failure to do so requires the completion of targeted learning to support the trainee in passing the MCQ Examination.

The MEQ, CEQ, SP, PWC and OSCE are expected to be attempted and passed by the time the trainee has completed 60 months of full-time equivalent (FTE) accredited training. Failure to do so will require the completion of Targeted Learning to support the trainee in passing the relevant Examination.

Targeted Learning

There are several measures for trainees to access if they are not meeting the required milestones or competencies of the Fellowship program.

Trainees who are unsuccessful in a rotation or have not passed the same summative assessment after two attempts, are required to commence assessment based targeted learning. Not passing an assessment by the trajectory point as per the Progression through Training Policy will enable a trainee to complete progression based targeted learning. The Progression through Training Policy and the Targeted Learning Policy and Procedure are provided as appendices 4.2.4_1 and 5.3.3.

If a trainee is not able to meet the milestones of the program after progressing through remedial supports, exclusion from the training program may be considered. Exclusion from the Fellowship Program is an involuntary exit from all training which is ratified by the RANZCP Board at the recommendation of its committees and is a step that is taken as a last resort.

A trainee may be excluded from the program due to:

- failure to progress through the training program
    - o three or more unsuccessful attempts of the same summative assessment
    - o not completing training requirements by the Training Review deadline
    - o failure to commence rotation-based targeted learning
    - o failure to achieve mandatory EPAs
    - o accrual of five years cumulative of break in training time
    - o accrual of 12 months cumulative of not in training time
    - o reaching the maximum time in training
- removal from the medical register or changes to a trainee's medical registration due to misconduct, unsatisfactory performance, or ethical breaches
- non-payment of training administration fees
- ethics or conduct grounds, including a breach of the RANZCP Constitution, Code of Ethics, Fellowship Regulations or other RANZCP policies or guidelines or professional conduct breaches potentially resulting in dismissal from employment or changes to medical registration.

Tables 5.3.3_1 and 5.3.3_2 provide data on the number of trainees who have undergone targeted learning or have been excluded from the Fellowship program over the last three years. Table 5.3.3_1 details the head count of trainees who have commenced targeted learning during the calendar year. It is possible that a trainee may have more than one instance of targeted training in a year, and it is also possible that a trainee is counted in more than one year.

Tables 5.3.3_2 shows the total number of trainees who have been excluded during the period 2019 – 2021. Table 5.3.3_3 provides further detail on those trainees from the 2012 Fellowship program who have been excluded, by cohort, since 2017. This suggests that most trainees who have been excluded from training from the program since the introduction of the 2012 Regulations are trainees who have transitioned from the 2003 Regulations.

It is not possible to provide data at this time on the number of trainees who have been provided with supported learning plans, as these are managed at the local level.

Table 5.3.3_1. Trainees undergoing Targeted learning 2019 - 2021

Year	Number	% remediated	Summary of outcomes
2021	64	3.2%	• 7 trainees have gained Fellowship since the completion of Targeted Learning.
2020	77	3.9%	• 29 trainees have gained Fellowship since the completion of Targeted Learning • 1 trainee has since withdrawn from training • 1 trainee has been excluded.
2019	108	5.9%	• 36 trainees have gained Fellowship since the completion of Targeted Learning • 3 trainees have since withdrawn from training • 2 trainees have been excluded.

Table 5.3.3_2. Trainees excluded from the Fellowship program 2019 - 2021

Year	Number	% dismissed	reasons
2021	0	-	-
2020	7	0.35%	• 4 trainees excluded for the accrual of 12 months of not in training • 2 trainees excluded for five MCQ fails • 1 trainee excluded for six MCQ fails
2019	13	0.7%	• 9 trainees excluded for the accrual of 12 months of not in training • 1 trainee excluded for the non-submission of a targeted learning plan after 60 days (trainee supported to re-enter training in 2021) • 3 trainees excluded for three rotation failures.

Table 5.3.3_3. Trainees excluded from the 2012 Fellowship program by cohort

Year	Intakes	Excluded	%	reason for exclusion
Cohort 2021	347	-	-	-
Cohort 2020	361	-	-	-
Cohort 2019	295	-	-	-
Cohort 2018	296	-	-	-
Cohort 2017	246	3	1.2%	• 2 excluded for the accrual of 12 months of not in training • 1 excluded for not having medical registration

5.3.4 The education provider has procedures to inform employers and, where appropriate, the regulators, where patient safety concerns arise in assessment.

The RANZCP may not always become aware of patient safety concerns arising in the course of assessments, as where those assessments are work-place-based, any concerns may be managed by the trainee or SIMG supervisor or DOT in accordance with workplace and regulatory requirements and without notifying the RANZCP. However, where the RANZCP does become aware of patient safety concerns through the assessment process, these concerns would be escalated up through the relevant committees for consideration, including the CFE, the CFT, the CSIMGE and the EC as per usual governance process. It is noted that RANZCP trainees and SIMGs are expected to comply with all relevant regulatory codes of conduct and the RANZCP Code of Ethics during their time on the Fellowship Pathway as per section 27.1 of the Education Training Regulation (Appendix 5.3.4).

Where the EC determines that it is appropriate to escalate the matter to an employer and/or regulatory body, having regard to all the relevant information and circumstances, the RANZCP Privacy Policy allows the RANZCP to make disclosures about these matters in certain circumstances. Alternatively, if disclosure is not provided for explicitly in the Privacy Policy, the RANZCP would seek consent from the trainee or SIMG to disclose these matters to the relevant regulator or employer as appropriate.

As per usual process, a trainee or SIMG would be provided with a chance to respond to any concerns raised by the Committee in accordance with procedural fairness and before any reports occur. There would also be appropriate focus placed on any support which the RANZCP could provide the SIMG or trainee in the course of these matters being address by the relevant body.

The RANZCP notes that where concerns are raised with a RANZCP by a member of the public or patient in relation to a trainee's or SIMG's performance, the RANZCP would refer that person to contact the relevant regulatory body directly to raise the matter or seek further advice, as the RANZCP does not have the authority to investigate complaints made by members of the public. Information regarding making a complaint to a regulatory body is provided on the RANZCP website (Complaints about psychiatrists | RANZCP).

5.4 Assessment quality

5.4.1 The education provider regularly reviews the quality, consistency and fairness of assessment methods, their educational impact and their feasibility. The provider introduces new methods where required.

The RANZCP utilises both periodic reviews and evaluations alongside continual quality improvement measures. Periodic reviews include the annual survey of STP trainees, the trainee Exit survey and more recently through the conduct of an external review of examinations and its process, the ACER review.

ACER review

In 2019 the RANZCP Board commissioned ACER to conduct an independent review of the RANZCP's examinations and associated processes. Initially commissioned to address specific concerns regarding the low success rates of candidates in the Essay-style examination, the scope was broadened to include all RANZCP examinations with a view to providing recommendations for improvements that reflect best practices in assessment.

Delivered in January 2020, the ACER report provided a series of recommendations proposing quality improvement and future directions in Education and Training that align with the evolving role of psychiatrists and community needs, and the contemporary trends in assessment.

An implementation plan has been developed and approved by the EC and the Board. To respond to the ACER recommendation to have a better alignment between training and assessment, the CFE and the CFT have been working closely to better oversee the implementation of any change that aligns the training program and assessments. The appointment of a Medical Education and Assessment specialist to the staff of the RANZCP is a key step in the implementation of recommendations. As outlined under standard 5.2.2, an Assessment Framework is being developed to better map and define the knowledge and skills that trainees and SIMGs are expected to demonstrate at the time of assessment with the intention to better align training with assessment.

The implementation plan clearly identifies and prioritises the actions associated with each recommendation, the expected outcomes, their feasibility, delivery timelines, responsibilities, and mitigation of any associated risks. The summary of the implementation plan is provided as Appendix 5.4.1_1. The plan provides a degree of flexibility to ensure a smooth transition to the changes.

Progress to date includes:

- the decoupling of the CEQ and MEQ components of the former Essay-style examination and evaluation of the outcomes
- initial scoping work towards a more flexible examination delivery system, with online written exams and distribution to examiners for marking
- consultation with key stakeholders regarding the feasibility of a summative OCA or alternative as a complimentary or alternative assessment method to the OSCE.

In the context of the future OSCE delivery, and in reference to the response to the ACER review, the discussion of the overall strategy for the program of assessments is commencing with multiple options presented to the Board and stakeholder groups. It is an opportunity for the RANZCP to address innovation in assessment and to integrate the learnings from the recent OSCE experiences while integrating the recommendations of the ACER review.

Responses to College evaluation – STP trainee survey and Exit Survey

Regular evaluation of trainee's experience in the Fellowship program are undertaken by the RANZCP. Two of these are the annual survey of trainees in posts funded by the Australian Government's STP and the Exit Survey of trainees being admitted to the Fellowship at the end of training. Both instruments are discussed in more detail under Standard 6, Monitoring and Evaluation.

The STP Trainee survey identified that trainees in rural and regional areas had less access to resources and support for the SP. This resulted in the development of better support resources available for all trainees for the SP. Exemplars for each of the project types are now available on the College website (Scholarly Project Examples | RANZCP).

The Trainee exit survey indicated that trainees felt that result letters did not provide sufficient feedback to candidates. In response to this recommendation, result letters to candidates have been refined to better reflect the areas of relative strengths and weaknesses for the trainee.

Responses to College evaluation – decoupling of the essay examination

In December 2020 the RANZCP Board and relevant committees, including the TRC, supported the recommendation of the ACER review to decouple the Essay-style examination. In August 2021, the previous Essay-style exam has been replaced by two independent examinations, the MEQ and the CEQ examinations.

The content and format of the two independent examinations have not changed from the components of the former combined Essay-style examination. The MEQ examination continues to have a clinical focus, testing the candidate's ability to apply knowledge and experience to a realistic clinical scenario. The CEQ comprises one essay question that tests the capacity for critical thinking about issues relevant to the practice of psychiatry including sociocultural, models of illness, ethical and complex service issues.

The two examinations are assessed independently, and candidates need to pass them separately to progress through their trajectory. This allows for better conditions of examination preparation and focus on the specific skills being assessed in that examination. The two examinations are held on the same day, but with some time gap between the two examinations. Candidates have the choice to sit both examinations on the same day or sit them in separate examination cycles.

The decoupled CEQ and MEQ are new assessments and have been monitored carefully over the two examination administrations to determine that they are performing as expected.

Evaluation of the decoupled exams is being undertaken on the evaluation of performance, comparability to non-decoupled structure and associated nuances and improvements that have been achieved.

Additionally, it has been suggested that the CEQ requires a review for its format and fitness for purpose. This work will continue, in consultation with relevant stakeholders, once the evaluation of the decoupled essay-style examination is completed. It was considered that the outcomes of the decoupled examination are more pertinent at this time in addressing systemically poor pass rates over the last several years and it was widely supported by stakeholders (Trainee representatives, TRC, SIMGs, DoTs, Committees) that the decoupling proceeds before the review of the CEQ. This allows for the evaluation of candidates' performance and progress, and candidate performance in two separate exams to get an insight into candidates' knowledge and skills.

The decoupled examination data allows an opportunity to analyse the individual examinations without the confounding effects of the combined assessment. This will help to ensure an evidence-based review of the CEQ format.

The CEQ review will include consideration of how the knowledge and skills assessed through the CEQ assessment align with the training program, and whether candidates receive sufficient training in how to approach the critical thinking assessment. This will also require more time, and will be considered as part of the overall review of the assessment strategy for the RANZCP that is currently being undertaken.

Preliminary analysis of the Decoupled Essay Examination

An analysis of the August 2021 MEQ and CEQ results show somewhat improved results for both the independent examinations. A large proportion of the candidates sat both the CEQ and the MEQ examinations at the same time. It is possible that this first cohort of candidates would have prepared for both the examinations concurrently as in the past, hence the large percentage (65% in the case of MEQ and 73% in the case of CEQ) of overlapping candidates.

From these overlapping candidates (who sat both MEQ and CEQ together), the MEQ pass rate was 51%, and CEQ pass rate was 73%. From the unique CEQ candidates, those who sat CEQ alone – there was a pass rate of 85%, but only 41% pass rate for those who sat the MEQ alone.

While the February exam showed improvement in the CEQ results, the MEQ results were similar to the previous results. However, the detailed analysis of the February 2022 examination will provide a better indication of any trend. This analysis will assist in shaping the review objectives and direction of the CEQ based on evidence and data.

Responses to College evaluation – AVOSCE and MSOSCE

Each of the iterations of the OSCE during 2020 and 2021 were evaluated at their conclusion, and the reports of each of these evaluations are provided as appendices 5.4.1_2, 5.4.1_3 and 5.4.1_4 to this report. The initial AVOSCE in November 2020 was developed and managed by the College staff as a proof of concept and delivery. The recommendations from the evaluation of AVOSCE in November 2020 developed by the project team were considered for implementation by the external project managers engaged to support delivery of the subsequent AVOSCEs and the MSOSCE in 2021.

Due to the significant impact of November 2021 AVOSCE, an external review has been commissioned by the RANZCP Board to be undertaken by an external consultancy firm. This is currently underway and a Steering Group has been formed to support the progression of the review.

Regular review and continual quality improvement

Workplace based assessment

The level of workplace-based assessment feedback is a significant strength of the RANZCP Fellowship program. From the beginning of training each trainee is provided with numerous regular opportunities to receive feedback relating to their performance through WBAs, EPAs and ITAs. WBAs provide trainees with the capacity to receive formative feedback and continue to address any identified deficiencies. The structure of the program enables this feedback to be provided over several different settings with approximately 10 different principal supervisors.

A continual challenge is equipping supervisors with the skills and confidence to provide constructive (that may be negative, critical, or difficult) feedback to trainees who may be underperforming and where appropriate, make the decision to fail components of the training program. The RANZCP is currently undertaking a project to streamline the information provided to supervisors across all programs and provide additional support to supervisors regarding trainees in difficulty. Further detail on this work is providing under standards 6 and 7 of this submission.

The RANZCP introduced the DOPS as a formative workplace-based assessment tool in 2016. The DOPS is a concise, validated method of assessment consisting of a supervisor observing a trainee conducting a procedural skill and providing feedback to the trainee about their performance. While the DOPS is a lesser used WBA tool, it provides trainees with the opportunity to utilise a tool to gain feedback regarding detailed procedural tasks such as ECT and use the opportunity as a learning process for improvement.

Summative assessment

As an internal continual improvement process, improved data analysis methods, assessment policies and processes have been developed with the aim to drive enhancement in the assessment area and assessment operations. These improvements are outlined in this section, along with plans for improvement during the next accreditation period.

General

- an online examination application process via InTrain has been developed and implemented in January 2022. This will eliminate the need for trainees to complete a manual application and email it through to RANZCP. This new process will be less time consuming and more efficient as it will also eliminate manual handling by staff of the examination applications and financial details into iMIS

- aligning requests for special consideration with National standards, by adopting recommendations as published by the Australian Disability Clearinghouse on Education and Training (ADCET)
- using results analysis from examination cohorts to identify any differences in the relative difficulty of content when compared to the standard setting exercise. This serves as an additional validation on the standards set when applied in context to the training program and the developmental stage of the examination cohort
- the process of releasing examination results to Trainees has been improved by integrating result statements into the InTrain portal. InTrain has become a central location to monitor progress and access results for Trainees.

The move towards more efficient assessment processing has progressed in the application and results release areas. In addition to the developments within InTrain to enable candidates to apply online, result/outcome letters and reports to DOT's will also be available via InTrain. These features are being implemented across each assessment area.

Written examinations

Prior to the pandemic, a significant process change to support candidates with these examinations was the allocation of RANZCP staff to each of the examination venues to ensure that examination processes were being followed correctly. This also provided candidates with immediate access to College staff in the event of an issue with the delivery of the examination.

More flexible examination delivery arrangements have been required over the last two years during COVID-19 to ensure that candidates were able to sit these exams during the pandemic-imposed restrictions. To provide greater flexibility, the College reverted to paper-based assessments invigilated locally, and instituted reserve papers.

As a response to the pandemic restrictions, the College is carefully exploring a delivery system for online assessments to enable candidates to take the examination across a wider range of locations. The MCQ exam is already delivered via computer however, access to the computers delivering them is presently restricted to specialist examination venues. The online delivery of these assessments is also expected to improve the processing time for results analysis, examiner marking and results release. The College's relevant committees have endorsed the work of transitioning the delivery of written assessments to online and this work is being undertaken as a collaboration between various teams in Education (Examinations and DES) and Information Technology. A specific staff member has been employed as a Business Improvement Analyst to progress the work.

The provision of a Reserve paper for the written exams as a contingency was implemented throughout 2021 and 2022 to accommodate trainees who have been impacted by COVID-19 or natural disasters such as the recent floods in Queensland and NSW. The process for activation of the Reserve paper has been communicated clearly to the trainee cohort and relevant Fellow stakeholders, including the triggers for activation and feasibility. An example of the communique to candidates is provided as Appendix 5.4.1_5.

MEQ and CEQ

The monitoring and analysis of non-responses in the examinations has led to a reduction in the number of examination items in the CEQ and MEQ providing candidates with increased time for response.

The quality and consistency of the CEQ and MEQ is managed through the processes for question development and standard setting outlined under standard 5.2.3. In addition:

- markers are assigned components of the examination, reducing the impact of any single marker on a candidate's outcome
- variation in results is monitored and broken down by candidate location, providing DOTs with comparative performance outcomes of candidates that can be interpreted with some contextual knowledge of those candidates.

Examination performance analysis now utilises item response theory (IRT) models, including Rasch, Partial Credit and Multifaceted. Prior to results release, MEQ item responses are analysed using the Masters Partial Credit model and the results used to evaluate each item's function and contribution to candidates' measure of performance. Results are used in conjunction with marker feedback on the congruence of candidate responses intended and observed with the score criteria applied. Poorly functioning items are reviewed and evaluated for contribution to candidates' scores and possible exclusion from the assessment. Any syllabus areas that are problematic are highlighted in the post examination report.

Pass rates over time, by number of attempts, and candidate location are reported regularly and published in the Training and Assessment Update bi-annually. The Training and Assessment Update is provided as Appendix 5.4.1_8.

MCQ

The quality and consistency of the MCQ is managed through the processes for question development and standard setting outlined under standard 5.2.3. In addition:

- examination content is reviewed prior to usage, with references checked and questions tweaked if necessary to improve clarity
- variation in results is monitored and broken down by candidate location, providing. DOTs with comparative performance outcomes of candidates that can be interpreted with some contextual knowledge of those candidates.

Prior to results release, item responses are analysed using the Rasch model and the results used to evaluate item function and contribution to candidates' measure of performance. Results are used as a check that the correct answer key is in place for each item. Items are subject to review and confirmation for the correct answer key. The difficulty of items as measured from the cohort is compared to the estimated difficulty of the items from the standard setting procedure, and items with large differences are reviewed.

Pass rates over time, by number of attempts, and candidate location are reported regularly and published in the Training and Assessment Update bi-annually (Appendices 5.4.1_7 and 5.4.1_8).

SP and PWC

The SP and PWC rely on the calibration of assessors and their subsequent application of the intended standard to deliver a fair and consistent application of the standard. The standard setting procedures have been outlined under standard 5.2.3. Marker calibration, dual marking and third marking when discrepancies arise are all mechanisms embedded into the process to maintain quality, fairness, and consistency.

To address plagiarism, the RANZCP is investigating anti-plagiarism software with a view to implementation during 2022-2023. This investigation includes the examination of workflow for both trainees and SIMG candidates and how it may be possible to integrate with InTrain. Consideration of the user experience for candidates, examiners and staff is an essential element of this scoping.

As mentioned before, the electronic submissions to replace paper-based documents in response to the pandemic has been well received, and a secure portal for these is being investigated as the next step in streamlining this process.

Achievement of the SP requirement through exemption has become an established pathway, but there were some issues where work published in peer reviewed journals had word limits imposed that sometimes made it difficult to demonstrate the required standard. Supplementary material that demonstrates the level of work undertaken to produce the published article can now be submitted as supporting material for an exemption application.

In addition to post-examination reports posted on the RANZCP website, pass rates over time, by number of attempts, and candidate location are reported regularly and published in the Training and Assessment Update bi-annually (Appendices 5.4.1_7 and 5.4.1_8).

OSCE

The OSCE has presented challenges during the period of the pandemic. Prior to 2020, the OSCE was a well-established, reliable assessment that had undergone several adjustments to the format to accommodate increasing numbers of candidates in the single venue face-to-face delivery format. These have been described under standard 5.2.1.

COVID-19 led to disruptions of the face-to-face OSCE and combined with an increased admissions to the Fellowship program, required changes to accommodate large candidate numbers in alternative delivery formats, as it was not possible to conduct the traditional centrally administered face to face OSCE.

The format of the OSCE has been reviewed and adjusted from three long stations with two examiners per station plus eight short stations with one examiner per station to a new format of six long stations with 1 examiner per station, plus an increase in the number of criteria assessed per station. Candidate reliability measures have been improved as a result. While the six station format deals with fewer scenarios than the 11-station format, the longer observation period in those six stations, supports a more accurate candidate assessment and allows for more criteria to be assessed within the station. This change also mitigates the challenges of securing sufficient examiner numbers.

Post examination, psychometric analysis of the results of the examination and each station are provided to content developers to support areas for improvement in the construction of future station content.

The attributes of OSCE examiners are measured and monitored to ensure a balance of 'hawks' and 'doves', along with feedback to examiners on their performance support the quality and consistency of the OSCE. During the OSCE, live monitoring of examiner scoring occurs and supports consistent scoring.

Pass rates over time, by number of attempts, and candidate location are reported regularly and published in the Training and Assessment Update bi-annually (Appendices 5.4.1_7 and 5.4.1_8).

The delivery format of the OSCE was adapted over the course of the pandemic, with four variations used:

- November 2020 a trial AV OSCE delivered to a smaller cohort of 42 candidates most likely to achieve Fellowship requirements by early 2021
- April 2021 an AVOSCE was delivered across central venues to 69 candidates, again for candidates closest to Fellowship prioritised
- July 2021 a multi-site OSCE was delivered in six jurisdictions across Australia and New Zealand to 96 candidates. Examination venues rather than hospital outpatient clinics were used, and no prioritisation was applied to candidates. Originally scheduled for delivery to 144 candidates, a last-minute lockdown in NSW, led to cancellations as neither the examination venues nor health services were able to run the assessment
- November 2021 an AVOSCE delivered to candidates' homes or workplaces for 248 candidates. All eligible trainees and SIMGs were able to sit this examination. Two forms of the examination material were developed to be delivered on the same day to two sessions – AM and PM - to avoid candidates acquiring any pre-knowledge of the examination content. Technology failures on the day resulted in the cancellation of the second session, with most candidates in the morning session unable to complete all station content. The technology partner contracted to provide the virtual platform for the examination was unable to deliver the examination and required support on the day, resulting in many candidates, role players and examiners being unable to enter the virtual examination rooms. Due to the inability to correct the failure and provide a solution, the Board decided on the day to cancel the afternoon examination rather than lose a full set of examination material and put candidates and examiners through a repeat of the AVOSCE morning experience.

Following the failure of the November 2021 AVOSCE, the AAP was developed and endorsed by the AMC as an appropriate pathway to offer to the impacted candidates. The AAP has previously been discussed under standards 5.1.3 and 5.2 and is further discussed later in this standard under Additional information.

Statistics requested by the AMC

Tables 5.4.1_1 to 5.4.1_5 provide the number and percentage of trainees passing the various summative assessments at first, second, third and subsequent attempts. Note that the CEQ and MEQ were introduced in 2021 as a result of the decoupling of the Essay-style examination.

Table 5.4.1_6 provides the number and percentage of trainees who have withdrawn from the Fellowship program in the period 2017 – 2021. As the provision of a reason for withdrawal is voluntary, the summary of reasons should be considered as indicative only.

Table 5.4.1_1. Cumulative MCQ pass rates by attempt 2017 - 2021

Summative Assessment Name:				MCQ					
Year				2017 to 2021					
	1st attempt			2nd attempt			3rd attempt or more		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	1195	1132	95%	164	148	90%	75	62	83%
Male	565	531	94%	81	78	96%	37	31	84%
Female	630	601	95%	83	70	84%	38	31	82%
NSW	293	284	97%	83	75	90%	19	15	79%
ACT	29	27	93%	4	2	50%	2	2	100%
NT	25	25	100%	1	1	100%	1	0	0%
QLD	229	210	92%	27	26	96%	21	19	90%
SA	76	73	96%	7	7	100%	2	2	100%
TAS	23	21	91%	-	-	-	-	-	-
VIC	278	263	95%	17	14	82%	19	18	95%
WA	92	88	96%	14	13	93%	6	3	50%
NZ	145	136	94%	11	10	91%	4	2	50%
No Zone	5	5	100%	-	-	-	1	1	100%

Table 5.4.1_2. Cumulative Essay-style examination pass rates by attempt 2017 - 2021

Summative Assessment Name:				Essay-style examination					
Year				2017 to 2021					
	1st attempt			2nd attempt			3rd attempt or more		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	605	517	85%	197	157	80%	150	97	65%
Male	288	230	80%	113	90	80%	90	55	61%
Female	317	287	91%	84	67	80%	60	42	70%
NSW	171	145	85%	55	47	85%	46	25	54%
ACT	13	11	85%	3	2	67%	2	2	100%
NT	1	1	100%	2	2	100%	-	-	-
QLD	110	89	81%	35	25	71%	28	24	86%
SA	42	40	95%	10	7	70%	1	0	0%
TAS	11	11	100%	4	4	100%	2	1	50%
VIC	165	144	87%	52	44	85%	52	35	67%
WA	41	37	90%	17	13	76%	13	7	54%
NZ	50	38	76%	19	13	68%	5	2	40%
No Zone	1	1	100%	-	-	-	1	1	100%

Table 5.4.1_3. Cumulative CEQ pass rates by attempt 2021

Summative Assessment Name:	CEQ								
Year	2021								
	1st attempt			2nd attempt			3rd attempt or more		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	188	151	80%	43	29	67%	45	33	73%
Male	96	78	81%	30	21	70%	28	20	71%
Female	92	73	79%	13	8	62%	17	13	76%
NSW	51	42	82%	14	8	57%	17	13	76%
ACT	4	3	75%	1	1	100%	1	1	100%
NT	4	3	75%	-	-	-	-	-	-
QLD	33	24	73%	6	5	83%	6	3	50%
SA	15	15	100%	2	1	50%	4	4	100%
TAS	1	1	100%	-	-	-	1	1	100%
VIC	41	28	68%	12	10	83%	11	6	55%
WA	11	9	82%	1	1	100%	4	4	100%
NZ	26	25	96%	5	3	60%	1	1	100%
No Zone	2	1	50%	2	0	0%	-	-	-

Table 5.4.1_4. Cumulative MEQ pass rates by attempt 2021

Summative Assessment Name:	MEQ								
Year	2021								
	1st attempt			2nd attempt			3rd attempt or more		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	205	116	57%	48	24	50%	50	17	34%
Male	97	54	56%	32	15	47%	32	12	38%
Female	108	62	57%	16	9	56%	18	5	28%
NSW	57	31	54%	16	8	50%	20	6	30%
ACT	4	3	75%	1	1	100%	1	0	0%
NT	3	0	0%	-	-	-	-	-	-
QLD	41	25	61%	8	5	63%	4	1	25%
SA	14	7	50%	2	0	0%	4	1	25%
TAS	1	0	0%	-	-	-	1	1	100%
VIC	49	26	53%	11	5	45%	11	5	45%
WA	14	5	36%	3	1	33%	6	1	17%
NZ	21	18	86%	5	4	80%	3	2	67%
No Zone	1	1	100%	2	0	0%	-	-	-

Table 5.4.1_5. Cumulative OSCE pass rates by attempt 2017 - 2021

Summative Assessment Name:				OSCE					
Year				2017-2021					
	1st attempt			2nd attempt			3rd attempt or more		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	785	746	95%	122	100	82%	75	53	71%
Male	384	359	93%	70	60	86%	52	36	69%
Female	401	387	97%	52	40	77%	23	17	74%
NSW	206	195	95%	34	29	85%	21	15	71%
ACT	8	8	100%	4	4	100%	1	0	0%
NT	4	4	100%	-	-	-	1	0	0%
QLD	154	143	93%	26	18	69%	23	18	78%
SA	49	48	98%	3	3	100%	3	3	100%
TAS	11	11	100%	3	2	67%	-	-	-
VIC	219	209	95%	33	26	79%	18	12	67%
WA	58	56	97%	8	8	100%	5	4	80%
NZ	1	0	0%	1	1	100%	2	1	50%
No Zone	3	2	67%	1	1	100%	-	-	-

The AMC has requested information on the number and percentage of trainee withdrawing from the program, along with the reason for withdrawal. The RANZCP has been monitoring the progress of each cohort of trainees entering the 2012 Fellowship program. The number and percentage of each cohort completing the program in five years or less is monitored and reported, along with the number and percentage of withdrawals. This data is reported monthly via the cohort progression monitor (refer to Table 2.2.2_1 in Standard 2 of this submission) and made available to the CFT and the EC, with additional information identifying the distribution of candidates who are enrolled but have not completed the program after seven years.

Trainees withdrawing from the program are asked to provide a reason for their decision, however it is difficult to enforce the provision of this information. The main reasons offered for withdrawal from the program are:

- moving / returning overseas
- family commitments
- changes in career plans.

Table 5.4.1_6. Trainees who have withdrawn from the program Cohorts 2017 – 2021 (Correct as of end-April 2022)

Year	Intakes	Withdrawn	%	Reason for withdrawal
Cohort 2021	347	5	1.4%	• Moving overseas • Pursuing training in a different speciality
Cohort 2020	361	19	5.3%	• Moving overseas • Returning overseas • Changes in career plans • Pursuing training in a different speciality • Negative perception of the training • Covid-19 related changes • Health issues
Cohort 2019	295	12	4.1%	• Returning overseas • Family commitments / Focus in family • Health issues • Changes in career plans
Cohort 2018	296	21	7.1%	• Health issues • Family commitments • Pursuing training in a different speciality • Changes in career plans • Returning overseas • Family commitments / Focus in family • Moving overseas
Cohort 2017	246	19	7.7%	• Family commitments • Changes in career plans • Pursuing training in a different speciality • Returning overseas • No interest in Psychiatry • Covid-19 related changes • Pursuing training in a different speciality • Changes in career plans

5.4.2 The education provider maintains comparability in the scope and application of the assessment practices and standards across its training sites.

For those summative assessments that are administered centrally, the scope and application of the assessment practices and standards are consistently applied.

The RANZCP was a leader in the introduction of workplace-based assessment for specialist medical training in Australia and New Zealand. The use of this assessment approach has proven valuable in the RANZCP's response to the challenges of COVID-19, particularly the use of the WBA as a competency assessment in the introduction of the AAP. The AAP was implemented in response to the failure of the November 2021 AVOSCE as a crisis management response that aimed to maximise assessment opportunities for impacted candidates and those closest to Fellowship.

However, workplace-based assessment presents challenges in ensuring comparability and consistency of standards across all training locations, and minimising variance introduced by individual supervisors. During the implementation of the AAP, which utilises the end of rotation ITAs to demonstrate mastery of the competencies normally tested in the OSCE, it was found that supervisors do provide robust feedback and a reliable assessment of competency in the workplace. Three ITAs were generally used in the portfolio review component, and these were generally conducted by three different supervisors.

To further support the development of supervisors, and to optimise the comparability and application of assessment practices and standards across training locations, two projects are currently underway:

- the quality and functionality of the EPAs is being reviewed, as discussed under standard 4
- a survey of supervisors, originally planned for 2020 but delayed due to the pandemic, has been undertaken in 2021. The report makes several recommendations relating to the areas identified by supervisors for their further development, along with their preferred learning methods. Supervisors identified a desire for a supervisor framework, dedicated sessions at Congress and increased online learning resources, and work has commenced on these items.

Standard 5. Additional information requested by the AMC in its response to the 2021 progress report

Changes in assessment dates during Covid-19

No written examinations were cancelled; however, a number were delayed or were presented in an alternative written format in response to local pandemic restrictions in force at the time. Reserve papers were executed for the written exams to those unable to sit on the original dates due to lockdowns and restrictions.

Assessment dates for the SP and PWC have not been impacted by the pandemic.

Table 5.4.2_1 shows the number of OSCE enrolments impacted by the cancellation of examinations. This includes only those examinations where enrolments were taken and subsequently the examination did not go ahead. This includes the April 2020 OSCE at the start of the pandemic, candidates in NSW in the July 2021 OSCE who were subject to restrictions imposed by the NSW Department of Health, and the November 2021 OSCE which could not be delivered due to technology failure. The July 2021 MSOSCE was cancelled in NSW on the advice of NSW Health which at that time did not have guidance for specialist medical colleges on the management of clinical examinations.

Note that Table 5.4.2_1 is based on enrolments and may have duplications of individuals who enrolled in more than one sitting of the OSCE. Table 5.4.2_2 shows the number of cancellations experienced by individual candidates and the totals are therefore smaller, with 21 individuals all from New South Wales experiencing 3 cancellations.

Note that the data is segmented by the current jurisdiction of training.

Table 5.4.2_1. OSCE cancellations

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUST	NZ	No Zone	Overall
Overall	**12**	**188**	**6**	**72**	**23**	**7**	**122**	**15**	**399**	**38**		**486**
Melbourne Apr 2020	7	54	3	38	9	1	61	4	177	15	-	192
Adelaide Sep 2020	-	-	-	-	-	-	-	-	-	-	-	-
MSOSCE July 2021	-	46	-	-	-	-	-	-	-	-	-	46
AVOSCE Nov 2021	5	88	3	34	14	6	61	11	222	23	3	248

Table 5.4.2_2. OSCE cancellations by individual candidate

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUST	NZ	No Zone	Overall
Overall	**10**	**109**	**5**	**57**	**18**	**6**	**103**	**12**	**320**	**35**	**3**	**358**
1 cancellation	9	51	4	43	13	4	83	9	216	32	3	251
2 cancellations	1	37	1	14	5	2	20	3	83	3	-	86
3 cancellations	-	21	-	-	-	-	-	-	21	-	-	21

In response to the failed November 2021 AVOSCE, the College developed and implemented the AAP designed to use candidate's workplace assessments to demonstrate the required skills to progress towards Fellowship. The AAP was offered to all candidates from the November 2021 AVOSCE who were unsuccessful or unable to be assessed sufficiently to achieve a successful outcome. The AAP was developed by a Board Taskforce, led by the President-elect using a co-design model with input from trainees with the aim of supporting trainees with their progression through training while continuing to maintain standards and robust assessment in the pandemic environment. Trainee and SIMG representatives, along with Board members and key Fellows, were part of the decision-making and contributed to the initial development process, and they continue to be involved in the Taskforce meetings as the AAP progresses.

Due to continued COVID-19 uncertainty and escalating risks, in consultation with the relevant committees and trainee representatives, the RANZCP Board decided to cancel the March 2022 OSCE. With the endorsement of the AMC, it was agreed to apply the AAP to the scheduled March 2022 OSCE as a replacement.

The application numbers for the March 2022 AAP are significantly greater than pervious OSCE rounds, due to both the increased number of candidates eligible to sit the OSCE and the use of pre-existing workplace assessments which require zero preparation time for most candidates.

Table 5.4.2_3 and 5.4.2_4 shows the number of applications for the March 2022 AAP, and the numbers of candidates in the round who have progressed through the PR and the CbD (correct as of 6 May 2022).

Table 5.4.2_3. Applications March 2022 AAP

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUST	NZ	No Zone	Overall
Overall	**6**	**136**	**6**	**128**	**28**	**6**	**144**	**43**	**497**	**46**	**-**	**543***
Trainees	5	126	6	122	28	4	122	39	452	46	-	498
SIMGs	1	10	-	6	-	2	22	4	45	-	-	45

*19 candidates applied to the March 2022 AAP waiting outcome for the November 2021 AAP are included in the statistics.

For trainees, the location is the zone of training and for SIMGs it is the state where they are employed.

Table 5.4.2_4. March 2022 AAP Portfolio review by outcome (Correct as 6 May 2022)

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUST	NZ	No Zone	Overall
Trainees	**5**	**126**	**6**	**122**	**28**	**4**	**122**	**39**	**452**	**46**	**-**	**498**
In progress	3	73	3	74	17	1	74	18	263	29	-	292
Satisfactory (Pass OSCE)	1	8	-	1	-	-	5	2	17	5	-	22
Unsatisfactory (CbD required)	-	1	-	-	-	-	-	-	1	-	-	1
Direct CBD	1	44	3	47	11	3	43	19	171	12	-	183
SIMGs	**1**	**10**	**-**	**6**	**-**	**2**	**22**	**4**	**45**	**-**	**-**	**45**
In progress	-	5	-	2	-	-	4	-	11	-	-	11
Satisfactory (Pass OSCE)	-	1	-	-	-	-	4	1	6	-	-	6
Unsatisfactory (CbD required)	-	-	-	-	-	-	-	-	0	-	-	0
Direct CBD	1	4	-	4	-	2	14	3	28	-	-	28
Overall	**6**	**136**	**6**	**128**	**28**	**6**	**144**	**43**	**497**	**46**	**-**	**543***
In progress	3	78	3	76	17	1	78	18	274	29	-	303
Satisfactory (Pass OSCE)	1	9	-	1	-	-	9	3	23	5	-	28
Unsatisfactory (CbD required)	-	1	-	-	-	-	-	-	1	-	-	1
Direct CBD	2	48	3	51	11	5	57	22	199	12	-	211

*19 candidates applied to the March 2022 AAP waiting outcome for the November 2021 AAP are included in the statistics.

For trainees, the location is the zone of training and for SIMGs it is the state where they are employed.

As previously outlined, the AAP comprises two parts:

- Portfolio Review of the three most recent end of rotation In Training Assessments (ITAs), including at least one at Stage 3 level
- where the Portfolio Review does not demonstrate the achievement of all competencies, a CbD is undertaken in the workplace with two external assessors.

The portfolio reviews are undertaken by Review Panels of two Fellows supported by a Portfolio Review Oversight Panel comprising four Fellows who report to the EC.

For the November 2021 cohort undertaking the AAP, after initially reviewing priority candidates who had only the OSCE to complete to achieve Fellowship, the Portfolio review for remaining candidates is now complete, and CbD commenced in February 2022.

The outcomes of the Portfolio review for November 2021 AAP are provided in Table 5.4.2_5 and the CBD progress (correct as 9 May 2022) in Table 5.4.2_6.

Table 5.4.2_5. November 2021 AAP Portfolio review by outcome

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUST	NZ	No Zone	Overall
Trainees	**4**	**50**	**2**	**28**	**13**	**1**	**35**	**13**	**146**	**13**	**1**	**160**
Satisfactory (Pass OSCE)	4	31	2	23	11	1	23	9	104	9	1	114
Unsatisfactory (CbD required)	-	15	-	4	1	-	8	2	30	4	-	34
Direct CBD	-	4	-	1	1	-	4*	2	12	-	-	12
SIMGs	**-**	**5**	**1**	**7**	**-**	**1**	**22**	**-**	**36**	**-**	**-**	**36**
Satisfactory (Pass OSCE)	-	1	1	7		-	19	-	28	-	-	28
Unsatisfactory (CbD required)	-	4	-	-	-	1	3	-	8	-	-	8
Direct CBD	-	-	-	-	-	-	-	-	-	-	-	-
Overall	**4**	**55**	**3**	**35**	**13**	**2**	**57**	**13**	**182**	**13**	**1**	**196***
Satisfactory (Pass OSCE)	4	32	3	30	11	1	42	9	132	9	1	142
Unsatisfactory (CbD required)	-	19	-	4	1	1	11	2	38	4	-	42
Direct CBD	-	4	-	1	1	-	4	2	12	-	-	12

* 1 trainee with the outcome "direct to CBD" withdrew the process.

