RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Capacity to Train Guidance

Final - 20/04/2023

Why this guidance?

For several years, the Royal Australasian College of Physicians (RACP) has identified concerns about capacity to train. The RACP had considered formulas to determine capacity to train, caps on training numbers and selection into training processes. These approaches were not progressed as they would not address the complexity of this issue. The RACP is choosing to use accreditation as the tool for monitoring training program capacity to train. This is to allow better consideration of both the qualitative and quantitative aspects at a setting which determines their capacity to deliver a training program to cohorts of trainees.

This guidance aims to support Basic Training programs address the accreditation standards and determine their capacity to train.

When you can utilise this Guidance

This guidance can be useful when:

- Establishing your capacity to train
- Prior to recruitment
- Discussions about changing capacity to train
- Monitoring training program performance
- Adding or modifying rotations
- Preparing for accreditation.

What is Capacity to Train?

Capacity to train equates to the number of trainees that can be trained to meet their respective training program requirements and ultimately meet the standard required to comply with the professional and education requirements of the RACP. These requirements ensure trainees, on entry to the profession, are competent and independent practitioners who perform their duties to a high standard and meet the expectations of the population they serve.

How does the RACP assess Capacity to Train?

The RACP does not set the maximum number of trainees allowed within each RACP Training Program delivered by a Training Provider. Instead, it monitors numbers of trainees and where required modifies the number when Training Provider accreditation standards are not met. For the Basic Training Program, Training Providers will need to meet all accreditations standards including the ones below.

Key document	Reference
Training Provider Standards	**3.3** The Training Provider has determined the numbers of trainees it has in relation to its capacity to resource training and ability to deliver work and training experiences that align with the curricula. **4.1 |** The training provider has a physician-led structure with the authority, time, funding, and staff to plan, administer and deliver physician training. **5.2** An educator has the capacity to train and lead.
Basic Training Accreditation Requirements Adult Internal Medicine (AIM) Paediatrics & Child Health (PCH)	**3.3.1** The number of Basic Trainees (BTs) allocated to a rotation does not exceed the rotation's capacity to train. **5.2.1** A Rotation Supervisor can supervise a maximum of three BTs and an Education Supervisor (ES) can supervise a maximum of five BTs at any one time. When a supervisor is both a Rotation and ES, the maximum number of trainees supported is six. **9.2.2** The Training Provider offers clinical examination placements equal to or greater than the number of trainees it has who are eligible for the clinical examination.

It is expected that trainees will meet all their Basic program training requirements within three years if they are working full time and progressing without interruptions or delays due to performance.

As part of the self-assessment process in advance of an external review, a Training Provider will provide their capacity to train for identified training programs. During the accreditation review, the RACP will assess the Training Provider's compliance statements for the Standards identified above, supporting documentation and feedback from interviewees and decide whether it agrees with the Training Provider's assessment.

How does a Training Provider assess its Capacity to Train?

To determine the maximum number of trainees a Training Provider should have in relation to its capacity, it considers: the capacity of each rotation and the training program.

What to consider when determining the capacity of a rotation?

When evaluating a rotation's capacity consider:

- For existing rotations, the maximum number of trainees currently placed into the rotation and how it is functioning from a trainee and educator perspective.
- Whether the learning environment is effective.
- Whether there is accessible, timely and supportive supervision.
- The breadth and depth of experiences and learning opportunities available in a rotation.
- Whether the rotation supervisors have the workload, trainee numbers (1 rotation supervisor for 3 Basic Training), time and resources to train.

What to consider when determining the capacity of a training program?

If you would like to review the capacity of a training program, then consider these:

Qualitative components:

- Resources to administer and deliver physician training.
- The breadth and depth of experiences which align to the curriculum and contribute to successful completion of the training program.
- Access to formal learning.
- Health and wellbeing of educators and trainees.
- Trainee performance and progression.
- Whether there is effective education supervision and training program leadership.
- Advice from the Training Program DPE.

