

## **Guidelines for Assessment Review Panel (ARP) Processes and Decision-Making**

This document is intended to be used by Victorian Health Services to guide decision-making processes and methods of Prevocational Assessment Review Panels with the aim of enhancing state consistency.

### **ARP Processes**

The ARP workflow requires consideration to three phases. While there are varied approaches, determining role allocation and health service processes will support effective ARP meetings.

#### **Prior to meeting:**

1. Collation of information
2. Triage into discussion categories
3. Preparation of individuals for discussion
4. Distribution of information to ARP members

#### **At the meeting:**

1. Review Routine – for noting (may consider random audit for learning)
2. Review Intermediate and complex:
  - a. Present the information
  - b. Review compliance
  - c. Review competence
  - d. Make progression decision
  - e. Determine next steps – plan for progression
    - i. Outcomes and learning goals
    - ii. Assessment and time/compliance recommendations
3. Documentation of the outcomes needs to be maintained (individual and systems)

#### **After the meeting:**

1. Communication to Prevocational Doctor – consider a template for routine and progress. Add in verbal discussion for those requiring support or feedback.
2. Communication to Medical Education – will be responsible for monitoring and support.
3. Communication to Unit Supervisors – requirements for support.
4. Communication regarding systems or unit-based issues as required.
5. Reporting to committees as per ToR.

**These components are outlined in the following sections.**

## Decision-making workflow

The decision-making workflow of the panel should generally include the following:

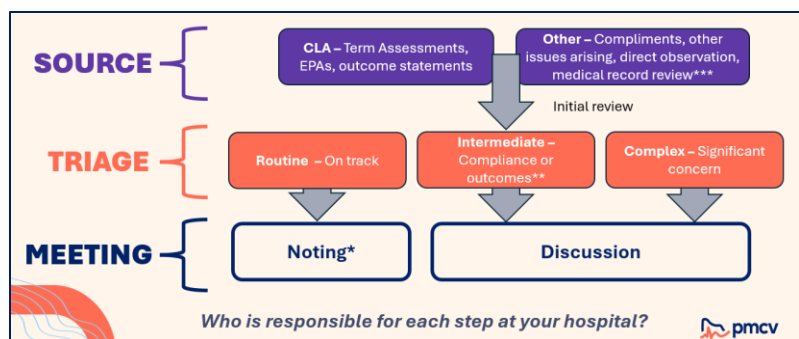
### 1. Collation of information – CLA and beyond

- ARPs collate and review written evidence including Term Assessments, EPA completion, and comments regarding compliments/concerns.
- The need for **written** (not just verbal) documentation is paramount to ensure procedural fairness and robustness.

### 2. Triaging cases

- Prior to the ARP meeting, cases can be triaged into ‘routine’, ‘intermediate’, or ‘complex’.

- Large hospitals (with large prevocational doctor cohorts) may have ‘routine’ cases as a ‘For Noting’ item only during panel discussions.
- Small hospitals may wish to discuss all trainees.



- Triaging guidance should be pre-defined by the ARP. Criteria may include:

- Routine – all assessments completed, all satisfactory or marked as 3+, no concerning comments
- Intermediate – any one of:
  - Non-compliant
  - Any domains marked as 1 or 2 in the Term Assessments
  - Borderline Global assessment
  - Levels marked OK, but comments raise concern
- Complex – concerns greater than intermediate

- The ARP will most commonly have an initial triage undertaken by the MEO or administration support with a DCT being involved for secondary triage where required.

### 3. Ensure compliance

- Ensure compliance with requirements (e.g., clinical experiences, adequate exposure, time, required assessments [EPAs, BoT/MT/EoT discussions]) – *this will be largely addressed through the CLA reports and initial year planning and should not add significantly to the meeting time.*
- Derives from regulation and guidance:
  - Medical Board of Australia’s ‘General Registration Standard’
  - AMC
  - PMCV
- See the **Table 1** for the Victorian approach to these areas

#### 4. Assess competence

- Assess competence compared to the AMC's **outcomes statements**, maintaining objectivity by focusing on written evidence over anecdotes.
- Group-based discussion and decision making (e.g., the Chair and 2 other ARP Members).
  - When a consensus is not reached, voting or the Chair's deciding vote may be used.
- A 'yes' or 'no' decision should be made before the remediation plan, including one of the following outcomes:
  - More information is required
  - Progress (no feedback required)
  - Progress (feedback required)
  - Delay progression (with feedback)
  - Refer to DMS/CMO

#### *A note on 'more information required'*

- As ARPs are developing, it is common to want more information. While understandable, if this approach is taken too frequently, then the timing and work of the ARP has the potential to become unwieldy. An alternate approach may be for the Chair to remind the panel that their role is to make a decision on the information they have in hand. Should the Prevocational Doctor feel that there was extra information that should have been considered, then this is the **role of an appeal**.
- Over time, the ARP may recommend feedback training for some supervisors or modify the triage approach to ensure adequate information is available ahead of time.

#### 5. Further steps

- Decisions and outcomes should be documented and communicated with relevant stakeholders (e.g., trainees, supervisors, committees).