Table 5.4.2_6. November 2021 CBD progress (correct as 9 May 2022)

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUST	NZ	No Zone	Overall
Trainees	**-**	**19**	**-**	**5**	**2**	**-**	**12**	**4**	**42**	**4**	**-**	**46**
Pass	-	11	-	2	1	-	6	1	21	2	-	23
Fail	-	-	-	1	-	-	1	-	2	-	-	2
Bookings	-	6	-	1	1	-	3	2	13	-	-	13
Pending for Booking	-	2	-	1		-	2	1	6	2	-	8
SIMGs	**-**	**4**	**-**	**-**	**-**	**1**	**3**	**-**	**8**	**-**	**-**	**8**
Pass	-	2	-	-	-	-	1	-	3	-	-	3
Fail	-	-	-	-	-	-	-	-	0	-	-	0
Bookings	-	1	-	-	-	1	2	-	4	-	-	4
Pending for Booking	-	1	-	-	-	-	-	-	1	-	-	1
Overall	**-**	**23**	**-**	**5**	**2**	**1**	**15**	**4**	**50**	**4**	**-**	**54**
Pass	-	13	-	2	-	-	7	1	24	2	-	26
Fail	-	-	-	1	-	-	1	-	2	-	-	2
Bookings	-	7	-	1	1	1	5	2	17	-	-	17
Pending for Booking	-	3	-	1	-	-	2	1	7	2	-	9

An evaluation of the Portfolio Review component has been completed, and the report is provided as Appendix 5.4.2_1. Key findings included:

- the review of end of rotation ITAs demonstrated that supervisors utilised the Fellowship domains well with genuine feedback provided to candidates. Minimal examples of block marking were identified when reviewing supervisor feedback
- there was no statistical evidence to indicate a difference in performance between trainees and SIMGs undergoing the Portfolio Review
- communication to candidates regarding the Portfolio Review process can be improved, specifically around the requirements to receive a conceded pass for the Portfolio Review. While Medical Expert and Manager domains are important, the gestalt of the trainee and trends in improvement for candidates are also considered when determining an outcome. Not meeting the Medical Expert and Manager domains on an end of rotation ITA does not automatically result in the candidate progressing to the CbD.

Decoupling of the Essay-style examination

As noted by the AMC, the written examinations were the exception to the consistent progress in pass rates across all assessments.

As previously outlined, the decoupling of the CEQ and MEQ was implemented in August 2021, and two rounds of the examination have occurred. A reserve CEQ paper was provided to a small group of candidates in October 2021 who were unable to sit the August examination due to late changes in pandemic restrictions and lockdowns. The RANZCP continues to closely monitor data for upcoming examinations however there are early indications that pass rates for CEQ have improved, as shown in Figures 5.4.2_2 and 5.4.2_3. As seen in the Figures, the pass rates for the CEQ of 76% and 73% are improved in comparison to the pass rates of the Essay-style examination which has ranged from 32% to 57% over the period 2016 – 2021. Performance will be monitored over time to evaluate the effect of the decoupling on the pass rates of candidates.

Figure 5.4.2_1. Results for the Essay-style examination from 2016 – February 2021

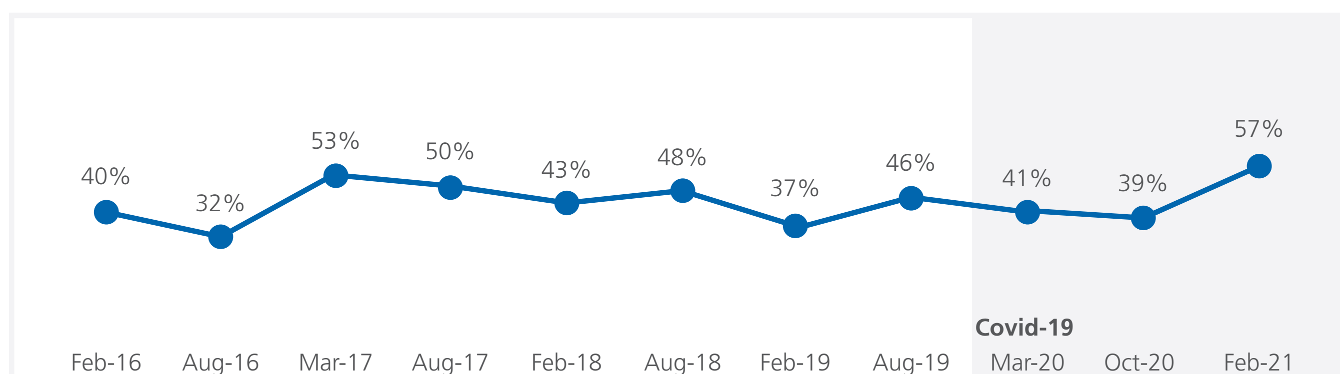


Figure 5.4.2_2. Results for the CEQ 2021- 2022

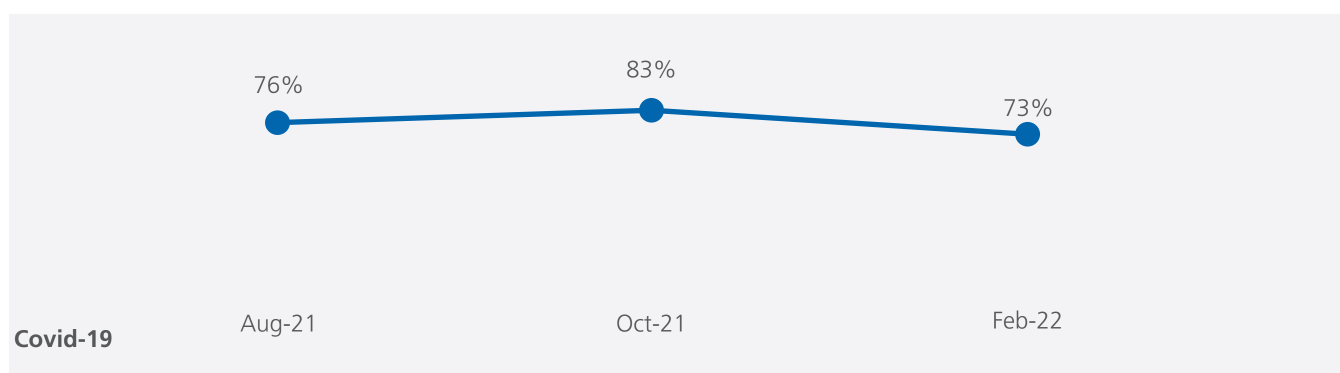
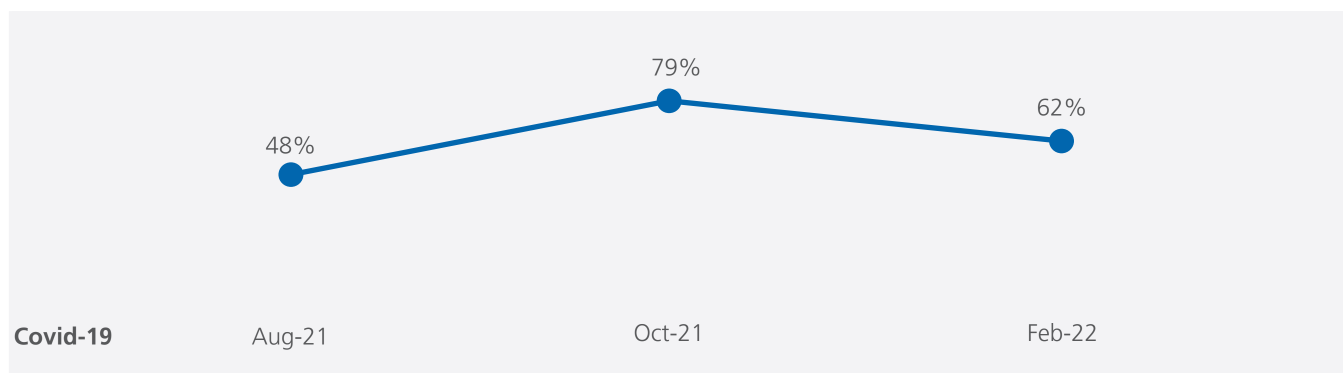


Figure 5.4.2_3. Results for the MEQ 2021 - 2022



Actions to support Trainees who have had repeated failure

The AMC requested some discussion, by assessment type, as to the actions taken by the RANZCP to support trainees who have had repeated failures.

OSCE, MCQ, CEQ and MEQ

Trainees who are unsuccessful at two attempts on these exams must undergo Targeted Learning, as outlined in the Targeted Learning Policy and Procedure (Appendix 5.3.3). Targeted learning is a process by which trainees receive additional assistance, support and mentoring as they work toward a specific training or assessment goal. The development and implementation of a targeted learning plan is compulsory for trainees who have not achieved the standard and/or progress requirements of the Fellowship Program. It is a collaborative process where the targeted learning plan is designed jointly by the trainee, the DOT and the relevant supervisors, and the plan must include agreed and clear:

- actions to be taken and by whom (e.g. trainee to complete practice assessment and supervisor/other to provide feedback on trainee's practice assessment)
- achievable goals aimed at improving the trainee's progress
- means of determining that such goals have been met
- specified timeframe within which these goals are to be achieved
- review date(s) of approximately every 3 months and prior to any related assessment application or submission
- anticipated or goal completion date (e.g. by the end of the next rotation, e.g. in time for a specific centrally administered summative assessment.

Online resources are available on the RANZCP website to support candidate preparation and their targeted learning and include:

- previous exams or exam content
- marking guides
- examination blueprints
- podcasts
- webinars
- examination reports.

Workplace based assessment

Trainees who are having difficulty with meeting the requirements of rotations are also supported by the Targeted Learning Policy and procedure, as outlined for the centrally administered summative assessments.

SP

Resources have been developed to support trainees with their SP. Available on the RANZCP website, these include:

- Scholarly Project E-Learning Module
- Planning Your Scholarly Project – infographic (Appendix 5.4.2_2)
- Elements of a Scholarly Project Proposal (Appendix 5.4.2_3)

Supported by funding through the STP, SP candidates were surveyed with an aim of identifying what additional support could be provided to candidates. One area that received strong support was access to examples of each of the different types of SPs commonly submitted. This work has resulted in several examples of candidates' work now available on the RANZCP website to help guide future candidates.

'The Thought Broadcast', a regular podcast linked to Australasian Psychiatry with a focus on the SP and research, specifically addressed the Scholarly Project. The - Chair of the SP Subcommittee, Dr Jeremy Couper, provided trainees with insights into the make-up of successful project, the expectations of the assessors, common trainee pitfalls, and tips for completing and submitting work of a standard worthy of publication. (An interview with Jeremy Couper)

Statistics and annual updates 2021

Tables 5.4.2_7 to 5.4.2_14 provide updates on the pass rates for each of the centrally administered summative assessments and the percentage of trainees who have passed at their first, second, third or more attempts.

OSCE (Table 5.4.2_7)

The Overall pass rate for the April 2021 AVOSCE was 67% and 72% for the MSOSCE held in July. Those for whom this was their third or fourth attempt at the OSCE had a significantly reduced pass rate in comparison to those sitting for the first time.

Table 5.4.2_7. Number of enrolments and pass rate for OSCE Examination in 2021

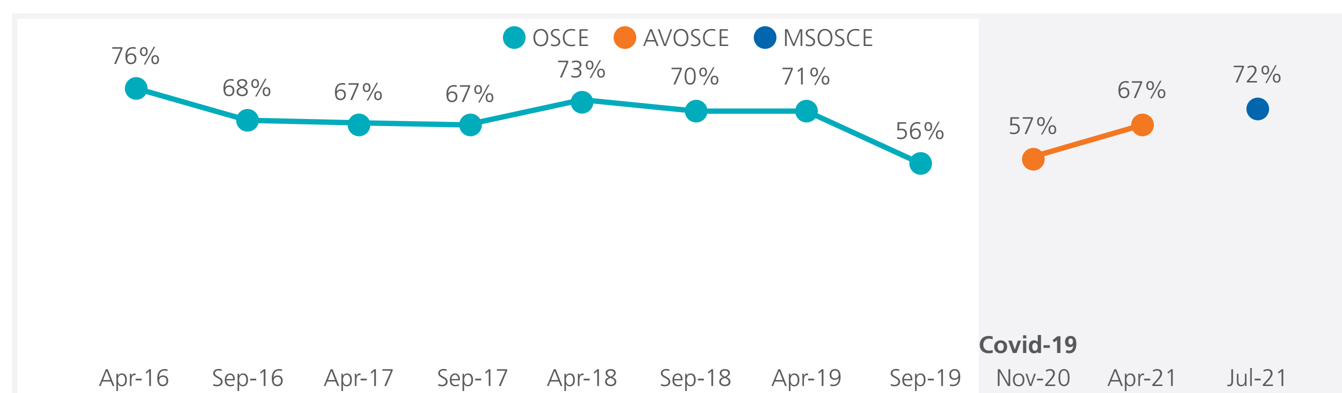
	AVOSCE - April			MSOSCE – July		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
OSCE Total	69	49	67%	96	69	72%
Trainees	57	41	72%	80	61	76%
SIMGs	12	5	42%	16	8	50%

	AVOSCE - April			MSOSCE – July		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	45	35	78%	79	62	78%
Second attempt	32	20	63%	11	5	45%
Third attempt	11	3	27%	5	2	40%
Four or greater attempt	18	0	0%	1	0	0%

It is important to note that each of the OSCEs conducted during the pandemic is significantly different to a traditional face to face OSCE, and to each other. The first AVOSCE in November 2020 was a proof of concept offered to a small number of priority candidates, including some who had previously failed more than one OSCE. The April 2021 AVOSCE also had a relatively small number of candidates and was followed by the MSOSCE. The MSOSCE was considered in the context of easing COVID-19 restrictions in mid-2021with the aim to maximise the number of candidates sitting the exam. The November 2021 AVOSCE was intended to accommodate a cohort that was comparable in size and composition to a traditional OSCE.

These differences mean that the comparison of the pass rates for the OSCE shown in Figure 5.4.2_4 should be considered with caution, as they are not truly comparable.

Figure 5.4.2_4. OSCE Pass-Rates



MCQ (Table 5.4.2_8)

The MCQ Examination was held in March and July 2021. In August 2021 an additional MCQ was held for a small cohort of candidates impacted by COVID-19 in July. In the March round in 2021, 111 candidates sat the examination with a pass rate of 95%. The second-round pass rate decreased to 68% in the July examination, and the additional MCQ in August increased to 87%. Most of the trainees were successful in their first and second attempt.

The variation in pass rates over the three examinations in 2021 has been reviewed in detail. The cohorts do not appear dissimilar, as the proportion of candidates at different stages in the training program are consistent. The difficulty of the examinations in terms of the proportion of correct responses required appears similar. There was a noticeable difference in the number of examination items identified with more than one possible correct response. The number of items in each examination with more than one correct answer was:

- March 2021 – 16
- July 2021 – 4
- August 2021 – 3.

The identification of MCQ content with possible multiple correct answers has become possible due to improvements in the post examination psychometric analysis techniques that are now applied.

Table 5.4.2_8. Number of enrolments and pass rate for MCQ in 2021

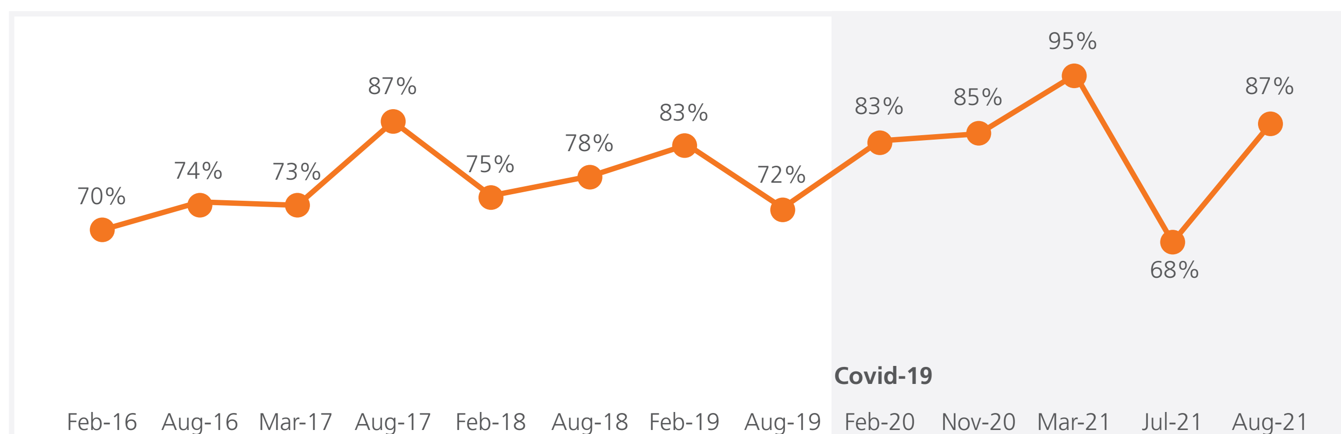
	Round 1 - March			Round 2 – July		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
MCQ Total	111	105	95%	162	110	68%

Round 3 – Additional August			
	# of candidates sitting	# of candidates passed	% of candidates passed
MCQ Total	53	46	87%

	Round 1 - March			Round 2 – July		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	98	95	97%	155	109	70%
Second attempt	3	2	67%	4	0	0%
Third attempt	3	2	67%	3	1	33%
Four or greater attempt	7	6	86%	-	-	-

Round 3 – Additional August			
	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	1	1	100%
Second attempt	50	44	88%
Third attempt	1	1	100%
Four or greater attempt	1	0	0%

Figure 5.4.2_5. MCQ Pass-Rates



Essay-style examination (Table 5.4.2_9)

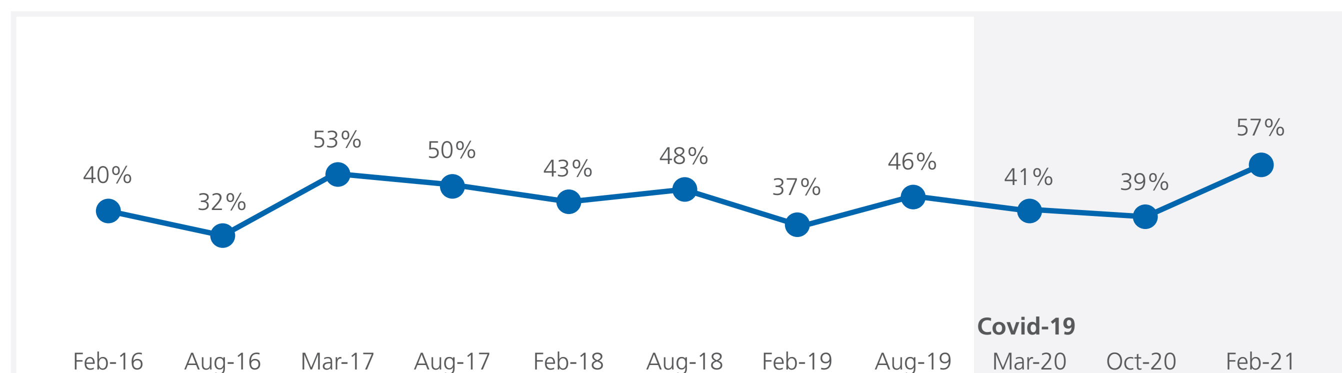
In response to the recommendation from the ACER, the Essay-style examination was decoupled for the August 2021 delivery into two independent examinations – MEQ and the CEQ Examinations. The final round for the Essay-style Examination was held in February 2021 and the pass rate was 57% from a total of 201 assessments completed.

Table 5.4.2_9. Number of enrolments and pass rate for Essay-style examination in 2021

	Last Round - February		
	# of candidates sitting	# of candidates passed	% of candidates passed
ESSAY Total	201	114	57%
Trainees	166	99	60%
SIMGs	35	15	43%

	Last Round - February		
	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	160	125	78%
Second attempt	36	26	72%
Third attempt	20	14	70%
Four or greater attempt	24	18	75%

Figure 5.4.2_6. ESSAY Style Pass-Rates



Critical Essay Question Examination (Table 5.4.2_10)

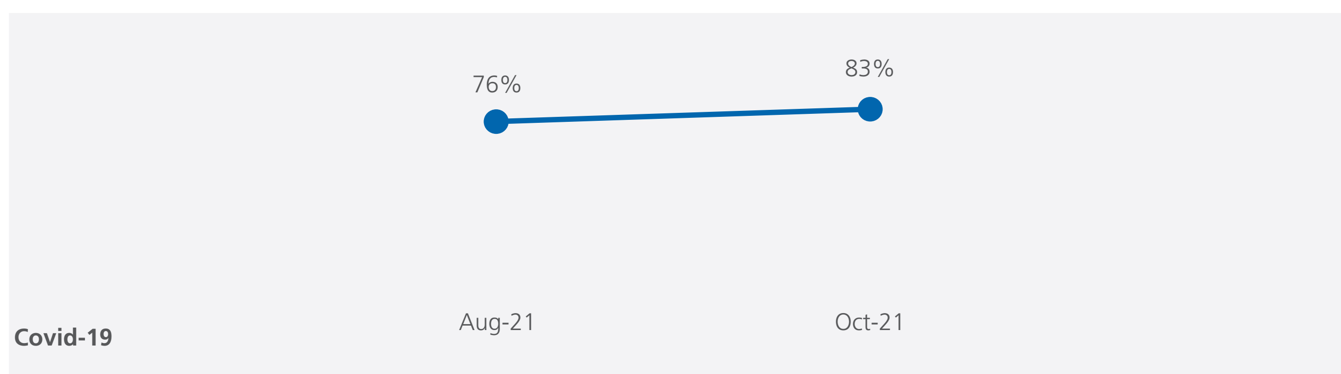
The decoupled CEQ Examination was held in August 2021.The pass rate was 76% from a total of 240 assessments completed. A reserve paper was implemented in October 2021 for candidates enrolled for the August exam and impacted due COVID-19. The pass rate for the reserve paper was 83% from a total of 36 assessments.

Table 5.4.2_10. Number of enrolments and pass rate for CEQ examination in 2021

	Round 1 - August			Round 2 – October		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
CEQ Total	240	183	76%	36	30	83%
Trainees	217	173	80%	35	30	86%
SIMGs	23	10	43%	1	0	0%

	Round 1 - August			Round 2 – October		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	160	125	78%	28	26	93%
Second attempt	36	26	72%	7	3	43%
Third attempt	20	14	70%	1	1	100%
Four or greater attempt	24	18	75%	-	-	-

Figure 5.4.2_7. CEQ Pass-Rates



Modified Essay Questions Examination (TTable 5.4.2_11)

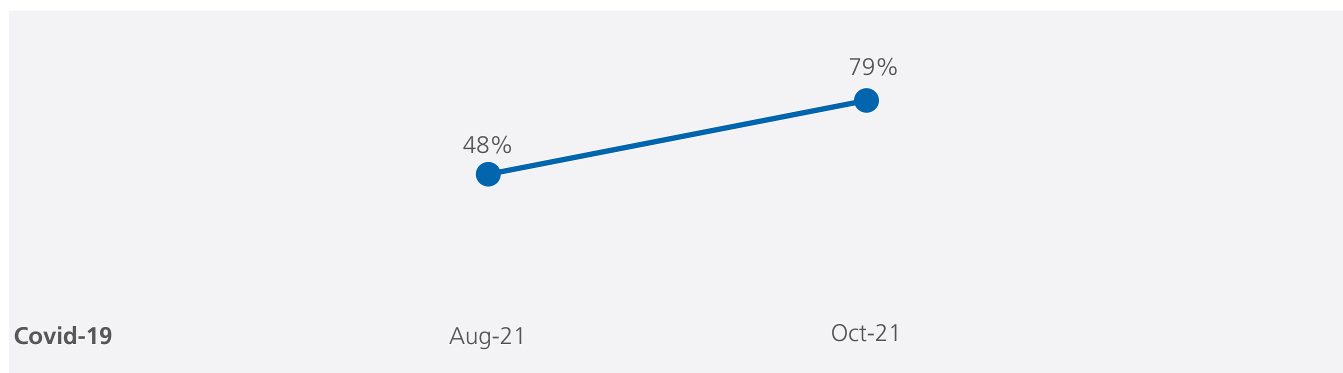
The first sitting of the Modified Essay Question Examination was held in August 2021. The pass rate was 48% from a total of 269 assessments completed. A reserve paper was implemented in October 2021 for candidates enrolled in the August examination and impacted due Covid-19. The pass rate was 79% from a total of 33 assessments.

Table 5.4.2_11. Number of enrolments and pass rate for Essay-style examination in 2021

	Round 1 - August			Round 2 – October		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
MEQ Total	269	130	48%	33	26	79%
Trainees	237	118	50%	32	25	78%
SIMGs	32	12	38%	1	1	100%

	Round 1 - August			Round 2 – October		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	181	96	53%	23	19	83%
Second attempt	41	19	46%	7	5	71%
Third attempt	19	3	16%	2	1	50%
Four or greater attempt	28	12	43%	1	1	100%

Figure 5.4.2_8. MEQ Pass-Rates



PWC (Table 5.4.2_12)

The PWC results for submissions received in February, May, August, and November 2021 are summarised in Table 5.4.2_12. Between 59 and 82 submissions were received in each round, and the pass rate varied between 63% and 72%. The data shows that most candidates will meet the requirements for the PWC in their first or second attempt and that no candidates required more than three attempts to complete this assessment.

Table 5.4.2_12. Number of enrolments and pass rate for PWC examination in 2021

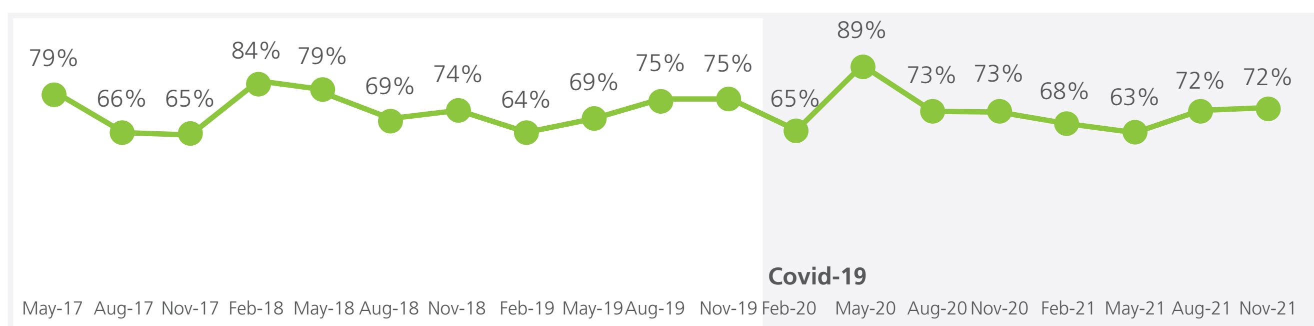
	Round 1 - February			Round 2 – May		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
PWC Total	59	40	68%	78	49	63%

	Round 3 - August			Round 4 – November		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
PWC Total	72	52	72%	82	59	72%

	Round 1 - February			Round 2 – May		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	42	27	64%	62	35	56%
Second attempt	16	12	75%	14	12	86%
Third attempt	1	1	100%	2	2	100%
Four or greater attempt	-	-	-	-	-	-

	Round 3 - August			Round 4 – November		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	51	33	65%	64	46	72%
Second attempt	18	17	94%	18	13	72%
Third attempt	3	2	67%	-	-	-
Four or greater attempt	-	-	-	-	-	-

Figure 5.4.2_9.PWC Pass-Rates



SP (Tables 5.4.2_13 and 5.4.2_14)

The pass rate for the SP assessment during 2021 showed little variation. Recognition of prior learning through publication in a peer reviewed journal or research thesis may be used to obtain an exemption from this assessment. The number of trainees using the exemption pathway for SP is becoming more evident. During 2021, 99 submissions for exemptions were received and 84 were approved (85%). The data again shows that most candidates achieve a pass in the SP in their first or second attempt at the assessment.

Table 5.4.2_13. Number of enrolments and pass rate for SP assessment in 2021

	Round 1 - March			Round 2 – July		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
SP Total	41	33	80%	66	60	91%

	Round 3 - November		
	# of candidates sitting	# of candidates passed	% of candidates passed
SP Total	56	48	86%

	Round 1 - March			Round 2 – July		
	# of candidates sitting	# of candidates passed	% of candidates passed	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	29	24	83%	54	48	89%
Second attempt	12	9	75%	12	12	100%
Third attempt	-	-	-	-	-	-
First attempt (New SP)	-	-	-	-	-	-
Second attempt (New SP)						

Round 3 - November			
	# of candidates sitting	# of candidates passed	% of candidates passed
First attempt	48	41	85%
Second attempt	3	3	100%
Third attempt	2	2	100%
First attempt (New SP)	3	2	67%
Second attempt (New SP)	-	-	-

Figure 5.4.2_10. SP Pass-Rates

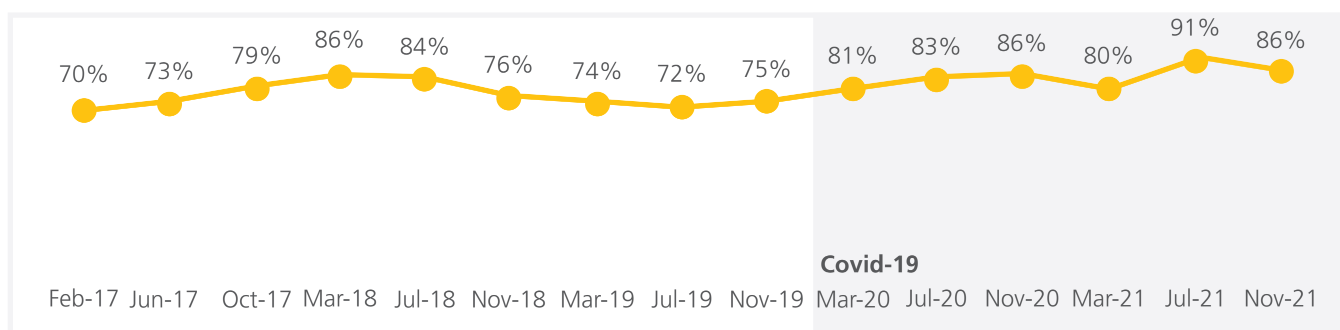


Table 5.4.2_14. Number of Exemptions for SP examination in 2021

Assessment Activity	Number of candidates sitting assessment	Number of candidates passed assessment	% of candidates passed assessment
SP Exemptions	99	84	85%

Table 5.4.2_15 indicates that trainees are progressing with assessments, with 68% of trainees having completed two or more assessments by stage 3. There are 36 trainees in stage 3 who have no summative assessments recorded. There are reasons for this situation:

- some trainees had just moved into stage 3 at the time of data extraction
- the trajectory was paused for 2020. This allowed the trainees in some instances to accrue more time than usual without any penalty and without passing the MCQ.

Table 5.4.2_15. Number of completed summative assessments by stage of training – trainees commencing in the 2012 Fellowship Program (as of end-April 2022)

	Stage 1						Stage 2						Stage 3						Total
	PT	%	FT	%	BIT	%	PT	%	FT	%	BIT	%	PT	%	FT	%	BIT	%	
None	67	13%	382	73%	8	2%	23	3%	246	34%	13	2%	6	1%	26	3%	4	0%	**775**
1	13	2%	48	9%	2	0%	35	5%	294	41%	14	2%	23	3%	181	22%	17	2%	**627**
2	-	-	-	-	-	-	5	1%	62	9%	3	0%	27	3%	115	14%	11	1%	**227**
3+	-	-	-	-	-	-	7	1%	17	2%	1	0%	77	9%	295	36%	42	5%	**439**
Total	**80**	**15%**	**434**	**83%**	**10**	**2%**	**70**	**10%**	**619**	**86%**	**31**	**4%**	**133**	**16%**	**617**	**75%**	**74**	**9%**	**2068**

Table 5.4.2_16 shows the number of assessments completed by months of FTE training. This data supports the contention that RANZCP trainees are delaying assessments until later in the Fellowship program. There are five trainees who have completed no assessments and have more than 60 FTE months of training recorded. Under the arrangements made to accommodate COVID-19 during 2020, these trainees had their trajectory paused. Four trainees have attempted the MCQ twice and failed and a training review has been requested due to progression issues. One trainee has been granted additional time to complete the MCQ.

Table 5.4.2_16. Number of completed summative assessments by FTE months of training – trainees commencing in the 2012 Fellowship Program (as of end-April 2022)

	0-12 Months						12.01-24 Months						24.01-36 Months					
	PT	%	FT	%	BIT	%	PT	%	FT	%	BIT	%	PT	%	FT	%	BIT	%
None	64	13%	375	75%	8	2%	18	5%	193	52%	9	2%	6	2%	53	15%	4	1%
1	10	2%	35	7%	2	0%	13	4%	116	31%	5	1%	23	7%	177	51%	10	3%
2	-	-	3	1%	-	-	-	-	13	4%	-	-	4	1%	53	15%	3	1%
3+	-	-	-	-	-	-	-	-	2	1%	-	-	6	2%	11	3%	-	-
Total	**74**	**15%**	**413**	**83%**	**10**	**2%**	**31**	**8%**	**324**	**88%**	**14**	**4%**	**39**	**11%**	**294**	**84%**	**17**	**5%**

	36.01-48 Months						48.01-60 Months						60.01+ Months						Total
	PT	%	FT	%	BIT	%	PT	%	FT	%	BIT	%	PT	%	FT	%	BIT	%	
None	7	2%	17	5%	3	1%	1	0%	11	4%	1	0%	-	-	5	2%	-	-	**775**
1	13	4%	136	40%	7	2%	9	3%	36	14%	3	1%	3	1%	23	9%	6	2%	**627**
2	10	3%	43	13%	3	1%	7	3%	46	18%	2	1%	11	4%	23	9%	6	2%	**227**
3+	15	4%	84	24%	6	2%	16	6%	124	47%	6	2%	47	19%	91	37%	31	13%	**439**
Total	**45**	**13%**	**280**	**81%**	**19**	**6%**	**33**	**13%**	**217**	**83%**	**12**	**5%**	**61**	**25%**	**142**	**58%**	**43**	**17%**	**2068**

Table 5.4.2_17 below shows the percentage of eligible trainees who have passed each of the summative assessments. Trainees are eligible to attempt the PWC and SP from the beginning of their Fellowship Program and 8% and 18% respectively of eligible trainees have passed these assessments. Both the PWC and the SP are longer-term assessments that take a considerable amount of time in planning and execution before submission for assessment.

Of current trainees commencing in the 2012 Fellowship Program, 59% have recorded a pass in the MCQ. 24% of trainees are eligible and have not passed or attempted the MCQ. For the OSCE, Table 5.4.2_17 shows that 15% of trainees have passed the assessment however, 33% are eligible and have not passed or attempted the OSCE. The Essay-style examination has been decoupled and trainee outcomes have been considered in the CEQ and MEQ calculations where 37% and 34% of trainees have passed the CEQ and MEQ and 34% and 31% are eligible and have not passed or attempted the CEQ and MEQ respectively. This is expected as data shows that trainees are deferring assessment to the later stages of training.

Table 5.4.2_17. Trainees summative assessment status – totals for trainees commencing in the 2012 Fellowship Program (as of end-April 2022); N=2068

	Pass	%	Eligible	%	No Eligible	%
MCQ	1225	59%	492	24%	351	17%
OSCE	314	15%	680	33%	1074	52%
PWC	159	8%	1909	92%	-	-
SP	368	18%	1700	82%	-	-
Essay	326	-	-	-	-	-
CEQ*	429	37%*	581	28%*	732	35%*
MEQ*	374	34%*	635	31%*	733	35%*

* MEQ and CEQ calculations consider the previous Essay style examination pass outcome

Currently there remain 84 trainees transitioned from the 2003 Fellowship Program to the 2012 Fellowship Program, and the status of their assessments are summarised in Table 5.4.2_18 below. Most transitioned trainees are in stage 3 and have completed three or more assessments. The single trainee in Stage 3 with no assessments recorded has been requested to undertake a training review due to progression issues.

Table 5.4.2_18. Transitioned trainees by stage of training and number of completed assessments (as of end-April 2022)

	Stage 1						Stage 2						Stage 3						Total
	PT	%	FT	%	BIT	%	PT	%	FT	%	BIT	%	PT	%	FT	%	BIT	%	
None	-	-	-	-	-	-	-	-	3	38%	-	-	-	-	1	1%	-	-	**4**
1	-	-	-	-	-	-	-	-	1	13%	-	-	2	3%	11*	14%	3	4%	**17**
2	-	-	-	-	-	-	-	-	1	13%	-	-	2	3%	16	21%	6	8%	**25**
3+	-	-	-	-	-	-	-	-	2	25%	1	13%	4	5%	26	34%	5	7%	**38**
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**7**	**88%**	**1**	**13%**	**8**	**11%**	**54**	**71%**	**14**	**18%**	**84**

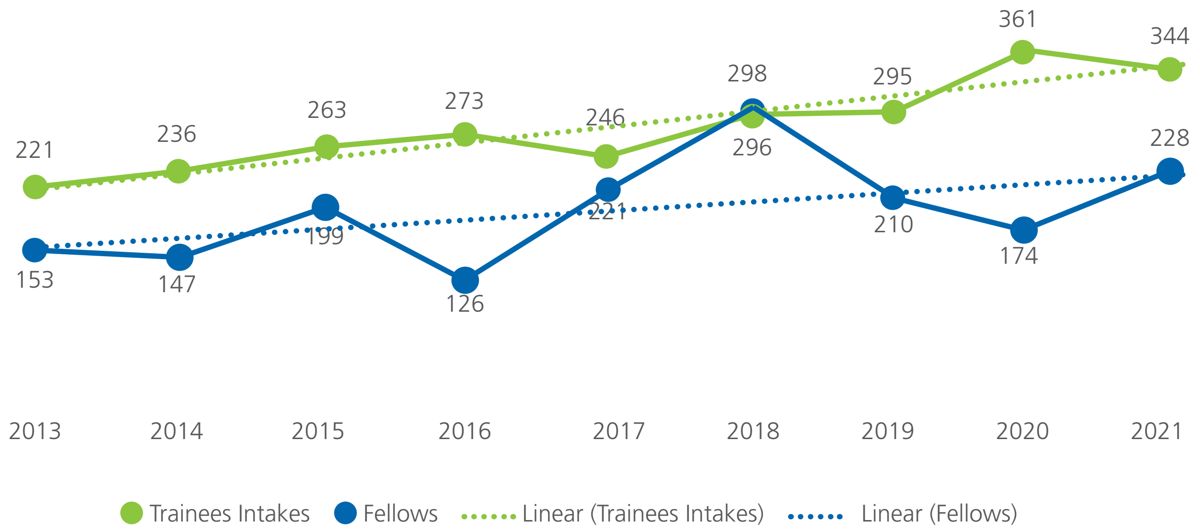
Table 5.4.2_19 includes data for trainees who were required to undertake a training review in 2021 as they had not met the standard expected. The Table separates transitioned trainees and trainees commencing in the 2012 program. None of the trainees undertaking a training review were excluded under the training review process. The RANZCP decided to make several examinations 'no disadvantage' in 2020 due to COVID-19 and for that reason these numbers may be different to previous years. The data shows that most trainees who have been through the training review process have remained in the training program, and that most exclusions from the program are due to trainees disengaging with training, rather than failing assessments.