Quantitative components

Maximum Number of RACP Registered Basic Trainees

Guidance	Worked example 1	Worked example 2
Step 1: Identify the number of trainees required for each rotation and sum them together to determine the total number of junior doctors required for clinical service.	St. Elsewhere has 3-month rotations. The general medicine and surgery rotation can have 4 trainees each, the relief and psychiatry rotation can each have 3 trainees each and the nephrology rotation can have 2 trainees. (4+4+3+3+2=16). The maximum number of junior doctors = **16**.	Bambino Hospital has 3-month rotations. General paediatrics can have 19 trainees, nights* and relief* can each have 10 trainees, Emergency Medicine can have 6 trainees, Neonatology can have 5 trainees. Allergy and Immunology, Developmental and Behavioural Paediatrics*, Endocrinology, Gastroenterology, Neurology, Medical Oncology, Paediatric Intensive Care Unit*, Psychiatry*, Respiratory Medicine, Surgery* each can have 2 trainees. Cardiology, Clinical Genetics, Haematology, Metabolic Medicine, Infectious Disease, Nephrology, Palliative medicine, Respiratory Medicine, Rheumatology, Sleep Medicine can each have one trainee. 19 + (2*10) + 6 + 5 + (2*10) + (10*1) = 80. The maximum number of junior doctors = **80**.
Step 2: Identify the capacity of the core rotations to determine the number of registered BTs in the training program. RACP registered BTs need to spend 67%1 of their time in core rotations.	The AIM Basic Training Program at St. Elsewhere has a training program delivery duration of 12 months. It has to offer a minimum of 8 months of core training. To achieve this College registered BTs at St Elsewhere, require 3 core rotations.	The PCH Basic Training Program at Bambino Hospital has a training program delivery duration of 36 months. It has to offer a minimum of 24 months core training. To achieve this College registered BTs at Bambino Hospital, require 8 core rotations.

[1] This percentage can be smaller if a training program can demonstrate a larger percentage of core training is being delivered by a training partner.

When there are multiple training programs using the same core rotation and bottle necks occur, determine a maximum number of trainees for each training program and use this number in determining the maximum number of RACP registered trainees.	Over a 12-month period, there are: 16 General Medicine rotations (=4*4) 16 Surgery rotations (=4*4) 12 Psychiatry rotations (=3*4) 12 Relief rotations (=3*4) 8 Nephrology rotations (=2*4). Total core rotations = 24 Total non-core rotations = 40 The maximum number of RACP registered AIM BTs is **8** (24/3). The number of non-RACP junior doctors is 8.	Over a three-year period, there are: 228 General Paediatrics rotations (=19*4*3) 120 Nights rotations (=10*4*3) 120 Relief rotations (=10*4*3) 72 Emergency medicine rotations (6*4*3) 60 Neonatology rotations (5*4*3) 252 Paediatric specialty rotations = (21*4*3) 96 non-core paediatric rotations = (8*4*3) Total core rotations = 612 Total non-core rotations = 336. The maximum number of RACP registered PCH Trainees is **76** (612/8). The number of non-RACP junior doctors is 4.
Step 3. Check the breadth of training opportunities available.	AIM BTs can complete a maximum of 6 months of general medicine within a single training program and 6 months in one medical specialty. At St Elsewhere, the training program offers six months of general medicine, 3 months in a medical specialty and 3 months of non-core training. The maximum number of RACP registered AIM BTs remains at **8**. The number of non-RACP junior doctors is 8.	PCH BTs require a minimum of 9 months of general paediatrics [3 rotations], and 3 months each [1 rotation] in emergency medicine, neonatology, and a paediatric specialty. At Bambino Hospital, the training program offers: 228 General Paediatrics rotations (228/3 = 76) 72 Emergency medicine rotations (72/1 = 72) 60 Neonatology rotations (60/1 = 60) 252 Paediatric specialty rotations (252/1 = 252). The capacity of the neonatology rotation would limit the maximum number of RACP registered PCH BTs to **60**. The number of non-RACP junior doctors is 20.