##### a. Plan

ARPs may recommend remediation and advise on the general structure of remediation plans (e.g., needs more time, further EPAs, IPAP) but will often delegate detailed goal and action planning to Medical Education Units. Further ARP involvement may be required if there are high level or persisting concerns, or assistance/endorsement has been requested by the Medical Education Unit.

##### b. Documentation

Documentation should include decision and rationale (considering confidentiality and level of detail required) in addition to observations of any unit or quality issues. Documentation reported to other committees should not include identifiable information.

### c. Communication

Clear, confidential communication with prevocational doctors, supervisors, and relevant committees is crucial and may include:

- A templated letter or in-person communication (if support required) for prevocational doctors.
- Communication to unit supervisors regarding unit feedback, prevocational doctor requirements, and advice regarding who to feed back to in Medical Education Units.
- Unit quality and issues may be communicated to quality committees.
- Progression issues will need to be communicated to the CMO/DMS and/or to the MBA/AMC.

Hospitals are encouraged to develop templates for standardised feedback and ensure supervisors receive information for ongoing support.

### Appeals

- Robust, fair, and consistent appeal processes are necessary, with appeals generally returning to the original panel in the first instance.
- Ensuring all trainees receive fair and consistent assessment, with adequate documentation and opportunities for feedback is vital, especially given the potential for appeals or legal challenges.
- Appeals will occur and require:
  - Grounds for appeal
  - Clear processes
  - Clear escalation procedures
  - Alignment with health service policy
- Note that an appeal does not mean that the ARP should change their decision.

### Consistency versus discretion on compliance-related matters

- **Table 1** highlights components of decision-making that require consistency in all ARPs across Victorian health services.
- Reminders and support structures should be in place for both junior doctors and supervising units to meet compliance requirements, including:
  - Sending reminders to all prevocational doctors and unit staff when mandatory components are approaching.
  - Referring trainees early to the ARP if non-compliant and communicating to the prevocational doctor that they will not be able to progress unless mandatory components are completed.
  - Providing appropriate feedback to units and prevocational doctors if mandatory compliance components are not being completed (consider the responsibility of the unit to make these opportunities available and the responsibility of the prevocational doctor to ensure these are done).

**Table 1.** Components of ARP decision-making for consistency.

Component	Determination
<i>Clinical time</i>	<ul style="list-style-type: none"> <li>• Trainees must complete 47 weeks (of at least 38-hours) and gain adequate experience in required clinical areas.</li> <li>• The 47-week requirement:               <ul style="list-style-type: none"> <li>○ Already accounts for annual leave</li> <li>○ Can include professional development leave</li> <li>○ Can include up to 10-days of personal leave</li> <li>○ Is based on a 38-hour working week or equivalent (i.e., a 76-hour working week averaged over a fortnightly 7-on-7-off roster)</li> <li>○ <u>Cannot be 'made up' with overtime</u></li> </ul> </li> <li>• The ARP has discretion to 45-weeks in some cases.</li> </ul>
<i>Adequate Clinical exposure</i>	<ul style="list-style-type: none"> <li>• There are <u>no exemptions</u> to clinical exposure type (A, B, C, D), term distribution, and planner compliance.</li> <li>• Compliant years should be planned at the start of the year (watch out for swaps).</li> <li>• Appropriate clinical exposure is as defined by the AMC and Medical Board standards.</li> <li>• The PMCV accreditation committee has advised that a minimum of seven weeks per clinical exposure must be undertaken for adequacy.</li> <li>• ARPs may determine that the full 10 weeks is required based on the information provided.</li> </ul>
<i>BoT, MT, and EoT assessments</i>	<ul style="list-style-type: none"> <li>• Beginning, mid-term, and end-of-term assessments are mandatory and should be tracked and enforced.</li> <li>• Consistent expectations and reminders are essential for fairness and to maintain standards.</li> <li>• Without the full suite of Term Assessments, a prevocational doctor may have grounds to appeal a decision based on procedural fairness (i.e., Were they given the opportunity to improve?)</li> <li>• The Health Service may develop templated reminders to Prevocational Doctors and units on the expectations in the Professionalism Domain.</li> </ul>
<i>EPAs</i>	<ul style="list-style-type: none"> <li>• There is an AMC requirement for EPAs to be conducted 10 times per year, with at least 2 completed per term, and with senior clinician involvement for at least one. There needs to be consistent messaging that these <u>must</u> be completed both to the prevocational doctor and unit supervisors.</li> <li>• There can be some ARP discretion for a make-up plan in 2026 to ensure equity to the prevocational doctors and to ensure there is workload equity between units.</li> <li>• ARPs may wish to review the number of EPAs completed at each term and send clear information prevocational doctors and the unit if there is non-compliance. Non-compliant EPAs <u>must</u> be made up for (but consideration is needed regarding when and where these are made up).</li> <li>• At the time of the final ARP, prevocational doctors may not have completed the mandatory 10 EPAs. The recommendation is that the prevocational doctor should have completed at least 9 to this point (i.e., have done at least one in the last term) and prevocational doctors and units should be advised they will not progress until all mandatory EPAs have been completed.</li> </ul>
<i>Professionalism and/or patient safety concerns</i>	<ul style="list-style-type: none"> <li>• These concerns <u>must</u> be escalated with clear documentation and escalation processes in place.</li> </ul>