Table 5.4.2_19. Training review

	2021							2017-2021 cumulative			
	Fellowship Program			Resolution							
Reason	Transitioned trainees	2012 trainees	Total	Not excluded	Excluded	Attained FRANZCP	Other	Not excluded	Excluded	Attained FRANZCP	Other
Failure of progression	-	-	**-**	-	-	-	-	3	-	1	2
3 fails MCQ	-	3	**3**	3	-	-	-	29	-	-	-
4 fails MCQ	-	-	**-**	-	-	-	-	1	-	1	-
5 fails MCQ	-	-	**-**	-	-	-	-	1	2	-	-
6 fails MCQ	-	-	**-**	-	-	-	-	-	1	-	-
3 fails Essay-style Exam	-	-	**-**	-	-	-	-	42	-	27	-
5 fails Essay-style Exam	-	-	**-**	-	-	-	-	4	-	2	-
7 fails Essay-style Exam	-	-	**-**	-	-	-	-	-	-	1	-
3 fails OSCE	-	1	**1**	1	-	-	-	13	-	3	1
5 fails OSCE	2	-	**2**	1	-	-	1	2	-	-	1
3 fails PWC	-	-	**-**	-	-	-	-	-	-	1	-
3 fails SP	-	-	**-**	-	-	-	-	-	-	1	-
3 fails rotations	2	-	**2**	-	-	-	2	3	4	-	3
Did not commence Targeted Learning	-	-	**-**	-	-	-	-	1	-	-	1
12 months not in training	1	2	**3**	1	-	-	2	1	24	-	7
P0PTotal	**5**	**6**	**11**	**5**	**-**	**-**	**5**	**101**	**31**	**37**	**15**

Figure 5.4.2_11 shows the number of trainees commencing each year, against the number of admissions to the Fellowship. This clearly demonstrates that admissions to the Fellowship have returned to pre-pandemic levels, and continues to maintain steady growth over time.

Figure 5.4.2_11. Growth in trainee intake and admission to the Fellowship



Standard 5: Documents provided check list

	Document
√	Assessment map or blueprint (showing how formative and summative assessments relate to curriculum and progression point decisions/hurdles though the program) and outlining standard setting processes Refer item 5.2.2 Assessment blueprint Appendix 5.2.2_2 SP assessment framework and marksheet Refer item 5.2.3 Standard setting processes Appendix 5.2.1 Fellowship mapping of competencies
√	The special consideration policy Appendix 5.1.3 Special consideration policy
√	The document(s) provided to trainees and the document provided to supervisors that explains the assessment policy, the nature of the assessments and the criteria used. Appendix 4.2.4_1 Policy progression through training Appendix 5.1.2_1 Policy and Procedure Essay Exams Appendix 5.1.2_2 Policy and Procedure Psychotherapy Written Case Appendix 5.1.2_3 Policy and Procedure Planning Your Scholarly Project Appendix 5.1.2_4 Policy and procedure MCQ Exam Appendix 5.1.2_5 OSCE Policy and Procedure Appendix 5.1.2_6 Policy and Procedure Workplace based Assessments Appendix 5.1.2_7 Policy and Procedure Entrustable Professional Activities
√	The assessment, grading and progression rules. Appendix 5.1.2_1 Policy and Procedure Essay Exams Appendix 5.1.2_2 Policy and Procedure Psychotherapy Written Case Appendix 5.1.2_3 Policy and Procedure Planning Your Scholarly Project Appendix 5.1.2_4 Policy and procedure MCQ Exam Appendix 5.1.2_5 OSCE Policy and Procedure Appendix 5.1.2_6 Policy and Procedure Workplace based Assessments Appendix 5.1.2_7 Policy and Procedure Entrustable Professional Activities
√	The policy and procedures for remediation and reassessment of trainees, and for supplementary examinations. Appendix 5.3.3 Targeted Learning Policy
√	If relevant, policy on dismissal from the specialist medical program Failure to Progress Policy (ranzcp.org)
-	Policy and procedures on informing employers and registration authorities of concerns about patient safety that arise from trainee assessment

Standard 6: Monitoring and Evaluation

Standard 6: Monitoring and evaluation

6.1 Monitoring

6.1.1 The education provider regularly reviews its training and education programs. Its review processes address curriculum content, teaching and learning, supervision, assessment and trainee progress.

The Committee for Educational Evaluation, Monitoring and Reporting (CEEMR) is a constituent committee of the Education Committee and has the responsibility for ongoing monitoring of the educational activities of the RANZCP. Its membership includes representatives from each of the Education Committees, a consumer representative, and a trainee representative. CEEMR replaces the former Committee for Educational Quality and Reporting (CEQR), and its terms of reference are provided for reference as Appendix 6.1.1_1.

CEEMR has developed a Monitoring and Evaluation Framework, based on the Kirkpatrick model of evaluation.

A comprehensive series of monitoring questions has been developed, based on each of the five stages, linked to the available data sources and method of collection. Not every question should be monitored routinely, some are better monitored through a specific time-limited data collection, however, the CEEMR are identifying key performance indicators that should be included in routine reporting (Appendix 6.1.1_2).

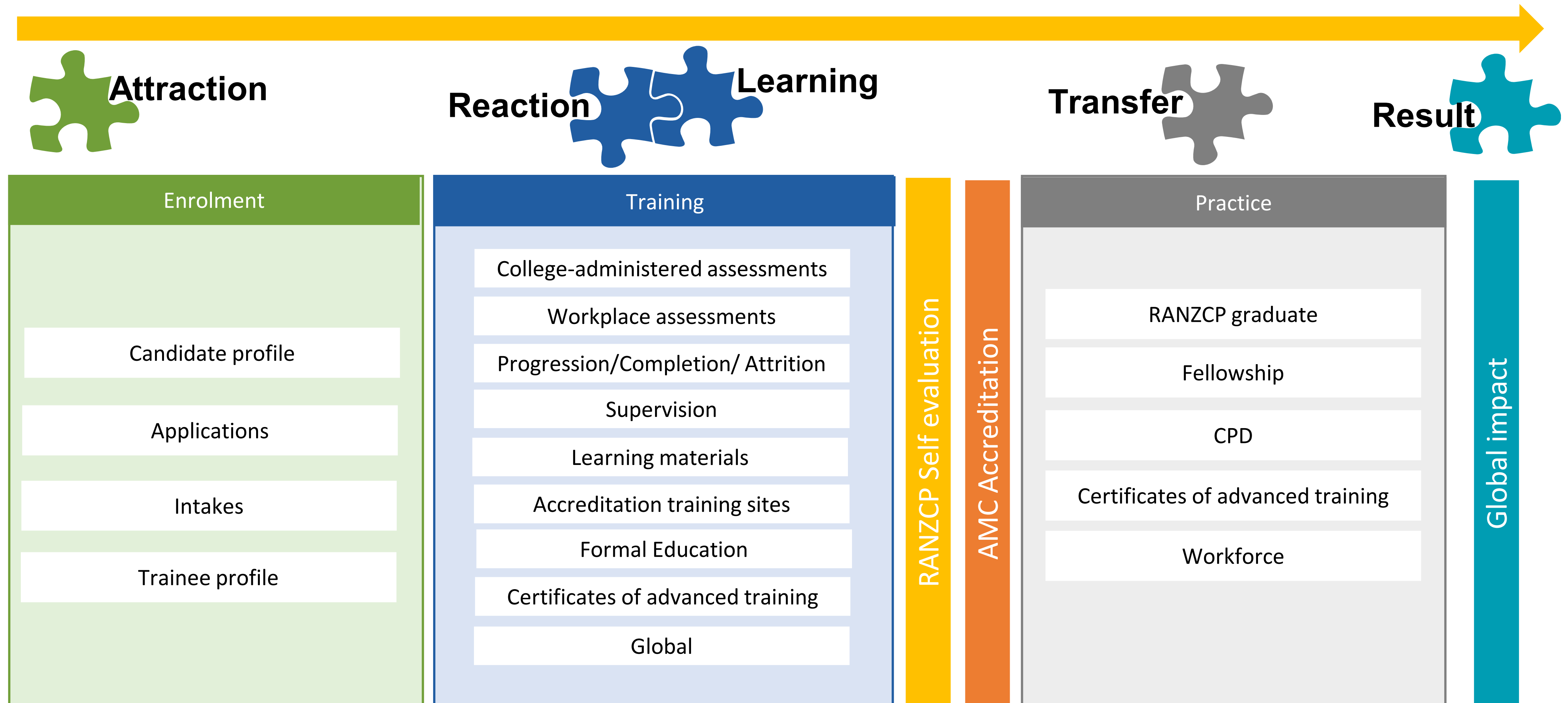
As provided under standard 2.2.2 (Table 2.2.2_1) a cohort progression monitor has been developed to monitor each cohort of trainees as they progress through the Fellowship Program. A copy of the tool is provided as Appendix 6.1.1_3. It is updated monthly and reported to the CFT, DOTs and the EC to provide oversight and visibility, particularly of the small number of trainees whose progress is significantly delayed.

In addition, the RANZCP conducts periodic reviews the Fellowship Program curriculum with a view to enhancing content and strengthening the assessment capabilities. External consultants are engaged where necessary for a specific purpose.

Current work in progress includes:

- the ACER review of assessments, discussed in detail under standard 5. This evaluation has made a series of recommendations that are being progressively implemented and evaluation of the decoupling of the MEQ and CEQ examinations is underway
- the syllabus review, which is aimed at ensuring that the theoretical basis for the curriculum is reflective of current knowledge and best practice in psychiatry
- the EPA Review is discussed in detail under standard 4. This review will ensure that the EPAs used in the Fellowship program are updated in line with the advances in medical education that have occurred since the introduction of EPAs in the 2012 Fellowship program. The Review aims to streamline the number of mandatory and elective EPAs and will increase focus on professional activities that are unique to the practice of psychiatry and not assessed in other areas of the curriculum
- the re-accreditation of the FECs, discussed in detail under standard 4. Following the reaccreditation of the FECs, and utilising some of the data collected during that process, a review of the role and purpose of the FEC in the curriculum is commencing in the second half of 2022.
- the review of the Comparability Assessment Framework (CAF), discussed in detail under standard 10. The CAF, used for the assessment of the comparability of SIMG applicants, was developed in 2016. The review is aimed at refining the discriminatory capacity of the tool and reducing the number of borderline decisions
- the supervisor resources project, discussed in detail under standard 4.2.4. This project has reviewed supervisor satisfaction with the level of training and support that they currently receive and has undertaken a gap analysis to determine where further training is required and where further resources are needed

Figure 6.1.1. RANZCP Evaluation and Monitoring model



- the catalogue of e-learning resources available via Learnit is being reviewed to establish the continued relevance of the resources, identify those that need to be updated or archived, and to establish a life cycle management process. This work is occurring under the guidance of the E-Learning Advisory Group (ELAG).

6.1.2 Supervisors contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses supervisor feedback in the monitoring process.

The RANZCP obtains feedback from supervisors through its program accreditation processes. Described in detail under standard 8, the program accreditation process includes feedback from the supervisors of trainees. Conducted by the RANZCP accreditation panel, confidential interviews with the supervisors provide frank advice on how the program is operating at the local level. This feedback is communicated to the AC and the CFT.

DOTs and supervisors are involved with reviews of components of the curriculum. The review of the EPAs (discussed under standard 4) includes current supervisors, along with DOTs, to ensure that the users of the EPAs are appropriately represented. Similarly, the membership of the working group undertaking the review of the CAF (discussed under standard 10) will include members who are actively supervising SIMG candidates.

The supervisor resources project (discussed under standard 4.2.4) will provide a mechanism to further develop the Fellowship Program, particularly as it moves to a greater emphasis being placed on workplace-based assessment. Their involvement in the AAP, as assessors in the CBD, has been essential, and their ongoing engagement in the design and delivery of workplace-based assessment is a critical success factor.

6.1.3 Trainees contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses their confidential feedback on the quality of supervision, training and clinical experience in the monitoring process. Trainee feedback is specifically sought on proposed changes to the specialist medical program to ensure that existing trainees are not unfairly disadvantaged by such changes.

Every trainee and SIMG who is admitted to the RANZCP Fellowship is invited to complete a confidential survey that seeks their views on a range of aspects of the Fellowship program, including supervision, training and clinical experience. Selected questions from the Medical Training Survey (MTS) are reproduced in the Exit survey to provide a comparison of the views of trainees during their training and at the conclusion of their training.

First administered in 2020, the response rates for the survey to date have been excellent for an online survey that has no inducement for completion. The response rates for the 2020 and 2021 surveys were 47.1% and 53.9% respectively. The survey reports are provided as appendices 6.1.3_1 and 6.1.3_2 to this submission.

The results of the Exit survey are reviewed by CEEMR, which develops recommendations based on the data. These recommendations are provided to the EC for approval and dissemination to the relevant committees for discussion of any required actions to be taken.

The way in which the report is promoted represented a change to previous practice. It is published on a dedicated page of the RANZCP website (Trainee exit survey report | RANZCP), which includes report highlights along with areas for improvement and the actions to be taken by the RANZCP. Articles in the Training and Assessment Newsletter, Psyche and the President's update were also published to inform the Fellowship of the report and its recommendations.

In addition to the Exit survey report, a separate report comparing the MTS and the Exit survey results is prepared annually. A copy of this report is also provided as an Appendix 6.1.3_3 to this submission. This report monitors the shifts of trainee perception over time and also compares the RANZCP results to those of other specialist medical college trainees.

Whenever a significant change is proposed to the Fellowship program consultation is undertaken with the trainee body through a variety of mechanisms. Education committees have trainee members who can provide feedback on any proposed changes. The full list of committees which have a trainee member is provided under standard 7.2.1 and reproduced here:

Jurisdictional representatives on the TRC represent trainees on the following committees:

- Branch Committees/New Zealand National Committee
- BTC/NZTC
- Tasmania STP Project Working Group (note this position is held by the Tasmanian Jurisdictional Member).

Non jurisdictional representatives on the TRC represent trainees on the following committees:

- Board constituent committees: CGRC, EC, MEC and PPPC
- Education Committee constituent committees: AC, CEEMR, CFE, and CFT
- Education steering groups set up by the Board for specific purposes such as the AVOSCE, the MSOSCE and the ERSG for the ACER review.

Trainees on these committees are full members with voting rights and can raise items for inclusion on the agenda if they wish.

Two important developments have occurred in the first half of 2022. May 2022 saw the appointment of a trainee to the Board of the RANZCP as an appointed Director, with full voting rights. Dr Pramudie Gunaratne is the first appointed Director, Trainee.

The TRC is consulted on changes and may use its networks to consult with the broader trainee body. In addition to this mechanism, further engagement is sought as needed from bodies such as the APTs. An example of this engagement has been the co-design of the AAP which is described in standard 5 of this submission.

To assist the AMC with its collection of feedback for the accreditation of the RANZCP, it has requested advice on any regular consultative processes with the following stakeholders:

- **trainees**

As described above, the primary mechanism for consultation with trainees is through the TRC. This is described in detail under standard 7.

- **supervisors of training**

Consultation with supervisors generally takes place as needed on specific issues, such as the supervisor survey undertaken in January 2022. It is through these periodic engagements that the College gathers the richness of data that is then addressed through further consultation with the DOT advisory group and the CFT. The regular mechanism for consultation with supervisors is through the program accreditation process, which is described in detail under standard 8.

- **health departments**

Whilst the RANZCP works regularly with the Australian Department of Health this tends to be as required for specific issues, such as for the introduction of rTMS to the Medicare Benefits Schedule (MBS) or the Specialist Training Program (STP).

- **other providers of specialist medical programs**

The primary means of consultation with other providers of specialist medical programs is through the Council of Presidents of Medical Colleges (CPMC) in Australia and the Council of Medical Colleges (CMC) in New Zealand.

- **consumer groups**

The primary means of consultation with consumers is through the Consumer Consultation Committee. Lived Experience Australia, which has representation on the CCC, also has a MOU with the RANZCP.

- **SIMGs**

There is no regular consultation with the SIMG cohort, consultation occurs on an as needs basis.

- **Deans of medical schools**

Consultation with the Deans of Medical Schools occurs primarily through the CPMC.

6.2 Evaluation

6.2.1 The education provider develops standards against which its program and graduate outcomes are evaluated. These program and graduate outcomes incorporate the needs of both graduates and stakeholders and reflect community needs, and medical and health practice.

CEEMR oversees a number of evaluative activities:

- the Trainee Exit Survey, which is administered to all trainees being admitted to the Fellowship
- the Training and Assessment update, published twice per year reporting on all educational activities in the first semester and then for the entire year
- the analysis of the Medical Training Survey against previous years and the outcomes of the Trainee Exit Survey.

The Trainee Exit survey was revised and reintroduced in 2020. Some questions from the MTS are included to provide a degree of comparison at two points in time – during training, and at the end of training. Trainees are surveyed at the time of their admission to the Fellowship. The first Exit survey in 2020 had a response rate of 47.1%, and the second Exit survey in 2021 had an increased response rate of 53.9%. The 2021 Exit survey is being analysed at the time of writing; however, the 2020 report is provided as Appendix 6.1.3_1.

The 2020 Trainee Exit survey was reported to the Membership in an improved way, with a dedicated web page outlining the highlights, the areas for improvement and the actions taken by the RANZCP (Trainee exit survey report | RANZCP).

Other components of the educational activities of the RANZCP are monitored and evaluated by the relevant committees as part of their business as usual. As discussed under standard 8 in more detail, the AC maintains a regular review process to ensure that the accreditation standards for posts and programs continue to be contemporary and reflective of the needs of stakeholders and the community. In 2022, the AC has commenced consideration of how cultural safety should be incorporated into the accreditation standards. This work will draw on the work being undertaken by the MCNZ and AIDA during its development.

The review of the syllabus, once complete, will become an essential component of the standards for the FECs. One of the standards for FECs is that the RANZCP syllabus is covered in its entirety. During the reaccreditation of the FECs in 2021, this standard was not met by two FEC providers, and these providers were given shorter periods of accreditation with recommendations regarding renewal of their curriculum to cover the syllabus.

In addition to monitoring and evaluation activities, the RANZCP EC and its constituent committees maintain a dedicated comprehensive Risk Register. This Risk Register is reviewed at least every six months with individual risks being reassessed according to any developments and the mitigation strategies reviewed. The Risk Register, and the accompanying Risk Matrix are provided as appendices to this submission (Appendices 6.2.1_1 and 6.2.1_2).

6.2.2 The education provider collects, maintains and analyses both qualitative and quantitative data on its program and graduate outcomes.

As described under standard 6.1.1 CEEMR has developed a monitoring and evaluation framework which describes the qualitative and quantitative data collected by the RANZCP. Data is collected and maintained through two main systems: the College's membership database and the InTrain trainee management system. InTrain has provided an increased capacity for the collection of data and for its analysis since its introduction in New Zealand in December 2018 and in Australia in February 2019. Prior to InTrain training data was collected manually using paper forms and a hard copy filing system.

Microsoft Power BI was introduced in 2021 as the College's data visualisation software, and it is being progressively introduced to provide dashboard style data for different departments. For example, the compliance with the CPD program overall, and the various elements of the CPD program are now available and updated automatically on a daily basis.

The Training and Assessment update provides a detailed snapshot of quantitative data collected on the educational activity of the RANZCP twice yearly – a report on the first half of the calendar year and then an end of year report covering the entire year. This data includes assessment data for the centrally administered summative assessments. The report is submitted to the EC for discussion by its members, and any recommendations for actions and collaborations.

The RANZCP has surveyed the trainees as part of the FEC reaccreditation, to gain feedback and information regarding the program and graduate outcomes. This data is driving program development and improvement and has informed decisions regarding the accreditation of FECs. A similar mechanism is used for program accreditation where feedback from trainees is used to inform further investigation by the accreditation panel and its decisions regarding accreditation.

As the Exit survey moves into its third year, trends are beginning to be established. Respondents to the first two surveys have expressed some lack of satisfaction and confidence in the area of Leadership and Management experiences, however the trend is not yet clear. If this trend is confirmed with the 2022 Exit survey a review of this component of the training program will be undertaken.

6.2.3 Stakeholders contribute to evaluation of program and graduate outcomes.

The main contributing stakeholders to the evaluation of program and graduate outcomes are Trainees, SIMGs and Fellows. The views of people with lived experience are an important component, but the gathering of community perceptions is challenging. The way that the RANZCP addresses this challenge is through the representatives of the CCC who members of the CEEMR and other committees. The CCC has been a committee of the RANZCP since 2009, under the previous General Council. Representatives of the CCC, who are also members of other committees, have full voting rights and contribute to decision making.

To ensure that all members of CEEMR have an equal opportunity to provide input to the analysis and development of recommendations and to minimise the phenomenon of group think the report and a pro forma for feedback are distributed prior to a CEEMR meeting where a particular survey or evaluation is being discussed. The collated responses are then discussed at the CEEMR meeting. This process ensures that appropriate time is given to consideration of the data rather than it being given a short time during a committee meeting.

The AMC has requested that evaluations undertaken in the last three years are tabulated, along with the main issues arising and the College's response. Tables 6.2.3_1 to 6.2.3_3 show evaluation activities for 2019, 2020 and 2021. The individual reports have been provided to the AMC as part of progress reports previously and are not included as appendices to this submission. They can be made available to the assessors upon request.

Table 6.2.3_1. 2019 Evaluation activity

Evaluation activity	Issues arising	RANZCP response to issues
2012 Fellowship Program Evaluation Stage 1,2 and 3 : Trainee Survey and Supervisor Survey	Revision of EPA requirements and workload for Stage 2 required.	Education Committee to form a Working Group to review the Stage 2 and 3 workload and EPA requirements.
	Review of the examination and assessment standard and availability of additional examination resources required.	Examination Support Measures Working Group to review measures put in place by the Education Committee. Committee for Examinations is to undertake a comprehensive review of the assessments, and the examination standards with the external consultant. The RANZCP continues to address resourcing/ expertise and recruitment of expert staff focus on specific developmental work.
	Provide more support, training and resources for supervisors.	Committee for Training has established a Working Group to provide oversight of the development of supervisor training, resources and support materials.
	Improve monitoring of completion of program requirements.	With the implementation of InTrain; monitoring of time taken for the completion of in training assessments and ongoing analysis of WBAs and EPAs will provide enhanced ability of the DOTs and supervisors to oversee progression of trainees and recommend targeted learning.
	Review the FEC variability, quality, consistency, and cost.	Working Group (WG) is being established under the Education Committee to review the FEC and address the mandatory nature and fit for purpose of the FEC programs. The WG will be working closely with the Committee for Training and DOTs.
STP Trainee Survey	The STP evaluation for trainees who occupied an STP training position in either rotation 1 or 2, 2018 closes on 22 March 2019.	Work is currently underway to collate and evaluate survey responses.
My CPD survey general	Issues with the online CPD portal.	Formal help desk was established to manage member queries. Upgrade to My CPD system in November 2019 RANZCP now proactively monitors trends in members' queries and tailors programs and responses accordingly. With the introduction of the new My CPD, the Help Desk and tailored email support reminders, the number of paper claims has decreased, the number of support calls has decreased, and the number of records completed by the close of the extended reporting period has increased from 88% in 2017 to 95% in 2018.
CPD Survey for Qualified Privilege	These annual surveys demonstrate the breadth and depth of issues and quality activities undertaken at a very local level by groups of peer psychiatrists.	No issues identified that require RANZCP response.
Review of the 2016/2017 Mentoring program for Rural Trainees	A number of recommendations were made for improved processes for the mentoring program. The executive summary is provided as Appendix 6.2.3_2	The recommendations have been incorporated into the current program.

Evaluation activity	Issues arising	RANZCP response to issues
Member Engagement Survey	From December 2017 to February 2018, all members of the RANZCP were invited to participate in a broad engagement study. The findings highlighted areas of importance to members. These included: • communication channels • strategies and approaches to content • development of additional resources to support members' involvement in the RANZCP • increased educational resources for members • member feedback mechanisms • opportunities to improve RANZCP processes and responses. The survey report is provided as Appendix 6.2.3_1	The Membership Engagement Committee recommendations to address the issues identified are as follows: • significantly update the approach to obtaining feedback from members. Options for short, focussed and frequent surveys with prompt feedback to members on findings and any actions should be explored. • improve the RANZCP's current member communications systems and content strategy. This should include a review and upgrade of the current bulk email platform; it should also include the adoption of a new content approach that is consistent across the RANZCP's various channels, which will provide more streamlined, effective, concise, and targeted communications to members. • undertake further enhancements to online CPD Program management, as planned for 2019. • develop new communication and engagement avenues via social media platforms. • improve the information to members on how their fees are spent. This could take the form of an infographic or other easy to digest summary. • continue to focus on what the RANZCP is doing well and building on these strengths – for example the strong involvement of members in RANZCP committees, development of new conference activities that meet members' needs, and growth of Faculties, Sections and Networks.

Table 6.2.3_2. 2020 Evaluation Activity

Evaluation activity	Issues arising	RANZCP response to issues
Review of Assessments by ACER – delivered December 2019	A series of 28 recommendations were made relating to: • written examinations • OSCE • assessment procedures and alignment/ integration with training.	The RANZCP has formed the ERSG to oversee the implementation of the recommendations of the ACER Review (commissioned end 2019). The work of the group is detailed under Standard 5 of this report.
STP Trainee Survey	• the 2019 survey provided positive feedback from the trainees on the effectiveness of the STP program, specifically, on the quality of training and supervision received, and the overall experience of the trainee at an STP post • aligning the resources and support available to trainees with what their peers receive at traditional metropolitan hospital/ teaching settings, would further improve the positive vocational experience for trainees at an STP post.	The RANZCP has identified as the main actions: • continuing to improve the experience of trainees in STP posts • improved promotion of STP posts to the RANZCP trainee population • continuing to work on redistribution of STP posts to preference rural and private locations
Trainee survey regarding assessments	• the linkage between the examinations with curriculum, training, support, and resources was strongly positive for the OSCE, marginally positive for the MCQ examination and less clear for the Essay-style examination • the workload associated with Certificates of Advanced training was generally considered as not too much extra work to take on during the Fellowship program.	This survey was an input to the ACER review and the RANZCP response to this survey is covered in detail under Standard 5 of this report. The results of the survey were published in the Training Newsletter, which is distributed to all trainees, supervisors, and DOTs.
Supervisor and Director of Training survey regarding assessments	• the statements associated with using examination results for evaluation of trainees and training were most difficult to agree with • most positive agreement was in relation to the OSCE followed by the MCQ examination then the Essay-style examination.	This survey was an input to the ACER review and the RANZCP response to this survey is covered in detail under Standard 5 of this report. The results of the survey were published in the Training Newsletter, which is distributed to all trainees, supervisors, and DOTs.
CPD surveys for qualified privilege	These annual surveys demonstrate the breadth and depth of issues and quality activities undertaken at a very local level by groups of psychiatrists.	No issues identified requiring RANZCP response. The survey reports will be published on the College website for members.

Table 6.2.3_3. 2021 Evaluation Activity

Evaluation activity	Issues arising	RANZCP response to issues
2019 Integrated Rural Training Pathway (IRTP) Trainee Survey	• 88% of respondents rated their overall experience of the 2019 training year in an IRTP post as being positive or very positive • trainees most encountered general adult patients (94%) with opportunities to consult Aboriginal and/or Torres Strait Islander patients (78%) • most trainees rated the quality of the supervision received as 'high' or 'very high' (66%) • of those trainees who were based in an IRTP post, 50% said they had not accessed support programs. 44% accessed the Mentoring Program with 6% utilising the Scholarly Project Grant. 1 respondent has benefited from the Educational grants for Congress and exam preparation courses offered to those trainees who identify as Aboriginal and/or Torres Strait Islander peoples • the least beneficial aspects of IRTP posts identified by trainees included: Research opportunities, Support to the trainee • upon completion of their training, 89% of respondents said that they would remain in a regional, rural, or remote area as a consultant. The 2019 IRTP Trainee Survey report is provided in Appendix 6.2.3_3	The following recommendations were made: • support the provision of additional support and education opportunities for supervisors • highlight the use of Rural Loading and PICS with health services to assist trainees' access to opportunities in metropolitan areas • review communication strategy to support trainees' and their supervisors' awareness of available support projects • explore opportunities to provide support for trainees undertaking RANZCP requirements such as the PWC and the SP • work with the Regional Training Hubs and Health Services to provide a more cohesive integration into the local community for all trainees undertaking an IRTP post • work with Health Services to continue to maintain the IRTP posts with the long-term goal of increasing the number of qualified Psychiatrists in regional, rural and remote areas.
2020 STP Trainee Survey	• The 2020 STP Trainee Survey has recently closed, and the report is scheduled to be completed in October 2021.	N/A
2020 Trainee Exit Survey	• the Essay-style examination was a source of dissatisfaction, as well as issues around feedback on exam performance, support from the RANZCP when needed around exams, and exams accurately reflecting the Fellowship curriculum • only 45% of new Fellows considered that the Formal Education Courses gave them the knowledge to prepare for examinations • there was a perception that trainee views are not adequately included in RANZCP committees, and that the views of trainees are not adequately considered in changes to the Fellowship program.	• results letters now better identify areas of strength and weakness and how they contribute to the overall exam result • the Essay-style exam has been decoupled into two independent exams - the MEQ and the CEQ • all FECs are being reaccredited during 2021. A specific survey of trainees will get more detailed responses on this issue. Once the reaccreditation process is complete, a working group will review the purpose and role of the FEC as a mandatory element of the Fellowship program • further dialogue between committees and trainees has been recommended.

Evaluation activity	Issues arising	RANZCP response to issues
2020 Overseas Fellows Survey regarding Continuing Professional Development (CPD)	• most respondents have retained their practising registration in Australia and New Zealand, and most intend to return to Australia or New Zealand to practise • Overseas Fellows wish to maintain their links with the RANZCP • the function in My CPD to search for a PRG does not appear to be widely used • the options for supervision and second opinions to serve as formal peer review are not well used • practice Improvement can be challenging in countries where this is less well understood or is not integrated into health care delivery. The 2020 Overseas Fellows Survey report is provided in Appendix 6.2.3_4	• the PRG search function in My CPD is being enhanced to improve usability • options for formal peer review other than PRGs, and the improved search function in My CPD will be promoted to all members
RANZCP 2020 Mentoring Program Evaluation	• 89% of mentoring partnerships completed the full 8-month program • 91% said that they would recommend the program to a colleague or friend • 81% said that, overall, their mentoring partnership had met their expectations • the top three areas mentees identified that their partnership had impacted on included: 'motivation and confidence', 'career planning', and 'professional development' • the top three areas mentors identified that they discussed with their mentees were: 'career planning', 'self-care and wellbeing', and 'professional development. The RANZCP 2020 Mentoring Program Evaluation report is provided in Appendix 6.2.3_5.	Feedback confirmed several previously identified areas for continuous improvement: • Introduce Mentor Peer Groups to assist mentors share and develop skills in their partnerships. • Include additional questions in the Expression of Interest process on the time commitment required to participate in the program (including training), the amount of time participants are willing to engage in the program per month, and whether their preference is for face-to-face mentoring or through online options.
Member Education E-Sessions evaluation survey	• over 2900 unique viewers attended across the series of eight webinars • the feedback was positive with strong support for the continuation of the series beyond the pandemic • the quality of slides is important to the experience of attendees • topics could be presented over more than one session to prevent a sense of "cramming" for participants and to enable adequate time for questions and answers • the polling feature used by two of the presenters was appreciated by participants as another way of interacting with the content and the session. The Member Education E-Sessions evaluation survey is provided in Appendix 6.2.3_6	Recommendations being considered by the RANZCP include: • repeating an expanded series, with topics presented over more than one session • the continued conversion of webinars to Learnit modules • the continuation of automatic uploading of CPD hours to My CPD records • improved guidance for presenters to support adaptation to the virtual environment.

Evaluation activity	Issues arising	RANZCP response to issues
2020 PIF Intro to Psychiatry Short Courses Evaluation	• 100% of the post-course survey respondents would recommend the short courses to other medical students and prevocational doctors interested in psychiatry • 89% of first course and 93% of second course respondents stated that short courses had met their needs • whilst the 2020 short courses were adapted to online delivery due to the pandemic, it is proven to have expanded its reach and impact Australia wide, including in rural settings. The 2020 PIF Intro to Psychiatry Short Courses Evaluation report is provided in Appendix 6.2.3_7.	• consider providing greater exposure to a wider variety of subspecialty areas • more junior registrar involvement, including a Certificate of Attendance and interaction in Q&A session • an annual online course, in addition to traditional onsite courses, is now planned for inclusion in the 2021 PIF program and beyond.
PRG survey	To comply with the requirements of qualified privilege the RANZCP surveys its PRGs on an annual basis. No issues were raised in the surveys that required a response from the RANZCP. TThe PRG survey report is provided in Appendix 6.2.3_8.	N/A

A key challenge for the RANZCP during 2022 and expected for 2023 is the review of assessment options for the RANZCP, following the failure of the November 2021 AVOSCE. The AAP, implemented as an emergency response, has addressed assessment backlogs and allowed a more flexible assessment approach that may become part of a strategy that is less reliant on high stakes examinations as an assessment **of** learning, and more in line with progressive assessment **for** learning. The evaluation of the portfolio review component is being finalised and will demonstrate strengths, opportunities for improvement, and whether this tool may be utilised as part of the ongoing assessment of trainee's clinical skills.

The FEC Review working group, once established later in 2022, will consider the recommendations arising from the FEC accreditation process and the alignment of the FEC to the success of candidates in the Fellowship program. As the FEC has been an element of the Fellowship program for many decades, there are many stakeholders with vested interests.

These developments may represent a significant change to the way that the Fellowship program operates but aim at sustainable training and the facilitation of assessment. Careful management of any change that arises from these reviews will be a critical factor in successful delivery of an improved Fellowship program.

In the area of CPD, and discussed in more detail under standard 9, a challenge will be the introduction of the CPD Home and continuing to demonstrate to the membership that CPD is relevant to them. Evaluation of activities, undertaken as part of the CPD program, will need to be evaluated, particularly those that are not "traditional continuing medical education". The value of 360-degree feedback, the novel practice peer review and the introduction of learning paths to Learnit will all require evaluation to produce lessons learnt and quality improvement opportunities and the challenge of engaging time-poor psychiatrists in this type of evaluation will need to be met.

6.3 Feedback, reporting and action

6.3.1 The education provider reports the results of monitoring and evaluation through its governance and administrative structures.

The results of all reports are published on the RANZCP website (RANZCP Education and Training Reports | RANZCP), and promoted through the College's newsletters and the President's update.

The CEEMR reviews the outcomes of evaluation surveys and develops specific recommendations that are provided to the EC prior to dissemination to relevant committees for consideration and action. An example of a recent report and recommendations is provided as Appendix 6.3.1.

Relevant committees are encouraged to respond to the recommendations formally to the EC to close the quality improvement loop.

It is through this process that the need for an independent review of the assessment processes was identified resulting in the ACER review.

Internally, there is cross-reporting of evaluation and monitoring data between the various areas of the college, including Policy Practice and Research, Membership and Events, and Education and Training areas. Examples, provided in the Tables under standard 6.2.3, include:

- the evaluation of the Member E-Learning Education Series (MEES), conducted by Membership and Events, resulting in a commitment to converting webinars to e-learning modules in Learnit
- the annual STP surveys, conducted by the STP team resulting in a commitment to the continued redistribution of posts to rural locations
- the evaluation of My CPD, resulting in the extension of the Information Technology's Help Desk to include the CPD administrative team. This has provided an improved experience for participants in the CPD program and more efficient use of resources.

6.3.2 The education provider makes evaluation results available to stakeholders with an interest in program and graduate outcomes, and considers their views in continuous renewal of its program(s).

CEEMR is committed to reporting evaluation and monitoring data and ensuring that it reports back to the Fellowship to increase the visibility and transparency of monitoring and evaluation. To this end, it submits posters on key training and assessment data for publication at the College's annual Congress as well as publishing reports with recommendations, as discussed under 6.2.1 of this submission. The posters from the 2022 congress are provided as appendices to this submission (Appendices 6.3.2_1 and 6.3.2_2).

6.3.3 The education provider manages concerns about, or risks to, the quality of any aspect of its training and education programs effectively and in a timely manner.

Each of the Education committees maintains a risk register, where risks relevant to the activity of that committee are recorded. A description of the risk, key indicators of the risk, and mitigation measures are recorded in the register, along with a rating based on the RANZCP risk matrix. A copy of the risk matrix is provided as an Appendix 6.2.1_1 to this submission.

Risk registers are reviewed every six months, but a newly identified risk can be recorded at any time. The risks from each of the education committees are consolidated into one overall Education and Training register which is also reviewed by the EC every six months. The Education and Training risk register is provided as Appendix 6.2.1_1 to this submission.

The risk registers of all Board constituent committees are consolidated into the comprehensive Board risk register.

Since early 2020, COVID-19 has presented concerns and risks to the training program. The Board established dedicated emergency steering groups during the initial period of the pandemic. These groups oversaw the introduction of flexibilities for trainees, including a pause to the trajectory and changed arrangements for assessments. These have been discussed in detail under standard 5 of this submission.

Issues from Exit Survey 2020

The AMC, in its response to the RANZCP 2021 progress report, has requested specific commentary on three items:

- the outcomes of the review of the ongoing role of FECs in the Fellowship Program and the blueprinting of the FEC content against assessments
- trainees' view that they do not have sufficient input to the program, including the role of the TRC
- the essay style questions and how trainees are experiencing the new format.

The review of the ongoing role of FECs in the Fellowship Program has been delayed. Its commencement was always intended to follow the conclusion of the reaccreditation of the FECs. The reaccreditation was concluded at the end of 2021, having been initially deferred from 2020 due to COVID-19. The commencement of the review is now expected to commence in the second half of 2022, with a conclusion in 2023. The rationale for delaying this review is twofold. The consequences of the failure of the November 2021 AVOSCE failure and the pivot to the AAP has required the attention of both staff and Fellows to achieve the volume of portfolio reviews and case-based discussions. This has impacted on the capacity of Fellows who would normally be expected to participate in this review to continue and sustain a significant pro bono workload. In addition, there is considerable concurrent work that will impact on the role of the FEC – the syllabus review is now reaching its conclusion, and the review of the assessment strategy and modelling following the AVOSCE failure in November 2021 will produce change that may impact on the role and structure of FEC and workplace-based training and assessment, as the College considers how workplace-based assessment and centrally administered summative assessment can be better integrated.

There have been significant efforts to increase the trainee input into the program over recent years, and a proposal from the TRC for its structural reform is discussed in detail in standard 7. The reaccreditation of the FECs during 2021 sought feedback directly from trainees regarding their FEC, a change from previous FEC accreditation practice resulting in a much more robust accreditation process. As FECs are mandatory only for stage 1 and 2 trainees, respondents to the Exit Survey will not have been included in the reaccreditation process and this exercise in trainee feedback will not be reflected in the Exit survey data.

Trainees have been part of the Steering Groups established during 2020 and 2021 to address the emerging implications from COCID-19, to contribute to the implementation and governance of the ACER recommendations, and to provide trainee perspective to the assessment and education related Steering Groups, such as CESG and OSCE Steering Groups that oversaw the development of AVOSCE and Multi-Site OSCEs in 2020-2021.

The decoupling of the Essay style examinations is discussed in detail under standard 5. Again, trainees responding to the Exit Survey in 2020 and 2021 will have sat the original Essay style examination rather than the MEQ and CEQ so their feedback will not be reflective of the new format. The role of the CEQ is being considered as part of the overall review of how centrally administered summative assessment can be better integrated with workplace-based assessments. Consultation that took place for the decoupling of the Essay-style examinations in line with the ACER recommendations included consultation with the TRC. The TRC Chair was a member of the ERSG (group set up to oversee the ACER recommendations).