Divisional Clinical Exam[2] (DCE)

Guidance	Worked example
Every two exam places require one patient and one local examiner (known as a team). Identify the number of local examiners available to the training provider. (Examiners). Determine the number of candidate places. (Places). 2 Places = 1 Examiner. Training programs[3] offer candidate places in multiples of 4, starting with 8 places as a minimum.	A PCH Basic Training Program at St. Somewhere has 16 local examiners. The maximum number of DCE places available is 32.[4] Therefore, no more than 32 RACP registered BTs enter BPT 1 at St Somewhere.

Supervisor Support

Guidance	Worked example
Identify each Rotation Supervisor (RS) and the number of BTs assigned to them. Determine if any RS has more than 3 BTs. Identify each Education Supervisor (ES) and the number of BTs assigned to them (ES). Determine if any ES has more than 5 BTs. If the supervisor is a RS and ES, the maximum number of BTs assigned is 6.	A Geriatric Medicine rotation at Nowhere hospital has 6 BTs and 4 rotation supervisors. 2 supervisors are overseeing 2 BTs and 2 supervisors are overseeing 1 basic trainee each. This is line with ratio of trainees to supervisors. While an ES at Nowhere hospital has 6 BTs. This is over the ratio and Nowhere Hospital must address this. Options for addressing this include an additional ES, a trainee being redistributed to another ES or registered trainee numbers in the program being lowered by one, or non-RACP junior doctor replacing a registered trainee.

[2] For non-network principal BT programs and networks
[3] Training Programs with less than eight candidates need to demonstrate a training partner is providing sufficient places and examiners for their eligible trainees.
[4] There can be other reasons to reduce number of DCE places. The maximum number of DCE places determines the training numbers.

DPE Support

Guidance	Worked example
Review the trainee to DPE ratios contained in Appendix 1 of the Basic Training Accreditation Requirements and ensure they are being met.	A PCH Basic Training Program has 36 trainees and is not part of a Training Network[5]. The DPE should have at least 0.4 FTE of their time available for the DPE role.
Review the trainee to Training Provider Capacity to Train ratios contained in Appendix 1[6] of the Basic Training Accreditation Requirements and ensure they are being met.	An AIM Basic Training Program Network has 80 trainees. Therefore, the Basic Training Network should have access to a DPE with 0.6 FTE (may be a shared role) to support the networked training program.

How does the RACP review and monitor a Training Provider's Capacity to Train?

Each four-year accreditation cycle involves an external assessment and ongoing monitoring. This is where the training program and Setting are assessed to ensure an appropriate learning environment, sufficient supervision and an appropriate breadth and depth of experiences and learning opportunities which align to the curriculum. The information shown below provides an overall assessment of a Setting's Capacity to Train:

- Number of trainees in a training program
- Number of trainees supported by each rotation and education supervisor
- Number of trainees eligible for the Divisional Clinical Examination in comparison to the number of examiners and places offered for the Divisional Clinical Exam.
- Number of educators who have completed the Supervisor Professional Development Program
- Number of trainees linked to a DPE.

How does a Training Provider change its Capacity to Train?

Where a Training Provider's Capacity to Train circumstances have changed or it wishes to discuss its Capacity to Train, the Training Provider is required to inform and contact the RACP.

What happens if a Training Provider exceeds its Capacity to Train?

If the Training Provider identifies its Capacity to Train is under stated, the Training Provider notifies the RACP. An assessment of the change may be undertaken by the Accreditation Committee.

If it occurs during an accreditation review, the accreditation panel will identify if there are any compliance issues with the relevant Standard, inform the Training Provider of their assessment, and make a recommendation to the Accreditation Committee about what should happen. During

[5] Multiple Settings collaborating to deliver an integrated training program.
[6] Refer to the end of Standard 4 – Training Management webpage

the initial implementation phase, only recommendations will be placed against the Capacity to Train Criteria and requirements for the first cycle under the new Accreditation program. Conditions may be placed against the Criteria and Requirements from the second cycle of the accreditation program.

If someone other than a Training Provider notifies the RACP about a Capacity to Train concern, the Accreditation Committee may undertake an accreditation review. This process will be managed through the Change of Circumstance process or Managing a Reported Breach of Training Provider Standards process[7].

[7] Change of Circumstance and Managing a Reported Breach of Training Provider Standards will be implemented from mid-late 2022.