Trainees and SIMG representatives continue to be part of decision making via their membership of the Taskforce to contribute to the AAP implementation and any quality improvement reforms that take place to strengthen the program and/or support the trainees and SIMGs in their assessment journey towards Fellowship.

Medical Training Survey

Has the College investigated results, or is planning to investigate the MTS results, and is making changes based on these investigations?

The RANZCP has investigated the results of each administration of the MTS. The first two surveys made comparisons of the RANZCP results with those of the National response. As the National response included interns, career medical officers, SIMGs and GP registrars it was necessary to undertake significant analysis to extract data to enable valid comparisons with other specialist medical colleges.

The RANZCP, in common with other medical education bodies, was concerned with the widespread reporting of bullying and harassment across the medical sector. These results have been shared with the CFT and it is expected that the revised policy and position statements on member welfare, discussed under standard 7.4.1, will go some way to begin to address these issues. The data for the RANZCP and other Specialist Medical Colleges is compared to the data from the RANZCP Exit survey. Several questions are common to the two surveys but are asked at different points in training. Results are also compared to the previous outcomes, and the CEEMR has agreed that the 2021 MTS outcomes should be the baseline against which further results are monitored and assessed.

DOTs and BTCs are advised of the results for the RANZCP overall and are encouraged to explore the online data repository to review data relevant to their jurisdiction and the health services involved in psychiatry training. The 2022 MTS will provide the first opportunity to report progress against that baseline. In the interim the CEEMR recommended monitoring of several key areas:

- orientation to the workplace, which is an accreditation standard for RANZCP programs
- assessments
- supervision – in 2020 CEEMR noted a positive perception of the quality of supervision with 86% of trainees rating their supervision as excellent or good and agreed that this should be the baseline for future comparisons
- access to teaching and opportunities for development. – CEEMR noted that job responsibilities were cited as getting in the way of training and this may be a proxy measure for excessive workload
- workplace environment and culture, with a higher-than-expected reporting of bullying and harassment
- overall satisfaction – 82% of RANZCP respondents endorsing their training position and 77% endorsing their workplace
- interest in psychiatry as a career option – this should be monitored against other specialist medical colleges with PGY1 entry.

Whilst the 2021 MTS analysis has been undertaken the approvals and reporting process is not final and the report is not yet published.

Has the College explored results with internal and external stakeholders?

The results of the 2019 and 2020 MTS have been shared with the EC and its relevant constituent committees, which include trainees. Some results of the 2021 MTS, and their comparisons to the RANZCP Exit survey, have been shared with the Fellowship through the publication of a poster at the RANZCP Congress (Appendix 6.3.2_2).

Now that the survey is becoming more established, with increased respondents, the emergence of trends will be explored further. Results by jurisdiction will be made available to accreditation panels to inform their assessment of training zones’ performance against the RANZCP accreditation standards.

The results of future surveys, and trends over time, along with the comparison to the RANZCP Exit survey, will continue to be reported to the EC and the MEC for discussion and identification of any actions that should be taken. It is expected that the publication of the 2022 MTS will enable this to occur with more efficacy in 2023.

Standard 6: Documents provided check list

	Document
√	The education provider's evaluation plan/strategy. Appendix 6.1.1_1 CEEMR regulations Appendix 6.1.1_2 Draft – RANZCP Evaluation and Monitoring Framework
√	Reports of recent reviews of the curriculum and/or sections of the program. Appendix 5.1.1 ACER RANZCP Examination review Appendix 5.4.1_1 ACER review implementation plan
√	Results of recent surveys of trainees and fellows. Trainee exit survey report | RANZCP
√	Examples of communications to stakeholders about recent plans for program changes. Appendix 6.4_1 CPD Newsletter sample Appendix 6.4_2 President's Update sample Appendix 6.4_3 Communique sample
√	Risk management plan/matrix for training and education. Appendix 6.2.1_1 Education and Training Risk Management register policy Appendix 6.2.1_2 Risk Matrix

Standard 7: Issues related to trainees

Standard 7: Issues relating to trainees

7.1 Admission policy and selection

7.1.1 The education provider has clear, documented selection policies and principles that can be implemented and sustained in practice. The policies and principles support merit-based selection, can be consistently applied and prevent discrimination and bias.

The selection of trainees takes place at the training program level by the College's BTCs.

The RANZCP has continued with a local BTC led process which provides the capacity for the applicant to determine which jurisdictions in which they wish to make an application, and also enables local programs to have direct involvement into the selection of candidates. Additionally, the RANZCP understands that each jurisdiction has its own local requirements, be that complying with National laws, the need for joint employment and College interviews, or instances where the local training program is solely responsible for recruitment. This process, led at the jurisdictional level by the BTCs allows for flexibility while utilising a standard selection process.

The selection process follows a standardised RANZCP selection protocol:

- the selection process is coordinated by a local BTC
- applicants first contact the local BTC to establish the availability of appropriate positions and obtain an application pack before contacting College Staff. Application packages are obtained from the relevant State/Territory Training Office or NZ Branch Office
- before qualifying for an interview, applicants must meet the essential criteria of:
    - o satisfactory completion of at least one post graduate year (1 FTE) of general medical training after completing their primary medical qualification
    - o evidence of good standing and eligibility for registration with the MBA or the MCNZ. This is checked by the Chair of the Selection Committee.
- a Selection Committee is convened locally, informed about the selection process, and the criteria described in Table 7.1.1 below. These panels aim to have a mix of personnel, including a trainee representative and often have an advisor with Human Resources (HR) experience and a consumer representative. Panel participants are members of BTC, local Training Program Committee and/or employing health service personnel. Consideration is given to gender balance on the panel and in New Zealand at times a local cultural representative may be included at the request of a Māori applicant.

Table 7.1.1. Selection criteria

Slection criteria	
Academic performance	Understanding of psychological factors in medicine and psychiatry
Employment history	Interpersonal and communication skills
Competence in general medicine	Information and communications technology (ICT) skills
Experience working as a doctor in a psychiatric setting	Other useful experiences and skills
Ability to work in teams	Professional conduct

The selection criteria in Table 7.1.1 are assessed within the applicant's written application and Curriculum Vitae (CV), referee reports, candidate statement and interview. In addition to these criteria, favourable consideration is given to those applicants who can document the following experiences:

- work with disadvantaged groups
- work with people from other cultures and Indigenous people
- work in rural areas
- skills in languages other than English.

The set criteria are applied to each applicant as they progress through the application process.

To be registered as an Associate of the RANZCP (trainee), the applicant must be accepted onto the training program, and they must also secure an accredited training position. The assessment of an applicant's suitability for training is within the purview of the College, while an applicant's suitability to perform a particular job is assessed by the employer. It is the applicant's responsibility to secure an appropriate training post however efforts are made by each BTC to facilitate placements of trainees.

Selection Panels must comply with any jurisdictional requirements in addition to the RANZCP requirements. Representatives of the local health services may be in attendance in joint RANZCP and employer interviews which are conducted in some jurisdictions.

There are essentially two models adopted – one in which the Selection Panel is linked with employing services so that selection and employment decisions are integrated and one in which there is a two-stage process of separate interviews with the employer and the RANZCP. An offer of employment by a health service does not mean an automatic entry to the RANZCP Fellowship program – a specific RANZCP selection interview is always required, either in conjunction with the employer in the initial phase, or as a separate interview.

An emerging area for consideration by the RANZCP is the forthcoming revised AMC National Framework for Prevocational Medical Training (NFPMT). Trainees may currently enter the Fellowship Program at the end of their first post graduate year (PGY1), at the point they have been granted general registration. Under the proposed NFPMT there will be challenges for this continued practice. Both the NFPMT and Stage 1 of the Fellowship program have mandatory workplace-based assessments, and these are not interchangeable. How to manage a potentially heavy burden of assessment, coupled with the need to manage two training management systems and wider workforce needs is an area of continued work for the RANZCP. If a satisfactory solution cannot be found the alternative may be to require completion of both PGY1 and PGY2 before application to the RANZCP Fellowship. This has been the outcome in New Zealand where junior doctors have a two-year prevocational program, despite the current selection processes permitting admission at the end of PGY1.

7.1.2 The processes for selection into the specialist medical program:

- use the published criteria and weightings (if relevant) based on the education provider's selection principles
- are evaluated with respect to validity, reliability and feasibility
- are transparent, rigorous and fair
- are capable of standing up to external scrutiny
- include a process for formal review of decisions in relation to selection which is outlined to candidates prior to the selection process.

Information regarding the selection process and appeals mechanisms are available via the College website; detailed information is available via the Registration for Entry into Training page.

As the selection process is administered by each BTC/NZTC detailed information regarding the local processes (how to submit an application, interview scheduling, employment requirements etc.) is provided by the BTC/NZTC. Applicants are advised and provided with the BTC/NZTC contacts via the website at Selection of trainees | RANZCP.

An example of a local training program's selection information is provided for the Queensland program.

The RANZCP Program Accreditation standards, specifically standard 3.1.2, requires that selection is based on the published selection criteria and conforms with the process outlined in the Registration for Entry into Training regulation and this ensures that the process is transparent and fair.

If an application to join the Fellowship program is unsuccessful, an applicant can request an appeal of the decision through the formal RANZCP Appeals Process. The applicant must write to the CEO within three months of being advised they have been unsuccessful requesting reconsideration. Applicants can access this information at any time via the Registration policy and procedure.

Unsuccessful applicants are informed of their rights to request reviews of decisions affecting them at time of notification of an unsuccessful outcome.

7.1.3 The education provider supports increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees.

The RANZCP actively monitors the recruitment rates of Aboriginal and Torres Strait Islander and Māori trainees noting a continued increase in trainees identifying as having Indigenous heritage.

A key strategy to support increased interest in psychiatry as a career option to Indigenous medical students and early career doctors is the Psychiatry Interest Forum (PIF). As of April 2022, 100 of the 3956 active PIF members identified as Aboriginal and/or Torres Strait Islander. Of the 1263 PIF members who have entered the Fellowship program since 2014, 32 (2.5%) identify as Aboriginal and/or Torres Strait Islander.

The PIF employs a range of strategies to promote careers in psychiatry to Indigenous medical students and early career doctors. These include:

- partnering with AIDA, sponsorship for Aboriginal and Torres Strait Islander PIF members to attend the annual RANZCP congress (five sponsorships in 2022)
- travel scholarships for Aboriginal and Torres Strait Islander PIF members to attend Australian Medical Students' Association (AMSA) events
- sponsorship for attendance at the AIDA conference
- supported by STP funding, the delivery of a short course – "Explore the Aspects of Psychiatry" – at the AIDA conference
- inclusion of a current RANZCP Fellow or Trainee who identifies as Aboriginal and/or Torres Strait Islander as a speaker at all Introduction to Psychiatry short courses, and in profiles in the A Day in the Life of a Psychiatrist article series
- selecting the topic of 'Cultural intelligence: how can seeing the world through Indigenous eyes help with improving health outcomes' for the most recent PIF Essay Competition (2021)
- working with university stakeholders to encourage medical students who are PIF members and identify as Aboriginal and/or Torres Strait Islander to participate in the forthcoming PIF pilot mentoring program.

New Zealand medical students and doctors are eligible to join the PIF but due to current funding arrangements can only participate in a limited way and are unable to access the majority of PIF program benefits. The RANZCP is internally funding a very small number of New Zealand members to participate in select aspects of the PIF program. In 2020, the RANZCP hosted 17 medical students at its annual New Zealand National Conference held in Napier. Of the 17 invited to the Conference, RANZCP also offered a full scholarship to one Māori medical student.

Work is being undertaken to expand the PIF program to New Zealand medical students and junior doctors, which will begin in 2022. Some of the new activities specific to New Zealand will include:

- specific opportunities for Māori and Pasifika medical students to engage with and be mentored by Māori and Pasifika psychiatrists including engagement with Te Ora
- opportunities for medical students and RMOs to attend and present at conferences and other educational events held in New Zealand, especially those that focus on Māori and/or Pasifika health and wellbeing
- a three-day event program for up to 20 New Zealand PIF members as part of the annual RANZCP New Zealand National Conference, including:
    - o scholarship opportunities to attend, including funded conference registration and travel grants,
    - o RANZCP trainees assigned as 'mentors' to small groups to provide guidance,
    - o an orientation session with a New Zealand member of the PIF Advisory Group,
    - o RANZCP training program Q&A and networking session.

The RANZCP will also seek to partner with key relevant organisations and further engage with the New Zealand Medical Students' Association (NZMSA) as well as the New Zealand Medical Students' Journal (NZMSJ).

A goal of the RANZCP is to reach a 3% target of Māori doctors participating in the PIF Program within the next three years moving towards 5% in following years.

In December 2019, the RANZCP introduced a financial support initiative to encourage the retention of Aboriginal, Torres Strait Islander and Māori psychiatry trainees. Through this initiative RANZCP provides financial support to Aboriginal, Torres Strait Islander and Māori RANZCP trainees. The financial support is provided to assist with the costs of specialist training, participation in RANZCP Congress and conferences, and other activities associated with the achievement of Fellowship. A maximum amount of $6000 AUD is available to each applicant in any one calendar year. This may be a pro-rata amount for those training at less than 1.0 FTE. This initiative is fully funded by the RANZCP. Table 7.1.3 below shows the distribution of financial support 2020 – 2022, noting that applications are still being received for 2022.

Table 7.1.3_1. Indigenous Financial Support Initiatives

Year		Total No. Applicants	Total No. Applications	Applications Awarded	$ Awarded	Total
2020	Aboriginal and Torres Strait Islander Trainees	9	14	11	20,313.21	25,705.82
	Māori	6	12	5	5,392.61	
2021	Aboriginal and Torres Strait Islander Trainees	11	27	22	28,709.00	32,933.00
	Māori	5	9	5	4,224.00	
2022	Aboriginal and Torres Strait Islander Trainees	9	10	4	10,150.00	10,150.00

In addition, through the STP support projects funding stream, grants were available to support reasonable costs associated with the 2021 mentoring program, and examination preparation grants of up to $3000 were available to access an examination preparation program.

The College also hosts two forums per year for Aboriginal and Torres Strait Islander trainees. The Trainee Forums provide an opportunity for the RANZCP to gain input directly from trainees on how to better attract and support its Aboriginal and Torres Strait Islander workforce in psychiatry. The forum also provides trainees with the opportunity to connect with other trainees, discuss training challenges and potential solutions.

The first Trainee Forum was convened in 2017 by the RANZCP Aboriginal and Torres Strait Islander Mental Health Committee. Following the success of this initial event, funding was secured as part of the STP support project.

An equivalent opportunity, provided to Māori trainees through Te Kaunihera, is discussed under standard 1 of this submission.

The College also assists in advocacy for trainees to attend these events with their employers recognising the difficulties that trainees can face in accessing time to attend such activities.

Provide information on the number of trainees entering the training program(s) in each of the last three years.

As requested by the AMC, information is provided on the number of Aboriginal and Torres Strait Islander and Māori trainees. It is not possible to provide with any accuracy the number of Indigenous applicants, as in most cases this information is not provided to the selection panel. The RANZCP does not know if an individual identifies as Aboriginal and/or Torres Strait Islander, or Māori, until they choose to identify at the time of registration with the College.

Table 7.1.3_2. Number of Aboriginal and Torres Strait Islander applicants

	Applied		Interviewed		Entered	
	AUS	NZ	AUS	NZ	AUS	NZ
Cohort 2019	-	-	-	-	6	-
Cohort 2020	-	-	-	-	5	-
Cohort 2021	-	-	-	-	3	-

Table 7.1.3_3. Number of Māori applicants

	Applied		Interviewed		Entered	
	AUS	NZ	AUS	NZ	AUS	NZ
Cohort 2019	-	-	-	-	-	6
Cohort 2020	-	-	-	-	-	1
Cohort 2021	-	-	-	-	-	9

7.1.4 The education provider publishes the mandatory requirements of the specialist medical program, such as periods of rural training, and/or for rotation through a range of training sites so that trainees are aware of these requirements prior to selection. The criteria and process for seeking exemption from such requirements are made clear.

In Stage 2, the College mandates a six month training experience in both Child and Adolescent and Consultation-Liaison experiences which are both outlined on the College website (About the training program | RANZCP).

This is in addition to the mandatory 12 months of adult psychiatry experience required in Stage 1, which must include at least six months in an acute adult psychiatry setting.

The College does not mandate a rural experience, nor does it require trainees to work across multiple training sites. The mandatory experiences may require a trainee to move services to access this experience and in some regional and rural settings may require relocation. This is advised to trainees at the time of selection.

7.1.5 The education provider monitors the consistent application of selection policies across training sites and/or regions.

As outlined under 7.1.1, selection processes are conducted at the Branch Training level using a standard RANZCP interview pro forma. The BTCs and NZTC report every six months to the CFT on any issues relating to selection and actions can be taken dependant on the issue. In some cases, the action will be very local. For example, in 2021 there were significantly more suitable applicants for training in Victoria than there were training positions and the Victorian Branch has negotiated successfully with the Victorian Department of Health for increased training positions.

The RANZCP has increased the number of new trainees entering the program during the last three years (see Tables 7.1.5_1 to 7.1.5_3). Females represent more than 50% of RANZCP trainees entering in the Fellowship Program in the period 2019-2021.

The number of Aboriginal and Torres Strait Islander and Māori trainees entering the program continues to grow. Twelve trainees identifying as Indigenous entered the 2019 cohort, 6 in 2020 and 11 in 2021. The current number of Indigenous trainees is 59, with an additional 7 identifying as Pasifika.

To maintain confidentiality, statistics relating to the number of Aboriginal and Torres Strait Islander and Māori are not reported by jurisdiction. This number may be under-represented as it relies on self-identification by trainees of their Indigenous heritage.

During 2021 the information systems used by the RANZCP were modified to include options for gender identification beyond the binary male/female choice. Currently one trainee, entering the program in 2020 identified as non-binary/ gender diverse. To maintain confidentiality, statistics relating to the number of non-binary / gender diverse trainees is not reported by jurisdiction.

Psychiatry has been determined as being a workforce shortage area and, through the work of programs such as the PIF, is actively working to increase the number of trainees accepted to the program with the aim to increase the number of graduates. The College will accept as many suitable applicants as it can possibly accommodate with the number of accredited training positions.

The number of trainees joining the program has continued to increase, with 2021 accepting the largest number of trainees on record with 369 applicants joining the program. The increased number of applicants has resulted in a more competitive application process and has required more BTCs/NZTC to implement short listing processes with only selected applicants progressing to an interview.

It is recognised that increased training numbers has an impact on the DOT resources required to manage the program locally. This is monitored via the program accreditation standards.

Additionally, the increased numbers of trainees in the program have an impact on the number of trainees accessing examinations. Whilst the increased numbers are currently being accommodated by the existing examiner and assessor cohort, further increases will present challenges with securing enough examiners and assessors.

A strength of the current selection process is its ability to ensure that local employment and health service requirements are met. However, there are challenges with this system particularly when an applicant is applying to more than one jurisdiction. Not only are multiple applications required, but there is also limited capacity for jurisdictions to share information regarding an applicant and the College has limited central data on the total number of applicants to the Fellowship Program.

Table 7.1.5_1. Number of trainees entering Fellowship Program in 2019

Number of trainees entering Fellowship Program										
Gender	**ACT**	**QLD**	**NSW**	**NT**	**SA**	**TAS**	**VIC**	**WA**	**NZ**	**Total**
Man	2	30	45	3	9	2	22	9	13	135
Non-binary / gender diverse					-					-
Woman	7	30	32	2	10	1	50	10	18	160
Total	**9**	**60**	**77**	**5**	**19**	**3**	**72**	**19**	**31**	**295**
Total number of Indigenous trainees entering in the Fellowship training program					Aboriginal and Torres Strait Islander					6
					Maori					6

Table 7.1.5_2. Number of trainees entering Fellowship Program in 2020

Number of trainees entering Fellowship Program										
Gender	**ACT**	**QLD**	**NSW**	**NT**	**SA**	**TAS**	**VIC**	**WA**	**NZ**	**Total**
Man	1	40	50	5	10	2	34	6	21	169
Non-binary / gender diverse					1					1
Woman	3	38	61	6	11	3	32	11	26	191
Total	**4**	**78**	**111**	**11**	**21**	**5**	**66**	**17**	**47**	**361**
Total number of Indigenous trainees entering in the Fellowship training program					Aboriginal and Torres Strait Islander					5
					Maori					1

Table 7.1.5_3. Number of trainees entering Fellowship Program in 2021

Number of trainees entering Fellowship Program										
Gender	**ACT**	**QLD**	**NSW**	**NT**	**SA**	**TAS**	**VIC**	**WA**	**NZ**	**Total**
Man	3	35	36	3	8	4	32	7	26	154
Non-binary / gender diverse					-					-
Woman	3	39	60	2	11	2	42	11	23	193
Total	**6**	**74**	**96**	**5**	**19**	**6**	**74**	**18**	**49**	**347**
Total number of Indigenous trainees entering in the Fellowship training program					Aboriginal and Torres Strait Islander					3
					Maori					9

7.2 Trainee participation in education provider governance

7.1.2 The education provider has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

The AMC has noted some concerns with the degree to which trainees are involved in the governance of their training. The College acknowledges the resignations of a significant number of Trainee representatives following the November 2021 OSCE. The RANZCP has identified that trainee engagement is an area of priority and improvement.

The TRC as it is currently structured reports directly to the RANZCP Board and its membership comprises:

- a Chair (or Co-Chairs)
- a Chair-elect
- a secretary
- ten jurisdictional members (one trainee employed in each Australian state and territory and two trainees employed in New Zealand)
- six non-jurisdictional positions, of whom two should be Stage 1 or Stage 2 trainees.

There is a call for nominations early in each year and trainees can nominate to be either a jurisdictional or non-jurisdictional member. For jurisdictional members when the number of nominations exceeds the number of positions there is a vote by ballot of the Trainees residing in that jurisdiction. This process is overseen by the RANZCP Governance Officer. When the number of nominations exceeds the number of non-jurisdictional positions the outgoing TRC considers the appointments. The TRC regulations are provided as Appendix 7.2.1 to this submission.

The TRC is fully supported and funded by the RANZCP with secretariat provided by the Bi-National Offices and Partnerships Department. The TRC typically meets seven times each year, with two face-to-face meetings held in Melbourne and immediately prior to Congress in pre-COVID-19 times. Support is provided to TRC members for travel and accommodation expenses for these meetings, as well as support to attend trainee forums held by the AMA, the CPMC and the CMC in New Zealand. Mechanisms for communication with trainees include:

- Training and assessment newsletter
- direct email to trainees
- Facebook groups.

Jurisdictional representatives on the TRC represent trainees on the following committees:

- Branch Committees/New Zealand National Committee
- BTC/NZTC
- Tasmania STP Project Working Group (note this position is held by the Tasmanian Jurisdictional Member).

Non jurisdictional representatives on the TRC represent trainees on the following committees:

- Board constituent committees: CGRC, EC, MEC and PPPC
- EC constituent committees: AC, CEEMR, CFE, and CFT
- Education steering groups set up by the Board for specific purposes such as the AVOSCE, the MSOSCE and the ERSG for the ACER review.

Trainees on these committees are full members with voting rights and can raise items for inclusion on the agenda if they wish.

Two important developments have occurred in the first half of 2022. May 2022 saw the appointment of a trainee to the Board of the RANZCP as an appointed Director, with full voting rights. Dr Pramudie Gunaratne is the first appointed Director, Trainee. The process undertaken was in line with established Board appointment processes. The College continues to explore how to further engage with the wider trainee cohort.

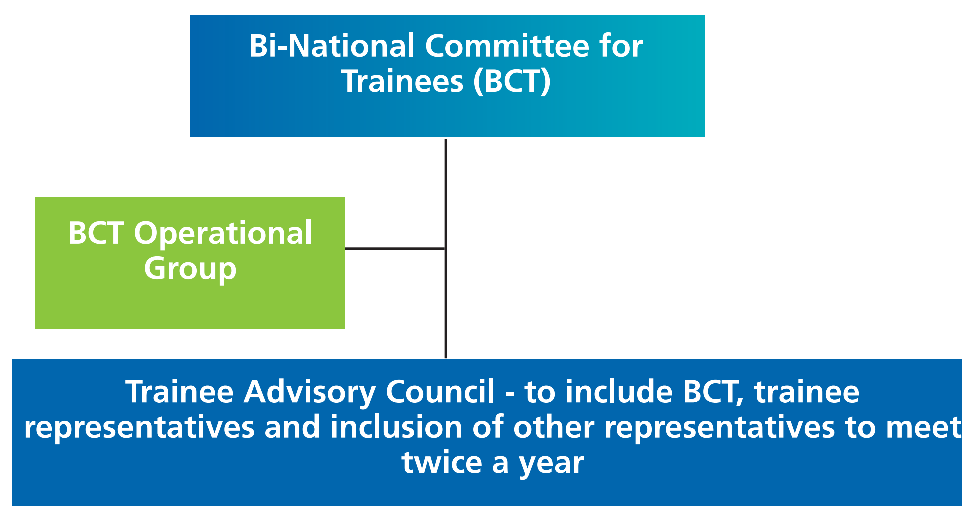
The RANZCP is now considering Constitutional change and the provision of voting rights to trainees and SIMGS. A survey of the Fellowship has been developed to understand the wider thoughts of the Fellowship and inform any necessary advocacy.

The second development was the in-principle approval of the RANZCP Board for structural reform of the TRC. This reform includes a proposed name change to the Bi-national Committee for Trainees (BCT), a series of governance changes to support and enhance engagement with the trainee body, and the reframing of responsibilities to include amongst other things the provision of:

- a forum for discussion between trainees at all levels, and from all Australian States and Territories and New Zealand, to identify concerns that might impact on their training and assessment, wellbeing and engagement with the RANZCP
- enhancement of the role of advocacy and enhancement for trainee voice to be heard and considered through all levels of decision making including Constitutional change.
- assistance in the dissemination of information from the RANZCP to trainees, in consultation with relevant groups and individuals, as appropriate.
- development of initiatives in the fields of training, assessment, examination, ethics, policy, research, and trainee welfare.

Continuing to report directly to the RANZCP Board, the proposed governance structure is illustrated in Figure 7.2.1 below.

Figure 7.2.1 Proposed Bi-national Committee for Trainees governance structure



The RANZCP has sought to engage with the external APTs to further engage with trainees and enhance transparency. Several meetings have been held with members of the Board to ensure there is an avenue of communication. The APTs have been included in the co-design of the AAP, members of the Taskforce, and stakeholder forum to inform the future of assessments within the College.

The Table below provides a summary of RANZCP activities in which trainees have a formal role, along with cross references to other areas of this submission providing further details.

Table 7.2.1_1. RANZCP activities with trainees' formal role

Activity	Standard
Accreditation – program, post and FEC	8
Trainee selection	7
EPA working group	4
Syllabus review working group	3
Alternative Assessment Pathway and Board Taskforce – co-design of alternative assessment	5
Committees	1

Table 7.2.1_2. Activity against conditions

Condition 16				**To be met by: 2022**
Work with trainees to ensure there are effective transparent mechanisms for trainees to be regularly engaged in the governance of their training (Standard 7.2.1)				
Finding	Unsatisfactory	Not progressing	Progressing	Satisfied and closed
AMC commentary in 2021				
Evidence of progress in addressing this condition to be reported to the Specialist Education Accreditation Committee by March 2022 and the College to provide evidence it has satisfied this condition in its 2022 reaccreditation assessment.				
Response to the AMC commentary				

The RANZCP has taken steps to ensure effective and transparent mechanisms for trainees to be regularly engaged in the governance of their training.

In May 2022, following a call for nominations and interview process, Dr Pramudie Gunaratne is the first Appointed Director, Trainee appointed with full voting rights to the RANZCP Board.

In April 2022 the RANZCP Board gave in-principle agreement to structural reform of the current TRC. This is described in detail under standard 7.2.1 and the proposed structure provides a framework for consultation that is like that employed for the Fellowship (i.e the Members Advisory Council)

Other more practical steps have included:

- prioritising TRC representation on agendas
- inclusion of trainees and SIMGs in the Board Taskforce for the co-design of the AAP
- consultation with APTs on various issues
- review of the style and frequency of communiques to trainees relating to assessments
- utilising the TRC in the design of surveys for the FEC accreditation process
- weekly updates from the Chair of the EC providing detail on the progress of the portfolio and CbD components of the AAP, including the number of completed assessments.

7.3 Communication with trainees

7.3.1 The education provider has mechanisms to inform trainees in a timely manner about the activities of its decision-making structures, in addition to communication from the trainee organisation or trainee representatives.

Trainees have representatives on key College committees and, from May 2022 representation through the appointed Director to the RANZCP Board.

Feedback from meetings is presented to the TRC at the following meeting and placed on the Trainee website for all to access or communicated through newsletters. Key decisions and events such as revised training material are communicated through training newsletters and/or the monthly Psyche bulletin. Any updated links or forms are communicated in a similar manner with a direct email to all Trainees being an option for important messages. DOTs, Supervisors, and branches also provide detailed information regarding College decisions through branch newsletters or other communications such as email dissemination.

Following the November 2021 AVOSCE failure, the RANZCP received very strong feedback that communication with Trainees was opaque, unhelpful, and not timely. In response, the College revised its communication tools and increased its channels of communication through various communiques that provided important assessment information and updates. Simpler and more direct language has been used, and the communiques regarding the AAP are provided weekly for example, and through the Presidents' communique. Examples of the communiques are provided as appendix 7.3.1 to this submission and have been provided to the AMC weekly.

The following initiatives have also been implemented; however, this is the beginning of a body of work to be undertaken by the College. In 2022 the College has:

- hosted multiple virtual information forums with Q&A on alternate assessment pathway
- implement member-led online reflective / support groups for trainees
- Board meetings with Trainees or President, or Board representative meeting with Trainee groups
- introduced a new 'first timers' event at Congress 2022 for all members, including trainees attending Congress for the first time
- ran the 'Welcome Aboard' function for new Fellows, post College Ceremony in 2022.
- delivered speed networking event at Congress 2022
- adapted its communications to be more supportive and encouraging.

Recently at the College's AGM, the Board also publicly apologised for the trauma, hurt and distress caused by the 2021 AV OSCE failure. We are genuinely committed to continuing on our journey of healing and working together to shape the future for our College.

Trainee and SIMG representatives continue to be part of committees and Working Groups associated with the AAP, such as the Board Taskforce and other assessment related Steering/Working Groups such as EPA Review and Assessment Framework Working Groups (as part of the implementation of ACER recommendations). The College has also developed reports for the DOTs in relation to assessment information and results.

In Train, the trainee management system has an "alerts" functionality which can be used to provide short updates that are related to the use of InTrain.

7.3.2 The education provider provides clear and easily accessible information about the specialist medical program(s), costs and requirements, and any proposed changes.

All information regarding the RANZCP Fellowship program, costs and entry requirements can be found on the RANZCP website.

RANZCP fees are communicated to trainees via the College website and also via the provision of annual invoices and exam application documentation. The fee summary can be found at Program administration | RANZCP.

The RANZCP prepares and presents to its members the audited financial reports at the Annual General Meeting (AGM) held each year in May during the annual RANZCP Congress. On an annual basis the RANZCP financial reports are communicated to its members in the Psyche newsletter and published on the RANZCP website. A breakdown of how membership fees are spent is also published at the Program administration | RANZCP webpage.

To note, there have been no increases in College training fees in 2021 or 2022.

The cost to trainees and SIMGs reflects the College as a not-for-profit organisation while ensuring the viability of operations on an ongoing basis.

The RANZCP training fees are compared with other equivalent specialist medical college fees and this benchmarking is communicated to the membership at the AGM. The RANZCP schedule of fees and charges are reviewed annually by the Finance Committee and any increase in fees is kept to a minimum when endorsing the fees for Board approval.

The annual training administration fees cover the management of the RANZCP training program and entitles trainees to a full range of benefits, resources and services to support trainees on the pathway to Fellowship. Membership to the RANZCP Faculties, Sections and Networks are at no cost to Trainees.

Trainees have the option to pay the annual training fee in two equal instalments in March and July each year. Additionally, trainees can request a personalised mutually acceptable payment plan which is assessed and granted on a case-by-case basis.

In 2021, the application for a reduced rate of subscription policy was expanded to include trainees (Appendix 7.3.2). This policy expansion allows trainees who are experiencing financial hardship, a serious medical condition, or other extenuating circumstances the ability to apply for a reduction to their training fees.

The College has recently heard from several members, expressing concern that the part time fee structures for Trainees has an adverse impact on women, mothers or other carers who may be required to undertake part time training. Trainees have requested that there be further flexibility in the application of pro rata fees for part time training. These concerns have been heard, and the College has initiated a review of the part time training fee structures and associated processes which will be undertaken as a priority.

7.3.3 The education provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

The training progression requirements are outlined in the Progression through training Policy and Procedure (Appendix 4.2.4_1).

Trainees can access their progression information at any time via the 'Progression' page on InTrain. InTrain provides trainees with a summary of their progress though each of the key progression points (for example examinations and maximum training time).

The College has a dedicated position, the Training Trajectory Coordinator, who is tasked with providing advice to trainees regarding their progression throughout the program. Additionally, this role contacts trainees who are reaching particular progression points in their trajectory. Trainees are required to complete a Targeted Learning plan (formerly called remediation) after two unsuccessful attempts of an assessment, after one unsuccessful rotation or if they have reached the targeted learning progression point. Trainees are advised of these requirements directly. Additionally, if a trainee reaches the Training Review point, individual correspondence will be provided to advise of this milestone and information regarding the process to be undertaken. The Training Trajectory Coordinator supports the trainee through this process.

The DOTs, or their delegate, also are required to meet with trainees at the end of each rotation to review their most recent training experience, to discuss the next rotation requirements and also to discuss their overall progression within the program.

7.4 Trainee wellbeing

7.4.1 The education provider promotes strategies to enable a supportive learning environment.

The College accreditation standards articulate the responsibility of Fellowship programs to support the health and wellbeing of trainees undergoing training. Each program is required to provide a safe workplace where the workload does not compromise a trainee's welfare (for example, the implementation of fatigue management programs and amenities to work overnight shifts).

Training programs are also required to monitor training morale within the program and make efforts to address these matters if concerns are identified.

Each program is also required to provide trainees with access to support, including access to an Employee Assistance Program (EAP) and access to mentoring. Mentoring may take place formally through the RANZCP mentoring program mentioned under standard 8.1.1, or informally at the local program level.

The Fellowship program also provides the capacity for trainees to take up to six weeks of leave in a 6-month FTE rotation should they experience ill health, without impacting the accreditation of their training time. Additional flexibilities have been provided for those trainees who have been impacted by COVID-19. Trainees are also encouraged to apply for extensions to their personal training trajectories to provide additional time to complete training requirements should this support their health and wellbeing.

In 2022, trainees can apply for reduced subscription fees, in addition to payment instalment plans, should they be experiencing ill health, financial stress, or have responsibilities as a carer.

A member who is facing personal or health issues has a range of confidential options, resources and supports available through the RANZCP member wellbeing support hub. Designed with members, the hub helps members experiencing distress navigate to the right starting point for assistance.

The College provides the Member Welfare Support Line, a dedicated and confidential service provided to all College members. This service is regularly advertised to trainees in College correspondence, through the College website and via a direct link through InTrain. A trainee accessing this service is provided with support regarding concerns that may involve an escalation to a College Fellow for support, a relevant Committee member, or College staff member.

Trainees are also able to make applications to the relevant Education Committees regarding matters of complaint in relation to their training requirements at any point during their training. A discussion regarding these matters takes place to establish if the matter requires confidential consideration.

The RANZCP considers that engaging in discrimination, bullying and harassment is a professional ethical issue, as reflected in the RANZCP's Code of Ethics. The Code of Ethics requires that psychiatrists 'uphold the integrity of the medical profession', which includes promoting 'a professional environment with an ethos characterised by mutual respect, and free of discrimination, bullying and sexual harassment'.

The RANZCP understands that experiencing discrimination, bullying and harassment can result in stress and affect a psychiatrist's or trainee's wellbeing and work life. Additionally, many experiences of discrimination, bullying and harassment are impacted by a power imbalance between the individuals involved which can add to the stress experienced.

Seeking to address issues relating to discrimination, bullying or harassment can be impacted by concerns around the complaint's possible consequences, such as impacts on employment, trainee status or future involvement with the RANZCP.

The RANZCP endeavours to ensure that making a complaint about discrimination, bullying and harassment will not unfairly disadvantage any person in their association with the RANZCP and can offer support and information throughout any complaints process.

The RANZCP has published the revised Discrimination, Bullying and Harassment Policy, in August 2021. This policy is provided as an Appendix 7.4.1 to this submission.

The RANZCP also participates in MBA and CPMC sessions relating to the broader issue of doctors health and wellbeing.

7.4.2 The education provider collaborates with other stakeholders, especially employers, to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training. It publishes information on the services available.

The College may learn of trainees experiencing personal or professional difficulties through several channels, for example:

- scheduled discussions with a DOT
- applications to the Education Committees
- through break in training applications
- feedback on end of rotation ITAs
- applications for fee reductions
- the Member Welfare Line.

The College aims to support trainees in relation to their circumstances, with DOTs being key in providing individual support to trainees in the first instance. This may include confidential discussions, providing support for employment-related matters or assisting to facilitate pauses/breaks in training.

(Additional criteria NZ) Comment how the RANZCP ensures a culturally-safe environment for all trainees, including those who identify as Māori.

The incorporation of culturally safe practice throughout the Fellowship program and the workplaces in which education and training are delivered is an ongoing challenge that is the subject of considerable discussion at present within the RANZCP.

As discussed under standard 2, Te Kaunihera is exploring the use of the Takarangi framework for cultural safety training in the mental health and addictions sector, with an intention that all trainees, Fellows, and Affiliates in New Zealand would participate. In addition, the RANZCP is participating in the consultation being undertaken by the CMC in the development of a cultural safety framework for medical practitioners.

The RANZCP recognises that cultural safety is an important concept that cannot be addressed simply by requiring members to complete a set of e-learning modules. The concept is focused not on knowledge, but on behaviours and attitudes, and this is work that will evolve over time. In the meantime, the supervision policy provided in Appendix 7.4.2 includes a requirement for supervision to be provided in a culturally safe manner.

(Additional criteria NZ) Comment how the RANZCP recognise that trainees who identify as Māori may have additional cultural obligations and has flexible processes to enable those obligations to be met.

Whilst there are not specific clauses dictating arrangements for ensuring the cultural obligations of Indigenous trainees are met, there is flexibility with leave provisions. As the responsibility for approval of leave from the workplace rests with the employer, it is difficult for the RANZCP to directly ensure that cultural obligations are met.

Te Kaunihera is a key support for Māori trainees, providing cultural supervision opportunities, along with access to the wisdom and experience of the RANZCP's Kaumātua Ms Moe Milne.

The College is developing a position statement on Trainee and Psychiatrist Well-being and Safety due in early 2022. Comment on this and how the College will respond to it should be included in the 2022 reaccreditation submission.

Position statement 48 Safety and wellbeing of psychiatrists and those in psychiatry training has been drafted and is underwent consultation during the first quarter of 2022. Feedback from that consultation has been incorporated and the revised draft is being considered by the MEC in June. The next steps, if the revised position statement is approved by the MEC, will be consideration by the CGRC before proceeding to the Board for approval.

7.5 Resolution of training problems and disputes

7.5.1 The education provider supports trainees in addressing problems with training supervision and requirements, and other professional issues. The education provider's processes are transparent and timely, and safe and confidential for trainees.

Trainees can raise concerns regarding their training and supervision at any point during their training pathway either through the local DOT or BTC, the trainee network, or through the College head office.

Each training program is required to have a system in place to collect feedback from trainees regarding supervisors' performance which provides the opportunity to identify concerns or trends for consideration and resolution where appropriate. For example, a local program may conduct a survey of trainees at the end of each six-month rotation.

Trainees are required to complete feedback on the end of rotation ITA regarding their training experiences, including commenting on matters such as access to supervision and protected education time. Additionally, trainees can challenge feedback provided by their supervisor and matters are escalated to the CFT for review in the first instance.

Trainees are also provided with the opportunity to meet with their DOT at least once during a six-month period where concerns regarding their training or supervision can be raised for consideration.

All College members are provided access to the Member Welfare Support Line which is a confidential service which can provide advice to trainees on matters which may include problems with training and dealing with complaints.

In the event of alleged bullying or harassment, the Discrimination, Bullying and Harassment Policy published on the RANZCP website should be followed.

7.5.2 The education provider has clear impartial pathways for timely resolution of professional and/or training-related disputes between trainees and supervisors or trainees and the education provider.

The resolution of professional and/or training-related disputes between trainees and supervisors, or trainees and the College always starts from the perspective of seeking to resolve the issue at the most local level possible. So, if there is an issue between a trainee and a supervisor the local coordinator of training at the employing health service would be the first to attempt to mediate a solution. If a local resolution is not possible concerns related to training and education are escalated to the DOT and BTC for resolution and from there to the CFT if there is not a solution.

This can be complicated by local industrial considerations and the responsibility of the local employing service to manage the behaviour of their staff. The RANZCP has little influence in the local employment arrangements, and its actions are limited to its scope. For example, if a supervisor is behaving poorly the RANZCP's sanctions are limited to removal of accreditation as a supervisor, and referral to the Professional Practice Committee, neither of which may have the desired effect.

Standard 7: Documents provided check list

	Document
√	Policy and criteria on selection into training Selection of trainees | RANZCP REG – Registration for entry to the Training Program (ranzcp.org) POL PROC – Registration (ranzcp.org) REG – Credit for Training (ranzcp.org) Procedure – Admission to Fellowship (ranzcp.org)
√	The policy and strategies relating to the recruitment of Aboriginal and Torres Strait Islander trainees of Australia and/or Māori trainees of New Zealand, including numbers of such trainees recruited. Information available to prospective trainees on: • The training places available. • Any quotas and other limits, such as the number of training positions. • Location of training, including periods of mandatory experience. Selection of trainees | RANZCP REG – Registration for entry to the Training Program (ranzcp.org) POL PROC – Registration (ranzcp.org) REG – Credit for Training (ranzcp.org) Procedure – Admission to Fellowship (ranzcp.org)
√	The policy or statement of principles concerning engagement with trainees and/or statement of rights and responsibilities of trainees. Regulations, policies & procedures | RANZCP
√	Policies to support trainees in fee distress Wellbeing support for members | RANZCP Wellbeing during COVID-19 | RANZCP
√	Policies relating to a supportive learning environment such as policies addressing bullying, discrimination and sexual harassment and poor supervision. Discrimination Bullying and Harassment Policy (ranzcp.org)
√	The policy relating to formal dispute resolution in the event complaints are not satisfactorily resolved. Training program documents | RANZCP

Standard 8: Implementing the program – delivery of education and accreditation of training sites

Standard 8: Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and education roles

8.1.1 The education provider ensures that there is an effective system of clinical supervision to support trainees to achieve the program and graduate outcomes.

All RANZCP trainees are undertaking training and practising Psychiatry under supervision with an effective system for performance evaluation and formative and summative assessments in the workplace.

The hours of supervision required for trainees are described in the supervision policy (Appendix 7.4.2):

- a minimum of four hours per week over a minimum of 20 weeks per six-month rotation for full-time trainees.
    - o a minimum of one hour per week must be individual supervision provided by the principal supervisor
    - o for stage one trainees at least one of the remaining three hours must be conducted as close supervision outside of ward rounds and case review meetings
    - o for trainees in stage two and three, the remaining three hours can be conducted individually or as a group

Principal supervisors must not have more than two trainees under their supervision at any one time. A trainee's principal supervisor must be working in the same clinical setting at the same time as the trainee for at least 0.3 FTE, to allow for an interactive and responsive oversight of competency development and performance in training.

This ratio is set to ensure the capacity to meet all supervision requirements.

Standards relating to supervision exist in both the program accreditation standards and the post accreditation standards, discussed in detail under standard 8.2. Ensuring that supervision meets the minimum hours as specified in the supervision policy is a particular focus of accreditation assessments, along with ensuring that there is always a clear line of responsibility for the clinical oversight of trainees' work. Accreditation may be removed from posts that do not meet the accreditation standards.

All supervisors undergo training, discussed under standard 8.1.3.

In addition, the role of the DOT provides oversight of all trainees within the training zone. DOTs meet with trainees at least once per six-month rotation and, as part of this discussion, monitor compliance with the supervision requirements.

Table 8.1.1_1 details the number of supervisors by jurisdiction / country in 2022. Data on supervisors is held in InTrain and historical data is not available. Modification to InTrain to provide improved data for the support of supervisors will be considered as part of the supervisor support project referred to under standard 4 of this submission.

Table 8.1.1_1. Number of supervisors by jurisdiction/country in 2022

	ACT	NSW	NT	QLD	SA	TAS	WA	VIC	NZ	Total
2022	75	1162	54	647	268	69	324	1091	464	4154

The RANZCP Mentoring program, first implemented through STP project funding in 2014, is available to all trainees and early career psychiatrists in their first three years post-Fellowship to participate in a facilitated 8-month mentoring program specifically designed to match and pair them with suitably experienced College Fellows and Affiliate members.

The program provides eligible trainees and early career psychiatrists with access to confidential, non-supervisory support from another, more experienced psychiatrist. It offers support, and professional inclusion, access to a collegiate network, and professional guidance towards achieving long-term career goals.

All participants receive:

- an 8-month structured and supported program from the College
- facilitated pairing and introductions
- the option to participate in an introductory welcome dinner event or webinar
- dedicated training resources and information on setting up mentoring partnerships for success
- advice and support from the College where needed
- the opportunity to participate in an evaluation and continuous improvement process
- the chance to expand networks and build lifelong networks and partnerships.

8.1.2 The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the specialist medical program and the responsibilities of the education provider to these practitioners. It communicates its program and graduate outcomes to these practitioners.

The responsibilities of the supervisor are articulated in the supervision policy (Appendix 7.4.2) and are communicated to supervisors at their initial accreditation training and the mandatory refresher training. Initial training, and refresher workshops, are provided by each BTC/NZTC. The course content includes the program outcomes and expected graduate outcomes, including the developmental descriptors which describe the performance level expected of trainees at each stage of training.

The supervision policy and procedures outline the following as the responsibilities of supervisors:

- reviewing the training requirements and objectives for a rotation with the trainee at the beginning of the rotation
- providing formative feedback on the trainee's progress, including towards the training objectives at the midpoint of each rotation on the mid-rotation ITA form (or earlier, and, where necessary, at later points during the rotation), which will be used to identify the trainee's strengths and weaknesses and their progress toward the training objectives of the rotation
- assessing WBAs and entrusting EPAs
- completing an end of rotation ITA at the end of the trainee's rotation, which must take into account the trainee's progress on the relevant training objectives, the areas identified in the mid-rotation ITA and further developments of the trainee's competence
- creating a suitable learning environment for the trainee under their supervision
- ensuring a wide range of opportunities are available to the trainee to develop their clinical skills
- being aware of the patients under the clinical care of the trainee
- enabling trainees to observe them conducting diagnostic and therapeutic interviews, with discussion about the interview style and the opportunity to reflect on any clinical and management issues raised
- observing the trainee conducting interviews, some of which may be undertaken during supervision time. Interview observation during supervision time can contribute toward the trainee's required OCA per 6-month FTE rotation if undertaken in accordance with the OCA Protocol.

The quality of supervision is critical to training programs which are grounded in the workplace. The RANZCP has been reflecting on the importance of supervision and considering how to better support supervisors in this important role. This has become increasingly relevant as the RANZCP considers how it will manage clinical assessments in the future in response to the challenges of COVID -19.

As discussed in detail under standard 4, a supervisor survey was conducted in January 2022 as the first stage in the supervisor supports project. There was clear support for both a supervisor job or role description, and for the development of a supervisory framework that is specific to psychiatry. The development of these documents will further support the degree to which the RANZCP meets this accreditation standard, and this work will be undertaken over the coming years.

8.1.3 The education provider selects supervisors who have demonstrated appropriate capability for this role. It facilitates the training, support and professional development of supervisors.

All supervisors must be accredited by the RANZCP to supervise trainees or Fellows in Training.

To become an accredited supervisor with the RANZCP, the applicant must:

- be a fit and proper person, prepared to undertake supervision in a collegiate manner
- have completed the required supervisor training
- have current medical or other health practitioner registration
- have appropriate qualifications.

Under some circumstances, with the approval of the CFT, a recently retired health practitioner with expertise in a specific aspect of psychiatry may be accredited as a supervisor with a limited scope, that specifically excludes any oversight of the clinical care of patients.

A principal supervisor for a training post must be accredited with the RANZCP and be:

- a psychiatrist registered as a specialist in Australia or
- registered with a vocational scope of psychiatry in New Zealand or
- a SIMG on the Substantially Comparable Pathway.

The BTC and NZTC have been delegated the responsibility for the accreditation of supervisors by the CFT.

The BTC/NZTC is responsible for ensuring a potential supervisor is competent in the elements of the Fellowship Program, such as WBAs, EPAs, and ITAs. The DOAT/local SAT is responsible for ensuring a potential supervisor is competent to supervise in one of the recognised Areas of Practice.

Where a supervisor is not performing to the expected standard, each BTC/NZTC has processes to manage unsatisfactory performance. The BTC works collaboratively with the DOT/DOAT, local coordinators of training, employers and other appropriate stake holders to reach a satisfactory solution that ensures the trainee continues to receive the appropriate level of supervision and support.

The BTC/NZTC has the capacity to consider and approve the removal of a supervisor’s accreditation status.

The BTC/NZTC or delegate of NZTC must provide or approve supervisor training workshops and supervisor update training. Locally delivered supervisor training programs must adhere to the following requirements:

- the duration of the training must be the equivalent of two half days
- the training must be conducted by a DOT and/or a delegated accredited supervisor.

Examples of supervisor training programs can include but are not limited to, e-learning modules, workshops connected to Congress and BTC/NZTC workshops.

During COVID-19 flexibility was provided to local programs to ensure accreditation and reaccreditation of supervisors could continue without requiring large face to face meetings. The CFT required, as a minimum, the completion of the following learning modules and discussion regarding supervision requirements and responsibilities with a BTC/NZTC member or a site coordinator of training:

- Introduction to InTrain
- Training Program - In-Training Assessments
- Training Program - Observed Clinical Activity
- Giving feedback to trainees

A review of individual supervisor performance by the BTC/NZTC is required after one year for new supervisors, and five-yearly thereafter.

Supervisors must attend supervisor peer review sessions (or a meeting of psychiatrists where supervision is the main focus) a minimum of three times per year or at a medical staff meeting where supervision is discussed.

The DOT, their deputy or a BTC/NZTC approved delegate must have regular contact with all supervisors in their local jurisdiction. Supervisors must be aware of how to contact the relevant DOT, their deputy or a BTC/NZTC-approved delegate for advice and support.

Supervisors are required to undertake accreditation training as a requirement of becoming an accredited supervisor with re-accreditation training being completed on a five-year cycle.

By enabling locally provided training, programs have capacity to ensure that information and upskilling provided is specific to their local needs. This ensures the overarching program and standards are relayed to supervisors. This does however lead to challenges with ensuring supervisors are calibrated in the best way possible. As supervisor training is conducted by DOTs who are heavily involved with the setting of training requirements and expectations, this works towards ensuring greater calibration. As discussed under standard 8.1.2, it is planned to develop a role description for supervisors and a supervisory framework specific to psychiatry. This should support improved calibration of supervisors.

8.1.4 The education provider routinely evaluates supervisor effectiveness including feedback from trainees.

Each local training program must have a system in place to collect feedback from trainees regarding supervisor performance. Examples include trainee surveys, end-of-rotation feedback about supervisor performance, or direct feedback to the DOT or their delegate. Trainees may raise issues at any point during their rotation to the DOT or the BTC/NZTC.

DOTs must report to the BTC/NZTC or delegate of the NZTC when issues are identified regarding the performance of a supervisor based on the routine feedback collected from trainees.

Supervisors must also receive feedback about the quality of their supervision, including commendable areas and areas for improvement.

The Exit survey, administered to all trainees at the time of their admission to the Fellowship includes questions on supervision. Satisfaction with supervision is monitored as a key performance indicator for the Fellowship Program.

During the implementation of the AAP, the PROP observed that the ITAs used for the assessment of trainee performance supported the view that supervisors are providing formative feedback across the range of competency domains, with ITAs longitudinally showing improvements in performance over time. As InTrain is now implemented across all training locations, and has several years of data collected, the College intends to explore how this data can be utilised to evaluate supervisor effectiveness and be made available to supervisors to reflect on their performance.

8.1.5 The education provider selects assessors in written, oral and performance-based assessments who have demonstrated appropriate capabilities for this role. It provides training, support and professional development opportunities relevant to this educational role.

To ensure that assessors have already reached the required standard it is a requirement that all assessors are Fellows of the RANZCP.

Generally, a request for assessors is made using an expression of interest released to the Fellowship of the College. As an incentive, Members receive CPD hours for the training and calibration activities associated with the assessing.

Once approved by the relevant committee, the new assessor receives an examiner package which includes:

- the current policy and procedures related to the assessment
- guidelines for examiners
- current marking timetable.

For each assessment type, there is a compulsory training and calibration element prior to assessing. There may be individual training and mentorship undertaken by Chairs of relevant committees and through observation of performance in the calibration sessions. New members of the assessing team are usually paired up with an experienced member.

Where prior performance data are available on assessors, this may be used in the selection of assessors and feedback is sought from the committee chairs or peers.

Psychotherapy Written Case (PWC) and Scholarly Project (SP)

Assessor training and calibration, held twice each year, involves familiarisation with the marking guide, its application with different content/material, and developing a common understanding and application of the categories that discriminate levels of performance. A common set of training material representing different content areas and borderline performance levels is used.

Newly appointed assessors are paired with an experienced member of the committee for several marking cycles. They will double mark and discuss their outcomes and written feedback with their allocated partner. This way both pass and fail submissions will be double marked and discussed.

This process supports the assessors in understanding the standard and expectation of the PWC and SP requirements by utilising the pairing system. However, there are challenges with the availability of assessors to attend calibration meetings, given that this is a pro bono activity.

CEQ and MEQ

Calibration meetings are scheduled prior to each marking activity. For the CEQ examination all performances are double marked independently. Sufficient assessors are assigned to mark performances within one month.

For the MEQ, assessors are assigned to individual questions with another assessor and a senior lead experienced assessor. Training and calibration activities are kept within the relevant MEQ content area that they have been assigned.

There are several strengths to this process:

- calibration sessions allow assessors to participate in general discussions with other colleagues to develop and maintain a common understanding of the standard being applied.
- keeping the assessors limited to assessing one MEQ helps to minimise the potential impact of inter-assessor variability.
- keeping the assessor group small and consistent between assessments supports the implementation of a consistent standard over time.

As for the PWC and SP, assessors' availability to commit to marking the required quota within the timeframe remains the major challenge.

Clinicals (OSCE)

Assessor training and calibration is held prior to each examination day and involves familiarisation with the marking guide, its application of the categories that discriminate levels of performance. A recorded performance is used to study and discuss the application of the marking criteria to be used with the content/station they have been assigned. Training day incorporates assessors working with simulated patients to better understanding the performance and assessing roles.

Keeping the assessors limited to assessing one station helps to minimise the potential impact of inter-assessor variability. An ongoing challenge for this assessment is ensuring that assessors apply a common understanding to the overall performance category, 'marginal performance', that is used in establishing the station cut score.

AAP

Assessors for the AAP have been drawn from those Fellows who are accredited as supervisors, including those who have acted as examiners previously in the OSCE, the AVOSCE or the MSOSCE.

As described under standard 5, the portfolio reviews are undertaken by panels of two Fellows with significant training experience, generally DOTs. To avoid any conflict of interest, the portfolios they review do not include any from their own training zone, even though all portfolios are deidentified. The panels are overseen by the PROP, which reviews and ratifies all decisions. This provides the opportunity for another review of the portfolio.

Assessors for the CBD component of the AAP are supervisors who have volunteered to undertake this task. Prior to commencing any CBD assessments, the assessors are required to participate in a calibration workshop. Both assessors are external to the trainee's health service and a conflict-of-interest policy is followed.

8.1.6 The education provider routinely evaluates the effectiveness of its assessors including feedback from trainees.

The mechanism the PWC and SP Subcommittees have in place is co-marking where all assessors are paired. If a PWC or SP is failed by an assessor, a second assessor will review the work. Should there not be a consensus; the submitted work is referred to the Chair, Case History/Scholarly Project Subcommittee for a final determination. Assessors are expected to discuss marks, criteria, disputes, feedback etc.

The Chair of the Case History/Scholarly Project Subcommittee reviews the feedback prior to providing it to the trainees to ensure quality and standard.

This provides a robust mechanism to ensure that assessment at the individual candidate level is effective, however there is opportunity to review collated data to evaluate if there are any trends in assessment that are related to the passage of time (e.g. are assessors failing more submissions as they become more skilled?) or the type of submission (e.g. are RCT reports assessed more leniently than a clinical audit?). The RANZCP Exit survey, re commenced for the 2020 graduates, offers an opportunity to consider trainee views and feedback on the effectiveness of assessors and this will be considered for addition to the Exit Survey for 2023.

During the marking period, MEQ assessors have access to a lead assessor for support on interpretation and application of the marking guide. Following the marking period, assessors are surveyed regarding the quality of the material they worked with including the examination content, marking guide and candidate performances. Each assessor is provided with a statistical comparison of their marking with their co-assessor.

Any CEQ assessor differences that may have an impact on candidate outcomes are referred to a third lead marker for determination. Each assessor is provided with a statistical comparison of their marking with their co-assessor. Co-assessor pairings are reconfigured during the marking period to form a matrix of connections between all assessors in the pool. This allows for a broader comparison of assessor performance.

For the OSCE, post examination discussion and feedback sessions are used to discuss and reflect on issues that became apparent during the examination day.

Assessors are provided descriptive statistics on the marks they assigned to candidates, along with a measure of assessor severity in the form of a z-score. The z-core assumes that there is no difference in the mean ability of candidates assigned to different streams/groups that may have been constructed in the delivery of the examination. Interpretation of the z-score gives the assessor a measure of how consistent they were with other assessors in the pool.

Mechanisms for providing feedback to supervisors in the role as assessors, including feedback from trainees, would benefit from further development. All programs have systems in place to collect feedback from trainees regarding their supervision, but there is a sense that trainees are reluctant to provide feedback if they feel they can be identified. Data from InTrain could provide a means for supervisors to benchmark their performance as assessors, but this requires further development.

8.2 Training sites and posts

8.2.1 The education provider has a clear process and criteria to assess, accredit and monitor facilities and posts as training sites. The education provider:

- applies its published accreditation criteria when assessing, accrediting and monitoring training sites
- makes publicly available the accreditation criteria and the accreditation procedures
- is transparent and consistent in applying the accreditation process.

The RANZCP accredits its training at two levels – training program or zone, and post or rotation. A training program or zone may include multiple health services, both public and private, operating over many training locations. The accreditation of programs or zones is managed centrally through the AC, which is a constituent committee of the EC. Accreditation of individual posts or rotations is managed at the local level by the relevant BTC/NZTC.

In addition, FECs, a mandatory component of the Fellowship program for trainees in stages 1 and 2, are also accredited by the AC.

It is important to note that health services or sites are not accredited in the RANZCP process. It is possible for a health service to have a combination of posts that are accredited for training and service posts that are occupied by career medical officers. This is an important difference to other specialist medical colleges with a procedural focus and a need for specific physical infrastructure.

The AC is responsible for the development and maintenance of the accreditation standards that apply to training posts, training programs and FECs, and accreditation activities including:

- co-ordinating, scheduling, and overseeing accreditations
- selecting and appointing accreditation panels
- maintaining and reviewing accreditation standards for training programs, training posts, certificates of advanced training, and FECs
- reviewing accreditation reports and monitoring of the implementation of any recommendations made by accreditation panels
- evaluating accreditation procedures for consistency and to promote quality improvement
- reporting to the EC regarding accreditation outcomes.

The following standards are provided as appendices to this submission, and are published on the RANZCP website (Training program accreditation | RANZCP):

- Training Program Accreditation Standards (Appendix 8.2.1_1)
- Training Post Accreditation Standards (Appendix 8.2.1_2)
- Formal Education course Accreditation Standards (Appendix 8.2.1_3)

The FEC standards and Post standards were reviewed in 2020, and the Program standards were reviewed in 2019.

Two policies and a guideline have been finalised by the AC since the last accreditation of the College:

- Accreditation Policy (Appendix 8.2.1_4)
- Removal of Accreditation Policy (Appendix 8.2.1_5)

- Guideline for appropriate adult acute inpatient workloads for RANZCP trainees (Appendix 8.2.1_6).

These are provided as appendices to this submission and are also published on the RANZCP website (Training program accreditation | RANZCP).

The accreditation process ensures that a training program is providing the experiences, supervision, and professional development opportunities mandated by the Fellowship Regulations and that the RANZCP Training Program Accreditation Standards are met. This ensures that trainees are provided with the opportunity to develop the required skills, knowledge, and attributes to deliver high-quality collaborative clinical care and meet the expected graduate outcomes.

The monitoring of programs through the accreditation cycle promotes continuous evaluation and quality improvement, as it assesses the ability of the training program to provide an environment that supports the education of trainees, their safety and welfare in their workplaces, and how learning is fostered.

Accreditation assessments provide trainees, supervisors, and health service managers and executives with opportunities to confidentially discuss their experiences of the training program with the accreditation panel, and to raise any concerns impacting on RANZCP training.

To date, overall accreditation decisions regarding training programs or zones have not been challenged. Individual recommendations that have been made by accreditation panels have been challenged, particularly if the recommendation is perceived by the training program as being outside of the scope of accreditation. In these circumstances a request is made to the AC for a reconsideration of the recommendation. The AC may confer with the accreditation panel to clarify and resolve the issue. The welfare of trainees and minimising any impact on their training is always a priority for the AC.

If a health service is unhappy with an accreditation decision regarding a training post, the process would be to request a review by the relevant BTC/NZTC. Escalation to the Committee for Training is the next step should resolution not be achieved.

RANZCP accreditation processes are subject to the RANZCP appeals process, discussed in detail under standard 1.

Each of the three sets of accreditation standards are mapped across broad domains that link to graduate outcomes and trainee welfare, and these are illustrated in Table 8.2.1_1.

Table 8.2.1_1. Domains of accreditation

Training Program Accreditation Standards	Formal Education Course Standards
• Training program coordination • Provision of the required training experiences • Selection, monitoring and support of trainees • Standard of training • Supervision	• Governance and Quality Improvement • Educational Philosophy • Structure and Delivery • Course Content • Infrastructure and Support • Orientation
Training Post Accreditation Standards	
• Service requirements and Post position description • Provision of required trianing experiences • Organisation, monitoring and support of trainees • Institutions, services and training psots • Supervision	

Several key components of the accreditation process are common across all accreditation processes at the RANZCP with some variation dependant on whether it is program, post or FEC accreditation.

- **Formation of an accreditation panel**

The accreditation of a training program is conducted by a panel composed of four RANZCP representatives appointed by the AC. The panel is composed of:

- a Lead Member (Fellow)
- a Second Member (Fellow)
- a trainee representative
- a RANZCP staff member with experience in accreditation.

Fellows and trainee members of accreditation panel are not from the training program/zone being accredited, and generally are not from the same jurisdiction.

The position descriptions documenting the roles and responsibilities of panel members are attached (Appendices 8.2.1_7 to 8.2.1_10). These outline the responsibilities of the accreditation panel and the criteria for selection as a panel member.

- **Collection of documentary evidence**

Documentary evidence, including health service policy, trainee rosters and educational timetables, is provided by the training program. Trainees are surveyed before the accreditation on how the training program meets each accreditation standard, and their views are also sought on which health services should be specifically reviewed as part of the accreditation. Data held by the RANZCP relating to assessments, the accreditation status of supervisors and of training posts is provided to the assessment panel. A pre-visit questionnaire, covering each of the standards, is completed by the DOT for the program in consultation with administrative support staff and local training committees. The questionnaire forms part of the pre-accreditation documentation provided to the accreditation panel, and its content is tested by the panel during the actual accreditation.

- **Interviews with stakeholders, physical inspections**

Confidential meetings are held by the panel separately with trainees, supervisors, the DOTs, and the health services' executive and management. Videoconferencing is used to ensure that all trainees, supervisors, and management participate. The accreditation panel tests the accuracy of any statements or claims in pre-accreditation documentation through these meetings.

Physical inspections are undertaken of the facilities of selected health services, when possible, during on-site face-to-face accreditation visits. If there have been historical problems at a location, or recommendations made that are specific to a location, then that location or training site will be visited.

- P**reparation of the report, recommendations, and commendations.**

The reports include:

1. commentary against each standard
2. recommendations with a timeline for implementation
3. commendations
4. a record of the timetable of interviews and schedule of physical inspections
5. a list of the documents and evidence used in the compilation of the report.

- **Fact checking**

Reports are reviewed by the DOT, or the education provider for FEC accreditation, for factual accuracy.

- **Approval of the report and communication to stakeholders.**

Following fact checking, the panel approves the report prior to its submission to the AC. The AC recommends the accreditation decision to the EC. Once approved by the EC and noted by the RANZCP Board, the report is provided to the relevant BTC/NZTC, the DOT and a summary is provided to trainees in the zone.

RANZCP staff coordinate the scheduling of the accreditation interviews with stakeholders, provide advice on the facilities that might be included for physical inspection, and advise on relevant RANZCP policies and training regulations. A staff member is part of the accreditation panel and assumes equal rights and responsibilities as the two Fellows and trainee in the panel. RANZCP staff draft accreditation reports in consultation with the accreditation panel.

The accreditation cycle for training programs, training posts and FECs is five years. There is a formal re-accreditation every five years, with a mid-cycle accreditation review of the training program/zones and FECs two to three years after accreditation. At mid-cycle, the training program or FEC is reviewed against the accreditation standards to identify any changes since the last accreditation. Feedback from the DOT and the current cohort of trainees on the status of the implementation of the recommendations the previous accreditation is also considered.

Training posts are re-accredited every five years by the BTC/NZTC.

The accreditation panel recommends accreditation status against each accreditation standard based on the criteria:

- **Fully met:** The requirements of the standard and criteria are demonstrated in all circumstances and supported by comprehensive documentation and evidence
- **Substantially met:** The requirements of the standard and criteria are demonstrated in most circumstances, supported by documentary evidence, and confirmed by discussions and evidence.
- **Partially met:** The requirements of the standard and criteria are demonstrated in some circumstances with minimal documentation or evidence
- **Not met:** The requirements of the standard and criteria fail to meet the accreditation standard owing to the lack of provision of documentary evidence or failure to improve or address the standard if previously identified in past reports.

The accreditation status of a training program may be full accreditation with or without recommendations, or, where there are more significant concerns, provisional accreditation with recommendations. In each case where there are recommendations, the implementation of the recommendations is monitored by the BTC/NZTC and progress is reported to the AC.

The accreditation and removal of accreditation policies of the RANZCP, attached as appendices, prescribe how a training program can be accredited or disaccredited.

Similarly, training posts might be fully accredited, provisionally accredited, disaccredited, or not accredited. Provisional accreditation includes recommendations for improvement that must be met within a timeframe to be monitored by the relevant the BTC/NZTC.

The option to withdraw accreditation is reserved for programs that consistently fail, over time, to rectify significant issues.

The input from trainees is critical to the success of the accreditation process. Trainees’ firsthand experiences in the training program identify strengths and weaknesses and issues with workplace conditions. All trainees in the training program are encouraged to complete a survey, circulated by the AC before the accreditation., Responses to the survey are confidential and anonymous. Any issues are drawn to the attention of the panel and may also inform which specific sites might be physically inspected.

At their meetings with the accreditation panel, trainees are questioned on topics related to the accreditation standards, including:

- supervisors and supervision
- access to the Director of Training
- lines of clinical responsibility to consultants
- accessibility of mandatory requirements, including to a FEC
- assessment, mentoring, and support
- orientation

- allocation to rotations/runs
- workplace conditions and safety
- rosters, and on-call frequencies

Similarly, supervisors contribute through their meetings with the accreditation panel with a specific focus on supervision processes, and any issues impacting supervisors' ability to provide training support.

Triggers for the review of accreditation status

A review of the accreditation status of a training program may be initiated at several points during the accreditation cycle:

- the mid-cycle accreditation review of a training program
- the formal accreditation of a training program, either as part of the pre-accreditation survey or during the accreditation process.
- through adhoc reports of issues.

The accreditation status of a training post can be reviewed by the BTC/NZTC in response to:

- the end-of-rotation review between DOT and trainees
- mid-rotation review meetings, and feedback from the DOT and trainees
- issues identified through the formal accreditation of a training program or zone
- Issues identified through the mid cycle review of a training program or zone.

Quality improvements since the last accreditation of the RANZCP

The accreditation standards for training programs and training posts were substantially revised in 2018 - 2019 to reduce the repetition and duplication within and between the two sets of standards, improve clarity, and increase the focus on evidence to demonstrate compliance with the standards.

The accreditation standards for FECs were substantially revised in 2020 prior to the re-accreditation of all 15 FECs during 2021. The revisions focussed on more clearly defining standards applicable to the education provider and what is more properly the responsibility of a training program.

The standards were initially developed for the 2012 Fellowship Program by the Accreditation Subcommittee of the CFT. Recognising that transparent accreditation processes require unbiased and independent views, the AC was formed in 2014 as an independent constituent committee of the EC at an equivalent level to the CFT.

The accreditation policy and the removal of accreditation policy were finalised in 2021. They were developed to codify and document practices and the levels of responsibility and accountability for accreditation decisions, including a process for the establishment of new training zones. This has proven to be timely, as in Western Australia it has been determined that the best approach to increasing the number of rural and remote trainees is the establishment of a new rural training zone. There has been no change to the RANZCP training zones since the last century.

The removal of accreditation policy was particularly important as prior to its publication the procedure for removing accreditation was somewhat opaque. The policy has clarified that decisions regarding the removal of accreditation cannot be approved by the body that provides accreditation. So, for example, a recommendation for the removal of accreditation can be made by the BTC, however, the decision must be made by its parent committee, the CFT. These decisions are not taken lightly, however, there are occasions when recommended changes necessary to ensure trainee welfare and safety have been repeatedly ignored, leaving the removal of accreditation as the action of last resort. In any circumstance where accreditation is removed from posts, or it is being considered for a training program, the welfare of trainees and their continued progression to Fellowship is a primary consideration.

A guideline for appropriate numbers of patients for acute inpatient rotations was published in 2018 (Appendix 8.2.1_6). This was developed to provide guidance to health services and clinical directors on appropriate patient numbers to support psychiatry trainees in their first year of the training program. Despite initial fears that it would be unworkable, it has proven to be a useful tool for DOTs and BTCs when advocating with health services for workloads that are supportive of trainees achieving their required training experiences.

COVID-19 has caused the process of accreditation to be reviewed in response to the restrictions on travel for the last two years. The use of virtual platforms has been introduced and has been reasonably successful, however, it has proven challenging to engage with all trainees in a zone with the virtual approach. In a face-to-face accreditation, it is far easier for the DOT or local hospital coordinators to "round up" trainees to attend a meeting. The virtual environment is a more solitary experience, and it is easier for trainees to avoid attending or to disengage with the process.

A significant emerging challenge is the increasing burden of accreditation on the relatively small AC. Consideration is being given to mechanisms to support the increased workload, and these include the potential for the establishment of a subcommittee to oversee the accreditation of FECs.

To support consistent approaches to accreditation, the RANZCP has developed an online training program for Fellows and trainees new to accreditation panels. The content of each of the four modules focusses on RANZCP accreditation practices and standards and provides a base level of orientation. To be appointed to lead an accreditation panel, Fellows must have participated in at least two previous program accreditations. This assists with ensuring consistency across the accreditation of programs. Additionally, the AC reviews Program accreditation reports for consistency in recommendations, language, and interpretation of the standards.

To assist programs, and panels, the accreditation submission paperwork is being reviewed and revised to provide more detailed advice on the interpretation of the standard and the evidence required to demonstrate the standard is being met.

Data requested by the AMC

Tables 8.2.1_2 to 8.2.1_6 show the outcomes for the accreditation of programs for the years 2017 – 2021. The pandemic in 2020 prevented accreditation from being carried out, and planned accreditation activity was deferred to 2021. During 2021 accreditation was undertaken virtually.

In 2018 a training program in New Zealand was pending accreditation following an extraordinary formative program review by the NZTC in advance of the scheduled accreditation in 2019. This extraordinary review was prompted by the mid cycle desk top review that had taken place. In 2019, following the formal accreditation review by the AC, the program was given provisional accreditation with recommendations to be implemented under the supervision of the NZTC. A final accreditation review in 2021 confirmed that recommendations had been implemented satisfactorily and the program was granted accreditation for the remainder of the 5-year cycle.

Table 8.2.1_2. Training Program Accreditation Activities 2017

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Total number of programs active	1	1	5	1	1	1	3	1	5	19
Number programs visited	-	1	1	1	-	-	-	1		4
Number programs accredited	-	1	1	1	-	-	-	1		4
Number of programs not accredited	-	-	-	-	-	-	-	-	-	-
Number of programs pending accreditation	-	-	-	-	-	-	-	-	-	-
Number of programs given provisional accreditation	-	-	-	-	-	-	-	-	-	-

Table 8.2.1_3. Training Program Accreditation Activities 2018

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Total number of programs active	1	1	5	1	1	1	3	1	5	19
Number programs visited	-	1	1	-	-	1	-	-	1	4
Number programs accredited	-	1	1	-	-	1	-	-	-	3
Number of programs not accredited	-	-	-	-	-	-	-	-	-	-
Number of programs pending accreditation	-	-	-	-	-	-	-	-	1	1
Number of programs given provisional accreditation	-	-	-	-	-	-	-	-	-	-

Table 8.2.1_4. Training Program Accreditation Activities 2019

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Total number of programs active	1	1	5	1	1	1	3	1	5	19
Number programs visited	1		2	-	-	-	1	-	2	6
Number programs accredited	1		2	-	-	-	1	-	1	5
Number of programs not accredited	-	-	-	-	-	-	-	-	-	-
Number of programs pending accreditation	-	-	-	-	-	-	-	-	-	-
Number of programs given provisional accreditation	-	-	-	-	-	-	-	-	1	1

Table 8.2.1_5. Training Program Accreditation Activities 2020

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Total number of programs active	1	1	5	1	1	1	3	1	5	19
Number programs visited	-	-	-	-	-	-	-	-	-	-
Number programs accredited	-	-	-	-	-	-	-	-	-	-
Number of programs not accredited	-	-	-	-	-	-	-	-	-	-
Number of programs pending accreditation	-	-	-	-	-	-	-	-	-	-
Number of programs given provisional accreditation	-	-	-	-	-	-	-	-	-	-

Table 8.2.1_6. Training Program Accreditation Activities 2021

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Total number of programs active	1	1	5	1	1	1	3	1	5	19
Number programs visited	-	-	-	1	1	-	2	-	1	5
Number programs accredited	-	-	-	-	1	-	-	-	1	2
Number of programs not accredited	-	-	-	-	-	-	-	-	-	
Number of programs pending accreditation	-	-	-	1	-	-	2	-	-	3
Number of programs given provisional accreditation	-	-	-	-	-	-	-	-	-	-

*In the RANZCP accreditation process, full accreditation is not granted until the responsible BTC/NZTC has provided a response to the AC detailing its plans for addressing any recommendations made in the Accreditation Report. During the period between the accreditation visit and the approval of the AC of the BTC's response the training program is considered to be accredited but reported as pending accreditation. The Northern Territory was assessed late in 2021 in response to concerns identified in the mid cycle review, and the outcome remains pending at the time of writing (March 2022).

The accreditation of RANZCP training programs scheduled for 2021 was deferred owing to the impact of COVID-19.

Table 8.2.1_7. Accreditation activities planned for 2022.

State/Country	Training Zone	Dates
NSW	South East Sydney/Illawarra	17-18 November 2022
NSW	North Sydney/Central Coast	3rd quarter - TBC
ACT	ACT	3rd quarter - TBC
NZ	Auckland	29 - 30 August 2022
NZ	Hamilton	28 June 2022
NZ	Wellington	3rd quarter - TBC

Post accreditation outcomes for the last 5 years

As previously noted in this standard, the RANZCP does not accredit sites or health services, it accredits individual training posts or rotations. The responsibility for the accreditation of posts is delegated to the BTC or NZTC and are conducted at the local level. This was codified in the accreditation policy published in 2021. Historic data prior to 2021 is not complete, in part due to changing reporting requirements over time. The introduction of InTrain focussed on trainee management initially, however functionality to assist with the management of accreditation of training posts is now being developed.

Table 8.2.1_8. Post accreditation activities 2021.

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Total number of Posts active	47	443	422	30	118	31	552	137	221	2001
Number posts visited	15	408	0	0	14	2	5	101	89	634
Number of new posts accredited	1	72	29	0	4	1	47	4	16	174
Number of new posts reviewed but not accredited	0	2	0	0	0	0	7	0	0	9
Number of new posts given provisional or conditional accreditation	1	34	7	0	0	1	2	0	5	50
Number of existing posts re-accredited	13	109	18	0	5	0	208	137	42	532
Number of existing posts losing accreditation	0	0	0	0	0	0	2	0	1	3
Number of existing posts given provisional or conditional accreditation	0	0	1	0	5	2	0	0	1	9

Table 8.2.1_9. Post accreditation activities 2020.

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Total number of Posts active	32	454	462	30	119	30	505	133	213	1978
Number posts visited	12	59	2	0	15	0	21	11	17	137
Number of new posts accredited	1	37	17	1	4	2	27	6	4	99
Number of new posts reviewed but not accredited	2	0	0	0	0	0	1	0	0	3
Number of new posts given provisional or conditional accreditation	1	1	9	0	4	1	1	0	0	17
Number of existing posts re-accredited	7	69	3	0	11	28	155	11	91	375
Number of existing posts losing accreditation	1	0	0	0	0	0	0	0	0	1
Number of existing posts given provisional or conditional accreditation	1	0	4	0	2	0	0	0	6	13

Table 8.2.1_10. Post accreditation activities 2019.

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Total number of Posts	35	403	360	27	80	21	463	90	189	1668
Number of Posts visited	8	0	0	0	0	2	0	0	12	22
Number accredited – new posts	0	0	0	7	0	0	34	0	0	41
Number provisionally or conditionally accredited – new posts	0	0	0	0	0	0	0	0	1	1
Number accredited -reaccredited posts	6	0	0	0	0	12	67	0	81	166
Number not accredited – new posts	0	0	0	0	0	0		0	0	0
Number losing accreditation– existing posts	1	0	0	0	0	0	3	0	4	8
Number given provisional or conditional accreditation – existing posts	1	0	0	0	0	2	0	0	8	11

Table 8.2.1_11. Post accreditation activities 2018.

	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Number of Posts visited	28	23	18	0	16	19	63	13	17	197
Number accredited	27	23	16	0	16	19	63	13	17	194
Number not accredited	0	0	0	0	0	0	0	0	0	0
Pending accreditation	0	0	0	0	0	5	0	0	22	27
Provisional accreditation	3	0	0	0	0	0	0	0	0	3

8.2.2 The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and:

- promote the health, welfare and interests of trainees
- ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner
- support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand
- ensure trainees have access to educational resources, including the information communication technology applications required to facilitate their learning in the clinical environment.

The accreditation standards essentially operationalise the 2012 Fellowship Regulations and therefore link directly to the outcomes of the Fellowship Program. Training programs are required to demonstrate that all required experiences of the Fellowship program are provided.

Health, welfare and interests of trainees

Accreditation criteria that promote the health, welfare, and interest of trainees are defined in the training program accreditation standards (Appendix 8.2.1_1), specifically standard 3:

- 3.5.1 The workload for trainees within each training post is such that clinical service delivery does not compromise training and trainee welfare
- 3.5.2 The working conditions for trainees within each post are such that the working conditions are conducive to training and trainee welfare
- 3.5.3 There are fatigue management programs, monitored by the Director of Training or deputy and reporting to the Branch Training Committee or the New Zealand Training Committee
- 3.6.1 There are systems and processes to maximise the safety of trainees and supervisors in the workplace. This includes afterhours policies, safe assessment areas, duress alarms, access to support and security staff, and training in the management of challenging behaviour
- 3.6.3 Stage-specific orientation and guidance are available to trainees on avenues for raising training, safety, and welfare concerns.

These requirements are assessed against the accreditation standards in each accreditation of a training program and are reflected in the accreditation standards for training posts.

Supervision

There is an emphasis by the RANZCP on the provision of supervision and clinical oversight of trainees. At their meetings with an accreditation panel, trainees are questioned on the provision of clinical oversight, and their supervision arrangements. Any ambiguous arrangements are then subject to further exploration when interviewing supervisors, DOTs, and local training coordinators. Accreditation criteria to ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills are defined throughout the training program accreditation standards, particularly standards 4 and 5. Examples include:

- 4.2.4 Psychiatrist staff provide clinical support to trainees, in addition to required supervision from approved supervisors
- 5.1.2 The ratio of accredited supervisors to trainees is adequate. Wherever possible, supervision is provided by RANZCP Fellows
- 5.1.3 The ratio of RANZCP supervisors to accredited non-RANZCP supervisors is monitored by the training program
- 5.1.4 There is a maximum ratio of one full-time supervisor to two trainees
- 5.1.5 Full-time trainees receive a minimum four hours of clinical supervision each week for a minimum of 20 weeks in a six-month rotation, as specified in the supervision policy
- 5.1.6 For Stage 1 trainees at least one of the remaining minimum three hours must be conducted as close supervision outside of ward rounds and case review meetings
- 5.1.7 For Stage 2 and 3 trainees the minimum other three hours can be conducted individually or as a group, of which a minimum of one hour must be in a clinical setting
- 5.1.8 Supervisors work alongside trainees at the same workplace for a minimum of three sessions weekly per rotation
- 5.1.9 The competence-based model of training is maintained

Diversity and number of training settings

The networked nature of the RANZCP Fellowship Program allows for training to occur in metropolitan, outer metropolitan, rural, and regional areas throughout Australia and New Zealand. There are no accreditation standards that prohibit training in rural and regional areas.

If there is adequate supervision which meets the accreditation standards, training can occur. Fly-in/fly-out supervision can be in place at rural areas, along with video and teleconference supporting arrangements within health services.

The RANZCP has successfully used Australian Government funded programs to expand the training opportunities in diverse settings, including the: STP, IRTP, PWP, MVPTP.

Tables 8.2.2_1 to 8.2.2_3 illustrate the distribution of the training posts funded under these programs, including across private settings, rural locations, and specific opportunities for the delivery of care to Aboriginal and Torres Strait Islander peoples. Training opportunities in the private sector are important to ensure that trainees have experience of low acuity high prevalence disorders, which are not usually represented in the public sector.

Table 8.2.2_1. STP funded training positions

State / Territory	Total FTE	No of Posts	Rural FTE (MM2-7)	Private FTE	Indigenous Health FTE
Australian Capital Territory	4.00	4.00	0.00	3.00	1.00
New South Wales	34.00	34.00	10.86	15.51	1.00
Northern Territory	8.00	8.00	8.00	0.00	8.00
Queensland	40.00	40.00	14.69	20.18	7.00
South Australia	7.00	7.00	3.40	1.33	2.00
Tasmania	5.00	5.00	5.00	2.00	0.00
Victoria	48.50	49.00	8.00	24.75	1.50
Western Australia	13.00	13.00	2.00	9.00	1.00
Overall	159.50	160.00	51.95	75.77	21.50

Table 8.2.2_2. IRTP posts

State / Territory	Total FTE
New South Wales	5.00
Northern Territory	4.00
Queensland	8.00
South Australia	3.00
Tasmania	3.00
Victoria	7.00
Western Australia	4.00
Overall	159.50

All posts cover the whole of pathway apart from one in New South Wales which is stage 3 only, and all posts are located in areas with a classification of 2 – 7 in the Modified Monash scale. One post in the Northern Territory is reserved to be filled by a trainee identifying as Aboriginal or Torres Strait Islander.

Table 8.2.2_3. PWP posts

State / Territory	Total FTE	No of Posts	Rural FTE (MM2-7)	Private FTE
Australian Capital Territory	2.00	2.00	1.00	1.00
New South Wales	3.00	3.00	2.00	0.00
Northern Territory	3.00	3.00	3.00	0.33
Queensland	3.00	3.00	2.00	1.25
South Australia	2.00	2.00	1.00	0.00
Tasmania	1.00	1.00	1.00	0.00
Victoria	3.00	3.00	3.00	0.10
Western Australia	3.00	3.00	2.00	0.00
Overall	20.00	20.00	15.00	2.68

The PWP commenced in February 2022, therefore the figures in Table 8.2.2_3 are based on the expressions of interest rather than confirmed contracts. A further breakdown of the anticipated percentage of Aboriginal and Torres Strait Islander patients in the client cohort for each post is provided in Table 8.2.2_4.

Table 8.2.2_4. Anticipated percentage of Aboriginal and Torres Strait Islander patients in the client cohort for the PWP.

Jurisdiction and post	% of Aboriginal and or Torres Strait Islander Patients	Jurisdiction and post	% of Aboriginal and or Torres Strait Islander Patients
ACT post 1	100%	SA post 1	0%
ACT post 2	10%	SA post 2	0%
NSW post 1	40.50%	TAS post 1	0%
NSW post 2	80%	VIC post 1	25%
NSW post 3	100%	VIC post 2	0%
NT post 1	100%	VIC post 3	0%
NT post 2	50%	WA post 1	0%
NT post 3	90%	WA post 2	70%
QLD post 1	47%	WA post 3	100%
QLD post 2	100%		
QLD post 3	50%		

Table 8.2.2_5. MVPTP posts

State / Territory	No of Posts	Rural FTE (MM2-7)	Private FTE
New South Wales	4.00	0.00	2.00
Queensland	3.00	1.00	3.00
South Australia	1.00	0.00	0.00
Victoria	1.00	0.00	1.00
Western Australia	1.00	0.00	1.00
Overall	10.00	1.00	7.00

The RANZCP is committed to expanding the training opportunities in rural and remote settings, and the Rural Psychiatry Roadmap 2021-2031: A pathway to equitable and sustainable rural mental health services (Appendix 8.2.2_1) provides a blueprint and implementation framework to achieve a greater rural presence. This is a project funded by the Australian Department of Health under the PWP and will be overseen by the Regional, Rural and Remote Training Steering Group which reports to the EC. The TOR are provided as an Appendix 8.2.2_2 to this submission. Progress to date includes:

- appointment of key staff
- engagement with stakeholders including Branch Chairs, BTCs, PIF and the Section of Rural Psychiatry
- review of selection regulations to develop selection criteria to prioritise rural, Aboriginal and Torres Strait Islander, and Māori applicants
- review of models of remote supervision used by other specialist medical colleges.

Again, it should be noted that the RANZCP accreditation standards do not have a metropolitan bias and can be met in rural and remote settings.

Educational resources

Access to educational resources is a specific criterion in the accreditation standards:

- 3.5 There is assured access for all trainees to library services, institutional or library internet access, and office desktop access to the health service intranet.

This access is critical as the RANZCP utilises several education resources that are technology based. Discussed in more detail under standard 1, these include:

- InTrain, the RANZCP trainee management system
- Learnit, the RANZCP learning management system
- Psyche Matters, the RANZCP podcast program
- the RANZCP website.

In addition, the Program standards require assured access to a FEC that is accredited by the RANZCP for all trainees in Stages 1 and 2. All FEC providers have the capacity to deliver some or all elements of their program virtually.

As previously detailed, there is a specific set of standards that are applied to FECs.

Challenges for the accreditation of training posts

Psychiatry has been identified as a medical specialty workforce in shortage, and this situation is likely to continue into the future.

Coupled with an increase in demand arising from the effects of the pandemic and longstanding structural and funding issues in the mental health systems this presents a significant challenge. The shortage of psychiatrists in rural and remote areas is compounded by difficulties maintaining the public sector workforce.

In recent years there have been more applicants to the Fellowship program than can be accommodated by the current number of training posts. The number of admissions is limited by several factors:

- the number of posts available in the public health sector, a factor external to the RANZCP's direct control
- the number of supervisors with capacity to provide quality supervision at the same time as addressing significant clinical caseloads
- bottlenecks due to the limited number of places for the stage 2 mandatory rotations of CAP and C-L.

The tension between service delivery and training remains as one of the greatest challenges for the ongoing accreditation of training posts, exacerbated by longstanding failure of jurisdictional governments to address the structural issues within the mental health system. The recent Royal Commission into Victoria's Mental Health System (the Royal Commission) has highlighted these critical structural issues.

8.2.3 The education provider works with jurisdictions, as well as the private health system, to effectively use the capacity of the health care system for work-based training, and to give trainees experience of the breadth of the discipline.

As described in detail under standard 8.2.2 the RANZCP works with jurisdictions and the private health system to accredit training posts, particularly to support Australian Government funded programs. For a post to be funded by the STP, it must be supported by the jurisdiction and have current accreditation as documented by the relevant BTC.

The College is also advocating for future training experiences in Aboriginal Community Controlled Health Organisations to further enhance the breadth of experiences.

The RANZCP's Policy Practice and Research (PPR) team through its network of policy advisors in the Branches and the New Zealand office advocates with jurisdictions for increased resourcing and training opportunities, including through pre-Budget submissions. This approach has been successful in several jurisdictions, notably Queensland, Victoria and more recently South Australia. In Queensland there has been an increase in the FTE for DOTs and for the administration of the large training program.

The Victorian Department of Health, in response to the outcomes of the Royal Commission, is working with the RANZCP Victorian Branch and BTC to:

- establish a collaborative body to support increased training opportunities in the jurisdiction
- increase the FTE for DOTs, including specific funding to support DOT functions for SIMG and rural training
- allocate increased jurisdictional funding to increase the number of training posts, including the mandatory experiences of CAP and C-L.

8.2.4 The education provider actively engages with other education providers to support common accreditation approaches and sharing of relevant information.

Psychiatry is unique in comparison to other interventional medical specialties which have a necessary and appropriate focus on clinical facility infrastructure such as operating suites and diagnostic imaging services. As stated previously, the RANZCP does not accredit individual health services or sites; it accredits specific training posts within health services and then the overall training program. However, the RANZCP pays close attention to changes in the accreditation status bestowed by other specialist medical colleges on health services, as withdrawal of accreditation may be a sign of an organisational culture or environment that may not meet the RANZCP standards.

In response to requests from the AMC, the RANZCP consistently contributes to consultations related to medical education accreditation. This includes the scheduled accreditation of specialist medical colleges and specific consultations such as the criteria for CPD Homes.

Standard 8: Documents provided check list

	Document
√	The criteria and process for accreditation of training sites. A list of accredited hospitals, community healthcare facilities and/or posts. Appendix 8.2.1_1 Training program accreditation standards Appendix 8.1.1_2 Training post accreditation standards Appendix 8.2.1_3 FEC accreditation standards Appendix 8.2.1_4 Accreditation policy Appendix 8.2.1_5 Removal of accreditation policy Appendix 8.5 List of accredited hospitals, community healthcare facilities and/or posts
√	Sample accreditation reports that illustrate the range of decisions the education provider makes. Appendix 8.3_1 Accreditation report HNE Appendix 8.3_2 Accreditation report NT Appendix 8.3_3 Accreditation report Dunedin
√	Position descriptions for supervisors of training and other training and assessing roles Appendix 7.4.2 Supervision policy and procedure DOT and DOAT Role Description DOT Terms of Reference Appendix 8.2.1_7 PD Lead Member_ Accreditation Assessment Panel Fellowship Program Appendix 8.2.1_8 PD Second Member_ Accreditation Assessment Panel Fellowship Program Appendix 8.2.1_9 PD Trainee Member_ Accreditation Assessment Panel Fellowship Program Appendix 8.2.1_10 PD Accreditation Officer
-	The education provider's statement of responsibilities for practitioners who contribute to the delivery of the training program and its responsibilities to these practitioners
√	Sample programs for supervisor training workshops, assessor-training workshops. 2012 Fellowship Program: supervisor resources | RANZCP Appendix 8.4 Training supervisor workshop program - sample

Standard 9: Continuing professional develpment, further training and remediation

Standard 9: Continuing professional development, further training and remediation

9.1 Continuing professional development

Meeting the accreditation standards for the new CPD Home is a great opportunity and a challenge that the RANZCP is looking forward to meeting and working towards once the standards are made public. The RANZCP has done substantial work on considering the positioning of the CPD Home for psychiatrists and other medical practitioners with an interest in psychiatry, and on how the RANZCP may use CPD to achieve systems change to improve the health outcomes of the community. Work is underway to link significant documents such as position statements and clinical guidelines with CPD to promote maximum engagement and translation to practice. It is hoped that this response to standard 9 will demonstrate the RANZCP's readiness to be acknowledged as the Australian CPD Home of choice for psychiatrists and other medical practitioners working in the area of mental health.

9.1.1 The education provider publishes its requirements for the continuing professional development (CPD) of specialists practising in its specialty(s).

The College operates a CPD program that aims to maintain a high standard of professional practice in psychiatry. All the requirements for the RANZCP CPD program are published on the RANZCP website (CPD program | RANZCP) and detailed information on the program is included in the CPD program guide, updated annually (Appendix 9.1.1_1).

Based on the requirements of the MBA and the MCNZ, the 2021 program requires a minimum of 50 hours across the following five sections:

- **Section 1 Professional Development Plan (PDP)**
    - Allocated 5 hours, a PDP is required annually to identify learning goals. There is guidance for the development of a PDP (Appendix 9.1.1_2) and a variety of templates. Alternatively, an employer's template can be used to meet this requirement.
- **Section 2 Formal Peer Review**
    - Currently a mandatory requirement of a minimum of 10 hours, with a choice of activities including Peer Review Groups, Supervision, and Practice Peer Review.
- **Section 3 Practice Development, Quality Improvement and Review**
    - Currently a mandatory requirement of a minimum of five hours, with a choice of activities relating to quality improvement and outcome measurement.
- **Section 4 Self-guided learning**
    - Currently a minimum of 25 hours covering traditional Continuing Medical Education and College activities.
- **Section 5 Additional hours**
    - Five hours from any of section 2, 3 or 4

At the time of the last AMC accreditation, completion of the CPD program was optional for members of the RANZCP. In 2017, completion of CPD was made a mandatory component of the maintenance of Fellowship of the RANZCP. Additionally, the CPD program was substantially reviewed then with several significant changes:

- removal of the triennium option
- introduction of an annual program of 50 hours

- minimum mandatory hours set for formal peer review and practice/quality improvement activities
- the introduction of an online reporting portal, My CPD, to replace the annual submission of a CPD claim. My CPD allows participants to:
    - o access their CPD record via mobile devices, tablets and computers
    - o monitor their CPD progression against program requirements
    - o upload documentation to substantiate activities
    - o log activities as they are completed
    - o record their reflection on their learning
    - o access the CPD program at any time
    - o download CPD certificates
    - o access CPD related news.

    My CPD also:
    - o removes the need to submit a separate CPD 'claim'
    - o creates a paperless CPD program
    - o allows for paperless audit.

In subsequent years, there have been further developments:

- replacement of the paper-based process for the annual audit of 10% of the enrolment with an online process based on the member's online CPD record
- significant upgrades to the original My CPD in 2019 with a move to a web-based platform and improvements to the performance of the system on small devices such as smart phones and tablets
- the pilot of the Practice Peer Review activity as a COVID-safe, flexible alternative to practice visits
- the review and updating of CPD resources on the RANZCP website (CPD Resources | RANZCP), including the development of specific advice on the construction of a PDP, along with templates
- the introduction of a Help Desk utilising a ticketing system which allows the CPD team to record, track and answer questions from members about technical aspects of My CPD, general questions about the CPD program, the suitability of specific activities and the provision of evidence of CPD compliance (letters of good standing, certificates of completion).

Current work underway includes:

- the development of an online option for the PDP within My CPD
- increased emphasis on cultural safety and health equity components of CPD activities
- a review of multi-source feedback (MSF) options for RANZP CPD participants
- the development of Learning Paths, curated collections of e-learning modules, podcasts, documents, and other activities related to a topic, within Learnit, the RANZCP's learning management system
- the introduction of a regular CPD newsletter that provides a personalised update of the member's progress across the CPD program and information on CPD activities and opportunities (Appendix 9.1.1_3).

Participants in the RANZCP CPD program include Fellows and Affiliates of the RANZCP and, on payment of the CPD fee set annually by the RANZCP, other practising psychiatrists and medical practitioners. Medical practitioners who are not members of the RANZCP are welcome to participate in the College's Continuing Professional Development (CPD) program and are required to submit the appropriate enrolment form (Appendix 9.1.1_4).

The CPD policy, provided as Appendix 9.1.1_5, outlines the requirements for enrolment into the CPD program.

In December 2021, the RANZCP Board approved the recommendation of the CCPD that the allocation of CPD hours be changed to meet the requirements of the revised Registration Standard: CPD published by the MBA. The option to combine the RANZCP sections of Formal Peer Review and Practice Improvement provides flexibility for psychiatrists, allowing the individual to tailor their CPD program to meet their own preferences. These sections are analogous to the MBA categories of peer review and measurement of outcomes.

Table 9.1.1. Changes in the allocation of CPD hours from 2023 CPD Program

	RANZCP 2022 Program	RANZCP 2023 Program
PDP	5 hours	2 hours
Formal Peer Review	10 hours	23 hours in total, with a minimum of 10 hours of Formal Peer Review and a minimum of 5 hours of Practice Development, Quality improvement and Review
Practice Development, Quality Improvement and Review	5 hours	
Self-guided Learning	25 hours	12.5 hours
Additional Hours	5 hours	12.5 hours

In response to the inclusion of repetitive Transcranial Magnetic Stimulation (rTMS) in the Medicare Benefits Schedule (MBS) in November 2021, and the requirements of the Commonwealth Department of Health, endorsement processes for rTMS training courses have been developed, which a Subcommittee of the CCPD oversees. Endorsed courses are published on the RANZCP website. The application form, which includes the educational criteria for endorsement, is provided as Appendix 9.1.1_6.

9.1.2 The education provider determines its requirements in consultation with stakeholders and designs its requirements to meet Medical Board of Australia and Medical Council of New Zealand requirements.

The CPD program is designed to enable participants to meet the requirements of the MBA and the MCNZ for maintenance of practising registration as a specialist psychiatrist. To ensure that the program aligns with these requirements, the RANZCP participates in all workshops, information sessions and forums conducted by the MBA and the MCNZ.

The CCPD, which has oversight of the CPD program, is a jurisdictional representative committee with a broad membership from a range of practice settings and areas of practice, and the membership includes representation from the RANZCP's CCC and the OTPC. There is not a trainee representative, as the TRC is focussed on the aspects of education that are of most relevance to the trainee body. The membership usually includes an early career psychiatrist. Its TOR are provided as Appendix 9.1.2_1. The CCPD continually reflects on the alignment of the program with the requirements published by the MBA and the MCNZ and has followed the development of the Professional Performance Framework over many years.

The College staff and CPD Manager monitor the developments of CPD in both Australia and New Zealand and provide advice to the CCPD on changes.

The program is evaluated primarily by CCPD at its bi-monthly meetings, which enables continuous quality improvement. RANZCP members are periodically surveyed regarding elements and resources of the program. The CEEMR and the EC also monitor the CPD program as part of their direct portfolios, with particular focus on the rates of compliance. The compliance with CPD is reported annually in the end of year Training and Assessment Update provided to the Board and published on the RANZCP website (Appendix 5.4.1_8).

The CPD Manager and CPD coordinator network with Medical College CPD Managers (and representatives) where there is opportunity for evaluation against comparable programs. They also liaise with the wider College, particularly IT, Membership and Communications, to ensure optimisation of the program and its resources to maximise member benefit.

Compliance with the CPD program is monitored by the CPD team through daily updates of the number of participants whose records show completion of all components. Additionally, the annual audit of 10% of participants identifies issues around how the program is interpreted by participants - for example their understanding of different sections, and this provides further quality improvement opportunities.

The following actions have been, or are currently undertaken, in response to evaluation of member feedback:

- communications to members regarding their compliance have been revised
- introduction of automatic alerts for Peer Dyads reaching the three-year expiry mark, has been developed as part of system review
- capacity in My CPD for reflection on and recording of cultural safety and health equity components in an activity has been introduced
- improved performance of My CPD on mobile devices
- enhancement of the "search" function in My CPD to enable members to find a PRG meeting their requirements with location, meeting format and area of practice
- development of My CPD to support tailored (including pro rata) programs, for example members on leave, and new Fellows
- review of the Refresher and Remediation programs
- review and revision of the format of the annual PRG survey to encourage greater response rates
- review and revision of the style and content of the CPD program to provide additional advice on what category an activity can be reported under.

The CCPD is currently reviewing the resources available for Multi-source Feedback (MSF). The forms and guidance for members to conduct their own MSF are being revised, and commercial options are being tested for their utility. The forms and guidance are provided as Appendix 9.1.2_2.

A dedicated CPD newsletter has been developed and introduced in March 2022. Designed to include an overview of the individual's progress as well as information on CPD opportunities and changes, the newsletter will initially be published quarterly during 2022. The response to the initial newsletter was very positive with an open rate of 66.49% which is significantly higher than the average open rate for RANZCP email campaigns of 50.5%. Appendix 9.1.2_3 gives the statistics for the first edition, and the newsletter is provided as Appendix 9.1.1_3.

Most recently, a sample of stakeholders was surveyed regarding the RANZCP CPD Program Guide, providing an opportunity for participants to provide feedback on the structure and requirements of the program as well as regarding the Guide itself. Consolidated feedback was reported to the CCPD for incorporation moving forward.

PRG Coordinators are surveyed annually regarding their groups, and this provides valuable feedback regarding the activity. This forms part of the required reporting to the New Zealand Ministry of Health and the Australian Department of Health to maintain the qualified privilege enjoyed by the activity. Reports are available on the College website (PRG survey results | RANZCP), and the reports from 2021 are provided as appendices 9.1.2_45 and 9.1.2_5.

There is a representative of the RANZCP CCC on the CCPD, with voting rights. This ensures that the views of consumers are heard by the CCPD and reminds the committee of the importance of the RANZCP's social contract with the community to assure the quality and currency of psychiatry practice.

9.1.3 The education provider's CPD requirements define the required participation in activities that maintain, develop, update and enhance the knowledge, skills and performance required for safe and appropriate contemporary practice in the relevant specialty(s), including for cultural competence, professionalism and ethics.

As outlined in 9.1.1, the CPD requirements clearly define the required participation in activities that maintain, develop, and enhance the knowledge, skills, and performance of psychiatrists.

The framework of the CPD program provides direction to meet this Standard. This is further supported by the embedding of the CanMEDs roles in the RANZCP Fellowship competencies.

The RANZCP CPD Program Guide advises:

> *"Competency-based education and training carries over into adult lifelong learning. The core Fellowship competencies, as outlined in the competency-based Fellowship training program, broadly define t he capabilities expected of all trainees on attaining Fellowship of the College. The concept of competency-based education is that these objectives, or competencies, should define the core skills needed for professional psychiatric practice"*

Members are encouraged to select learning activities appropriate to work settings and roles. The CCPD continues to emphasise the importance of performance- and team-based learning as its preferred learning approach. While completion of the program is essentially self-directed within the defined framework, and topics are not mandated, there is an emphasis on cultural competence and members are encouraged to specifically reflect on this component when entering activities to My CPD.

9.1.4 The education provider requires participants to select CPD activities relevant to their learning needs, based on their current and intended scope of practice within the specialty(s). The education provider requires specialists to complete a cycle of planning and self-evaluation of learning goals and achievements.

The mandatory PDP provides opportunity for participants to consider their learning needs and map their program. The "Think, Plan, Do, Review" model is emphasised in the RANZCP CPD Program Guide for the PDP. Several PDP templates and guidance on the development of a PDP are available on the College website (CPD Resources | RANZCP). The PDP templates and planning guide encourage a focus on the individual's scope of practice and includes the capacity for the scope of practice to be documented as part of the annual planning cycle.

While a mandatory secondary reflective component of the PDP is under development in My CPD, participants currently have the opportunity to self-evaluate learning goals and achievements upon entry of activities to My CPD – specifically the mandatory recording of "Learning outcomes" (see Appendix 9.1.4).

9.1.5 The education provider provides a CPD program(s) and a range of educational activities that are available to all specialists in the specialty(s).

The RANZCP CPD program is available to all specialist psychiatrists, with one exception. Psychiatrists who have a proven sexual boundary violation are not permitted to participate in any RANZCP activities Ethical Guideline 12 Zero tolerance policy on proven sexual boundary violations was adopted in March 2016, and the guideline is provide as an Appendix to this submission. (Appendix 9.1.5_1)

Activities that can be undertaken are listed in the Program Guide in summary Tables at pages 18, 21-23 and 26-30. Resources to support activities are available to all participants in the CPD program on the College website "CPD Resources" page. (CPD Resources | RANZCP).

Formal peer review, through RANZCP PRGs, is the corner stone of the program with more than 90% of members participating in at least one group. This strength of the program, and the participation rate of members, means that the move to increased formal peer review will not be too threatening for members. These groups, which operate under qualified privilege in Australia and New Zealand, are routinely cited by members as the most valuable CPD activity they undertake. Further opportunities for formal peer review are being developed through the novel Practice Peer Review activity following its successful pilot in 2020. This activity is discussed in greater detail at the end of this standard.

The RANZCP provides a full range of scientific conferences and webinars that are available to all members. This has continued despite COVID-19 with the RANZCP moving to either online and hybrid models. These activities, including the annual Congress, are listed in Appendix 9.1.5_2. CPD activities are a feature of the annual events calendar of all Branches, and a sample of the variety of activities are provided as Appendix 9.1.5_3.

A feature of the last two years during the COVID-19 pandemic have been the Member e-learning Education Sessions (MEES) webinars (Member Education E-Sessions | RANZCP), which have been evaluated and very well received by members. The evaluation is provided as Appendix 6.2.3_6. The success of this initiative has led to it being included in the normal annual program of events for the RANZCP, with increased resourcing being recruited for support. In addition to the MEES series, webinars have been embraced by the Faculties and Sections of the RANZCP for the provision of CPD content to their members. An example of this activity is the monthly Attention Deficit Hyperactivity Disorder (ADHD) Network Grand round Case Presentation.

In 2021 Psych Matters was launched, a podcast series published approximately every fortnight. A full list of podcasts since the launch is provided as Appendix 9.1.5_4.

Work is currently focussed on utilising more features of the SAP Litmos LMS used for Learnit, with the implementation of Learning Paths. Learning Paths are curated collections of activities (podcasts, e-learning modules, documents etc) on a particular topic, with learning checks. This work will facilitate the reporting of reading of key college documents (e.g., position statements, clinical guidelines) as CPD activity in My CPD and provide encouragement to more Fellows to read and consider these important documents.

A proof of concept/prototype on the topic of Family and Domestic Violence is in production with an anticipated publication date of June 2022. The full catalogue of e-learning modules and podcasts from the Royal College of Psychiatrists (RCPsych) is available to members, however, there is a new focus on increasing the Australasian content of the catalogue. Recent recruitment of staff with specific technical expertise will support the conversion of the significant audio-visual content that the RANZCP generates through virtual conferences and webinars into Learnit resources.

The RANZCP publishes two peer-reviewed journals which are utilised by members for professional reading:

- Australian and New Zealand Journal of Psychiatry (ANZJP)
- Australasian Psychiatry (AP).

In addition, RANZCP members enjoy access to a wide range of leading international medical journals and online psychiatric resources including:

- MEDLINE (full text)
- Psychology and Behavioral Sciences Collection (full text)
- the British Journal of Psychiatry (BJPsych) (full text)
- BJPsych Advances (full text)
- the Australian Journal of Rural Health (full text)
- World Psychiatry
- Discounted subscriptions to PEP-Web: Psychoanalytic Electronic Publishing.

RANZCP-endorsed activities and other events which can contribute to CPD are also advertised on the College website, in the new CPD newsletter and in publications such as the Psyche Bulletin.

9.1.6 The education provider's criteria for assessing and crediting educational and scholarly activities for the purposes of its CPD program(s) are based on educational quality. The criteria for assessing and crediting practice-reflective elements are based on the governance, implementation and evaluation of these activities.

Educational criteria, fees, application forms and the endorsement policy are published on the RANZCP Website (Apply for event endorsement | RANZCP) The CCPD considers the application against the educational criteria and if the application meets the criteria, endorsement and the use of the RANZCP logo is permitted.

Relatively few activities are endorsed by the RANZCP as the educational criteria are quite specific and require that activities are developed by, and targeted to, psychiatrists.

As the RANZCP program is a self-guided program, based on adult learning principles with the learner identifying their learning needs, the onus is on the learner to undertake relevant activities. This means that there is not an imperative for other educational providers to gain endorsement of the RANZCP. Many applicants for endorsement are advised that whilst their educational activities do not meet the endorsement criteria, they are clearly excellent educational opportunities and the RANZCP will promote them to the membership.

Applications for RANZCP endorsement by the CCPD must demonstrate how the following educational criteria are met:

- a learning delivery environment and support services are provided as needed that reflect the intent of the activity and are effective for achieving all expected learning outcomes
- content includes clear and concise learning objectives and intended outcomes for each learning event or activity based on identified needs
- learning outcomes are relevant to the scope of practice of a specialist psychiatrist and are based on sound clinical and educational principles
- qualified personnel are involved in planning and conducting each learning activity. If a psychiatrist has not provided advice or other input into the design and delivery of the program, the program must be sponsored or endorsed by a Fellow of the RANZCP
- procedures established during planning are used to assess achievement of the learning outcomes
- a complete, permanent record of each learner's attendance and satisfactory completion can be provided upon request
- the activity does not contravene any College policy and / or advocacy statement.

Suitability of other individual activities is assessed as per the Policy and Procedure for CPD Audits (Appendix 9.1.5_5).

The exception to this is training for the delivery of rTMS in Australia. In November 2021 rTMS for the treatment of major depressive disorders was included on the MBS with requirements that providers must have undergone training that is endorsed by the RANZCP. To accommodate this specific circumstance a subcommittee of the CCPD was formed comprising members with educational and subject matter expertise in rTMS. This group meets to consider the applications for endorsement of a course of training. Applications need to demonstrate how the course addresses the syllabus and curricular requirements specific to rTMS, including assessment and demonstration of learner competence.

Full details of the requirements relating to rTMS training can be found on the RANZCP website (rTMS endorsement | RANZCP)

Questions from members regarding the suitability of individual CPD activities can be answered through reference to the RANZCP CPD Program Guide or by contacting the CPD team via telephone during office hours or through cpdhelp@ranzcp.org.

Audits are conducted by the CPD administrative team on 10% of CPD claims each year for the purposes of quality assurance and in accordance with the requirements of medical boards and registration authorities. To achieve success in audit, participants must provide evidence to verify their participation in the minimum requirements of the program as outlined in the RANZCP CPD Policy (Appendix 9.1.1_5).

9.1.7 The education provider provides a system for participants to document their CPD activity. It gives guidance to participants on the records to be retained and the retention period.

Participants are required to document their CPD activity using the online My CPD system. Details of how to use the system are included in the Program Guide (page 7), with online Help being available within the system. An additional online tutorial is currently under development and will be supported by a pdf guide for those members who still prefer a hard copy.

PDPs are uploaded as a document, and various templates are available for use. A PDP developed as part of a member's employment can also be used if it includes relevant professional development goals. This reduces the paperwork burden on Fellows.

Most Fellows (>90%) are members of a Peer Review Group. Attendance at PRGs is recorded by the PRG Coordinator or the Recordkeeper of the group, if one is appointed.

All other CPD activities are submitted via a CPD activity form (Appendix 9.1.7_1) which requires the participant to enter:

- the number of hours for the activity
- start and end date
- the title of the activity
- a description of the activity
- the learning outcomes of the activity, involving a reflection on what has been learned and its application to practice.

The form allows the upload of relevant documents and for the activity to be recorded as having a cultural safety or health equity component. The learning outcomes would record the detail of the cultural safety of health equity component; the check box has been included as a prompt for members and also to assist with auditing.

The Policy and Procedure for CPD Claims (Appendix 9.1.7_2) documents the details of the requirements around reporting of CPD. The CPD year commences on 1 January and concludes on 31 December of each year, with an extended reporting period until 31 March of the following year.

While the Policy does not currently reference retention periods, this advice (3 years retention period, as advised by the regulators) is included in the CPD Program Guide.

9.1.8 The education provider monitors participation in its CPD program(s) and regularly audits CPD program participant records. It counsels participants who fail to meet CPD cycle requirements and takes appropriate action

Participation and progress towards completion of the CPD program is monitored daily through a dashboard that reports on completions and exemptions of the cohort for the CPD year. This data is graphed and provided to the CCPD and the EC for monitoring of overall completions. Additional reporting of the progress and compliance with each section is provided via a dashboard report to each CCPD and EC meeting. The dashboard report for the March 25 EC meeting is provided as Appendix 9.1.8_1.

In previous years, email reminders have been sent to members who have not completed all requirements of the program. In 2022, a new approach is being taken and all members now receive the quarterly CPD newsletter which gives an overview of the hours recorded in their My CPD record along with specific CPD news.

Each year, commencing in April, 10% of participants' records are audited by the College. New Fellows in their first full year of Fellowship and CPD participants who have been audited in the last 3 years, are excluded from the selection for audit. Participants whose documentation did not achieve the required standard when audited in the previous year may be selected for a repeat audit, in addition to those randomly selected.

If selected for audit, CPD participants are advised of their selection and required to ensure that evidence to support their claim is recorded in My CPD. To ensure that audits are undertaken with the minimum of imposition on participants, the College recommends that substantiating documentation is uploaded when entering activities on My CPD. For a record to meet the required standard, documentation in My CPD must show that the participant has completed a program of CPD sufficient to meet the minimum annual requirements. The audit is undertaken by the RANZCP College staff. Once their record is determined to meet the required standard, members receive their Certificates of Completion for that CPD year.

Failure to participate in audit requirements, for example, not providing requested additional information to verify CPD activities, may result in Fellows and Affiliates being referred to the RANZCP Board and potentially regulators.

The CCPD does not assess competence or performance of members, these are dealt with by regulatory bodies. There is a Membership Conduct Committee of the Board established to consider matters, as referred by the Board Directors and Chief Executive Officer, and, where appropriate, to make recommendations regarding the conduct of a College member. The CCPD may be called upon to verify CPD compliance.

Failure to complete the RANZCP CPD Program currently can result in Fellows' and Affiliate members' names being referred to the RANZCP Board. However, a procedure for management of CPD noncompliance (Appendix 9.1.8_2) has been approved by Board for implementation from 2022. This will be carefully communicated to members while being mindful of member wellbeing.

All members whose records are not complete at the close of the CPD reporting period (31 March) are followed up and their record is reopened for a period to allow them to report the missing activity. Members are supported by the CPD team who contact them offering specific support for what is missing in their records. If a PDP is missing, then the member will receive an email with PDP templates and a link to the PDP guidance. If it is Formal Peer Review that is short of meeting the requirement, the member is reminded of the alternatives to Peer Review Groups, such as formal second opinions or supervision.

The actions for members who have not met the CPD requirements despite the support of the CPD team differ according to the size of the deficit. If the deficit is five hours or less – what is referred to as a "small deficit" – the member is permitted to make up that deficit in the following year. So, for example, if a member has reported only nine of the required 10 or more hours of Formal Peer Review in 2021 their CPD program is modified to require 11 hours of Formal Peer Review in 2022.

If the deficit is greater than five hours, the reasons for the deficit are explored with the member. In many instances the deficit is due to circumstances that meet the criteria for deferral and, where appropriate, a retrospective deferral is granted. Where the member has no grounds for deferral, and no valid reason for not completing the required program, they are initially referred to the CCPD Chair for advice and/or resolution. If there is no resolution the member is referred to the Education Committee and the Board for further action.

When members are experiencing difficulty with particular aspects of their CPD, members of the CCPD provide informal counselling. This is always offered before other options such as the use of a remediation program for members who are serial non-compliers, and the Board reserves the option of removing Fellowship as a last resort.

Figure 9.1.8. Non compliance schedule 2022-2023

Tables 9.1.8_1 to 9.1.8_5 show the participation rates in the RANZCP CPD programs from 2017 to 2021. The total number of CPD participants has grown from 4231 to 4787 over the five years, and compliance rates have improved from just under 89% in 2017 to over 90% in 2019. In 2020, when CPD was not mandatory for continued registration in Australia and New Zealand, the compliance fell significantly, with 27.9% of members completing the requirements. However, the participation rate continued to be high, with 98.44% of members recording some activity in My CPD.

Table 9.8.1_1. CPD participation in 2017

Member Type	CPD participants #	Participants meeting requirements #	Participants meeting requirements (% Member Type)	Participants meeting requirements (% Total CPD participants)
Affiliate Australia	10	10	100	0.27
Affiliate New Zealand	174	160	91.95	3.78
Fellow Australia	3521	3128	88.84	73.93
Fellow New Zealand	362	319	88.12	7.54
Fellow Overseas	66	54	81.82	1.28
Individual	98	85	86.73	2.01
TOTAL	4231	3756	-	88.77%

Table 9.1.8_2. CPD participation in 2018

Member Type	CPD participants #	Participants meeting requirements #	Participants meeting requirements (% Member Type)	Participants meeting requirements (% Total CPD participants)
Affiliate Australia	12	12	100	0.28
Affiliate New Zealand	177	172	97.18	3.99
Fellow Australia	3583	3409	95.14	79.15
Fellow New Zealand	365	356	97.53	8.27
Fellow Overseas	67	64	95.52	1.49
Individual	102	93	91.18	2.16
TOTAL	4307	4106	-	95.33

Table 9.1.8_3. CPD participation in 2019

Member Type	CPD participants #	Participants meeting requirements #	Participants meeting requirements (% Member Type)	Participants meeting requirements (% Total CPD participants)
Affiliate Australia	15	14	93.33	0.31
Affiliate New Zealand	193	186	96.37	4.06
Fellow Australia	3765	3422	90.89	74.77
Fellow New Zealand	377	350	92.84	7.65
Fellow Overseas	88	78	88.64	1.70
Individual	111	93	83.78	2.03
TOTAL	4577	4143	-	90.52

The RANZCP received advice from the MCNZ and the MBA regarding CPD requirements for members during the COVID-19 pandemic. As a result, the RANZCP Board took the following actions:

- Completion of the 2020 CPD program was made voluntary, and it was not required for continuation of membership
- No audits were conducted of CPD submissions for the 2019 CPD year
- No audits were conducted of 2020 CPD submissions
- Certificates of Participation rather than completion were awarded to Members who did not complete all requirements of the 2019 or 2020 CPD years.

Table 9.1.8_4. CPD participation in 2020

Member Type	CPD participants #	Participants meeting requirements #	Participants meeting requirements (% Member Type)	Participants meeting requirements (% Total CPD participants)
Affiliate Australia	16	4	25	0.08
Affiliate New Zealand	206	84	40.78	1.77
Fellow Australia	3925	1072	27.31	22.57
Fellow New Zealand	388	107	27.58	2.25
Fellow Overseas	93	28	30.12	0.59
Individual	119	30	25.21	0.63
TOTAL	4750	1325	-	27.90

In 2021, CPD was resumed as normal and Australian and New Zealand psychiatrists were required to complete the usual 50 hours of the RANZCP CPD program. An audit of a random selection of 10% of CPD claims for the 2021 CPD year has resumed in 2022.

Table 9.1.8_5. CPD participation in 2021

Member Type	CPD participants #	Participants meeting requirements #	Participants meeting requirements (% Member Type)	Participants meeting requirements (% Total CPD participants)
Affiliate Australia	15	14	93.33	0.30
Affiliate New Zealand	215	213	99.07	4.54
Fellow Australia	3886	3793	97.61	80.77
Fellow New Zealand	375	366	97.60	7.79
Fellow Overseas	90	82	91.11	1.75
Individual	115	105	91.30	2.24
TOTAL	4696	4572	-	97.36

9.2 Further training of individual specialists

9.2.1 The education provider has processes to respond to requests for further training of individual specialists in its specialty(s).

The RANZCP has used endorsement of short courses to address requests for further training in the field. As previously mentioned under Standard 2 and standard 9.1.6, the RANZCP has worked with the Australian Commonwealth Department of Health to support the quality of rTMS delivered under the MBS through the endorsement of courses. To be eligible to claim the MBS benefit, psychiatrists must have completed one of the courses endorsed by the RANZCP.

For members returning to practice, guidance has been developed (Appendix 9.2.1) which includes advice regarding moving into a different area of practice. A refresher program is available and is discussed in more detail under standard 9.2.2.

Periodically there are requests from various quarters for mandatory training in specific topics to be included in the CPD program. Whilst the worth of the cause and training is not in doubt, mandating training in CPD presents significant challenges and does not meet the principles of adult learning. Mandatory training in a multitude of niche areas fragments the learning and is very difficult to pitch in a sufficiently nuanced way to meet the spectrum of experience and learning requirements that is present in the psychiatry workforce.

In response to this challenge, the RANZCP is investigating the full use of the capabilities of the SAP Litmos platform to provide Learning Paths, curating existing standalone educational activities along with relevant College documents relating to a topic, that can more readily be promoted to the Membership. It is hoped that this approach will be helpful in meeting the requests for inclusion of mandatory CPD components.

There are also opportunities for Fellows to undertake training in one of the Certificates of Advanced Training.

9.3 Remediation

9.3.1 The education provider has processes to respond to requests for remediation of specialists in its specialty(s) who have been identified as underperforming in a particular area.

There are two programs related to the remediation of specialists.

The Specialist Refresher Program (SRP) is available as a voluntary program for psychiatrists returning to practice following a period of up to 12 months away from practice. With an educational supervisor appointed in consultation with the RANZCP the participant prepares a learning plan with identified learning outcomes. Over a period of six to twelve months the learning plan is completed with the educational supervisor acting as a mentor to the participant. Most recently, an overseas trained psychiatrist in New Zealand was advised by the MCNZ to complete the program as they were changing their scope of practice from research to clinical. Policy to support the SRP is currently going through the approval process and the draft is provided as Appendix 9.3.1_1.

The Specialist Performance Remediation Program is a more formal and targeted program. To date, it has been undertaken by psychiatrists who have been identified by a regulator as having a performance issue that can be remediated through a focussed program of CPD.

It has mostly been used by the MCNZ over the last five years, with only a couple of psychiatrists having been referred to the program. Over a twelve-month period, the psychiatrist works with a College-appointed supervisor with monthly supervision meetings to ensure that the learning outcomes prescribed are being met. Issues that have been addressed by this program have included communication styles, record keeping and prescribing practices.

As the College moves to the more formalized reporting of noncompliance with CPD to the MBA and the MCNZ the SPRP will be used to address serial non-compliers with the CPD program.

The steps involved in the remediation process are outlined below:

- application
    - o the member must complete the Specialist Performance Remediation Program Application Form (Appendix 9.3.1_2)
    - o the RANZCP (represented by the CPD Manager) and member must jointly agree on a suitable educational supervisor.
- learning Plan development
    - o Using the educational framework of the CPD Program, the member and educational supervisor will determine learning needs and develop learning outcomes to:
        1. address knowledge of current developments in the field,
        2. develop clinical skills so that the Fellow / Affiliate can resume clinical practice competently and ethically
        3. participate in the RANZCP CPD program
        4. address any specific learning requirements identified by a referring regulatory body.
- progress and Supervision
    - o To support the member's progress, the educational supervisor liaises with the CPD Manager regarding progress and, at the program's conclusion, submits necessary evaluation documentation for the CPD Manager and CPD Chair's consideration. This may be noted in CCPD Minutes and escalated as per the SPRP Policy. Reports are provided to the relevant Regulatory Authority if required.

Part of the recent review of these programs was revision of the documents relating to Refresher and remediation programs, available at Refresher and remediation programs | RANZCP. These are completed and submitted by participants and, following further planned development will be accessible and reflected in in My CPD.

Additional information requested by the AMC in its response to the 2021 progress report

Updates to My CPD

My CPD continues to be updated with periodic releases to improve functionality for both members and staff.

A major update in 2021 provided greatly improved performance for the entry of CPD activity on mobile devices, both phones and tablets.

The next major release, due in April 2022 will provide:

- an enhanced search function for PRGs open to new members
- enhanced performance on mobile devices for PRG coordinators to enter attendance data
- the ability for My CPD to support tailored programs, for example members with pro-rata requirements.

Further development planned for release in the second half of 2022/early 2023 will include:

- an online PDP form
- a module for the management of the Practice Peer Review Program
- a module for the management of the SRP and the SPRP.

Practice Peer Review (PPR) pilot program.

The AMC has requested an update on the pilot of the PPR. The PPR comprises a series of structured discussions between two matched psychiatrists, facilitated by a third psychiatrist with some training in the principles of coaching. Figure 9.3.1 illustrates the structure of the program.

The evaluation of the pilot is provided as Appendix 9.3.1_3.

In the pilot, 114 psychiatrists participated with 48 peer dyads formed and supported by 27 facilitators. Evaluation surveys showed 74% of participants and 81% of the facilitators were satisfied or highly satisfied with the learning experience.

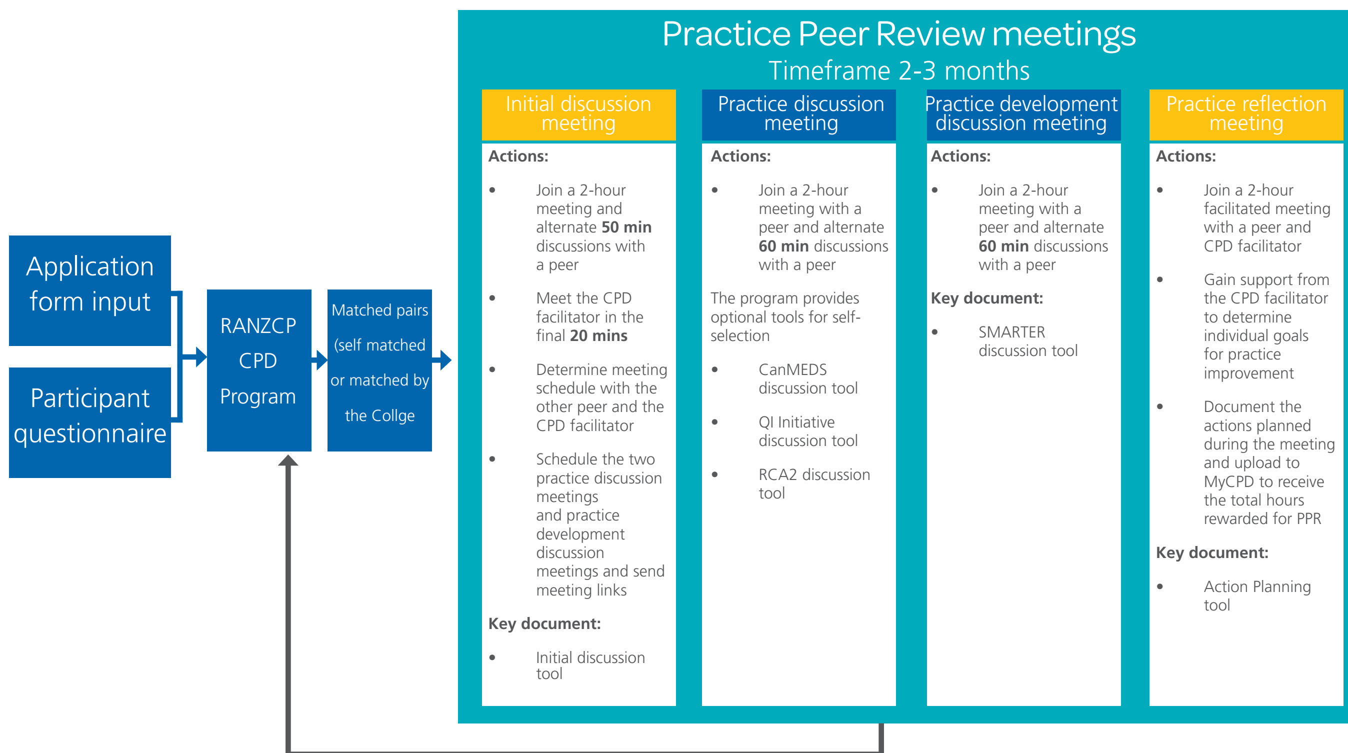
Evaluation showed that the PPR was seen by participants to improve psychiatric practice. A net promoter score of 28 indicates that participants are likely to recommend the activity to peers. Facilitators were less likely to recommend the PPR as an activity to their peers, however they still recorded a positive net promoter score.

One round of PPR will be offered during 2022 to further fine tune operational processes and it is expected that two rounds of the PPR will be offered annually as part of the CPD program.

Improvements to the 2022 round, based on the feedback on the pilot, include:

- simplification of the paperwork, with a streamlined application process, fewer tools and more succinct guidance
- increased and specific guidance to the facilitators
- further guidance on formats that can be used for the meeting
- the development of Learning Paths in Learnit for facilitators, using learning checks to ensure understanding of the role and its coaching focus.

Figure 9.3.1. Practice Peer Review



Standard 9b: Additional Standards for CPD – New Zealand

9.1.1 The education provider provides a recertification programme(s) that is available to all vocationally registered doctors within the scope(s) of practice, including those who are not fellows. The education provider publishes its recertification programme requirements and offers a system for participants to document their recertification programme activity.

The RANZCP CPD program is available to all doctors in New Zealand practising in the vocational scope of psychiatry. All RANZCP Fellows are enrolled at the time of admission to the Fellowship. Overseas trained doctors who choose to become Affiliates of the RANZCP are enrolled at the time of the formal acknowledgement of their Affiliate status by the RANZCP board. Those who do not wish to become Affiliates of the RANZCP are able to enrol in the CPD program upon payment of the published fee.

The requirements of the RANZCP CPD program are published on the RANZCP website and the CPD program guide, and specific requirements for New Zealand doctors are noted. This has been described in detail under standard 9.

As outlined previously under standard 9.1.7, My CPD, the online portal for the RANZCP program, is designed to accommodate the specific requirements of the MCNZ.

The RANZCP program allows for the mix of CPD activities required by the MCNZ and not only permits the reporting of activities related to the workplace it encourages this approach of embedding CPD in the workplace. The My CPD portal has been reconfigured to allow for New Zealand participants to record that they have had an annual conversation with a peer regarding their career and PDP, and guidance has been developed for a structured conversation regarding the PDP (Appendix 9b.1.1). While this guidance has been developed primarily for the use of PRGs, it provides a useful framework for discussions for smaller groups or pairs.

The MCNZ also require that there are resources that can be used for regular practice review. The PPR has been developed to provide the opportunity for regular practice review in a flexible COVID-19 safe manner that is accessible for all psychiatrists.

9.1.2 The education provider determines its requirements in consultation with stakeholders and designs its recertification programme to meet Medical Council of New Zealand requirements and accreditation standards.

The RANZCP attends all relevant meetings held by the MCNZ and the CMC. The CCPD includes a representative of the New Zealand National Committee, and at the present time has three New Zealand members, including the Chair. Through the New Zealand office, the RANZCP is involved with the work of the CMC on the development of cultural safety training frameworks and resources, and the College 's CPD team works closely with the NZ office on these matters. The College has relationships with key organisations such as Te Ora and the Pasifika Medical Association who help shape our work in New Zealand.

9.1.3 The education provider's recertification programme(s) requirements define the required participation in activities that maintain and develop the knowledge, skills and performance required for safe and appropriate practice in the relevant scope(s) of practice, including the areas of cultural safety, professionalism and ethics

Please refer to Standard 9.1.3 in the previous section.

9.1.4 The education provider determines the appropriate type of activities under each continuing professional development (CPD) category - The RANZCP assigns greater weight to activities that evidence shows are most effective in improving a doctor's performance

The RANZCP does not "weight" CPD activities, however it uses a minimum allocation of hours to ensure that activities that have been shown to be more effective are included in a doctor's CPD program. Hence, Formal Peer Review and Practice Improvement have mandatory requirements of 10 and five hours respectively in the 2022 program and these will increase in 2023 to a combined total requirement of 23 hours per annum with a minimum of 10 hours of Formal Peer Review and a minimum of 5 hours of Practice Improvement activities.

9.1.5 The education provider ensures that in each cycle, participants are required to undertake a mix of activities across all three CPD categories:

I. Reviewing and reflecting on practice

II. Measuring and improving outcomes

III. Educational activities (continuing medical education - CME).

The three CPD categories as defined by the MCNZ are incorporated within the RANZCP CPD program as outlined below:

- reviewing and reflecting on practice
    - o In the RANZCP program this includes Section 1 (the PDP) and Section 2 (Formal peer review)
- measuring and improving outcomes
    - o Section 3: Practice Improvement.
- educational activities (continuing medical education - CME).
    - o This would most often be achieved via Section 4: Self-guided learning (SGL). SGL activities include continuing medical education activities, research or other learning activities that support practice. These involve new knowledge acquired in a variety of settings and contexts.

Each of these sections has a minimum of hours required, therefore a mix of activities across all three categories is ensured within the program's annual requirement of a minimum 50 hours.

9.1.6 The programme requires participants to undertake a structured conversation, at least annually, with a peer, colleague or employer - The RANZCP offer a process and guidance to support this activity to ensure the greatest benefit is gained from this process

It is a requirement of the MCNZ that New Zealand members have an annual conversation with a peer about their practice. This often occurs within the workplace and should be demonstrated in the PDP. There is a new resource for use within Peer Review Groups to assist members with the development of their PDP (Appendix 9b.1.6). This tool provides a list of questions which can be used to stimulate discussions in PRGs. This not only helps NZ members achieve their "annual discussion" but can also help members plan what they would like to achieve in their CPD year.

It is not mandatory for PDPs to be discussed within a group however many members, binationally, find it useful. 10 hours (minimum) of formal peer review however is mandatory and here PDPs can be, and often are, discussed.

There is now capacity in the My CPD program for this annual conversation to be recorded in the CPD record.

9.1.7 The programme requires participants to develop and maintain a professional development plan

Section 1 of the program requires that participants develop and maintain a PDP. Guidance and templates are available for participants' use and an employer's template can be used if preferred. An online option in My CPD is in development.

9.1.8 The education provider ensures that cultural safety and a focus on health equity are embedded within and across all of the three CPD categories and all other core elements of the recertification programme - The recertification programme support participants to meet cultural safety standards.

My CPD now facilitates the ability to note if an activity includes a cultural safety or health equity component. This checkbox is optional and is introduced to help New Zealand members to meet their CPD requirements. The "checkbox" enables the RANZCP to monitor that this is embedded in activities. When making the My CPD entry there is opportunity for members to reflect on the activity and its learning outcomes and how cultural safety and health equity are considered.

Members are advised that the MCNZ sets the high-level requirements for recertification and continuing professional development (CPD) programmes for New Zealand doctors, and that it has published standards that describe the principles and values underpinning good medical practice, including standards for cultural safety.

The RANZCP New Zealand office is working on two projects that relate to cultural safety and health equity. Working alongside the CMC, the RANZCP is embarking on the development of a cultural safety framework which will guide further consideration of how cultural safety and health equity can be embedded across CPD programmes for all specialties. In addition, it is working on the implementation of cultural safety training for all trainees and psychiatrists through the Takarangi Competency Framework, which is designed for use in the mental health and addictions sector.

The College has published PS 107 Recognising the significance of Te Tiriti o Waitangi (provided as a link in Standard 1, section 1.6.4). This Position Statement aims to describe Te Tiriti within the context of improving hauora Māori (Māori health) and the steps RANZCP is taking to meet its responsibilities under Te Tiriti.

Tu Te Akaaka Roa and Te Kaunihera, working with other Committees including the NZTC and Vocational Education and Advisory Body Committee, have developed this position statement to ensure Te Tiriti informs the RANZCP's mahi (work) undertaken within a New Zealand context.

The position statement will support the RANZCP's policy and advocacy work, inform overseas trained psychiatrists, and be a reference document for training purposes and for CPD activities.

To ensure that courses endorsed by the RANZCP consider cultural safety and health equity, the application for RANZCP endorsement requests detail on how the education provider will ensure that cultural safety and inclusivity are accommodated within the context of the activity.

The CCPD is working with the PPPC to further develop resources to incorporate into the RANZPC CPD program and link-in the work of the Indigenous Board Priority Group – which encompasses cultural safety. Meanwhile there are links published in the Program Guide to noteworthy MCNZ resources, and a list of other resources is being compiled to make available to members.

9.1.9 The education provider makes available a multisource feedback process for participants to voluntarily undertake, should they wish to do so

Multi Source Feedback (MSF) is an activity which can be claimed in Section 3 and the RANZCP provides resources to support this as listed below.

- How to perform multi-source feedback
- Evaluation summary template
- Patient questionnaire
- Peer questionnaire
- Self-reflection questionnaire
- Invitation letter.

These resources are currently under review by the CCPD to provide more up to date tools and guidance. Committee members are also trialling commercially available MSF to determine their utility for psychiatrists in both private and public practice.

9.1.10 The education provider makes available a process for collegial practice visits (sometimes referred to as Regular Practice Review) for participants to voluntarily participate in, should they wish to do so

Collegial practice visits have historically been available to members via Section 2.2 of the program: "Practice Visits". However, the program has not enjoyed significant participation and a project instigated in 2019 to review and update the program was forced to reconsider its focus with the COVID-19 pandemic. The resulting PPR, described in detail in a the end of standard 9.3 in the previous section of this submission, is being introduced as a method of regular practice review which is:

- fit for purpose for psychiatrists
- accessible to all psychiatrists, regardless of location
- sustainable in a pandemic environment that has restricted the movement of individuals
- cost effective.

The RANZCP does not comprehensively collect information about the numbers of and outcomes for practitioners who undertake regular practice reviews, however this is an evolving part of the PPR and My CPD will be updated to incorporate improved recording of information relating to PPR as a specific CPD activity.

9.1.11 The education provider has a documented process for recognising and crediting appropriate and high-quality recertification activities that are undertaken through another organisation

Should an external organisation seek RANZCP endorsement of an activity for CPD credit it can do so, however it must meet specific criteria as previously discussed under standard 9.1.6. CPD participants undertake a self-guided program as adult learners, identifying areas for further development and deciding what activities will further their learning. If they complete an activity provided by an external organisation which does not have formal RANZCP endorsement, but which the participant deems to be appropriate for their learning the individual can self-report in My CPD. The annual QA audit of 10% of complete records provides a mechanism for checking that this is being used appropriately.

The CPD program guide provides clear advice on suitable activities.

9.1.12The education provider ensures there is a method by which review and continuous quality improvement of the recertification programme occurs

As outlined previously under section 9.1.2, the program is evaluated primarily by the CCPD at its bi-monthly meetings which enables continuous quality improvement. RANZCP members are occasionally surveyed regarding elements and resources of the program. The CEEMR and the EC also monitor the CPD program as part of their direct port folios.

The CPD Manager and coordinator network with Medical College CPD Managers (and representatives) where there is opportunity for evaluation against comparable programs. They also liaise with the wider College, particularly IT, Membership and Communications, to ensure optimisation of the program and its resources to maximise member benefit.

Additionally, the annual audit of 10% of participants, identifies issues around how the program is interpreted by participants, for example their understanding of different sections, and this provides further quality improvement opportunities.

9.1.13 The education provider has a process in place for monitoring participation and reviewing whether participants are meeting recertification requirements - The RANZCP defines the categories of participants (for example Fellows/associates/members) and the number of participants undertaking the recertification programme

This has been outlined previously under standard 9.1.8. The process for monitoring is the same for both Australia and New Zealand.

The categories of participants, along with the number of participants enrolled, are provided in Table 9b.1.12.

Table 9b.1.12. Categories of participation in the New Zealand recertification programme

Category	Number of participants	Deferred
Fellow – New Zealand	375	15
Affiliate – New Zealand	215	13
Individual – participating in the New Zealand CPD program	115	4

9.1.14 The education provider regularly audits the records of programme participants, including completeness of evidence and educational quality - The RANZCP has a process to address participants' failure to satisfy programme requirements (Explain if the process include action taken by the RANZCP to encourage compliance/re-engagement, and the threshold and process for reporting continuing nonparticipation to the Medical Council of New Zealand).

Each year, 10% of complete records are audited by the College at the conclusion of the extended reporting period on 31 March. To meet the standard of the audit, documentation in My CPD must show that the participant has completed a program of CPD sufficient to meet the minimum annual requirements. Where this is not clear, the participant is contacted by CPD staff in the first instance for resolution and support to correct the record. Failure to participate in audit requirements, or to satisfy programme requirements, currently may result in Fellows and Affiliate members being referred to the RANZCP Board.

All participants whose records are not complete at the end of the extended reporting period are contacted by the CPD staff. My CPD records are re-opened for a limited period to allow correction of any deficits and the CPD staff provide advice on what can be done to meet the standard. This includes suggesting activities which may have been overlooked, such as formal second opinions or professional reading. Where there is a small deficit, i.e. five hours or less, the deficit can be made up in the subsequent year. For example, if a participant has only logged nine of the required 10 hours of formal peer review, they are required to log 11 hours of formal peer review in the subsequent year. My CPD is currently being upgraded to enable this to be more visible to the participant.

Where this process of remediation is unsuccessful, and there is not re-engagement of the participant, their record is marked as not compliant, and a certificate of completion is not available to the participant. Their names are forwarded to the Board for noting. If necessary, members of the CCPD will provide direct counselling to participants who are experiencing challenges in completing their CPD programme.

Repeated non-compliance can lead to the participant being directed to the SPRP, and ultimately removal of Fellowship.

It has been usual practice for the RANZCP to report to the MCNZ New Zealand doctors who have been non-compliant in two consecutive years. However, it is anticipated that with the implementation of reporting requirements in Australia reporting to the MCNZ will become annual to streamline reporting processes and management of compliance.

In addition, the RANZCP complies with any request from the MCNZ as part of its regular audit practices.

9.1.15 The RANZCP reports to the Medical Council of New Zealand as soon as practicable when a participant fails to re-engage and satisfy programme requirements and gives immediate notification of any participant who withdraws from their programme

The RANZCP can meet any reporting requirement of the MCNZ regarding participants who fail to satisfy programme requirements and can notify the withdrawal of participants as soon as advised of a participant's withdrawal. The RANZCP is a signatory to a memorandum of understanding with the Medical Council outlining a joint commitment to ensuring doctors are safe and competent to practise. This sets out the circumstances for the reporting of participants who do not meet the requirements of the recertification programme.

The RANZCP does not collect information about whether practitioners have undertaken a credentialling process. Credentialling is a local employment requirement that differs between health services and jurisdictions. It is not practical for the RANZCP to collect this type of information and keep it current, some psychiatrists will undergo repeated credentialling if they are for example working as locums. Sometimes CPD staff are contacted for verification of members' participation in RANZCP CPD, however checks are not in place as such to otherwise ensure that practitioners are doing CPD appropriate for their clinical responsibilities. This is considered to be a professional practice issue and relevant to the individual and not to the RANZCP, which is not a regulatory body.

Standard 9: Documents provided check list

	Document
√	The continuing professional development program, /recertification program handbook Appendix 9.1.1_1 CPD Program Guide 2022
√	The policy on further training of individual specialists and returning to practice after an absence Appendix 9.2.1 Guidance for leave and return policy Refresher and remediation programs | RANZCP
√	The policy on remediation for underperforming fellows. Appendix 9.3.1_1 Specialist refresher program policy Refresher and remediation programs | RANZCP

Standard 10: Assessment of specialist international medical graduates

Standard 10: Assessment of specialist international medical graduates

10.1 Assessment framework

10.1.1 The education provider's process for assessment of specialist international medical graduates is designed to satisfy the guidelines of the Medical Board of Australia and the Medical Council of New Zealand.

From 2016 the 2012 Fellowship Program regulations were applied to all SIMG candidates who are assessed as Partially Comparable, with the requirement to successfully complete a minimum of 24 months full-time equivalent (FTE) on the Specialist Pathway, workplace-based assessments, and centrally administered summative assessments.

The 'Substantial Comparability requirements for RANZCP Fellowship' policy (Appendix 10.1.1_1) was updated to reflect the MBA Good Practice Guidelines for the specialist international medical graduate assessment process (2015) and confirms that 'it is expected that any gaps would be minor, for example, ECT training, or are feasibly able to be undertaken concurrently with the program'. This ensures that the supervised work placement can be completed within 12 (FTE) months.

Candidates who do not successfully complete the requirements within the specified timeframe may apply for an extension which is considered on a case-by-case basis. Candidates may also apply for a break during their period of supervised practice if they can demonstrate extenuating circumstances. Extensions or breaks are only approved for a small number (approximately 5% -10%) of substantially comparable SIMGs.

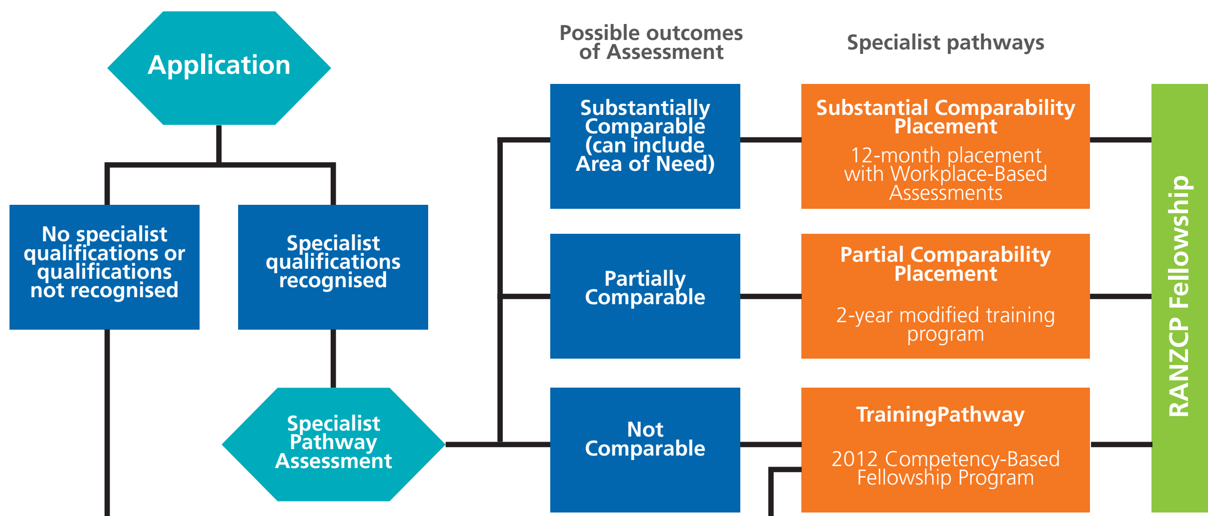
Specialist Pathway assessments are performed by CSIMGE-appointed and trained assessment panels. Assessment panel members must be RANZCP Fellows and have the role of evaluating SIMG applicants' comparability and, if applicable, their suitability to enter Area of Need (AON) specialist level positions. The assessment panels make a recommendation, taking into consideration the paper-based application and interview, to a CSIMGE member who is tasked with reviewing the application and final recommendation. If required, the CSIMGE can make the final determination on the assessment outcome and is responsible for the assessment procedures and processes, fairness and standardisation of assessments, and the delivery of the final outcome.

The process for assessment of comparability and AON is described in Appendix 10.1.1_2 and is shown in Figure 10.1_1.

The assessment panel makes a preliminary assessment based on the application documentation only. As part of this assessment the panel may specify if:

- further information about previous training, assessments and experiences is required by the panel prior to the interview - this may include requiring the applicant to resubmit the application with reference to the RANZCP training guidelines
- there are areas for clarification that the panel wishes to advise the applicant in advance are to be clarified at the interview - such as gaps in time or documentation
- advice is required from CSIMGE at its next monthly meeting as to how to proceed (e.g., uncertainty if the applicant holds the highest qualification in their home country).

Figure 10.1.1_1. Specialist pathway to Fellowship



The SIMG applicant receives a summary of preliminary review (SPR) letter after the completion of the preliminary assessment. The preliminary comparability assessment outcome is not communicated to the applicant however, the SPR letter provides the applicant with:

- indication if the primary source verification has been reflected on the AMC portal
- indication of the primary medical qualification and if this has been reflected on the AMC portal
- if the medical internship completed is comparable to RANZCP requirements
- the relevant specialist qualification(s) inclusive of a summary of relevant training dates and examinations / other learning as documented in the application. If areas for clarification have been identified in the preliminary assessment, the applicant will be advised within this correspondence
- confirmation if evidence has been provided as a specialist in the country of training
- a summary of specialist experience as documented in the application
- confirmation if evidence has been provided of CPD participation
- the scheduled interview date, time and location.

The applicant is expected to use the preliminary notification to prepare for their interview and is also provided with a minimum of 21 days to provide clarification of any identified errors or perceived gaps in training or experience, or to submit additional evidence that may have been omitted in the initial application.

Following the paper-based assessment, and considering any additional information provided in response to the SPR, the applicant is interviewed. Interviews are intended to be face-to-face, however videoconference interviews have been acceptable for those applicants who are not in Australia or New Zealand. In response to COVID-19, videoconference has been utilised for all interviews. Up to one and a half hours is allocated for conducting the interview. The interview must take place within six months of the preliminary paper-based assessment, or the assessment will expire, and the applicant will need to reapply for Specialist Pathway assessment.

The interview seeks to:

- determine comparability by confirming or clarifying details of the training, qualification and experience as outlined in the application

- provide an opportunity for the applicant to gain an understanding of the standards of competence and safe practice expected of a specialist psychiatrist in Australia or New Zealand
- consider matters of the applicant's good standing and fitness to undertake a pathway to Fellowship. For example, to explore gaps in employment, idiosyncratic progress through training, stalled progress post specialist training, quality of commentary by referees, employers or peers which may indicate the applicant may be /has been at some time an impaired doctor/ not of good character/or not in good standing. The personal declaration statement is an important adjunct to this consideration
- clarify the applicant's suitability for an Area of Need position (if applicable).

Area of Need (AON)

The AON page page outlines the application process and requirements for SIMGs who wish to take up an AON position

SIMGs who wish to work in an AON/Specialist position must identify a position for which an employer considers them suitable and gain an offer of employment for that position. Applicants must undergo an AON assessment by the RANZCP and be found to have the necessary skills to work competently and safely in the designated AON position. Generally, applicants would require to be assessed as Substantially Comparable to meet the requirements for an AON position.

Specialist assessment and AON assessment can be applied for, and will be assessed by, the RANZCP concurrently. Information on applying concurrently for specialist assessment and AON assessment is available on the Applying for specialist assessment page.

A SIMG who is approved for an AON position is only permitted to work in that specific AON position. If the position description changes, or the SIMG wishes to move to another AON position, a new AON application must be submitted to the College with the required supporting documents and application fee.

New Zealand

In New Zealand, the MCNZ seeks advice from the Vocational Education and Advisory Body (VEAB) for psychiatry via the New Zealand National Office regarding a SIMG's training and experience. This process of assessment for vocational registration is independent of the RANZCP pathway to Fellowship for SIMGs, and specific guidance on what is required for assessment of psychiatry qualifications and experience is provided on the MCNZ website and is provided as an Appendix (Appendix 10.1.1_3) to this submission. The MCNZ may overturn the decision of the VEAB. The report of the activity for 2021 is provided as an Appendix to this submission (Appendix 10.1.1_4).

Most SIMGs in New Zealand do not pursue the FRANZCP qualification, preferring to follow the MCNZ pathway to registration in a vocational scope of practice. If they wish they may apply to become Affiliates of the RANZCP once their vocational registration has been confirmed.

A SIMG who has vocational registration in New Zealand and is seeking FRANZCP with the intention to work in Australia as a psychiatrist must submit either a Specialist Assessment only application to the RANZCP, or if applying for an AON position, a combined AON/Specialist Assessment application to the RANZCP.

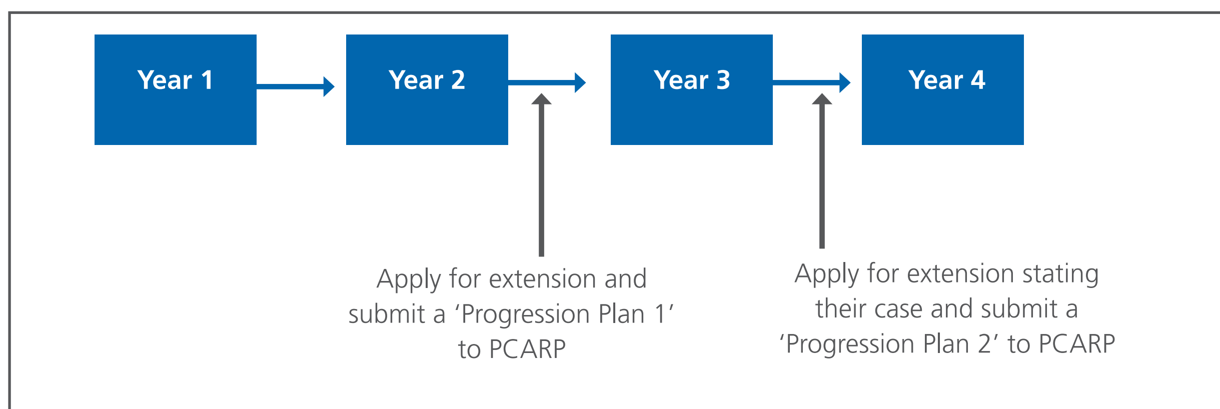
SIMGs residing in New Zealand who seek to pursue FRANZCP and who are not seeking to practice psychiatry in Australia, can apply for Specialist Assessment only by the CSIMGE. A panel of accredited New Zealand assessment panel members (Fellows of the RANZCP) convenes on an ad hoc basis to review applications and conduct assessment interviews. The RANZCP Specialist Assessment process, policy and procedure for New Zealand applicants remains consistent with those for Australian applicants.

Extension of Comparability Status

Partial comparability candidates

The extension process was developed as illustrated in Figure 10.1.1_2 based on the time requirement in the specialist pathway. The AHPRA Best Practices Standards require that the maximum time on the specialist pathway provided to partially comparable candidates is 'a total of four years to complete up to 24 (FTE) calendar months of supervised practice and upskilling with associated assessment including formal examinations where required' Possible reasons for seeking extension include failure to complete one or more centrally administered summative assessments within the 24 month timeframe, failure of one In-Training Assessment (ITA) or requiring a break in comparability status.

Figure 10.1.1_2. Revised extension of comparability status process



Process for seeking extension after 24 months

- candidates apply for the first extension and provide an educational plan to be called 'Progression Plan 1' as part of their application for extension
- PCARP reviews the application and the plan – if satisfied, an extension can be given for 12 months. Where an extension is being sought for a failed ITA, a six-month extension will be granted
- extensions are noted by the CSIMGE
- a support letter from the employer is required for all applications for extension.

Process for seeking a second extension after 36 months

- submission of an application and a second detailed educational plan, Progression Plan 2
- PCARP reviews the application and the plan – if satisfied with the plan, an extension can give for a further 12 months
- PCARP clearly specifies that this is the final extension – if the candidate fails to successfully complete the pathway requirements during this extension, the PCARP will be recommend to the CSIMGE for withdrawal from the pathway
- extensions noted at the regular CSIMGE meeting.

If PCARP decides not to grant the second extension, the Chair will write to the CSIMGE recommending that the candidate be withdrawn from the specialist pathway, providing reasons for the recommendation.

Whilst the policy suggests that no further time extension will be provided if a candidate fails four times in an assessment or in three end of rotation ITAs, the merits of each case are considered individually by the CSMIGE and the EC. In response to the challenges of COVID-19 there has been additional flexibility allowed for the duration of the pathway and the number of examination attempts.

Failure of three attempts at a summative assessment/ failure to successfully complete two ITAs

Where a candidate is unsuccessful in three attempts at the OSCE or three attempts at the Essay examinations, a Progression Plan must be submitted prior to a fourth attempt being granted.

Candidates who fail two ITAs are also required to submit a Progression Plan before they can be granted an extension to complete and get their required time accredited on the pathway.

Figure 10.1.1_3. Failure at Summative Assessment

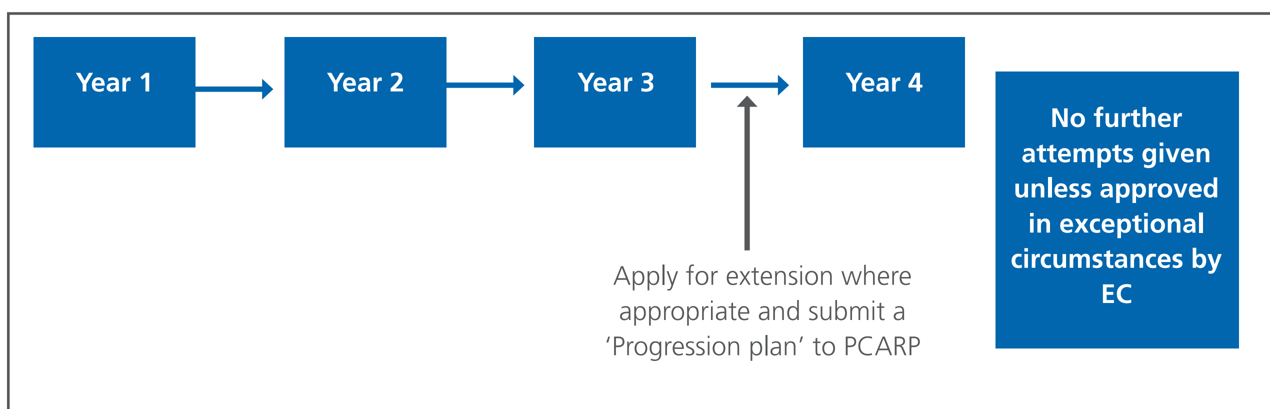
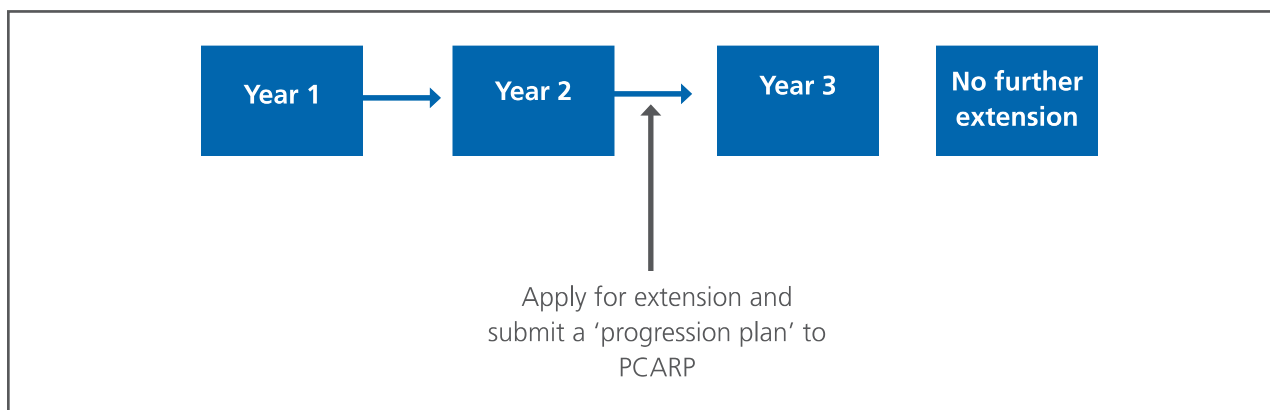


Figure 10.1.1_4. Failure at two ITAs



Candidates failing to make any attempt at an assessment

Candidates must attempt an assessment within the 24 months on the specialist pathway. Failure to do so may result in not being granted any extension and withdrawal from the specialist pathway.

Requirements of a Progression plan

The underlying principle for submitting the progression plan remains relevant as per Section 9.1 of the Maintenance policy. Candidates are required to submit an achievable educational plan focused on successful completion of their outstanding requirement. It is important that the progression plan is supported by the candidate's employer and supervisor.

The plan should address in detail:

- progress that has been made to date
- outstanding requirements
- results from previous failed attempt/s clearly identifying the domains, topics, and areas where the candidate did not meet the standard expected at the end of Stage 3

- a self-reflection on previous examination attempts, with clear actions to address each area needing improvement – these are not limited to content and may include personal issues such as anxiety, time management issues or inter-personal skills
- consideration of any other issues that may impact the candidate's progression towards Fellowship
- an action plan clearly outlining what measures and strategies will be put in place to ensure improvements in areas of weakness
- time frames to complete all outstanding requirements and/or assessments
- identification of support resources such as trial and practice examination sessions, attendance at workshops and appropriate preparation opportunities, especially in areas of practice where the candidate previously did not perform well.

Progression plans are generally required be submitted within three weeks of the date of the outcome letter from PCARP. The timing is tight to ensure the candidate has the best opportunity to successfully complete the requirements within the AMC/AHPRA time frames.

Changes regarding extension of comparability status and approval to sit a summative assessment after three failures at that assessment were implemented to offer a more streamlined, fair, and objective process where decisions can be taken in a timely manner.

The Changes to the Show Cause and Extension Processes were published on the College website in May 2018 and candidates informed via email. The Communique is provided as Appendix 10.1.1_5. As these changes were to the advantage of the RANZCP SIMG candidates there was minimal impact to candidate and changes were implemented with immediate effect.

10.1.2 The education provider bases its assessment of the comparability of specialist international medical graduates to an Australian- or New Zealand- trained specialist in the same field of practice on the specialist medical program outcomes.

Applications made to the RANZCP for practice as a psychiatrist in Australia are assessed in three main aspects:

- specialist psychiatrist equivalence (training, qualification, and experience) to RANZCP
- supervision and upskilling requirements to be met, as evidence by seniority, familiarity with practice in Australia, and any gaps in training and experience
- suitability for employment offered in a deemed AON position (if applicable).

The purpose of the RANZCP Specialist Pathway assessment process is to determine the level of comparability a SIMG psychiatrist has to a Fellow of the RANZCP. The process involves assessment of the training, qualifications and experiences of the SIMG applicant using the Comparability Assessment Form (CAF) scoring method (Appendix 10.1.2_1). This involves reviewing the application documentation (paper-based assessment), as well as conducting an interview of the applicant. Taking the paper-based assessment and interview into consideration, the applicant is scored on each of the domains in the CAF:

- qualifications
- training program standards
- accreditation criteria
- scope of practice as consultant psychiatrist
- adaptation to practice in Australia or New Zealand as a consultant psychiatrist and/or Advanced Trainee equivalent
- recognition of further learning
- progress factors (for SIMGs who are reapplying for Specialist Pathway assessment).

A score is given for each domain and the final score determines whether an applicant is deemed substantially, partially, or not comparable.

A Comparability Assessment criteria checklist (Appendix 10.1.2_2) is available to assist applicants in determining the level of comparability of their training and qualifications.

10.1.3 The education provider documents and publishes the requirements and procedures for all phases of the assessment process, such as paper-based assessment, interview, supervision, examination and appeals.

The RANZCP Specialist Assessment process, policy and procedure for both Australia and New Zealand are published on the Overseas Specialists, Applying for Specialist Assessment page.

Applicants are advised to familiarise themselves with the Specialist pathway handbook (Appendix 10.1.2_3) as it contains detailed information regarding the different stages of the process. The Flowchart of specialist pathway and Area of Need application process is also published on this page and shows the steps involved in specialist assessment with the expected timeframes(Appendix 10.1.2_4).

A Comparability Assessment criteria checklist is provided to assist applicants in determining the level of comparability of their training and qualifications (Appendix 10.1.2_2).

The Forms and documents webpage provides links to the Complaints resolution and appeals policies and procedures that may be applicable to SIMGs.

The application process is supported by robust review and administrative processes to ensure that SIMGs can be kept informed of the progress of their application at any stage. In the event of any appeals by an applicant, a robust administrative process facilitates the consideration of that appeal. The administrative process is summarised below. An annual schedule of critical assessment dates, designed to meet the performance indicators set by Ahpra, is provided as Appendix 10.1.2_5.

Assessment Panel

The CSIMGE retains oversight of the whole process. Each assessment panel is allocated a CSIMGE member as a 'Mentor' who is an immediate resource to assessment panel members for advice on any aspect of a particular application. The CSIMGE maintains responsibility for Specialist Pathway assessment procedures and processes, for ensuring the fairness and standardisation of assessments and for delivering the final determination.

Upon receipt by the RANZCP of a complete application for Specialist Pathway assessment, a panel is assembled within the required timeframe via a Survey Monkey availability survey. The survey is sent to all suitably trained assessment panel members in the relevant Australian state or territory/New Zealand the applicant will be moving to. Suitability of panel members includes declaration of Conflict of Interest.

The assessment panel members and the CSIMGE Mentor receive a copy of the complete application from the RANZCP SIMGE administrative team generally via the RANZCP online portal. The allocated assessment panel members individually review each application. All panel members complete a paper-based assessment of the application and complete a preliminary CAF, which is submitted to the RANZCP SIMGE administrative team.

Panel members discuss their paper-based assessment outcomes to reach a preliminary consensus and complete a Preliminary Summary Form D with the panel's preliminary consensus score. The Form D and Preliminary CAF's are submitted to the RANZCP SIMGE administrative team by the required date, as per the internal assessment schedule. (Appendix 10.1.2_6) Through Form D, the assessment panel may request the RANZCP SIMGE administrative team to seek specific additional information, documentation, or clarification from the applicant, to be provided prior to or at the scheduled interview.

A preliminary decision is made, which specifies:

- information about obtained training, assessments and experiences required by the panel to be submitted by the applicant **prior to the interview** - this may include requiring the applicant to resubmit their training and experience information as documentation with their application form with reference to the RANZCP training guidelines and Comparability Assessment criteria checklist
- areas which the panel wishes to advise the applicant are to be clarified **at the interview** - such as gaps in time or documentation, quality of experiences.

The SIMG applicant receives a Summary of Preliminary Review (SPR) letter from the RANZCP SIMGE administrative team advising of their scheduled interview date, time and location, as well as any items requiring further clarification prior to or at interview. The preliminary comparability assessment outcome is not communicated to the applicant, however qualitative feedback is provided in relation to the domains scored as per the Comparability Assessment criteria checklist.

The applicant is expected to use the preliminary notification to prepare for their interview and to keep RANZCP informed of any changes to his/her plans.

If the assessment panel cannot reach an interim decision based on the application submitted, the Chair may either:

- request the applicant to submit additional information, or
- seek advice from the CSIMGE at its next monthly meeting as to how to proceed.

Interview

The assessment panel attend a pre interview discussion at least half an hour before the scheduled interviews to confirm the structure of the interview and any specific points to be covered. During the interview, assessment panel members record notes. At the conclusion of the interview, the panel has a discussion and reaches a consensus. The Chair completes a final recommendation form, Form F (Appendix 10.1.2_7), based on the consensus findings. Form F needs to convey to the CSIMGE:

- Brief reference to the information upon which the panel relied e.g., "Dr X's interview evidence supported the application evidence of satisfactory completion of all equivalent RANZCP mandatory training and experiences, and of five (5) years peer reviewed post specialist qualification experience as a consultant psychiatrist"
- Suitability for employment in an AON position (if applicable), specifying any limitations on the nature and extent of their practice and supervision requirements
- Exact details of additional training and experience required.

For complicated applications/assessments, the information needs to reflect assessment panel reasoning and justify recommendations about advanced training or Psychotherapy experience. In the case of straightforward applications/assessments, this information only needs to be brief. When a not comparable outcome is recommended, the justification needs overall detail and specificity. In cases where further information is required, the recommendation may be delayed but there are mandatory timelines which must be met.

When consensus cannot be reached, the Chair discusses the issues with the Mentor.

Form F is then submitted to the SIMGE administrative team, and once approved by the Mentor, the final outcome letter and accompanying MBA report 1 or Combined report summarising the comparability decision is issued to the applicant with copies going to the panel members, SIMG DOT and uploaded to the AMC portal for AHPRA registration purposes.

Clarification of the final outcome

SIMG applicants who disagree with the final outcome of their assessment can submit a request for informal reconsideration to the CSIMGE for review at its next monthly meeting. SIMG applicants may not at any stage communicate with individual assessment panel members about any matter related to their application or employment. If approached, assessment panel members are advised to decline to respond, direct the applicant to the RANZCP SIMGE administrative team, and to inform the CSIMGE.

The procedure for SIMG applicants to follow is available on the Complaints Resolution page of the RANZCP website.

Training and assessment complaints are recorded internally by the SIMG Administrative team and reported annually to the MBA.

Scheduling of assessments

Applications cannot be submitted to the assessment panel for assessment until they have been deemed complete by the SIMGE administrative team. The documentation requirements are listed for the applicant within Section 17: Application Checklist of the 2022 Specialist Pathway assessment application form. The key steps in the process are provided in Table 10.1.2 below.

Table 10.1.2. SIMGE Key Administration processes.

Step	
Step 1 Application closing date	Monthly dates are outlined in the 2022 National Assessment Panel dates document available to applicants on the RANZCP website.
Step 2 Availability survey sent out	Generally on the Tuesday after the application completion date, the SIMGE administrative team will email the pool of accredited assessment panel members seeking their availability for the upcoming round of assessments. The email will include a link to the online Survey Monkey survey.
Step 3 Availability survey returned by	For this process to work efficiently, a response to the survey is required by the following Friday to allow College staff to finalise the schedule for the assessment round.
Step 4 Confirmation of schedule	College staff will collate all responses from the online availability survey and will match up ideally three (3) assessment panel members with the same available dates and times to conduct the paper-based assessment and interview for the assessment round. A confirmation email will be sent to the allocated assessment panel members with an interview schedule attached. Allocated assessment panels will be given the opportunity to make any changes to the interview schedule. The assessment panel members not required for the round will also be advised at this time via email.
Step 5 Applications received by assessment panel members	Applications are uploaded to the RANZCP online portal by the SIMGE administrative team for the relevant Australian state or territory/New Zealand assessment panel members to access.
Step 6 Reminder email Form D	The Chair records the preliminary assessment details in a Form D and submits to the College. College staff will email a reminder to the scheduled panel members about two (2) days before Form D is due.
Step 7 Preliminary decision	The Chair collates three (3) CAFs from each of the allocated panel members, leads a consensus discussion, identifies any gaps in information to be sought and reaches a conclusion. The Chair records the preliminary assessment details in the Form D and submits to the College in addition to a preliminary consensus CAF. The three preliminary CAFs from each individual assessment panel member are also submitted to the College.
Step 8 Preliminary outcome	After receiving Mentor approval, College staff will send a preliminary letter to each applicant advising of the interview date and time, as well as outlining any items for clarification required prior to or at interview.

Step	
Step 9 Interview reminder email	One (1) week before the scheduled interview, College staff will email a reminder to panel members and branch staff with the interview schedule attached and relevant forms to be completed following the interview/s for that round. Panel members will have received advice of the interview dates and times earlier in Step 4.
Step 10 Interviews	The allocated assessment panel members conduct the interview for each applicant generally within the allocated interview week and complete the relevant forms.
Step 11 Form F and final CAF returned to College staff	The Chair submits a completed Form F and final consensus CAF to the College following the interview.
Step 12 Final assessment outcome released	After final CSIMGE Mentor approval, The SIMGE Administrative team will send a final assessment outcome letter via email to each applicant in the assessment round as well as an accompanying MBA Report 1 or Combined report which is then uploaded to the AMC portal shared by the MBA/ AMC/Specialist Medical Colleges for registration and assessment purposes.

10.2 Assessment methods

10.2.1 The methods of assessment of specialist international medical graduates are fit for purpose.

As mentioned under standard 10.1.2, the CAF is the tool used to assess the comparability of SIMG candidates. This is specifically designed to assess the experience and training of the SIMG to determine the degree to which they align with that of Australasian psychiatrists. The domains of the CAF, outlining the elements currently assessed, are shown in Table 10.2.1.

This illustrates that key to assessment of the comparability of a SIMG candidate is what deficits they have in knowledge, skills, and experience in comparison to a trainee completing the RANZCP Fellowship Program. This ensures that the graduate outcomes of the Fellowship Program, which are designed to meet the needs of the Australian and New Zealand communities, are achievable by SIMG candidates.

In alignment with the guidelines and regulations of the AMC and the MBA, there are two SIMG pathways to Fellowship of the RANZCP, Substantial Comparability and Partial Comparability, each with its own assessment requirements.

Substantially Comparable SIMG candidates are assessed within the workplace using:

- Supervisor placement reports
- CBD assessed by an external assessor
- Multi source Feedback.

These assessments are appropriate and fit for purpose as the SIMG's training and experience has been assessed as being substantially comparable to that of a trainee completing the RANZCP Fellowship program. The substantially comparable SIMG has demonstrated specialist psychiatric knowledge and the competencies demonstrated by trainees in the RANZCP centrally administered summative assessments through an equivalent program in their country of qualification. Substantially comparable candidates tend to come from or have significant work experience in countries with similar health systems to those in Australia and New Zealand. The assessment is of the SIMG candidate's capability to practice as a psychiatrist in the Australasian context. This work is overseen by the Substantial Comparability Assessment Review Panel (SCARP) of the CSIMGE.

From 2016, the 2012 Fellowship Program regulations applied to all SIMG candidates who were assessed as Partially Comparable. They are required to complete a minimum of 24 months FTE time on the Specialist Pathway, including the completion of a series of workplace-based assessments and centrally administered summative assessments.

These assessments are appropriate and fit for purpose as Partially Comparable SIMGs have deficits in their knowledge, skills, and experience in comparison to that of a trainee completing the RANZCP Fellowship. These assessments are required for the Partially Comparable SIMG candidates to demonstrate the competencies required of doctors completing the RANZCP Fellowship. This work is overseen by the PCARP of the CSIMGE.

A significant change with the application of the 2012 Fellowship regulations was the removal of the Modified Observed Clinical Interview (MOCI) examination and the implementation of workplace-based assessments.

Further review and adjustments to process may be considered in response to an anticipated increase in the number of applicants in coming years.

Table 10.2.1. Domains of the CAF

Domain	Description	Maximum Score
Qualifications	1.The highest qualification in clinical psychiatry to enable registration for practice as a specialist psychiatrist in the country of their qualification 2.Qualification by national external written and clinical examination which is accredited by an independent national body.	3
Training program standards	3. Mental Health Program includes: • acute Inpatient services integrated with general hospital services, including emergency and accredited ECT program • community-based ambulatory services linked with mobile outreach services (CAT/ CCT/homeless) • MDT led by psychiatrists within bio-psychosocial mode • public /private mix • Mental Health Act (MHA), includes appeal/external review processes • significant participation of consumer, carer and NGO sectors in service delivery.	18
	4. At least 3 years (FTE) basic training following enrolment in a formal training program. Regular participation in formal participatory educational program benchmarked against international standards, throughout training. Sub-specialty experiences delivered in dedicated rotations; rotation-specific supervision. Mandatory experiences in general adult psychiatry and ECT; and selection of old age psychiatry, addictions, forensic and indigenous.	
	5 Satisfactory participation in supervision that comprises problem-based and professional development centred individual time by specialist psychiatrist in addition to any group delivered supervision; Supervision that was regular, and includes direct observation, modelling, feedback, and formal evaluation – formative/summative.	
	6. 6 months (FTE) Child and Adolescent Psychiatry training (Basic or Advanced).	
	7. 6 months (FTE) Consultation-Liaison Psychiatry training (Basic or Advanced).	
	8 Psychotherapy or equivalent training as per RANZCP Regulations. (psychodynamically informed therapy and long case; supportive psychotherapy; cognitive behaviour therapy for anxiety).	
	9 Advanced training of at least 2 years (FTE) includes RANZCP equivalent biological, social, psychological, management, leadership, and ethical experiences, scholarly project, and ongoing assessment and supervision.	
Accreditation criteria	10 National Mental Health Care Plan	9
	11 External accreditation of Health Service by national or state body	
	12 External accreditation of training program by national or state body	
	13 PGY1 (2): range of rotations, national curriculum, formal teaching, supervision direct observation, and formative/summative evaluation	

Domain	Description	Maximum Score
Scope of practice as consultant psychiatrist	16 Number of years as consultant psychiatrist after obtaining the highest psychiatry specialist qualification • Less than 3 years – score of 0 • 3-4 years – score of 1 • 5-9 years – score of 2 • 10 + years – score of 3 17 Quality of Scope of practice includes: • the assessment, investigation, diagnosis, including formulation and management of mental health issues in inpatient, outpatient and on call acute and emergency environments as a consultant specialist and in collaboration with multidisciplinary mental health teams. • the ability to develop an in depth understanding of the individual and their environment that encompasses their history, life trajectory, familial and socio -cultural milieu. • an awareness of the values, goals, autonomy, family relationships and community of that individual. • the capacity to provide physical, medical, psychological and social therapies for mental illness and related conditions. • the ability to provide leadership, collegial support and collaboration with multidisciplinary teams and multiagency care providers. • the capacity to provide training and guidance to junior medical staff. • an awareness and ability to utilise mental health and other relevant legislation. • evidence of continuing professional development (peer review; supervision/ second opinion; self-directed learning; accredited courses)	6
Adaptation to practice in Australia or New Zealand as a consultant psychiatrist and/or advanced trainee equivalent	18 Demonstrated participation in activities which enable adaptation to psychiatric practice in Australia and/or New Zealand including cultural awareness whilst working in a Consultant Psychiatrist, Staff Specialist, Advanced Trainee Equivalent, or Senior Medical Officer post.	2
Recognition of further learning – evidence of progression, continuity and currency	19 Clinical Rigour: Key leadership role (e.g. unit head) in a substantive component unit of a multimodal service with clinical care, supervisory, teaching and leadership responsibility. Evidence of: • excellence in clinical function (as evidenced by serial multisource feedback or equivalent workplace peer review) • excellence in supervisory function (as evidenced by formal evaluations or outcomes • significant documented contributions to clinical service quality improvement through e.g. audits, root cause analysis, critical incident management as evidenced by outcomes • sound participation in local/regional service development/ management; • sound participation in RANZCP or other College /Professional Association activity • further qualification of at least diploma level	9

Domain	Description	Maximum Score
Recognition of further learning – evidence of progression, continuity and currency	20 Academic Rigour: • further academic qualification • academic appointment to senior lecturer or equivalent • publications in international/national peer reviewed journals • editorial contributions to well recognised national/international journals • invitations to deliver papers at well recognised national/international meetings • significant contributions to notable national /international academic societies • funded research projects (as evidenced by research grants received) • excellence in teaching (as evidenced by formal teaching evaluations/ initiatives).	
	21 Administrative Rigour: • senior administrative/budgetary responsibility for services of the extent and complexity generally found in Australian regional or metropolitan district centres • evidence of sound contribution to quality improvement and service development projects • evidence of sound contributions in working with consumer, carer and NGO groups • evidence of involvement in National /Regional Mental Health Policy development • an additional qualification in management.	
Progress Factors	22 Lack of Evidence of Continuous Professional Development to a satisfactory standard:– Scores -1	Provide a negative score of up to -3
	23 Progression to Fellowship (for existing candidates): • 3 or more failed attempts at clinical examination 3 attempts (-1), 6 attempts (-2), 9 attempts (-3). • Deficient progression for 6 months (-1), 12 months (-2), 18 months (-3).	

10.2.2 The education provider has procedures to inform employers, and where appropriate the regulators, where patient safety concerns arise in assessment.

The Maintenance of Comparability Status on the Specialist Pathway policy (Appendix 10.2.2) states in Section 13 that monitoring of candidates on the Specialist pathway will involve 'regular assessment of candidate's professional and ethical conduct throughout their time on the Specialist Pathway, including their interactions with the College and workplace'. In addition, this section states that evidence from workplace-based assessments, referee reports, reports from external bodies (including employers) and Regulatory bodies will be considered by the CSIMGE. In accordance with AMC's 'Standards for Assessment of Specialist medical Graduate Programs and Professional Development Programs' the RANZCP is required to inform employers, and where appropriate the regulators, where patient safety concerns arise in assessment.

The RANZCP may not always become aware of patient safety concerns arising during assessments. Where those assessments are work-place-based, any concerns may be managed by the SIMG supervisor or DOT in accordance with any workplace and regulatory requirements and without notifying the RANZCP.

However, where the RANZCP does become aware of patient safety concerns through the assessment process, these concerns would be escalated up through the relevant committees for consideration, including the CFE, the CSIMGE and the EC as per usual governance process. It is noted that SIMGs are expected to comply with all relevant regulatory codes of conduct and the RANZCP Code of Ethics during their time on the Fellowship Pathway as per relevant sections of the Maintenance of Comparability Status on the Specialist Pathway policy.

Where the EC determines that it is appropriate to escalate the matter to an employer and/or regulatory body, having regard to all the relevant information and circumstances, the RANZCP Privacy Policy allows the RANZCP to make disclosures about these matters in certain circumstances. Alternatively, if disclosure is not provided for explicitly in the Privacy Policy, the RANZCP would seek consent from the SIMG to disclose these matters to the relevant regulator or employer as appropriate.

As per usual process, a SIMG would be provided with a chance to respond to any concerns raised by the Committee in accordance with procedural fairness and before any reports occur. There would also be appropriate focus placed on any support which the RANZCP could provide the SIMG during these matters being address by the relevant body.

The RANZCP notes that where concerns are raised with a RANZCP by a member of the public or patient in relation to a SIMG's performance, the RANZCP would refer that person to the relevant regulatory body directly to raise the matter or seek further advice, as the RANZCP does not have the authority to investigate complaints made by members of the public. Information regarding making a complaint to a regulatory body is provided on the RANZCP website (Complaints about psychiatrists | RANZCP).

10.3 Assessment decision

10.3.1 The education provider makes an assessment decision in line with the requirements of the assessment pathway.

Assessment decisions for SIMG candidates wishing to join the pathway

As previously described under standard 10.2.1 the comparability of a candidate is determined using the CAF. This score determines whether the applicant is Substantially Comparable, Partially Comparable or Not Comparable. The comparability decision is communicated to the applicant in the form of a final outcome letter and concurrent MBA Report 1 which are issued following paper-based assessment and interview by the Assessment Panel.

The Comparability Assessment criteria checklist (Appendix 10.1.2_2) follows the structure of the CAF, which is the assessment tool used to uniformly determine the comparability of a SIMG to an Australian / New Zealand trained psychiatrist. This checklist is provided as a self-assessment tool and should be used as a guide only to assist with the application process. This does not constitute the final eligibility of the assessment outcome.

In accordance with MBA Standards: Specialist medical college assessment of specialist international medical graduates, there are three possible outcomes of the RANZCP specialist assessment process:

- substantially comparable
- partially comparable
- not comparable.

Assessment decisions for SIMGs already on the specialist pathway: PCARP and SCARP

Responsible directly to the CSIMGE, the PCARP oversees the progress of each candidate on Partial Comparability pathway. It reviews all workplace-based assessments and other training requirements and ensures that summative assessments have been completed successfully in the specified time period. The PCARP's key responsibilities include:

- managing any candidate's unsatisfactory progress on the Partial Comparability pathway
- where required, confirming or not confirming a candidate's Partial Comparability status, documenting the outcome and providing a recommendation to the CSIMGE
- Undertaking quality assurance of 2012 Fellowship Program Specialist Pathway (Partial Comparability) requirements by providing CSIMGE with recommendations in relation to policy management and process.

Responsible directly to the CSIMGE, the SCARP oversees all assessments of candidates on the Substantial Comparability pathway. Based on this review, the SCARP makes a recommendation to CSIMGE to confirm/not confirm the candidate's Substantial Comparability status which leads to eligibility for Fellowship.

CSIMGE delegates the oversight of individual candidate progress in work-place assessments to SCARP. CSIMGE may also seek and /or accept advice from SCARP about SCP policy management, process and procedure. The SCARP's key responsibilities include:

- overseeing the progress of each candidate in a Substantial Comparability Placement through review of Supervisor and Employer reports, Case Based Discussion reports and MSF reports
- management of any candidate's unsatisfactory progress on the Substantial Comparability pathway
- where required, confirming or not confirming a candidate's Substantial Comparability status, documenting the outcome and providing a recommendation to the CSIMGE.
- recruitment, training and accreditation of Substantial Comparability assessors and supervisors
- monitoring the performance of Substantial Comparability assessors and supervisors

- undertaking quality assurance of assessor training by calibration activities, and of assessor function by audit, including direct observation
- undertaking quality assurance of Substantial Comparability assessments by providing CSIMGE with recommendations in relation to policy management and process.

SIMGs are required to undertake specific experiences and assessments to support their knowledge, behaviour, and skills in the area of cultural safety. These are outlined previously in this submission under standard 3.

10.3.2 The education provider grants exemption or credit to specialist international medical graduates towards completion of requirements based on the specialist medical program outcomes.

Applications made to the RANZCP for practice as a psychiatrist in Australia are assessed in three main aspects:

- specialist psychiatrist equivalence (training, qualification, and experience) to RANZCP
- supervision and upskilling requirements to be met, as evidenced by seniority, familiarity with practice in Australia, and any gaps in training and experience
- suitability for employment offered in a deemed AON (if applicable).

The outcome of the Comparability assessment determines the requirements necessary for admission to the Fellowship of the RANZCP. These requirements are less than the requirements of the Fellowship Program, and essentially provide credit or exemption through recognition of previous experience and training. The three comparability statuses, along with the requirements of the pathway are outlined below.

Not comparable

- Applicants assessed as Not Comparable, with a final CAF score of 20 or less, are not accepted onto the Specialist Pathway to RANZCP Fellowship. These applicants may choose to apply to the Fellowship Program and complete the full range of training and assessment. SIMG applicants may be considered Not Comparable for any one or more of the following reasons:
- not possessing a qualification in psychiatry which is recognised for specialist registration in that country
- not possessing a qualification which is the highest specialist qualification in the relevant country
- not possessing a qualification obtained through a clinical training program of at least three years duration
- requiring more than 12 months of additional training to meet the necessary standard.

Partially comparable

Applicants assessed as Partially Comparable, with a final CAF score of 21-28, are accepted onto the Partially Comparable pathway to RANZCP Fellowship. They are required to complete the following requirements of the RANZCP Fellowship pathway:

- a minimum of 24 months FTE time on the pathway
- four formative OCAs
- eight summative EPAs from Stage 3
- four summative end-of-rotation ITAs
- the OSCE
- the CEQ and MEQ examinations

- additional training and requirements:
    - o Psychotherapy: three patients for at least six sessions each (Stage 3 requirement)
    - o Leadership and Management training (Stage 3 requirement)
    - o Experience with Indigenous peoples - can only be gained in an Australasian setting. The assessment panel may exempt an applicant from this requirement if evidence of appropriate experience being gained in an Australasian setting is provided.
    - o Any other additional training and/or requirements identified by the assessment panel to rectify gaps in training. EPAs undertaken to rectify any gaps in training will be from Stage 2 of the 2012 Fellowship Program.

Any extensions beyond the 24 months will be considered by the CSIMGE on a case-by-case basis. Additional recognition of prior learning is available to partially comparable candidates who believe they may have prior experience in the areas listed above. The Recognition of Prior Learning policy is provided as Appendix 3.3.2.

Substantially comparable

SIMG applicants, with a final CAF of 29 or greater, and who meet the following eligibility criteria are accepted onto the Substantially Comparable pathway and must:

- provide confirmation of employment as a consultant/specialist psychiatrist within Australia or New Zealand for the required placement period, plus a position description
- hold current medical registration in Australia or New Zealand or be registered at the time of starting the placement
- be employed for at least 0.6 FTE in a suitable position and work at least 0.3 FTE in a clinical role
- have a statement of employer support for the full placement period and for all required WBAs, including support for external assessor access to relevant clinical files
- have nominated a supervisor who holds current accreditation as a RANZCP Substantial Comparability Supervisor
- have completed a three (3)-month job orientation period prior to starting the placement.

Feedback indicates that having a 3-month orientation period prior to commencing on the pathway has been received positively by both SIMG candidates and supervisors. This time helps SIMGs become familiar with the workplace, health service policies and procedures, the pathway requirements, and build a caseload to enable the completion of workplace requirements while on the pathway.

The Substantial Comparability pathway involves a series of workplace-based assessments, over a period of 12 months:

- four Case based Discussions – one formative and three summative
- three Supervisor Reports
- one Multi Source Feedback assessment.

Experience with Indigenous peoples in an Australasian setting may also be required if previous appropriate experience in an Australasian setting is not available upon assessment.

10.3.3 The education provider clearly documents any additional requirements such as peer review, supervised practice, assessment or formal examination and timelines for completing them.

The RANZCP clearly documents any additional requirements through the website, policy and the candidate's final outcome letter and accompanying MBA report which is issued within 2 weeks of interview. If timelines are extended or if additional supervision requirements are requested by candidate and employers, these are clearly documented in correspondence from the relevant committee to the individual SIMG applicant. This is further expanded under standard 10.3.4 and the flowchart in 10.1.

10.3.4 The education provider communicates the assessment outcomes to the applicant and the registration authority in a timely manner.

The RANZCP Specialist Pathway assessment dates and timeframes have been structured to align with the MBA's Standards: Specialist medical college assessment of specialist international medical graduates and performance benchmarks.

RANZCP staff provide a Specialist Pathway Final Assessment Outcome Letter, (defined by the Medical Board of Australia as the specialist recognition interim assessment) to the applicant via email within two weeks of their Specialist Pathway assessment interview. The letter is accompanied with a completed MBA Report 1 Assessment of international medical graduates Specialist pathway (specialist recognition) or MBA Report 1 Combined Report -Assessment of international medical graduates Specialist pathway (combined AON/specialist recognition) outlining the comparability assessment outcome and AON details if applicable , scope of practice, recommendations for supervision, supervised practice duration and any training and assessment requirements for completion. A copy of the letter and report are uploaded to the AMC portal for assessment applicant registration purposes.

If the Assessment Panel cannot reach a final decision based on the application submitted and information gained at the interview, advice can be sought from CSIMGE. In such cases, the applicant is advised by RANZCP staff that their application and assessment panel recommendations have been referred to the CSIMGE for final determination, informed of the committee meeting date, and advised that this will delay the outcome by a further two weeks. In the event that the CSIMGE is unable to reach a determination, cases may be referred to the Education Committee for advice.

Once the CSIMGE have reached their final determination, the applicant is issued with a Final Assessment Outcome letter indicating the comparability assessment outcome and training and assessment requirements and an accompanying MBA Report 1. In the case of not comparable assessment outcome, a CSIMGE assessment feedback letter is provided to the applicant outlining how their training and experience scored against each of the RANZCP CAF domains.

The RANZCP's process, as illustrated earlier under standard 10.1 in the flowchart, adheres to the Ahpra reporting requirements and key performance measures relating to time frames for decisions and assessments. The Ahpra report for 2021 is provided as Appendix 10.3.4.

To respond to the AMC's request, data relating to the applications and outcomes for specialist recognition for the period 2017 – 2021 are provided in Table 10.3.4. This Table includes only one New Zealand SIMG who has undertaken the pathway to Fellowship (marked with * in the Table).

Information related to the assessment of SIMG candidates by the VEAB is shown in the rows labelled "equivalent to or as satisfactory as" and "not equivalent to or as satisfactory as". The data represents both preliminary and final recommendations made by the VEAB to the MCNZ, and individuals may be counted twice, having had a preliminary and final recommendation. It is important to note that the MCNZ and not the RANZCP makes the final decision. The MCNZ may choose not to accept the recommendation of the VEAB.

Table 10.3.4. Applications and outcomes for specialist recognition 2017 – 2021

	2017		2018		2019		2020		2021	
	AUS	NZ	AUS	NZ	AUS	NZ	AUS	NZ	AUS	NZ
Total applicants	**81**	**0**	**71**	**0**	**83**	**2**	**71**	**0**	**50**	**0**
Specialist/vocational registration	62	0	61	0	75	2	65	0	48	0
Area of need	1	0	0	0	0	0	0	0	0	0
Combined Specialist Recognition and Area of need	21	0	10	0	9	0	6	0	2	0
Initial assessment	83	0	6	0	6	2	1	0	1	0
Second stage assessment	75	0	62	0	77	2	70	0	49	0
Assessment outcome:										
Not comparable	8	0	6	0	6	0	1	0	1	0
Partially comparable	32	0	36	0	31	0	36	0	25	0
Substantially comparable	42	0	26	0	48	0	34	0	23	0
In progress	12	0	0	0	0	0	0	0	1	0
Equivalent to or as satisfactory as (NZ)	NA	36	NA	29	NA	32	NA	37	NA	33
Not equivalent to or as satisfactory as (NZ)	NA	1	NA	3	NA	2	NA	1	NA	0
Completed requirements and admitted to fellowship	40	1	88	2	55	0	38	0	58	0

10.4 Communication with specialist international medical graduate applicants

10.4.1 The education provider provides clear and easily accessible information about the assessment requirements and fees, and any proposed changes to them.

The The RANZCP provides information regarding the Specialist Pathway assessment requirements and application process via the Applying for specialist assessment webpage.

This webpage is updated when there are changes to the process and describes the types of application fees. The page further links to the Forms and documents – overseas specialists web page where applicants can locate the 2022 fee schedule and the 2022 refund schedule. Both schedules are published on the website at the beginning of each year and outline all possible application and assessment fees and refund amounts applicable for new applicants and existing Specialist International Medical Graduates who have already entered the program.

10.4.2 The education provider provides timely and correct information to specialist international medical graduates about their progress through the assessment process.

RANZCP staff contact the applicant via email at relevant points within the Specialist Pathway application and assessment process:

- application acknowledgement email- issued to the applicant by RANZCP staff within 7 working days of receipt of their application for specialist assessment. The email notes the date of receipt and reminds the applicant of the relevant assessment dates and timeframes, assessment fees and assessment criteria information as noted on the RANZCP website. A copy of the Flowchart of specialist pathway and Area of Need application process which outlines the relevant steps and anticipated overall timeframe of the RANZCP specialist assessment process is attached to the email as well as a copy of the monthly National Assessment Panel dates for the applicants reference
- summary of Preliminary Review (SPR) Letter- issued to applicant by RANZCP staff within 3 weeks of paper-based assessment by the RANZCP Assessment Panel and before interview. The letter outlines the preliminary comparability information which the RANZCP Assessment Panel will use to make a final assessment decision and includes the interview date, time, and location
- Specialist Pathway Final Assessment Outcome Letter- sent to applicant, and the Australian Health Practitioner Regulation Agency (AHPRA) detailing scope of practice comparability outcome and training and assessment requirements. An e-copy of Report 1 or Combined Report 1 detailing the assessment outcome is sent to the applicant and AHPRA from the RANZCP.

Additional information requested by the AMC in its response to the 2021 Progress Report

In its response to the 2021 Progress Report, the AMC asked about the review of the CAF Due to COVID-19 and the associated focus on delivering essential assessments during 2021, work on the review of the CAF was temporarily paused. A working group is being established with the intent of commencing the review of the CAF during 2022. The scope of the project will include:

- a detailed review of the Standards: Specialist medical college assessment of specialist international medical graduates to assess impact on the RANZCP specialist pathway to Fellowship
- streamlining where possible the processes while still complying with the Standards
- review and revise the CAF scoring system

- revision of supporting resources, information and training materials to reflect any changes.

The draft TOR are provided as an Appendix 10.4.2 to this submission, and the project is anticipated to be completed by August of 2024.

Standard 10: Documents provided check list

Document
The web address and/or access to the information available to specialist international medical graduates seeking assessment by the provider. Information for specialist international medical graduates (SIMGs) who are seeking registration to practice as a psychiatrist in Australia and New Zealand is available via the Overseas specialist (Overseas specialists | RANZCP) and Applying for specialist assessment (Applying for specialist assessment | RANZCP) webpage.

Section B: Report on Quality Improvement Recommendations

College to report to the AMC assessment team in 2022 on any action it has taken to address the Quality Improvement Recommendation.

Quality Improvement Recommendations are suggestions for the education provider to consider. These are included in the accreditation report and are monitored in progress reports. The AMC is interested in how the College considers these, and what, if any, action occurs as a result.

Quality Improvement Recommendation	**Has the College undertaken any activities against this recommendation?** If yes, please describe below	**If no activities have occurred, will the College be considering this recommendation in the future?** If yes, please indicate below when the College is likely to consider the recommendation If no, please comment below on why the College has decided not to adopt the recommendation
Standard 1: The context of training and education		
Nil remain.		
Standard 2: The outcomes of specialist training and education		
Nil remain.		
Standard 3: The specialist medical training and education framework		
Nil remain.		
Standard 4: Teaching and learning approach and methods		
Nil remain.		
Standard 5: Assessment of learning		
Nil remain.		
Standard 6: Monitoring and evaluation		
Nil remain.		
Standard 7: Issues relating to trainees		
OO Consider including trainee representation with voting rights on the RANZCP Board to build trust with trainees (7.2.1) The RANZCP Board has appointed an Appointed Director, Trainee. This position has full voting rights.		
Standard 8: Implementing the program – delivery of education and accreditation of training sites		
Nil remain.		

Standard 9: Continuing professional development, further training and remediation
Nil remain.
Standard 10: Assessment of specialist international medical graduates
Nil remain.

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